

**AGENDA ITEM SUMMARY**

**DATE:** 8/30/2011    **DEPARTMENT:** Administrative    **DEPT. HEAD SIGNATURE:** Heather Dawson

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**SUBJECT:**

Motion to ratify grant application for Idaho State Historical Society funding of \$2,500 toward the interpretive exhibits construction at the Hailey Welcome Center.

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**AUTHORITY:**  ID Code \_\_\_\_\_     IAR \_\_\_\_\_     City Ordinance/Code \_\_\_\_\_  
(IF APPLICABLE)

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**BACKGROUND/SUMMARY OF ALTERNATIVES CONSIDERED:**

After preparing a conceptual plan for the interpretive exhibits, Hailey plans to fabricate a portion of the exhibits in advance of the building opening in January, 2013. This grant application asks for \$2,500 toward that endeavor, which is also supported by \$2,500 in donated funds.

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**ACKNOWLEDGEMENT BY OTHER AFFECTED CITY DEPARTMENTS:** (IF APPLICABLE)

___ City Attorney	___ Clerk / Finance Director	___ Engineer	___ Building
___ Library	___ Planning	___ Fire Dept.	___ _____
___ Safety Committee	___ P & Z Commission	___ Police	___ _____
___ Streets	___ Public Works, Parks	___ Mayor	___ _____

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**RECOMMENDATION FROM APPLICABLE DEPARTMENT HEAD:**

Move to ratify grant application to Idaho State Historical Society, requesting \$2,500 for exhibits fabrication and installation.

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**FOLLOW-UP REMARKS:**

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Project Name: "Coming Together through Time" Exhibit  
Applicant Name: City of Hailey  
County: Blaine  
Contact: Tracy Anderson, 115 S Main St., Ste H, Hailey, ID 83333  
Ph: 208-788-4221, ext. 26 Fax: 208-788-2924  
[tracy.anderson@haileycityhall.org](mailto:tracy.anderson@haileycityhall.org)

Funding Requested: \$2,500

Proposal Summary: The Hailey Historic Preservation Commission (HPC) will install an exhibit at the Werthheimer Park Welcome Center. The exhibit will occupy a 630 square foot exhibit space and will tell the story of how the community has come together over and over again during the last 100 years to make something special happen at the Werthheimer Park site. The Hailey rodeo is a major part of the exhibit, with more than 60 years of site history.

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Tracy Anderson  
Grant Administrator

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Date

## Section 1. Project Summary

### Project Description

The City of Hailey Historic Preservation Commission (HPC) will install an exhibit at the Werthheimer Park Welcome Center. The exhibit will occupy a 630 square foot exhibit space and will tell the story of how the community has come together over and over again during the last 100 years to make something special happen at the Werthheimer Park site. Although the Hailey rodeo is a major part of the exhibit, with more than 60 years of site history, most of the Hailey community is unfamiliar with the story of the site prior to 1949. These early stories will also be included in the project, as will stories related to the site's current uses.

In 2010, the City of Hailey received an Idaho State Historical Society community grant to conduct the research for this project (Phase I). At the conclusion of the research, the city initiated the concept design for the exhibit (Phase II). The \$35,000 concept design was completed with the assistance of an Idaho Humanities Council grant, private donations and city funds (several sample sheets from the concept design are included as an attachment). The city is now ready to begin the final design, fabrication and installation of a portion of the exhibit (Phase III), in tandem with fundraising, and plans to continue with final design, fabrication and installation of the remaining portions of the exhibit (Phase IV) once fundraising is complete. Phase III, for which the city seeks funding in this application, will include implementing, at minimum, a welcome kiosk, several exhibit wall panels, an oral history component and a film footage component. This approach will allow the city to "make a beginning" and also provides a platform for continued fundraising for the project.

### Project Location

The project is located at the site of the new Werthheimer Park. Werthheimer Park (formerly referred to as the Hailey Rodeo Park) lies along Hailey's Main Street, as one enters Hailey proper from the south. This site is the location of Hailey's original rodeo arena. The old arena was structurally unsound and noncompliant with ADA requirements, leading to a new master plan for the rodeo grounds property that involved demolishing the old arena and building a new arena, building a Welcome Center, adding a separate ice rink facility, and expanding Hailey's existing world class skateboard park. The new arena and skateboard park expansion are complete. The ice rink facility is currently fundraising. The Welcome Center is under construction and will be complete in mid-September 2012.

The 1,731 square foot Welcome Center will serve two purposes. The Hailey Chamber of Commerce will occupy approximately two-thirds of the space; the other one-third is dedicated exhibit space. Please see the attached floor plan.

### Detailed Scope of Work

The primary objective of the overall project is to preserve, celebrate and communicate the rich history of community at the Werthheimer Park site. History, oral narratives, written literature, art, and folklore are the humanities disciplines that form the backbone of the project. The team has already collected numerous historic photographs, film footage, memorabilia, artifacts and oral histories to be used in the exhibit. A professional concept design has also been completed. The final exhibit will add layers of narrative and history to the site, giving the location depth and significance that will make it more than a recreational area.

Hailey anticipates completing the project in phases. Phases I and II are complete. Phase III will be based on the concept design and will include design, fabrication and installation of a welcome kiosk, three exhibit wall panels with photographs and text, and an oral history component. Film footage will also be edited for playback on a simple flat screen TV monitor. The goals in Phase III are to introduce the viewer to the overall exhibit concept, interpret some key components of the site history, and establish a foundation for raising further funds. A combination of Idaho State Historical Society community grant funds, city funds, and a matching donation would be used to support this Phase III.

Completion of Phase III will be celebrated with an open house, inviting the community to attend.

Key resources and team members for the project are the Sawtooth Rangers, the Blaine County Historical Museum, the Sun Valley Center for the Arts, the Community Library Association Regional History Department, the Hailey Chamber of Commerce, Hailey Ice, the Hailey Public Library and its Mallory Collection, Dr. Jenny Emery Davidson (Project Scholar) and Florence Blanchard (Project Historian).



### **Project Importance**

The Hailey community has deep cultural roots in both the Hailey rodeo and the larger story of this specific project site, and it is essential that the story of community development at the site be preserved and communicated. In the spring and summer of 2009, Madeline Buckendorf Consulting, LLC, performed an intensive-level survey and provided historic documentation for the Hailey rodeo grounds property. This survey was made possible by a CLG grant from the Idaho State Historic Preservation Office. The Historic Sites Inventory Report states that the rodeo grounds are “historically significant under Criterion A, for its role in recreation and entertainment in Blaine County, as well as its role in the community development of Hailey. The structures that function for the rodeo reflect the area’s longtime ranching history and nostalgia for “cowboy” traditions. It also exemplifies the role rodeo activities played in community development of Hailey during the twentieth century.” While it was determined that siting, safety and ADA issues precluded the preservation of the structure, Hailey city officials, the HPC and the Hailey community determined that the story of the site be told as a condition of building a new rodeo facility.

William T. Riley deeded the property to Hailey on June 5, 1903, marking the beginning of more than a century of cooperative efforts by the community to develop and maintain this centrally located property for the recreational and civic needs of the populace. In 1913, Leopold Werthheimer, a local shopkeeper, contributed \$1,000 for park improvements. The project research has uncovered little-known early history of the site, from its use by the community as a race track, baseball field and fairgrounds. In 1949, the Sawtooth Rangers founded the Hailey Rodeo, and the site’s long association with rodeo began (a use that continues to this day). In the 1990’s, the community joined together once again to build a world class skateboard park at this site, adjacent to the rodeo arena. The cooperative efforts of the community continued in the 2000’s, with a new master plan for the site encompassing the improvements stated earlier.

The Werthheimer Park site is not only a monument to the region’s ranching heritage by its strong connection with the Hailey Rodeo, it is also an important as a reminder of the cooperative community efforts that have helped shape Hailey’s history and development.

### **Lasting Legacy**

The exhibit will be an integral part of the new Welcome Center at Werthheimer Park. The stories, photographs, artifacts, memorabilia, oral histories and film footage will tell the story of how this particular geographic location has represented a focal point for community involvement and community pride. The exhibit is intended to provide a “lasting legacy” keeping alive the rich history and tradition that has been such an important part of this community.

### **Ensuring Historical/Cultural Accuracy**

The city conducted extensive research for the project (Phase I) to ensure historical and cultural accuracy. Florence Blanchard conducted the research, and remains part of the project team. In addition, HPC Chair, Dr. Rob Lonning, will assist in this area in his role as Project Director. Dr. Jenny Emery Davidson has been part of the project team from the beginning, and will continue to support the project during this phase as well. The oral histories for the project were conducted by the Community Library Association Regional History Department, an organization well-versed in work of this nature.

## **Section 2. Financial Need**

### **Grant Funds Are Critical to Overall Funding Package**

Acquiring Idaho State Historical Society community grant funds for Phase III is critical to the overall funding package for this project. The Welcome Center building is now being completed, using allocated funds from a bond that was approved by Hailey voters in 2010 to complete the site master plan infrastructure, including the new rodeo arena, the expanded skateboard park and the Welcome Center. The bond issue did not include funding for the exhibit.

Hailey has already expended nearly \$40,000 on the exhibit project for Phases I and II, including city staff time. The city has allocated an additional \$50,000 for the project in the FYE 2013 budget. This allocation must be leveraged with other funding to complete the exhibits in a high quality and professional manner.



Hailey will utilize \$2,500 from community donations as match to the Idaho State Historical Society community grant. In addition, the city will include \$2,500 in the budget for Phase III (from its FYE 2013 allocation), for a total budget for Phase III of \$7,500.

### **Grant Funds Allow for Project Completion**

The successful acquisition of Idaho State Historical Society community grant funds is essential to completing Phase III. This is a large exhibit project, with multiple sources of funding required. The receipt of a grant award is strategically important to success with other funding sources, and Hailey is confident of acquiring all funding necessary to complete the project.

### **Grant Funds are Part of a Larger Project**

While not all funding is in hand for the overall exhibit project, the city has a good start on securing the funding. A \$50,000 match challenge has been pledged; the donor will match each dollar raised with an equal amount, up to \$50,000. By completing the project in phases, with an eye towards developing portions of the project that will support fundraising, there is some likelihood that funding may be secured. Phase III can be implemented as a standalone project if necessary, and can be designed in that way. If no further funding is secured, the result of Phase III can stand alone.

## **Section 3. Collaboration**

### **Collaborator Roles**

**Sun Valley Center for the Arts:** Provide guidance and support in exhibit design and implementation. Provide support in text development.

**Blaine County Historical Museum:** Loan historical artifacts that would complement the exhibit displays. The museum has a large storage collection of photographs and artifacts that may be useful in the development of displays for the exhibit.

**Hailey Public Library:** Allow access/use of the Mallory Photographic Collection. The Mallory photographs are an important source of historical information and reproductions of the photographs may be incorporated into the exhibit.

**Sawtooth Rangers Riding Club:** Provide design review of exhibits to ensure accuracy.

**Hailey Ice:** Provide design review of exhibits to ensure accuracy.

**Hailey Chamber of Commerce:** Provide design review of exhibits as gauge of interest to tourists/visitors.

**Community Library Association Regional History Department:** Continue conducting oral histories that will become a key part of the exhibit.

### **Scholar Qualifications and Roles**

**Florence Blanchard, Project Historian:** Florence is the Project Historian. For the past 10 years, she has been a grants consultant and historical researcher for Idaho Heritage Trust, Technical Assistance program for historic preservation projects. From 1981-1983 she was the Project Director of "A Wood River Valley Legacy: The Hailey Centennial Photo Essay Project," supported by the Idaho Humanities Council. She holds a B.A. in English from the University of California, Northridge. Florence conducted the research for this project under a prior Idaho State Historical Society community grant. She will continue in the role of Project Historian for Phase III, assuring accuracy of the exhibit content. She will also assist with text development for the exhibit.

**Dr. Jenny Emery Davidson, Project Scholar:** Jenny holds a Ph.D. in American Studies from the University of Utah, Salt Lake City. Her fields of study include Literature and History of the American West, Environmental Literature and Regional Folklore. She is presently the Director of the College of Southern Idaho Blaine County Center and a board member of the Idaho Humanities Council. Jenny joined the exhibit project team during the research phase of the project. She has been involved in all aspects of project development, and will provide project support for Phase III.

## **Section 4. Anticipated Benefits**

### **Benefits to Hailey HPC and Preservation of Idaho's History and Culture**



Since its inception, the HPC has made steady progress in fulfilling its mission of promoting the historic, architectural, archaeological and cultural heritage, features and qualities of Hailey. With the successful conclusion of *Coming Together through Time*, the commission's reputation will be enhanced and the historic preservation program will be noticed and seen in a positive light, all leading to a greater ability to attract donations and compete for grant funding for additional preservation projects. The HPC is committed to completing this project with a high degree of professionalism.

Without this project, the history of the Werthheimer Park site, including the Hailey rodeo, has the potential to fade into anonymity. Newcomers who enjoy the new Werthheimer Park will have little, if any, idea of how the community came together at this site, over and over again, to shape the history of the town and the area. The exhibit will assist the HPC in better preserving this part of Idaho's history and culture.

**Benefits to the Community/Region/State and Lasting Legacy Benefits**

The project benefits the community by preserving an important part of its history, and making that history accessible to current and future generations of Hailey citizens and visitors.

Interpretive centers around the world are a kind of new-style museum, often associated with visitor centers, and located near cultural or historical sites. The Hailey Welcome Center's exhibits, entitled *Coming Together through Time*, will provide interactive and user-friendly displays to help visitors understand and connect with our community, intellectually and emotionally. A specific focus will be directed toward the community's use and development of the land surrounding the center, previously known as Werthheimer Park, as a metaphor of community reinventing itself through generations and various gathering activities in a beloved, downtown location. Hailey is unique in that this prime, downtown location also serves in preserving the history of an icon of western culture: the rodeo. Rodeo has played a large part in the rich history of towns throughout Idaho, including Hailey. Those who visit here from other parts of Idaho can learn from this exhibit for many years to come, and perhaps it will give these viewers pause to remember the rodeos of days gone by in their own home towns, or to cherish those rodeos that are still in operation.

The project benefits the community, region and state because it is a heritage tourism attraction. Hailey, as part of the larger Sun Valley area, relies on tourism as part of its economic base. The many tourists who already visit Idaho, the region or Hailey would have one more reason for visiting, or one more thing to do while they are here. And the ongoing development of heritage tourism assets throughout the state makes it more marketable as a tourist destination.

Stories that are not recorded will fade from collective memory. The original uses for the property, prior to the construction of the original rodeo arena more than 60 years ago, are already only vaguely remembered by a few. The exhibit will collect and share those stories for all future generations of Hailey citizens and visitors adding to the rich fabric of Hailey history.

**Section 5. Project Administration**

**Projected Project Timeline** The city will complete Phase III of the exhibit project well in advance of May 31, 2013. With the completion of the Welcome Center building scheduled for mid-September, the team is already planning the implementation of Phase III, and would like to conclude the majority of the work prior to the end of the year.

***Phase III***

Task 1	Project Management & Administration	10/1/12 – 2/28/13
Task 2	Select Photos & Write Text for Kiosk/Wall Panels	10/1/12 – 10/31/12
Task 3	RFQ/Select Graphic Designer	10/1/12 – 10/31/12
Task 4	Edit Film Footage	10/15/12 – 11/15/12
Task 5	Edit Oral Histories	10/15/12 – 11/15/12
Task 6	Design Kiosk/Wall Panels	11/1/12 – 11/15/12
Task 7	Acquire Fabricators	11/15/12 – 11/30/12
Task 8	Fabrication	11/30/12 – 12/15/12
Task 9	Installation	12/15/12 – 12/31/12
Task 10	Opening Celebration	January 2013



**Budget, Cash Match, In-Kind and Use of Grant Funds**

Item	Grant Funds	Hailey Cash Match	In Kind	Total
<b>Personnel</b>				
Project Manager (Volunteer) Rob Lonning 40 hrs @ \$25/hr	0	0	1,000	1,000
Grant Administrator (City Staff) Tracy Anderson 20 hrs @ \$28/hr	0	0	560	560
City Administration (City Staff) Heather Dawson 1% of Salary Time	0	0	1,000	1,000
<i>Subtotals</i>	0	0	2,560	2,560
<b>Tasks</b>				
Design Welcome Kiosk Content and Exhibit Wall Panels (Graphic Designer)	1,500	0	0	1,500
Write Text for Welcome Kiosk and Exhibit Wall Panels Volunteers 3 Team Members @ 15 hours each @ \$25/hr	0	0	1,125	1,125
Edit Film Footage (Contractor)	0	500	0	500
Edit Oral Histories (Volunteers) 1 Team Member @ 4 hours @ \$25/hr 1 Student @ 8 hours @ \$7.25/hr	0	0	158	158
Fabrication of Kiosk and Exhibit Wall Panels	1,000	3,350	0	4,350
Furnishings & Miscellaneous Supplies	0	1,000	0	1,000
Installation (Volunteers) 3 Team Members @ 8 hours each @ \$25/hr	0	0	600	600
Opening Celebration	0	150	0	150
<i>Subtotals</i>	2,500	5,000	1,883	9,383
<b>GRAND TOTALS</b>	<b>2,500</b>	<b>5,000</b>	<b>4,443</b>	<b>11,943</b>

**Administration and Management**

**Dr. Rob Lonning, Project Director**, is the current HPC Chair. He has nearly forty years of experience as an educator and has been involved with the HPC since its inception. During his tenure as chair of the HPC three historic buildings in Hailey have been added to the National Register of Historic Places and in 2009 he was co-director of a successful State Historic Records Advisory Board (SHRAB) grant that resulted in the digitization and uploading to the Internet of the historic Martyn Mallory Photographic Collection.

**Tracy Anderson, Hailey Grant Administrator**

Grant administration experience includes numerous grant projects from both federal and state agencies. In the last three years, responsible for the administration of approximately \$5 million dollars in grant awards. She has been with the City of Hailey for eight years.





Keith Petersen, State Historian/Associate Director  
Idaho State Historical Society  
North Idaho Office  
112 W 4<sup>th</sup> St., Suite #7  
Moscow, ID 83843

Dear Mr. Petersen:

The Hailey Chamber of Commerce is a collaborative partner with the City of Hailey for the new Hailey Rodeo Interpretive Center. The creation, procurement and appropriate display of exhibits are activities our community is working on to tell our story, today and yesterday.

The Chamber is a natural partner for the role of "providing design review of exhibits as gauge of interest to tourists and visitors." The environment of the space lends itself to have an appeal for a broad spectrum of interest, consisting of visitors as well as our local population, children and adults alike.

The collaborative process of working with others in the community is enriching and seems to create an enhanced finished product to benefit all involved.

The Hailey Chamber of Commerce supports this rewarding and worthwhile project.

Sincerely,

A handwritten signature in cursive script that reads "Geegee Lowe".

Geegee Lowe  
Hailey Chamber of Commerce

Hailey Chamber of Commerce  
706 S. Main Street  
P.O. Box 100 Hailey, Idaho 83333  
Phone: (208) 788-3484  
Fax: (208) 578-1595  
[www.hailevidaho.com](http://www.hailevidaho.com)



Keith Peterson, State Historian/Associate Director  
Idaho State Historical Society  
North Idaho Office  
112 w. 4<sup>th</sup> St., Suite #7  
Moscow, ID 83843

August 24, 2012

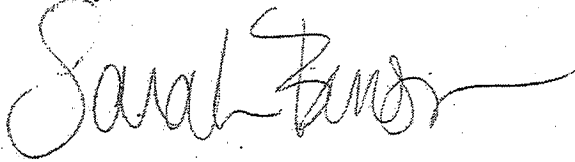
Dear Mr. Peterson,

Hailey Ice is writing to offer its support as a partner on the Werthheimer Park Welcome Center exhibit, *Coming together Through Time*. Hailey Ice became involved in the project during the concept design phase, and is excited to continue its support.

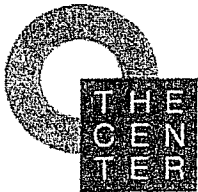
Hailey Ice is part of the history being made today at the Werthheimer Park site. The main message of the exhibit project states, "Werthheimer Park is at the heart of the community's identity, and has been for over 130 years. Again and again, the people of Hailey have come together to make something special happen at this site." Nothing could be truer regarding the evolution of the ice rink facility planned for this site. Ultimately, the ice rink will be built because the community cares enough to make it happen.

Hailey Ice is pleased to support the project by providing reviews of the proposed exhibit design to ensure that the Hailey Ice segment of the Werthheimer Park story is accurately told.

Sincerely,



Sarah Benson  
Executive Director Hailey Ice



August 23, 2012

Keith Petersen, State Historian/Associate Director  
Idaho State Historical Society  
North Idaho Office  
112 W 4<sup>th</sup> St., Suite #7  
Moscow, ID 83843

Dear Mr. Peterson,

I write in support of the Wertheimer Park (formerly Hailey Rodeo Park) exhibit project. I have served as a member of the steering committee for the project and believe it is being guided by a group of committed, thoughtful citizens who are motivated by love of community and a collective desire to celebrate history as a way to shape the future.

A great deal of work has been done to date to determine the best way to tell the story of this site in a way that is compelling for multiple and varied audiences. Photographs, artifacts and research has been gathered and codified and now we are poised and ready to build an exhibition. The Historical Society's assistance would be transformative and not only help us realize a portion of the installation but would also enable us to use that installation as a way to further develop the project.

I have been and will continue to be engaged as a member of the steering committee and have also offered my professional help as a curator with exhibit design, text development and installation options.

I hope you are able to support this very worthy project.

Sincerely,

Kristin Poole  
Co Executive Director and Artistic Director

Sun Valley Center for the Arts  
delivery: 191 Fifth Street East, Ketchum, ID 83340  
mailing: PO Box 656, Sun Valley, ID 83353  
[www.sunvalleycenter.org](http://www.sunvalleycenter.org) 208.726.9491

AGENDA ITEM SUMMARY

DATE: 8/30/2011 DEPARTMENT: Administrative DEPT. HEAD SIGNATURE: Heather Dawson

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**SUBJECT:**

Motion to authorize Resolution 2012-62, authorizing the mayor to sign the Plan document by which Meritain Health, acting third party administrator on behalf of the Idaho Independent Intergovernmental Authority (III-A), shall administer payments to employees for health claims, as approved by the City of Hailey to be in conformance with the previous plan document under Hailey's former insurer, Blue Cross of Idaho.

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**AUTHORITY:**  ID Code \_\_\_\_\_  IAR \_\_\_\_\_  City Ordinance/Code \_\_\_\_\_  
(IF APPLICABLE)

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**BACKGROUND/SUMMARY OF ALTERNATIVES CONSIDERED:**

The signature page of the attached will be amended prior to Thursday's meeting to reflect that Hailey is the signer, not III-A.

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**ACKNOWLEDGEMENT BY OTHER AFFECTED CITY DEPARTMENTS:** (IF APPLICABLE)

___ City Attorney	___ Clerk / Finance Director	___ Engineer	___ Building
___ Library	___ Planning	___ Fire Dept.	___ _____
___ Safety Committee	___ P & Z Commission	___ Police	___ _____
___ Streets	___ Public Works, Parks	___ Mayor	___ _____

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**RECOMMENDATION FROM APPLICABLE DEPARTMENT HEAD:**

Motion to authorize Resolution 2012-\_\_\_\_, authorizing the mayor to sign the Plan document by which Meritain Health, acting third party administrator on behalf of the Idaho Independent Intergovernmental Authority (III-A), shall administer payments to employees for health claims, as approved by the City of Hailey to be in conformance with the previous plan document under Hailey's former insurer, Blue Cross of Idaho.

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**FOLLOW-UP REMARKS:**

\*

**CITY OF HAILEY  
RESOLUTION NO. 2012-62**

**RESOLUTION OF THE CITY COUNCIL FOR THE CITY OF HAILEY  
AUTHORIZING THE EXECUTION OF AN INSURANCE PLAN WITH III-A, FOR  
MAJOR MEDICAL INSURANCE TERMS AND CONDITIONS FOR CITY  
EMPLOYEES.**

WHEREAS, the City of Hailey desires to enter into an agreement with the III-A under which the III-A will provide major medical insurance to Hailey City employees.

WHEREAS, the City of Hailey and the III-A have agreed to the terms and conditions of the agreement, a copy of which is attached hereto.

**NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF HAILEY, IDAHO,** that the City of Hailey approves the III-A Insurance Plan between the City of Hailey and the III-A and that the Mayor is authorized to execute the attached Application,

Passed this 30th day of August 2012.

City of Hailey

\_\_\_\_\_  
Fritz X. Haemmerle, Mayor

ATTEST:

\_\_\_\_\_  
Mary Cone, City Clerk

**Idaho Independent Intergovernmental Authority Trust  
A Self-Funded Health Plan  
(This is not insurance)**

**City of Hailey  
Group No.: 13533**

**Plan Document  
and  
Summary Plan Description**

**Effective: March 1, 2012**



P.O. Box 27267  
Minneapolis, MN 55427-0267  
(800) 925-2272  
[www.meritain.com](http://www.meritain.com)

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## ESTABLISHMENT OF THE PLAN

Idaho Independent Intergovernmental Authority Trust (the "Employer" or the "Plan Sponsor") has adopted this Plan Document and Summary Plan Description effective as of March 1, 2012 for the Idaho Independent Intergovernmental Authority Trust - A Self-Funded Health Plan (hereinafter referred to as the "Plan" or "Summary Plan Description"), as set forth herein for the exclusive benefit of its Employees and their eligible Dependents. Government entities who elect to participate in the Idaho Independent Intergovernmental Authority Trust are referred to in this document as "Employer" or "Your Employer." "Employee" refers to an Employee of an organizational member of the Idaho Independent Intergovernmental Authority Trust.

### Purpose of the Plan

The Idaho Independent Intergovernmental Authority Trust has established the Plan for your benefit and for the benefit of your eligible Dependents, on the terms and conditions described herein. The Idaho Independent Intergovernmental Authority Trust purpose in establishing the Plan is to help to protect you and your family by offsetting some of the financial problems that may arise from an Injury or Illness. To accomplish this purpose, the Idaho Independent Intergovernmental Authority Trust must attempt to control health care costs through effective plan design and the Plan Administrator must abide by the terms of the Plan Document and Summary Plan Description, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to manage their healthcare costs.

The Plan is not a contract of employment between you and your Employer and does not give you the right to be retained in the service of your Employer.

The purpose of this Plan is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses. This Plan is maintained by the Plan Administrator and may be inspected at any time during normal working hours by you or your eligible Dependents.

This Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any applicable collective bargaining agreement, as well as a list of Participating Employers, may be obtained, upon request and free of charge, by contacting the Plan Administrator during normal business hours.

### Adoption of this Plan Document and Summary Plan Description

The Idaho Independent Intergovernmental Authority Trust, as the settlor of the Plan, hereby adopts this Plan Document and Summary Plan Description (SPD) as the written description of the Plan. This Plan represents both the Plan Document and the Summary Plan Description. This Plan Document and SPD amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Idaho Independent Intergovernmental Authority Trust has caused this Plan Document and Summary Plan Description to be executed as of the date set forth below.

Idaho Independent Intergovernmental Authority Trust

Dated: \_\_\_\_\_

By: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

## GENERAL OVERVIEW OF THE PLAN

The Plan Administrator has entered into an agreement with Aetna PPO (the "Network"). This Network offers you health care services at discounted rates. Using a Network provider will normally result in a lower cost to the Plan as well as a lower cost to you. There is no requirement for anyone to seek care from a provider who participates in the Network. The choice of provider is entirely up to you.

Covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level when a:

- (1) Covered Person has an Emergency Medical Condition requiring immediate care.
- (2) Covered Person receives services by a Non-Participating Provider (e.g. anesthesiologists, radiologists, pathologists, etc.) who is under agreement with a Network facility.
- (3) Non-Participating Provider provides services at a Network facility.
- (4) Covered Person receives services from a Network surgeon who uses a non-Network Assistant Surgeon.
- (5) Participating Provider is not available within a 50-mile radius of the Network area.

Not all providers based in Network Hospitals or medical facilities are Participating Providers. It is important when you enter a Hospital or medical facility that you request that ALL Physician services be performed by Participating Providers. By doing this, you will always receive the greater Participating Provider level of benefits.

A current list of Participating Providers is available, without charge, through the Third Party Administrator at [www.meritain.com](http://www.meritain.com) or you may use the Network website address listed on the Employee identification card. If you do not have access to a computer at your home, you may contact your Employer or the Network at the phone number on the Employee identification card to obtain a paper copy of the Participating Providers available.

You have a free choice of any provider and you, together with your provider, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The Participating Providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any Participating Provider.

### **Costs**

You must pay for a certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Copay, Member Share and Plan Share percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum set by the Plan.

### **Plan Share**

Plan Share is the percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Plan Share a Covered Person is required to pay is the difference from what the Plan pays as shown in the Medical Schedule of Benefits and the total Covered Expense(s).

There may be differences in the Plan Share percentage payable by the Plan depending upon whether you are using a Participating Provider or a Non-Participating Provider. These payment levels are also shown in the Medical Schedule of Benefits.

### **Copay**

A Copay is the portion of the medical expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Member Share, Plan Share or Out-of-Pocket Maximum.

### **Member Share**

A Member Share is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan. The family Member Share maximum, as shown in the Medical Schedule of Benefits, is the maximum amount which must be Incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one (1) individual Member Share amount to a family Member Share.



If two (2) or more covered family members suffer injuries from the same Accident, only one Member Share will be applied to all charges incurred for the treatment of those injuries during the Calendar Year.

### **Out-of-Pocket Maximum**

An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum, if applicable, is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied; however each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of covered expenses for any Covered Person in the family during the remainder of that Calendar Year.

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

- (1) Copays, including Prescription Drug Copays.
- (2) The Member Share.
- (3) Precertification penalties.
- (4) Charges over Usual and Customary Charges for Non-Participating Providers.
- (5) Charges over a Maximum Benefit of the Plan.
- (6) Charges for non-covered services and supplies.

Reimbursement for these non-accumulating expenses will continue at the percentage payable shown in the Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not a Covered Expense. In addition, you must pay any expenses that are in excess of the Usual and Customary Charges for Non-Participating Providers and any penalties for failure to comply with requirements of the Medical Management Program section of the Plan or any other penalty that is otherwise stated in this Plan. You are responsible for charges incurred by you from a Non-Participating Provider that exceed the Usual and Customary Charges. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward your Out-of-Pocket Maximum.

Once you have paid the Out-of-Pocket Maximum for eligible expenses incurred during a Calendar Year, the Plan will reimburse additional eligible expenses incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact your Plan Administrator for assistance.

### **Integration of Member Shares and Out-of-Pocket Maximums**

If you use a combination of Participating Providers and Non-Participating Providers, your total Member Share amount and Out-of-Pocket Maximum amount required to be paid will not exceed the amount shown for Non-Participating Providers. In other words, the amount of the Member Share expense and Out-of-Pocket Maximum you pay for both Participating Providers and Non-Participating Providers will be combined and the total will not exceed the amount shown for Non-Participating Providers during a single Calendar Year.

## MEDICAL MANAGEMENT PROGRAM

You, your eligible Dependents or a representative acting on your behalf, must call the Medical Management Program Administrator to receive certification of Inpatient admissions (other than admissions for an Emergency Medical Condition), as well as other non-Emergency Services listed below. This call must be made at least 48 hours in advance of Inpatient admissions or receipt of the non-Emergency Services listed below. If the Inpatient admission is with respect to an Emergency Medical Condition, you must notify the Medical Management Program Administrator within 48 hours or if later, by the next business day after the Emergency Medical Condition admission. Failure to obtain precertification or notify the Medical Management Program Administrator within the time frame indicated above may result in eligible expenses being reduced or denied. Please refer to the penalty section below.

Medical Management is a program designed to help ensure that you and your eligible Dependents receive necessary and appropriate healthcare while avoiding unnecessary expenses. The program consists of:

- (1) Precertification of Medical Necessity. The following items and/or services must be precertified before any medical services are provided:
  - (a) Chemotherapy - all settings including services rendered in a Physician's office
  - (b) Dialysis - all settings including services rendered in a Physician's office
  - (c) Durable Medical Equipment – in excess of \$1,000
  - (d) Home health care, including IV home infusion therapy
  - (e) Hospice care
  - (f) Inpatient admissions, including inpatient admissions to a Skilled Nursing Facility, Extended Care Facility, Rehabilitation Facility, and inpatient admissions due to a Mental Disorder or Substance Use Disorder
  - (g) Radiation - all settings including services rendered in a Physician's office
  - (h) Imaging, limited to the following: CT/MRA/MRI/PET scans, scintimammography, capsule endoscopy and U.S. bone density (heel)
  - (i) Transplants
  - (j) Outpatient Surgical procedures in excess of \$1,000, excluding Surgery rendered in a Physician's office
- (2) Concurrent Review for continued length of stay and assistance with discharge planning activities.
- (3) Retrospective review for Medical Necessity where precertification is not obtained or the Medical Management Program Administrator is not notified.

### **Medical Management Does Not Guarantee Payment**

All benefits/payments are subject to the patient's eligibility for benefits under the Plan. For benefit payment, services rendered must be considered an eligible expense under the Plan and are subject to all other provisions of the Plan.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other healthcare provider.

### **How the Program Works**

#### **Precertification**

Before you or your eligible Dependents are admitted to a medical facility or receive items or services that require precertification on a non-Emergency Medical Condition basis (that is an Emergency Medical Condition is not involved), the Medical Management Program Administrator will, based on clinical information from the provider or facility, certify the care according to the Medical Management Program Administrator's policies and procedures.

The Medical Management Program is set in motion by a telephone call from you, the patient or a representative acting on your behalf or on behalf of the patient.

To allow for adequate processing of the request, contact the Medical Management Program Administrator at least 48 hours before receiving any item or service that requires precertification or an Inpatient admission for a Non-Emergency Medical Condition with the following information:

- (1) Name, identification number and date of birth of the patient;
- (2) The relationship of the patient to the covered Employee;
- (3) Name, identification number, address and telephone number of the covered Employee;
- (4) Name of Employer and group number;
- (5) Name, address, Tax ID # and telephone number of the admitting Physician;
- (6) Name, address, Tax ID # and telephone number of the medical facility with the proposed date of admission and proposed length of stay;
- (7) Proposed treatment plan; and
- (8) Diagnosis and/or admitting diagnosis.

If there is an Inpatient admission with respect to an Emergency Medical Condition, you, the patient or a representative acting on your behalf or on behalf of the patient, including, but not limited to, the Hospital or admitting Physician, must contact the Medical Management Program Administrator within 48 hours after the start of the confinement or on the next business day, whichever is later.

Hospital stays in connection with childbirth for either the mother or newborn may not be less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother.

You, the patient and the providers are NOT REQUIRED to obtain precertification for a maternity delivery admission, unless the stay extends past the applicable 48- or 96-hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified with the Medical Management Program Administrator or a penalty will be applied.

The Medical Management Program Administrator, in coordination with the facility and/or provider, will make a determination on the number of days certified based on the Medical Management Program Administrator's policies, procedures and guidelines. If the confinement will last longer than the number of days certified, a representative of the Physician or the facility must call the Medical Management Program Administrator before those extra days begin and obtain certification for the additional time. If the additional days are not requested and certified, room and board expenses will not be payable for any days beyond those certified.

If the patient does not obtain precertification for their Inpatient admission at least 48 hours in advance of the admission or notify the Medical Management Program Administrator within 48 hours after an Emergency Medical Condition admission or if precertification is obtained or notification received outside the time frames specified, eligible expenses may be reduced or denied. Please refer to the penalty section below.

#### **Penalty**

If you fail to obtain precertification or fail to notify the Medical Management Program Administrator within the time periods described above, benefits under the Plan will be reduced as follows:

- (1) Covered Expenses will be reduced by \$500 per occurrence and this penalty amount will not accumulate toward any Out-of-Pocket Maximum limit.

If the Plan's required review procedures are not followed, a retrospective review will be conducted by the Medical Management Program Administrator to determine if the services provided met all other Plan provisions and

requirements. If the review concludes the services were Medically Necessary and would have been approved had the required phone call been made, benefits will be considered, subject to the penalty outlined above. However, any charges not deemed Medically Necessary will be denied.

### **Concurrent Review, Discharge Planning**

Discharge planning needs is part of the Medical Management Program. The Medical Management Program Administrator will assist and coordinate the initial implementation of any services the patient will need post hospitalization with the attending Physician and the facility. If the attending Physician feels that it is Medically Necessary for a patient to stay in the medical care facility for a greater length of time than has been precertified, the attending Physician or the medical facility must request the additional service or days.

### **Concurrent Inpatient Review**

Once the Inpatient setting has been precertified, the on-going review of the course of treatment becomes the focus of the program. Working directly with your Physician, the Medical Management Program Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

### **To File a Complaint or Request an Appeal to a Non-Certification**

Verbal appeal requests and information regarding the appeal process should be directed to the Medical Management Program Administrator as identified on the General Information page of this Plan.

### **Case Management**

When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the patient's condition is diagnosed, the patient might need extensive services or might be able to be moved into another type of care setting, even to the patient's home.

Case management is a program whereby a Case Manager contacts the patient to obtain consent for case management services. The Case Manager monitors the patient and explores, discusses and recommends coordinated and/or alternate types of appropriate medical care. The Case Manager consults with the patient, family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient.

This plan of care may include some or all of the following:

- (1) Personal support to the patient;
- (2) Contacting the family to offer assistance and support;
- (3) Monitoring Hospital or skilled nursing care or home health care;
- (4) Determining alternative care options; and
- (5) Assisting in obtaining any necessary equipment and services.

Case management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The Case Manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan staff, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Medical Management will not interfere with your course of treatment or the Physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.

The Medical Management Program Administrator contact information for this Plan is identified on the Employee identification card and also on the General Information page of this Plan.

## MEDICAL SCHEDULE OF BENEFITS

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
<b>LIFETIME MAXIMUM BENEFIT</b>	Unlimited	
<b>CALENDAR YEAR MAXIMUM BENEFIT</b>	\$1,250,000	
<b>CALENDAR YEAR MEMBER SHARE</b>		
Single	\$1,000	\$1,000
Family	\$2,000	\$2,000
<b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM (excludes Member Share)</b>		
Single	\$1,500	\$3,000
Family	\$4,500	\$9,000
The Plan has a Pre-Existing Condition limitation. Please refer to the Pre-Existing Condition Limitation section for further details regarding coverage limitations and provisions for Creditable Coverage. This provision does not apply to any Covered Person under the age of 19.		
MEDICAL BENEFITS		
<b>Accident Related Dental Services</b> Dental services required as the result of an accidental injury. Services include, but are not limited to, crowns, caps, bridges, and root canals.	60% after Member Share	60% after Member Share
Combined Lifetime Maximum Benefit	\$1,000 per Member	
<b>Allergy Testing</b>	\$30 Copay, then 100%, Member Share waived	60% after Member Share
<b>Allergy Serum</b>	100%, Member Share waived	60% after Member Share
<b>Allergy Injections</b>	100%, Member Share waived	60% after Member Share
<b>Ambulance Services</b>	80% after Member Share	Paid at Participating Provider level of benefit
<b>Cardiac Rehabilitation &amp; Pulmonary Rehabilitation (Outpatient)</b>	80% after Member Share	60% after Member Share
Combined Calendar Year Maximum Benefit	18 visits	
<b>Chemotherapy (Outpatient)</b>	80% after Member Share	60% after Member Share
<b>Chiropractic Care/Spinal Manipulation</b>	\$30 Copay, then 100%, Member Share waived	\$30 Copay, then 100%, Member Share waived
Calendar Year Maximum Benefit	15 visits	
<b>Diabetic Education &amp; Self-Management</b>	\$30 Copay, then 100%, Member Share waived	60% after Member Share
Calendar Year Maximum Benefit	12 visits	

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>Diagnostic Testing, X-Ray and Lab Services (Outpatient)</b>	80% after Member Share	60% after Member Share
CT/MRA/MRI/PET scans, Scintimammography, Capsule Endoscopy, Sleep Studies and U.S. Bone Density	80% after Member Share	60% after Member Share
<b>Durable Medical Equipment (DME)</b>	80% after Member Share	60% after Member Share
Wheelchair Maximum Benefit	\$10,000 per wheelchair	
<b>Emergency Services – Emergency Medical Condition</b>	80% after Member Share	Paid at Participating Provider level of benefit
<b>Emergency Room – Non-Emergency Medical Condition</b>	\$100 Copay, then 80% after Member Share	\$100 Copay, then 80% after Member Share
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
<b>Foot Orthotics</b>	80% after Member Share	60% after Member Share
Lifetime Maximum Benefit	3 pairs of custom-molded orthotics	
<b>Genetic Testing and Counseling</b>	80% after Member Share	60% after Member Share
Calendar Year Maximum Benefit	1 counseling session and related testing	
<b>Hemodialysis (Outpatient)</b>	80% after Member Share	60% after Member Share
<b>Home Health Care</b>	80% after Member Share	60% after Member Share
Calendar Year Maximum Benefit	100 visits	
<b>Hospice Care</b>	80% after Member Share	60% after Member Share
<b>Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)</b>		
Inpatient	80% after Member Share	60% after Member Share
Room and Board Allowance*	Semi-Private Room rate*	Semi-Private Room rate*
Intensive Care Unit	80% after Member Share ICU/CCU Room rate	60% after Member Share ICU/CCU Room rate
Miscellaneous Services & Supplies	80% after Member Share	60% after Member Share
Inpatient Physiotherapy Services (Occupational Therapy, Physical Therapy, & Speech Therapy)	80% after Member Share	60% after Member Share
Combined Calendar Year Maximum-Benefit	90 days	
Outpatient	80% after Member Share	60% after Member Share
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
<b>IV Infusion Therapy</b>	80% after Member Share	60% after Member Share
<b>Maternity (Prenatal, Delivery and Postnatal)</b>	80% after Member Share	60% after Member Share
<b>Medical Supplies</b>	80%, Member Share waived	60%, Member Share waived

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>Mental Disorders and Substance Use Disorders</b>		
Member Share (Separate from Major Medical Member Share):		
Single	\$2,000	N/A
Family	\$4,000	N/A
Inpatient	60% after Mental/Substance Use Disorder Member Share	Not Covered
Calendar Year Maximum Benefit	10 Inpatient days (2 partial hospitalization days count as 1 Inpatient day)	
Outpatient	60% after Mental/Substance Use Disorder Member Share	Not Covered
Calendar Year Maximum Benefit	20 visits	
<b>Neuropsychological Testing</b>	60% after Member Share	60% after Member Share
<b>Outpatient Therapies</b> (e.g., occupational, physical, speech)		
Physician's Office	\$30 Copay, then 100%, Member Share waived	60% after Member Share
Outpatient Facility	80% after Member Share	60% after Member Share
Combined Calendar Year Maximum Benefit	20 visits	
<b>Physician's Services</b>		
Inpatient/Outpatient Services	80% after Member Share	60% after Member Share
Physician Office Visit:		
Office Visit Charge	\$30 Copay, then 100%, Member Share waived	60% after Member Share
All Other Services and Supplies Rendered During an Office Visit	80% after Member Share	60% after Member Share
Physician Office Surgery	80% after Member Share	60% after Member Share
<b>Preventive Services and Routine Care</b> (includes the office visit and any other eligible item or service received at the same time as the preventive service or routine care, whether billed at the same time or separately)	100%, Member Share waived	60% after Member Share
Immunizations: Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rotavirus, Rubella, Tetanus, Varicella (Chicken Pox), Hepatitis A, Meningococcal, Human papillomavirus (HPV) and Zoster. The specifically listed immunizations may be adjusted accordingly to coincide with federal government changes, updates and revisions.	100%, Member Share waived	100%, Member Share waived

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>Preventive Services and Routine Care (continued)</b> Immunizations (not specifically listed, when Medically Necessary) There are no benefits for travel immunizations.	80% after Member Share	60% after Member Share
<b>Prosthetics</b>	80% after Member Share	60% after Member Share
<b>Radiation Therapy (Outpatient)</b>	80% after Member Share	60% after Member Share
<b>Skilled Nursing Facility</b>	80% after Member Share	60% after Member Share
Calendar Year Maximum Benefit	90 days	
<b>Transplants</b>	80% after Member Share (Aetna IOE Facility only)*	Not Covered
Transportation and Lodging Maximum Benefit	\$10,000	
Transportation and Lodging Daily Limit	\$50 per person (\$100 maximum)	
* Organ transplant benefits will only be paid at the Participating Provider level if services are received at an Aetna IOE Facility (see the Aetna Institutes of Excellence (IOE) section of the Plan).		
<b>Urgent Care Facility</b>	80% after Member Share	60% after Member Share
<b>All Other Eligible Medical Expenses</b>	80% after Member Share	60% after Member Share



## PRESCRIPTION DRUG SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT
<b>Retail Pharmacy: 30-day supply</b>	
Generic Drug	\$10 Copay, then 100%
Preferred Drug	\$25 Copay, then 100%
Non-Preferred Drug	\$40 Copay, then 100%
<b>Mail Order Pharmacy: 90-day supply</b>	
Generic Drug	\$20 Copay, then 100%
Preferred Drug	\$50 Copay, then 100%
Non-Preferred Drug	\$80 Copay, then 100%

### Dispense as Written

The Plan requires Retail Pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug in addition to the Preferred or Non-Preferred Drug Copay. The Covered Person's share of the Prescription Drug cost does not apply toward the Plan's Out-of-Pocket Maximum.

## PRE-EXISTING CONDITION LIMITATION

A Pre-Existing Condition Limitation applies to all Employees and Dependents age 19 and older. A Pre-Existing Condition is defined as an Illness or Injury, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period prior to the individual's Enrollment Date.

No coverage is provided for expenses in connection with a Pre-Existing Condition.

Full Plan coverage will be available for such condition(s) on the day immediately following the expiration of 12 months after your Enrollment Date. You have the right to demonstrate any Creditable Coverage and the applicable period will be reduced by any Creditable Coverage unless it occurred before a Significant Break in Coverage.

The Pre-Existing Condition Limitation does not apply to:

- (1) Maternity benefits.
- (2) An Employee or Dependent under age 19.
- (3) Genetic Information provided there has been no diagnosis of a condition related to the Genetic Information.
- (4) Prescription Drugs purchased through the Prescription Drug Card program.

The length of the Pre-existing Condition Limitation may be reduced or eliminated if a Covered Person has Creditable Coverage provided there was not a Significant Break in Coverage. A Covered Person may request a Certificate of Creditable Coverage from their prior plan within 24 months of losing coverage. Certificates of Creditable Coverage should be submitted to the Plan Administrator and appropriate credit for time covered will be applied to the Pre-Existing Condition Limitation. A determination letter will be sent to the Covered Person, advising of the credit applied to any Pre-Existing Condition Limitation. The determination letter will also include an explanation of the Plan's appeals procedures and give you a reasonable opportunity to present additional evidence.

All questions about the Pre-Existing Condition Limitation and Creditable Coverage should be directed to the Plan Administrator as identified in the General Information section of the Plan.

### **Certificates of Creditable Coverage**

The Plan generally will automatically provide a Certificate of Creditable Coverage to anyone who loses coverage under the Plan. In addition, a Certificate of Creditable Coverage will be provided upon request at any time while the individual is covered under the Plan and up to 24 months after the individual loses coverage under the Plan.

The Plan will make reasonable efforts to collect information applicable to any Dependents and to include that information on the Certificate of Creditable Coverage, but the Plan will not issue an automatic Certificate of Creditable Coverage for Dependents until the Plan has reason to know that a Dependent has lost coverage under the Plan.

All questions about the Certificate of Creditable Coverage may be directed to the Plan Administrator. Refer to the General Information page.

## ELIGIBILITY FOR PARTICIPATION

### Employee Eligibility

A full-time Employee of the Employer who regularly works 32 or more hours per week will be eligible to enroll for coverage under this Plan once he/she completes a waiting period of 30 days from his/her first date of employment. Participation in the Plan will begin as of the first day of the month following completion of the waiting period provided all required election and enrollment forms are properly submitted to the Human Resources Department of the Participating Employer.

An Elected Official and Appointed Official will be eligible to enroll for coverage under this Plan as of his/her first date of employment. Participation in the Plan will begin as of the first day of the month following his/her first date of employment provided all required election and enrollment forms are properly submitted to the Human Resources Department of the Participating Employer.

You are not eligible to participate in the Plan if you are a part-time, temporary, leased or seasonal employee, an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency) or a person covered by a collective bargaining agreement that does not provide for participation in this Plan.

### Dependent Eligibility

Your Dependents are eligible for participation in this Plan provided he/she is:

- (1) Your Spouse.
- (2) Your Child until the end of the month in which he/she attains age 26.
- (3) Your Child age 26 or older, who is unable to be self supporting by reason of mental or physical handicap and is incapacitated, provided the child suffered such incapacity prior to the end of the month in which he/she attained age 26. Your Child must be unmarried and primarily dependent upon you for support. The Idaho Independent Intergovernmental Authority Trust may require subsequent proof of your Child's disability and dependency, including a Physician's statement certifying your Child's physical or mental incapacity.
- (4) A child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Administrator at no cost.

The below terms have the following meanings:

"Spouse" means a person of the opposite sex recognized as the covered Employee's husband or wife under the laws of the state where you live. Specifically excluded from this definition is a spouse by reason of common law marriage or a spouse of the same gender, whether or not permitted in your State. The Plan Administrator may require documentation proving a legal marital relationship.

"Child" means your natural born son, daughter, stepson, stepdaughter, legally adopted child (or a child placed with you in anticipation of adoption), or a child for whom you are the Legal Guardian. Coverage for a child for whom you are the Legal Guardian will remain in effect until such child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such child has attained age 18 (or any other applicable age of emancipation of minors). The term "Child" shall include a child of your Domestic Partner provided such child is unmarried, lives with you for more than one half of the calendar year and relies on you for more than one half of his or her support. The term "Child" shall include a child of your Domestic Partner.

"Child placed with you in anticipation of adoption" means a child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

"Legal Guardian" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree or other order of any court of competent jurisdiction.

### **When you and your Spouse are both Covered Employees**

When both you and your Spouse are covered Employees, each of you must choose coverage as either an Employee or as a Dependent. You may not be covered under this Plan as both an Employee and a Dependent.

### **Court Ordered Coverage for a Child**

Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below.

The Plan Administrator shall enroll for immediate coverage under this Plan any Child, who is the subject of a "qualified medical child support order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll you for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no child is eligible for Plan coverage, even if you are required to provide coverage for that child under the terms of a separation agreement or court order, unless the child is an eligible Child under this Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan Administrator.

### **Timely Enrollment**

Once you are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to your Human Resources Department within 30 days after satisfaction of the eligibility requirements. If you are required to contribute towards the cost of coverage you must complete and submit a payroll deduction authorization for the Plan Administrator to deduct the required contribution from your pay. In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your Dependents. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

Coverage under the Plan is subject to a Pre-Existing Condition Limitation. Please refer to the section entitled "Pre-Existing Condition Limitation" for more information.

If you fail to complete and submit the appropriate election and enrollment forms within the 30-day period described above, you will not be eligible to enroll in the Plan until the next open enrollment period or unless you experience a Special Enrollment Event or a Status Change Event.

### **Open Enrollment Period**

You and your Dependents may enroll for coverage during the Plan's open enrollment period, designated by the Plan Sponsor and communicated to you prior to such open enrollment period. During this time you will be permitted to make changes to any existing benefit elections. Benefit elections made during the open enrollment period will be effective as of October 1 and will remain in effect until the next open enrollment period unless you experience or your Dependent experiences a Special Enrollment Event or Status Change Event.

### **Late Enrollment**

If you did not enroll during your original 30-day eligibility period you may do so by making written application to the Plan Administrator during the annual open enrollment period (refer to annual open enrollment period section above). In these circumstances, you and/or your eligible Dependents will be considered Late Enrollees.

Late Enrollees are subject to the Plan's Pre-Existing Condition Limitation. This means that the Plan will not cover any expenses in connection with a Pre-Existing Condition for the first 12 months of coverage under the Plan. Please refer to the section entitled, "Pre-existing Condition Limitation" for more information.

### **Special Enrollment Event**

A special enrollment event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy or acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees.

Each special enrollment event is more fully described below:

- (1) **Loss of Other Coverage (other than under Medicaid or SCHIP).** If you declined enrollment for yourself or your Dependents (including your Spouse) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage for yourself and/or your Dependents under this Plan if the other health coverage is lost as a result of one of the following:
  - (a) The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;
  - (b) Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or
  - (c) Employer contributions cease for the other health coverage.

If you are already enrolled in a benefit option available under the Plan and your Dependent lost his or her other health coverage, you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent.

You must submit the appropriate election and enrollment forms to your Human Resources Department within 30 days after the date the other health coverage was lost. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to your Human Resources Department.

- (2) **Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy.** If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a State sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates or you or your Dependents become eligible for a State premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or after your or your Dependents' eligibility for a State assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to your Human Resources Department within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a State premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to your Human Resources Department.

- (3) **Acquisition of a New Dependent.** If you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents. You must submit the appropriate election and enrollment forms to your Human Resources Department within 30 days after the date you acquire such Dependent.
  - (a) Coverage becomes effective for a Dependent Child who is born after the date your coverage becomes effective as of such child's date of birth provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after the child's birth. Failure to enroll in the Plan within this 30-day period will result in no coverage under the Plan.

- (b) Coverage for a newly acquired Dependent due to marriage will be effective on the first day of the month coinciding with or immediately following the date of marriage provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after your date of marriage. Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan.
- (c) Coverage for a newly acquired Dependent due to adoption (or placement with you in anticipation of adoption) will be effective as of the date of adoption (or placement in anticipation of adoption) provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after adoption or placement in anticipation of adoption, as applicable. Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan.

### **Status Change Event**

Generally your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event (described above) or a Status Change Event. If a Status Change Event occurs you may make a new election under the Plan provided your new election is consistent with the Status Change Event. A Status Change Event includes the following:

- (1) A change in your legal marital status, including divorce, legal separation or annulment;
- (2) The death of your Spouse or Dependent Child;
- (3) Termination or commencement of employment by you, your Spouse or your Dependent Child that results in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;
- (4) A reduction or increase in your hours of employment or those of your Spouse or your Dependent Child, including a switch from part-time to full-time or commencement or return from an unpaid leave of absence, resulting in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;
- (5) A change due to your Dependent Child satisfying or ceasing to satisfy the requirements for Dependents under the Plan;
- (6) A change in the place of residence or work of you, your Spouse or your Dependent Child;
- (7) Entitlement to or loss of entitlement to Medicare or Medicaid by you, your Spouse or your Dependent Child;
- (8) Receipt of a Qualified Medical Child Support Order ("QMCSO") which requires that you provide the child named in the Order with health care coverage under the Plan. If the required coverage is different from your current coverage under the Plan, you may change your election accordingly;
- (9) A change due to you, your Spouse or your Dependent Child gaining coverage under another employer's plan;
- (10) A significant increase in the cost of your coverage under the Plan during the Plan Year. If the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose one of the following options: (a) maintain existing coverage and agree to pay the increased cost; (b) revoke your existing election and elect similar coverage under another Plan option (if any); or (c) drop coverage under the Plan, but only if there is no similar option available under the Plan;
- (11) Addition or significant improvement of a Plan option. If the Plan adds a new option or significantly improves an existing option, you may revoke your existing election and elect coverage under the new option. Any eligible Employee, regardless of whether or not he/she elected coverage under the Plan previously, may elect coverage under any new option or significantly improved option for himself or herself and any eligible Dependents;
- (12) Significant Curtailment of Coverage without Loss. If your coverage under the Plan is significantly curtailed without a loss of coverage (for example, a significant increase in the Out-of-Pocket maximum you are required to pay), you may revoke your existing election under the Plan and elect coverage under a similar Plan option, if any. If no similar option is available, then you must maintain your existing election until the end of the current Plan Year;

- (13) Significant Curtailment of Coverage with Loss. If your coverage under the Plan is significantly curtailed with a loss of coverage (for example, elimination of a benefit option under the Plan), then you may either revoke your existing election under the Plan and elect coverage under a similar Plan option (if any) or drop your existing coverage provided there is no similar Plan option available; and
- (14) Change in Election under another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including another plan maintained by the Employer or a plan maintained by the employer of your Spouse or Dependent Child) provided the election change satisfied the regulations under Code Section 125 regarding permitted election changes or the election is for a period of coverage under the plan maintained by the other employer which does not correspond to the Plan Year of this Plan.

You must submit the appropriate election and enrollment forms to your Human Resources Department within 30 days after the Status Change Event. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to your Human Resources Department.

## TERMINATION OF COVERAGE

### Termination of Employee Coverage

Coverage under the Plan will terminate on the earliest of the following dates:

- (1) The date the Plan terminates, in whole or in part;
- (2) If you fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;
- (3) The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained below;
- (4) The end of the month in which you cease to be eligible for coverage under the Plan;
- (5) The end of the month in which you terminate employment or cease to be included in an eligible class of Employees;
- (6) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; and
- (7) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

### Termination of Dependent Coverage

Coverage under the Plan will terminate on the earliest of the following dates:

- (1) The date the Plan terminates, in whole or in part;
- (2) The date the Plan discontinues coverage for Dependents;
- (3) The date your Dependent becomes covered as an Employee under the Plan;
- (4) The date coverage terminates for the Employee;
- (5) If you and/or your Dependents fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;
- (6) The date the Dependent Spouse reports to active military service;
- (7) The end of the month in which a Dependent ceases to be a Dependent as defined by the Plan;
- (8) The date your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud; and
- (9) The date your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.

### Retroactive Termination of Coverage

Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.



### **Rehire Provision**

After you become covered under the Plan, if your employment ends and you are rehired by the Employer within 90 days after your termination date, your coverage will take effect on the date you complete at least one hour of service with the Employer. The waiting period and the Pre-Existing Condition Limitation will be waived. If you were not covered under the Plan on the date of your termination or you are rehired by the Employer more than 90 days after your termination date, you will be treated as a new Employee and will be required to satisfy the waiting period and the Pre-Existing Condition Limitation will apply.

### **Continuation of Plan Coverage due to Approved Leave of Absence.**

Medical and prescription drug coverage will be continued by your Employer for you and your Dependents in the event of an approved leave of absence. Coverage will continue as follows:

- (1) In the event of an approved leave of absence, your coverage will continue for three (3) months.

If your leave qualifies under the Family and Medical Leave Act (FMLA), any continuation of coverage provided under this provision will run concurrent with FMLA.

Coverage under this provision will continue in accordance with the same terms and conditions of an active Employee and any period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

### **Continuation of Coverage under the Family and Medical Leave Act (FMLA)**

The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period. Failure to make required payments within 30 days of the due date established by your Employer will result in the termination of coverage for you and/or your eligible Dependents.

If you fail to return to work after the FMLA leave, the Employer may have the right to recover its contributions toward the cost of coverage during the FMLA leave.

If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for you and your covered Dependents if you return to work at the end of the FMLA leave.

### **Continuation of Coverage under State Family and Medical Leave Laws**

To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

### **Continuation of Coverage under USERRA**

You may elect to continue Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from work due to military service in the Uniformed Services (as defined under USERRA). You may elect to continue coverage for yourself and any of your Dependents that were covered under the Plan at the time of your leave. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.

To elect coverage under USERRA, you must submit your election to continue coverage under USERRA, on a form prescribed by the Plan Administrator to your Human Resources Department within 60 days after the date of your leave. Coverage under the Plan will become effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

If your leave is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you

remained an active Employee of the Employer. Your Employer will notify you of the procedures for making payments under this Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period or pre-existing condition exclusionary period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period or exclusionary period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

## ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made for services provided to the Covered Person and will be considered eligible only if the expenses are:

- (1) Routine care or preventive services provided such services are ordered and performed by a Physician and not otherwise excluded under the Plan; or
- (2) Due to Illness or Injury provided such services are ordered and performed by a Physician, Medically Necessary and not otherwise excluded under the Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses Incurred at a Participating Provider will be reimbursed to the provider.

- (1) **Allergy Services:** Allergy testing, serum and injections. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (2) **Ambulance Service:** Professional ground or air ambulance service to transport the Covered Person:
  - (a) To the nearest Hospital equipped to treat the specific Illness or Injury in an emergency situation; or
  - (b) To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the Covered Person; or
  - (c) To and from a Hospital during a period of Hospital confinement to another facility for special services which are not available at the first Hospital; or
  - (d) From the Hospital to the individual's home or to a convalescent facility when there is documentation the Covered Person required ambulance transportation.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (3) **Ambulatory Surgery Center:** Services and supplies provided by an Ambulatory Surgery Center.
- (4) **Anesthetics:** Anesthetics and their professional administration.
- (5) **Blood and Blood Derivatives:** Blood, blood plasma or blood components not donated or replaced.
- (6) **Cardiac Rehabilitation:** Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery or any other medical condition if medically appropriate; and (c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (7) **Chemotherapy:** Services and supplies related to chemotherapy. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (8) **Chiropractic Care/Spinal Manipulation:** Skeletal adjustments, manipulation or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (9) **Circumcision:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as part of the mother's expenses.

- (10) **Contraceptives:** Contraceptive procedures and medications, including, but not limited to: orals, patches, injections, diaphragms, intrauterine devices (IUD), implants and any related office visit. Some contraceptives may be available under the Prescription Drug Card program. The Plan does not cover contraceptive supplies or devices available without a Physician's prescription or contraceptives provided over-the-counter.
- (11) **Cosmetic Procedures/Reconstructive Surgery:** Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:
- (a) For the correction of a Congenital Anomaly for a Dependent Child.
  - (b) Any other Medically Necessary Surgery related to an Illness or Injury.
  - (c) Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:
    - (i) Reconstruction of the breast on which the mastectomy has been performed;
    - (ii) Surgery and reconstruction of the other breast to produce symmetrical appearance; and
    - (iii) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person.

- (12) **Dental Care:** Dental services and x-rays rendered by Dentist or dental surgeon for:
- (a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
  - (b) Emergency repair due to Injury to sound natural teeth within one (1) year of the Accident, including the replacement of sound natural teeth.
  - (c) Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
  - (d) Excision of benign bony growths of the jaw and hard palate.
  - (e) External incision and drainage of cellulitis.
  - (f) Incision of sensory sinuses, salivary glands or ducts.

General anesthesia and Hospital expenses are covered for eligible dental care services that would require the service be performed in a Hospital to monitor the patient due to a serious underlying medical condition, such as heart condition, blood disorder, etc. or is necessary due to accidental Injury to sound natural teeth.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (13) **Diabetic Education:** The following diabetic education and self-management programs: diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with diabetes. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (14) **Diagnostic Testing, X-ray and Laboratory Services:** Diagnostic testing, x-ray and laboratory services, including services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (15) **Durable Medical Equipment:** The rental of oxygen, wheelchairs, walkers, special Hospital beds, iron lungs and other Durable Medical Equipment subject to the following:
- (a) The equipment must be prescribed by a Physician and Medically Necessary; and
  - (b) The equipment will be provided on a rental basis; however such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item (oxygen equipment is not limited to the purchase price); and
  - (c) Benefits will be limited to standard models as determined by the Plan; and
  - (d) The Plan will pay benefits for only one of the following unless Medically Necessary due to growth of the Covered Person or if changes to the Covered Person's medical condition requires a different product, as determined by the Plan: a manual wheelchair, motorized wheelchair or motorized scooter; and
  - (e) If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered; and
  - (f) Expenses for the rental or purchase of any type of air conditioner, air purifier or any other device or appliance will not be considered eligible.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (16) **Emergency Services:** The Plan will pay the greater of the following amounts for Emergency Services received from Non-Participating Providers:
- (a) The amount negotiated with Participating Providers for Emergency Services provided, excluding any Copay or Plan Share that would be imposed if the service had been received from a Participating Provider. If there is more than one amount negotiated with Participating Providers for the Emergency Services provided the amount paid shall be the median of the negotiated amounts, excluding any Copay or Plan Share that would be imposed if the service had been received from a Participating Provider; or
  - (b) The amount for the Emergency Services calculated using the same method the Plan generally uses to determine payments for services provided by a Non-Participating Provider (such as Usual and Customary Charge), excluding any Copay or Plan Share that would be imposed if the service had been received from a Participating Provider; or
  - (c) The amount that would be paid under Medicare (Part A or Part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Services, excluding any Copay or Plan Share that would be imposed if the service had been received from a Participating Provider.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(17) **Family Counseling.**

- (18) **Foot Care:** Treatment for the following foot conditions: (a) bunions, when an open cutting operation is performed; (b) non-routine treatment of corns or calluses; (c) toenails when at least part of the nail root is removed; (d) any Medically Necessary Surgical Procedure required for a foot condition. In addition, orthopedic shoes when an integral part of a leg brace will be covered, as well as the initial purchase, fitting and repair of custom-fitted foot orthotics when determined to be Medically Necessary by the attending Physician are covered by the Plan. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (19) **Genetic Testing:** Diagnostic testing of Genetic Information and counseling when Medically Necessary. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(20) **Hemodialysis/Peritoneal Dialysis:** Treatment of a kidney disorder by hemodialysis or peritoneal dialysis as an Inpatient in a Hospital or other facility or for expenses in an outpatient facility or in the Covered Person's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person's home as shown under the Durable Medical Equipment benefit. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(21) **Home Health Care:** Services provided by a Home Health Care Agency to a Covered Person in the home. The following are considered eligible home health care services:

- (a) Home nursing care;
- (b) Services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);
- (c) Visits provided by a medical social worker (MSW);
- (d) Physical, occupational or speech therapy if provided by the Home Health Care Agency;
- (e) Medical supplies, drugs and medications prescribed by a Physician;
- (f) Laboratory services; and
- (g) Nutritional counseling by a licensed dietician.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each four (4) hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, transportation services, housekeeping services and meals, etc., be considered an eligible expense.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(22) **Hospice Care:** Hospice care on either an inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of six months or less.

Covered services include:

- (a) Room and board charges by the Hospice.
- (b) Other Medically Necessary services and supplies.
- (c) Nursing care by or under the supervision of a registered nurse (R.N.).
- (d) Home health care services furnished in the patient's home by a Home Health Care Agency for the following:
  - (i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and
  - (ii) physical and speech therapy.
- (e) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits

(23) **Hospital Services or Long-Term Acute Care Facility/Hospital:**

(a) Inpatient

Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital. Care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units).

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

(b) Outpatient

Services and supplies furnished while being treated on an outpatient basis.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(24) **Infertility Testing:** Diagnosis and testing of infertility (the inability to conceive). However, treatment, drugs or procedures for the promotion of conception will not be considered eligible (e.g., invitro fertilization, GIFT, artificial insemination, etc).

(25) **IV Infusion Therapy:** Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(26) **Lenses:** Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages.

(27) **Maternity:** Expenses Incurred by an Employee or a Dependent Spouse for:

(a) Pregnancy.

(b) Services provided by a Birthing Center.

(c) One (1) amniocentesis test per Pregnancy.

(d) Up to two (2) ultrasounds per Pregnancy (more than 2 only when determined Medically Necessary).

Elective induced abortions in the case of fetal abnormality. Elective induced abortions will also be covered for any Covered Person when carrying the fetus to full term would seriously endanger the life of the mother. If complications arise after the performance of any abortion for any Covered Person, any expenses incurred to treat those complications will be eligible, whether the abortion was eligible or not.

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission, unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified or a penalty may be applied.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(28) **Medical and Surgical Supplies:** Casts, splints, trusses, braces, crutches, orthotics, dressings and other Medically Necessary supplies ordered by a Physician. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(29) **Mental Disorders:** Covered charges for care, supplies and treatment of a Mental Disorder including, but not limited to treatment for autism, ADD and ADHD. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (30) **Nutritional Counseling.**
- (31) **Occupational Therapy:** Rehabilitative occupational therapy rendered by a qualified Physician or a licensed occupational therapist under the recommendation of a Physician. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (32) **Outpatient Pre-Admission Testing:** Outpatient pre-admission testing performed within seven (7) days of a scheduled Inpatient hospitalization or Surgery.
- (33) **Physical Therapy:** Physical therapy rendered by a qualified Physician or a licensed physical therapist under the recommendation of a Physician. Maintenance Therapy will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (34) **Physician Services:** Services of a Physician for medical care or Surgery.
  - (a) Services performed in a Physician's office on the same day for the same or related diagnosis. Services include, but are not limited to: examinations, x-ray and laboratory tests (including the reading or processing of the tests), supplies, injections, cast application and minor Surgery.
  - (b) For multiple or bilateral surgeries performed during the same operative session which are not incidental or not part of some other procedure and which add significant time or complexity (all as determined by the Plan) to the complete procedure, the charge considered will be: (i) 100% for the primary procedure; (ii) 50% for the secondary procedure, including any bilateral procedure; and (iii) 50% for each additional covered procedure. This applies to all Surgical Procedures, except as determined by the Plan.

For surgical assistance by an Assistant Surgeon, the charge will be 20% of the Usual and Customary Charge for the corresponding Surgery.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (35) **Preventive Services and Routine Care:** The following Preventive Services and Routine Care are paid as shown in the Medical Schedule of Benefits:
  - (a) Preventive Services
    - (i) Evidence-Based Preventive Services
 

Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (the "Task Force") with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the Task Force issued in 2002 will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.
    - (ii) Routine Vaccines
 

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
    - (iii) Prevention for Children
 

With Respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.



(iv) Prevention for Women

With respect to women, such additional preventive care and screenings, not otherwise addressed by the Task Force, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at: <http://www.healthcare.gov/center/regulations/prevention/recommendations.html>. For a paper copy, please contact the Plan Administrator.

**Note: Certain preventive medications will be covered under the Prescription Drug Card Program; please contact the Prescription Drug Card Program Administrator for a list of medications.**

(b) Routine Care

Routine care including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or inoculations, well child care, pap smears, mammograms, colon exams and PSA testing. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other illness.

The above routine care items are covered in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan.

- (36) **Prosthetic Devices:** Artificial limbs, eyes or other prosthetic devices when necessary due to an illness or injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (37) **Pulmonary Therapy:** Pulmonary therapy under the recommendation of a Physician. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (38) **Radiation Therapy:** Radium and radioactive isotope therapy treatment. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (39) **Reconstructive Surgery:** See Cosmetic Procedures/Reconstructive Surgery.
- (40) **Rehabilitation Facility:** Inpatient care in a Rehabilitation Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and (c) is not for Custodial Care.

See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (41) **Routine Newborn Care:** Routine newborn care including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the mother's expense.

If the newborn is ill, suffers an injury or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense.

- (42) **Second Surgical Opinion:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.

If the second opinion conflicts with the first opinion, the Covered Person may obtain a third opinion, although this is not required.

- (43) **Skilled Nursing Facility:** Skilled nursing care in a Skilled Nursing Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (c) is not for Custodial Care.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (44) **Sleep Disorders:** Sleep disorder treatment that is Medically Necessary.
- (45) **Speech Therapy:** Restorative or rehabilitative speech therapy rendered by a qualified Physician or a licensed speech therapist under the recommendation of a Physician, necessary because of loss or impairment due to an illness, injury or surgery or therapy to correct a Congenital Anomaly. Speech therapy for developmental delay or to change voice sound will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (46) **Sterilization:** Elective sterilization procedures (this does not include reversal of sterilization).
- (47) **Substance Use Disorders:** Charges for care, supplies and treatment of a Substance Use Disorder, including smoking cessation. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (48) **Transplants:** See the Aetna Institute of Excellence section of the Plan with respect to transplant coverage.
- (49) **Urgent Care Facility:** Services and supplies provided by an Urgent Care Facility. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

## AETNA INSTITUTE OF EXCELLENCE (IOE)

The Institute of Excellence (IOE) is a facility that contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

### Transplant Expenses

Once it has been determined that you or one of your eligible Dependents may require an organ transplant, you or your Physician must call the Medical Management Program Administrator to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements. Organ means solid organ; stem cell; bone marrow and tissue.

Benefits may vary if an IOE facility or a non-IOE facility is used. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered at the Participating Provider level only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that are provided by a facility that is not specified as an IOE network facility, even if the facility is considered a Participating Provider for other types of services, will be covered at the Non-Participating Provider level. Please read each section below carefully.

### Covered Transplant Expenses

Covered transplant expenses include the following:

- (1) Charges for activating the donor search process with national registries.
- (2) Compatibility testing of prospective organ donors that are immediate family member. For purposes of this section an "immediate" family member is defined as a first-degree biological relative. These are your biological parent, sibling or child.
- (3) Inpatient and outpatient expenses directly related to a transplant.
- (4) Charges made by a Physician or a transplant team.
- (5) Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- (6) Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant services are typically Incurred during the four (4) phases of transplant care described below. Expenses Incurred for one transplant during these four (4) phases of care will be considered one (1) transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date the patient is discharged from the Hospital or outpatient facility for the admission or visits related to the transplant, whichever is later.

The four (4) phases of one (1) transplant occurrence and a summary of covered transplant expense during each phase are as follows:

- (1) Pre-transplant evaluation/screening. Pre-transplant evaluation screening includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
- (2) Pre-transplant candidacy screening. Pre-transplant candidacy screening includes Human Leukocyte Antigen (HLA) typing/compatibility testing of prospective organ donors that are immediate family members.

- (3) Transplant event. A transplant event includes Inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your Inpatient stay or outpatient visits, including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your Inpatient stay or outpatient visits; cadaveric and live donor procurement.
- (4) Follow-up care. Follow-up care includes all covered transplant expenses; home health care services; home infusion services and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

#### **One (1) Transplant Occurrence**

The following are considered one (1) transplant occurrence:

- (1) Heart.
- (2) Lung.
- (3) Heart/Lung.
- (4) Simultaneous Pancreas Kidney (SPK).
- (5) Pancreas.
- (6) Kidney.
- (7) Liver.
- (8) Intestine.
- (9) Bone marrow/stem cell transplant.
- (10) Multiple organs replaced during one (1) transplant surgery.
- (11) Tandem transplants (stem cell).
- (12) Sequential transplants.
- (13) Re-transplant of same organ type within 180 days of first transplant.
- (14) Any other single organ transplant, unless otherwise excluded under the Plan.

#### **More Than One (1) Transplant Occurrence**

The following are considered more than (1) transplant occurrence:

- (1) Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant).
- (2) Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).
- (3) Re-transplant after 180 days of the first transplant.
- (4) Pancreas transplant following a kidney transplant.
- (5) A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- (6) More than one (1) transplant when not performed as part of a planned tandem or sequential transplant (i.e. a liver transplant with subsequent heart transplant).

**Limitations**

Transplant coverage does not include charges for the following:

- (1) Outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.
- (2) Services and supplies furnished to a donor when recipient is not a Covered Person.
- (3) Home infusion therapy after the transplant occurrence.
- (4) Harvesting or storage of organs without the expectation of immediate transplant for an existing illness.
- (5) Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
- (6) Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

**Travel and Lodging Expenses**

Travel and lodging expenses will be covered under the Plan subject to the conditions described below.

- (1) Distance requirement. The IOE facility must be more than 100 miles away from the patient's residence.
- (2) Travel allowances. Travel is reimbursed between the patient's home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll cost will be reimbursed. Mileage reimbursement is \$.14 per mile.
- (3) Lodging allowances. Reimbursement of expenses incurred by the patient and any companion for hotel lodging away from home is reimbursed at a rate of \$50 per night, per person to a maximum of \$100 per night.
- (4) Overall maximum. Travel and lodging reimbursement is limited to \$10,000 for any one (1) transplant or procedure type, including tandem transplants. This is a combined maximum for the patient, companion and donor.
- (5) Companions. One (1) companion is permitted per adult and one (1) parent or guardian is permitted per Child

## ALTERNATIVE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternative treatment plan, in which case those charges incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative treatment plan is Medically Necessary and cost effective. If the Plan elects to provide alternative treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

## GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

- (1) **Abortions:** Expenses related to elective abortions will not be considered eligible, except as specified under the Maternity benefit under Eligible Medical Expenses.
- (2) **Acupuncture:** Expenses for acupuncture will not be considered eligible.
- (3) **Adoption:** Expenses related to adoption will not be considered eligible.
- (4) **Biofeedback:** Expenses related to biofeedback will not be considered eligible.
- (5) **Close Relative:** Expenses for services, care or supplies provided by a Close Relative will not be considered eligible.
- (6) **Cognitive and Kinetic Therapy:** Expenses for cognitive therapy and kinetic therapy will not be considered eligible. Cognitive therapy is defined as therapy which embraces mental activities associated with thinking, learning and memory. Kinetic therapy is defined as therapy related to motion or movement (e.g., the study of motion, acceleration or rate of change). This exclusion will not apply to expenses related to a neurological brain impairment resulting from an acute major illness or the diagnosis, testing and treatment of ADD or ADHD.
- (7) **Complications:** Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan will not be considered eligible, except complications from abortions as specified under Eligible Medical Expenses.
- (8) **Convenience Items:** Expenses for personal hygiene and convenience items will not be considered eligible.
- (9) **Cosmetic Procedures:** Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under Eligible Medical Expenses.
- (10) **Counseling:** Expenses for religious, marital, bereavement or relationship counseling will not be considered eligible, except as specified under Eligible Medical Expenses.
- (11) **Coverage Under Other Plans:** Expenses for treatment for which the Covered Person is also eligible for benefits under any other group insurance or service plan through any employer (see Coordination of Benefits section); or the medical payment or personal injury sections of automobile, casualty or liability insurance regardless of whether such policy is owned by the Covered Person or some other party (see Subrogation, Third Party Recovery and Reimbursement section); will not be considered eligible.
- (12) **Custodial Care:** Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.
- (13) **Dental Care:** Expenses incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified under Eligible Medical Expenses. Removal of impacted teeth will not be considered eligible.
- (14) **Developmental Delays:** Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, occupational therapy, physical therapy and any related diagnostic testing will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.
- (15) **Exercise Programs:** Exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

- (16) **Experimental and/or Investigational:** Expenses for treatment, procedures, devices, drugs or medicines which are determined to be Experimental and/or Investigational will not be considered eligible.
- (17) **Foot Care:** Expenses for routine foot care, treatment of weak, unstable or flat feet will not be considered eligible.
- (18) **Gambling Addiction:** Expenses for services related to gambling addiction will not be considered eligible.
- (19) **Governmental Agency:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).
- (20) **Hair Loss:** Expenses for hair loss or hair transplants will not be considered eligible.
- (21) **Hearing Exams/Aids:** Expenses for routine hearing examinations, hearing aids (including the fitting thereof) and supplies will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.
- (22) **Homeopathic Treatment:** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.
- (23) **Hypnotherapy:** Expenses for hypnotherapy will not be considered eligible.
- (24) **Illegal Occupation/Felony:** Expenses for or in connection with an Injury or Illness arising out of an illegal occupation or commission of a felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.
- (25) **Infertility:** Expenses for confinement, treatment or services related to infertility (the inability to conceive) or the promotion of conception will not be considered eligible, except diagnosis and testing of infertility as specified under Eligible Medical Expenses.
- (26) **Maintenance Therapy:** Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.
- (27) **Mandible Treatment:** Expenses for appliances, medical or surgical treatment for correction of a malocclusion or protrusion or recession of the mandible; maxillary or mandibular hyperplasia or maxillary or mandibular hypoplasia will not be considered eligible. (Malocclusion - teeth do not fit together properly, bite problem; mandible protrusion or recession: underbite, chin excessively large or overbite, chin abnormally small; maxillary/mandibular hyperplasia: overbite due to excess growth of upper/lower jaw; maxillary/mandibular hypoplasia: undergrowth of upper/lower jaw). This is considered dental Surgery, performed by dental surgeons. This is not considered a medical procedure.
- (28) **Massage Therapy:** Expenses for massage therapy will not be considered eligible.
- (29) **Maternity:** Maternity expenses Incurred by a Dependent other than an Employee's Spouse will not be considered eligible, except when required as a result of Complications of Pregnancy and except as otherwise covered as a preventive service under the Eligible Medical Expense section of the Plan.
- (30) **Medically Necessary:** Expenses which are determined not to be Medically Necessary will not be considered eligible.
- (31) **Missed Appointments:** Expenses for completion of claim forms, missed appointments or telephone consultations will not be considered eligible.
- (32) **Morbid Obesity:** Expenses for surgical and non-surgical treatment of Morbid Obesity will not be considered eligible.



- (33) **No Legal Obligation:** Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where state law requires this Employer's plan to be primary.
- (34) **Non-Covered Procedures:** Expenses for services related to a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed.
- (35) **Not Performed Under the Direction of a Physician:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.
- (36) **Not Recommended by a Physician:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.
- (37) **Nutritional Supplements:** Expenses for nutritional supplements or other enteral supplementation will not be considered eligible. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.
- (38) **Obesity:** Surgical and non-surgical care and treatment of obesity including weight loss or dietary control, whether or not it is in any case a part of a treatment plan for another illness, will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.
- (39) **Operated by the Government:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related illness or injury.
- (40) **Outside the United States (U.S.):** Expenses for services or supplies if the Covered Person leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment will not be considered eligible.
- (41) **Over-the-Counter (OTC) Medication:** Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive services under the Eligible Medical Expenses section of the Plan.
- (42) **Plan Maximums:** Charges in excess of Plan maximums will not be considered eligible.
- (43) **Prior to Effective Date:** Expenses which are incurred prior to the effective date of your coverage under the Plan will not be considered eligible.
- (44) **Private Duty Nursing:** Expenses for private duty nursing will not be considered eligible, except those nursing services which are considered eligible under the Home Health Care and Hospice Care benefits.
- (45) **Radioactive Contamination:** Expenses incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.
- (46) **Recreational and Educational Therapy:** Expenses for recreational and educational services; learning disabilities; behavior modification services; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies; will not be considered eligible. Diabetic education is considered eligible as specified under Eligible Medical Expenses. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.
- (47) **Refractive Errors:** Expenses for radial keratotomy, lasik Surgery or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible.
- (48) **Required by Law:** Expenses which would be eligible for payment under any plan or policy required by law, whether the Covered Person chose to be covered under such plan or not will not be considered eligible. Under required No-Fault auto coverage, the minimum required coverage or actual coverage elected, whichever is higher, will be treated as an additional Member Share.

- (49) **Riot/Revolt:** Expenses resulting from a Covered Person's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.
- (50) **Sex Transformation:** Expenses in connection with sex transformation will not be considered eligible.
- (51) **Sexual Dysfunction/Impotence:** Expenses for services, supplies or drugs related to sexual dysfunction and/or impotence not related to organic disease will not be considered eligible. Expenses for sex therapy will not be considered eligible.
- (52) **Stand-by Physician:** Expenses for technical medical assistance or stand-by Physician services will not be considered eligible.
- (53) **Sterilization:** Expenses for the reversal of elective sterilization will not be considered eligible.
- (54) **Surrogate:** Expenses related to surrogate parenting will not be considered eligible.
- (55) **Temporomandibular Joint Dysfunction (TMJ):** Expenses for treatment or services due to Temporomandibular Joint Dysfunction (TMJ) will not be considered eligible.
- (56) **Travel:** Expenses for travel will not be considered eligible, except as specified under Eligible Medical Expenses.
- (57) **Usual and Customary Charge:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.
- (58) **Vision Care:** Expenses for vision care, including routine eye exams, professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages and as otherwise covered as a preventive service under the Eligible Medical Expense section of the Plan.
- (59) **Wage or Profit:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (including self-employment) will not be considered eligible.
- (60) **War:** Expenses for the treatment of Illness or Injury resulting from a war or any act of war or terrorism, whether declared or undeclared or while in the armed forces of any country or international organization will not be considered eligible if the Covered Person was a direct participant in an act of terrorism resulting in bodily Injury to themselves.
- (61) **Weekend Admissions:** Expenses for care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or Saturday will not be considered eligible, unless Surgery is scheduled within 24 hours.
- (62) **Worker's Compensation:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Worker's Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Worker's Compensation or similar law and have reached the maximum reimbursement paid under Worker's Compensation or similar law will not be eligible for payment under this Plan.

## PRESCRIPTION DRUG CARD PROGRAM

Eligible expenses include Prescription Drugs and medicines prescribed in writing by a Physician and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician, diabetic supplies; smoking deterrents and contraceptives (regardless of intended use).

**Note: Certain preventive medications will be covered under the Prescription Drug Card Program; please contact the Prescription Drug Card Program Administrator for a list of medications.**

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 30-day supply. Maintenance drugs of more than a 30-day supply may be purchased through the mail order program.

When using the mail order program, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Expenses for injectables that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under this Plan subject to any applicable major medical Member Share and Plan Share as well as any coverage limitations and exclusions applicable to the major medical component of the Plan. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section of the Plan.

**Note: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Idaho Independent Intergovernmental Authority Trust and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for injectables that are not covered under the Prescription Drug Card Program). However, Prescription Drugs are subject to the overall Calendar Year maximum shown in the Medical Schedule of Benefits. For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Manager identified in the General Information section of this Plan and listed on the back of your Employee identification card.**

### **Dispense as Written**

The Plan requires Retail Pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug in addition to the Preferred or Non-Preferred Drug Copay. The Covered Person's share of the Prescription Drug cost does not apply toward the Plan's Out-of-Pocket Maximum.

**Generic Drug:** A Prescription Drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

**Non-Preferred Drug:** Any Brand Name drugs that do not appear on the list of Preferred Drugs.

**Preferred Drug:** A list of Brand Name drugs that has been developed by a Pharmacy and Therapeutics Committee comprised of Physicians, Pharmacists and other health care professionals. The Prescription Drug card service will have a list of Preferred Drugs available.

**Prescription Drug:** Any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription"; (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

## COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event".

### Qualified Beneficiary

In general, you, your Spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a "qualified beneficiary".

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary".

If the qualifying event is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, a covered Retiree and his or her covered Spouse, surviving Spouse or Dependent Child of such Retiree will also be considered qualified beneficiaries provided the bankruptcy results in the loss of their coverage under the Plan.

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

### Qualifying Event

If you are a covered Employee, you, your Spouse and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced or
- (2) Your employment ends for any reason other than your gross misconduct.

You, your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage.

You, your Spouse and Dependent Child have an independent right to elect COBRA Continuation Coverage. You and/or your Spouse may elect coverage on behalf of either one of you and parents may elect coverage on behalf of their Dependent Child.

If you are the Spouse and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events:

- (1) Your spouse/parent-Employee dies;
- (2) Your spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B or both); or
- (3) You/your parents become divorced or legally separated.

Your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such Spouse and/or Dependent Child provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA Continuation Coverage and their obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If you are a Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose coverage under the Plan because you cease to be eligible for coverage under the Plan as a Dependent Child. You may elect to continue coverage under the Plan for up to a maximum period of 36 months provided you provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of; (a)

the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage and your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

**Extension of 18-Month Continuation Coverage Period**

If you, your Spouse or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61<sup>st</sup> day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to your Employer within 60 days after the later of the date (a) of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice. In any event, notice must be given to your Employer prior to the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify your Employer within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension in coverage, notification must be given to your Employer within 60 days after the later of (a) the date coverage under the Plan would end due to the qualifying event or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

**Notice Requirement**

The notice must be postmarked (if mailed) or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

- (1) Name and address of the covered Employee or former employee;
- (2) Name and address of your Spouse, former Spouse and any Dependent Children;
- (3) Description of the qualifying event; and
- (4) Date of the qualifying event.

In addition to the information above, if you, your Spouse or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

- (1) Name of person deemed disabled;
- (2) Date of disability determination; and
- (3) Copy of SSA determination letter.

If you cannot provide a copy of the decree of divorce or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage or extension of such coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

Notice must be sent to the COBRA Administrator at:

Meritain Health, Inc.  
P.O. Box 27935  
Golden Valley, MN 55427-0935  
Fax No.: (763) 852-5079

**Termination of COBRA Continuation Coverage**

COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however coverage may end before the end of the maximum period on the earliest of the following events:

- (1) The date the Idaho Independent Intergovernmental Authority Trust ceases to provide any group health plan coverage;
- (2) The date on which the qualified beneficiary fails to pay the required contribution;
- (3) The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise) or entitled to either Medicare Part A or Part B (whichever comes first). However, a qualified beneficiary who becomes covered under a group health plan which has a Pre-Existing Condition limit that affects that individual; he/she will be allowed to continue COBRA continuation coverage for the length of the pre-existing condition or to the COBRA maximum time period, if less; or
- (4) The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

**Payment for COBRA Continuation Coverage**

Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated.

**Additional Information**

Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator, who is identified on the General Information page of this Plan.

**Current Addresses**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.

## CLAIM PROCEDURES

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information. The Employee identification card will show your Participating Provider Network and the Medical Management Administrator.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

Meritain Health, Inc.  
P.O. Box 27267  
Minneapolis, MN 55427-0267  
(800) 925-2272

Most claims under the Plan will be "post service claims." A "post service claim" is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

- (1) The date of service;
- (2) The name, address, telephone number and tax identification number of the provider of the services or supplies;
- (3) The place where the services were rendered;
- (4) The diagnosis and procedure codes;
- (5) The amount of charges (including Network repricing information);
- (6) The name of the Plan;
- (7) The name of the covered Employee; and
- (8) The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a "claim" since an actual written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

### Timely Filing

All claims must be filed with the Third Party Administrator within 12 months following the date services were incurred. Claims filed after this time period will be denied.

### Procedures for all Claims

The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e. you and your covered Dependents) must follow the procedures outlined in this section. There are four (4) different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

- (1) **Urgent Care Claims.** If your claim is considered an urgent care claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail

to provide sufficient information for the Plan to decide your claim, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. In determining if the initial claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

- (2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Plan Administrator will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Plan Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- (3) **Pre-Service Claims.** For a pre-service claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Plan Administrator notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan Administrator expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

- (4) **Post-Service Claims.** For a post-service claim, the Plan Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Plan Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).



**Manner and Content of Notice of Initial Adverse Determination**

**Consistent with Idaho Code Chapter 59 the Plan will comply with rules regarding External Review.** If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

- (1) An explanation of the specific reasons for the denial;
- (2) A reference to the Plan provision or insurance contract provision upon which the denial is based;
- (3) A description of any additional information or material that you must provide in order to perfect the claim;
- (4) An explanation of why the additional material or information is necessary;
- (5) Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;
- (6) A statement describing your right to request an external review or, if applicable, to bring an action for judicial review;
- (7) A copy of any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and
- (8) If the adverse determination is based on the Plan's Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination also will include the following information:

- (1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);
- (2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;
- (3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- (4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and
- (5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than three (3) days after the oral notification.

**Internal Review of Initially Denied Claims**

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the procedures described below.

You have 180 days after you receive notice of an initial adverse determination within which to request a review of the adverse determination.

If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

- (1) The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse

determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse determination.

- (2) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.
- (3) The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.
- (4) For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.
- (5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.
- (6) You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of its determination on review to give you a reasonable opportunity to respond prior to such determination.
- (7) The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.
- (8) The Plan will provide you with continued coverage pending the outcome of an internal appeal.

All requests for review of initially denied claims (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.  
Appeals Department  
P. O. Box 1380  
Amherst, NY 14226-1380

**Deadline for Internal Review of Initially Denied Claims**

- (1) **Urgent Care Claims.** For urgent care claims, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives your request for review of an initial adverse determination by the Plan.
- (2) **Pre-Service Claims.** For a pre-service claim, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination.
- (3) **Post-Service Claims.** For a post-service claim, the reviewer will notify you of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives your request for review of the initial adverse determination.

### **Manner and Content of Notice of Decision on Internal Review of Initially Denied Claims**

Upon completion of its review of an initial adverse determination, the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

- (1) A description of the Plan's decision;
- (2) The specific reasons for the decision;
- (3) The relevant Plan provisions or insurance contract provisions on which its decision is based;
- (4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;
- (5) A statement describing your right to request an external review, or, if applicable, to bring an action for judicial review;
- (6) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request;
- (7) If the adverse determination on review is based on a Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request; and

Any notice of adverse determination will include the following information:

- (1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);
- (2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;
- (3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- (4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and
- (5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

### **Calculation of Time Periods**

For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of a denied claim) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

### **Adverse Determination**

For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an

item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

#### **Plan's Failure to Follow Procedures**

If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy (including any available external review process) under State law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

However, the Plan will not be treated as failing to follow its claim procedures and you will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "*de minimis* violation" that does not cause and is not likely to cause prejudice or harm to you as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may request a written explanation of any violation by the Plan of these procedures. If you request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal claim procedures to be exhausted. If a court or external review rejects your request for an immediate review (based on a claim that you should be deemed to have exhausted the Plan's internal claim procedures), because the court or external reviewer determines that the "*de minimis* violation" exception applies, the Plan will provide to you a notice of your right to resubmit your internal appeal with a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for you to re-file your claim will begin to run when you receive that notice from the Plan.

#### **External Review of Denied Claims**

If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse determination for certain health benefit claims.

The Plan will provide for an external review process in accordance with applicable State law. Requests for External Review can be submitted to:

Meritain Health, Inc.  
Appeals Department  
P. O. Box 1380  
Amherst, NY 14226-1380

For any adverse determination for which external review is available, the external review requirements are as follows:

- (1) Within five (5) business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one (1) business day after it completes the preliminary review whether the claim is eligible for the external review process:
  - (a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the Employee Benefits Security Administration.
  - (b) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the four-month deadline described in (1) above to provide the necessary additional information or materials.
- (2) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the

request for external review. Within five business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

- (3) The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within ten business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.
- (4) Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:
  - (a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;
  - (b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
  - (c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;
  - (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
  - (e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to you;
  - (f) A statement that judicial review may be available to you; and
  - (g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

#### **Expedited External Review**

You may request an expedited external review if you have received:

- (1) An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- (2) A final internal adverse determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final internal adverse determination concerns an admission, availability of care, continued stay or health care item or service for which you received emergency services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

- (1) Immediately following the date the Plan receives the external review request the Plan will complete a preliminary review. The Plan will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.
  - (a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.

- (b) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the four-month deadline described in (1) above to provide the necessary additional information or materials.
- (2) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available expeditious method (e.g. telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.
  - (3) The IRO must provide notice to the claimant and the Plan (either in writing or orally) as expeditiously as the claimant's medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO's notice is required to contain the following information:
    - (a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;
    - (b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
    - (c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;
    - (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
    - (e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to you;
    - (f) A statement that judicial review may be available to you; and
    - (g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

#### **Effect of External Review Determination**

A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable State or Federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

#### **Notice of Right to External Review**

If an Employee or eligible Dependent is notified of a denied claim. The Plan Administrator will provide written notice to the Covered Person of final adverse benefit determination along with, at the same time, notice of your right to external review. This notification will include an authorization form compliant with federal regulation 45 CFG Section 164.508 regarding disclosure of protected health information. The State external review process is available for:

- (1) An adverse determination that involves medical judgment (including, but not limited to determinations based upon the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Expense; or the Plan's determination that a treatment is Experimental and/or Investigational), as determined by the external reviewer; and
- (2) A rescission of coverage.

For any adverse determination for which external review is available, the external review requirements are as follows:

- (1) You have four (4) months following the date you receive notice of the Plan's final internal adverse determination within which to request an external review. The request for an external review must be submitted to the following address:

#### **Appointment of an Authorized Representative**

A Covered Person may name another person, including the treating health care provider, to act as the Covered Person's authorized representative for an external review request. The Plan Administrator will provide the Covered Person a form for designation of an authorized representative along with a medical information disclosure authorization.

#### **Your Right to An Independent External Review**

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on the health carrier. Except in limited circumstances. You will have no further the right to have further review of your claim reviewed by a court, arbitrator, mediator or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as more fully explained below under "Binding Nature of the External Review Decision."

If we issue a final adverse benefit determination of your request to provide or pay for a health care service or supply, you may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

- (1) The Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of your health care service or supply, or
- (2) Our determination your health care service or supply was Experimental and/or Investigational.

You must first exhaust our internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal, or unless you requested or agreed to a delay, our failure to respond to a standard appeal within 35 days in writing or to an urgent appeal within three business days of the date you filed your appeal. We may also agree to waive the exhaustion requirement for an external review request. You may file for an internal urgent appeal with us and for an expedited external review with the Idaho Department of Insurance at the same time if your request qualifies as an "urgent care request" defined below.

You may submit a written request for an external review to:

Idaho Department of Insurance  
ATTN: External Review  
700 W State St., 3rd Floor  
Boise ID 83720-0043

For more information and for an external review request form:

- See the department's website at <http://www.doi.idaho.gov>, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request. Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without your completed authorization form. If your request qualifies for external review, our final adverse benefit determination will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

### **Standard External Review Request**

You must file your written external review request with the department within four (4) months after the date we issue a final notice of denial.

- (1) Within seven (7) days after the department receives your request, the department will send a copy to us.
- (2) Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five (5) business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
- (3) If your request is eligible for review, the department will assign an independent review organization to your review within seven (7) days of receipt of our notice. The department will also notify you in writing.
- (4) Within seven (7) days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
- (5) The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

### **Expedited External Review Request**

You may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

"Urgent care request" means a claim relating to an admission, availability of care, continued stay or health care service for which the Covered Person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

- (1) Could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function;
- (2) In the opinion of the treating health care professional with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the disputed care or treatment; or
- (3) The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one (1) business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department. If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of the approval of coverage our intent to pay the covered benefit as soon as reasonably practicable, but not later than one (1) business day after making the determination receiving notice of the decision.

### **Binding Nature of the External Review Decision**

If your plan is subject to state laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on us. If you elect to request external review, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of our denial after the independent review organization issues its final decision. If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court. Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.



## Appendix B

The notice below provides an acceptable format approved by the director as meeting the requirements of Idaho Code Section 41-5905. A health carrier may change the terms "you, your" to "covered person" and "we, our" to the health carrier's name, or similar references consistent with the health carrier's typical terminology.

### NOTICE OF YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on the health carrier. Except in limited circumstances, you will have no further right to have further review of your claim reviewed by a court, arbitrator, mediator or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA) – see above under "Binding Nature of the External Review Decision" for more information.

We have denied your request to provide or pay for a health care service or supply. You may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

- (1) The Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of your health care service or supply, or
- (2) Our determination your health care service or supply was Experimental and/or Investigational.

No later than four (4) months from the date of this denial, you may submit a written request for an external review to:

Idaho Department of Insurance  
ATTN: External Review  
700 W State St., 3rd Floor  
Boise ID 83720-0043

### Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

### Appointment of Authorized Representative

A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

### Physical Examinations

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose illness or injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

## COORDINATION OF BENEFITS

### Benefits Subject to This Provision

This provision applies to all benefits provided under any section of this Plan.

### Excess Insurance

If at the time of injury, sickness, disease or disability there is available or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under the Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be secondary to:

- (1) Any primary payer besides the Plan;
- (2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (3) Any policy of insurance from any insurance company or guarantor of a third-party;
- (4) Worker's compensation or other liability insurance company; or
- (5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

### Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

### Allowable Expenses

"Allowable expenses" shall mean any Medically Necessary, Usual and Customary item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

### Other Plan

"Other Plan" means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment.

Plan includes:

- (1) Group and nongroup insurance contracts and subscriber contracts;
- (2) Uninsured group or group-type coverage arrangements;
- (3) Group and nongroup coverage through closed panel plans;
- (4) Group-type contracts;
- (5) The medical care components of long-term care contracts, such as skilled nursing care;
- (6) Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;

- (7) The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts. No plan is required to coordinate benefits provided that it pays benefits as a primary plan. If a plan coordinates benefits, it shall do so in compliance with the provisions of this Plan.

Plan shall not include:

- (1) Hospital indemnity coverage or other fixed indemnity coverage;
- (2) School accident-type coverages, such as contracts that cover students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from school" basis;
- (3) Specified disease or specified accident coverage;
- (4) Accident only coverage;
- (5) Benefits provided in long-term care insurance policies for non-medical service; for example, personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- (6) Limited benefit health coverage as defined in IDAPA 18.01.30, "Individual Disability and Group Supplemental Disability Insurance Minimum Standards Rule," Sections 012 and 029;
- (7) Medicare supplement policies;
- (8) A state plan under Medicaid; or
- (9) A governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary.

#### **Application to Benefit Determinations**

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. When this Plan is secondary, this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of allowable expenses.

#### **Order of Benefit Determination**

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim:

- (1) A plan without a coordinating provision will always be the primary plan;
- (2) The plan covering the person directly rather than as an employee's dependent is primary and the other plans are secondary.
- (3) Active/laid-off or Retirees: The plan which covers a person as an active employee (or as that employee's dependent) determines its benefits before the Plan which covers a person as a laid-off or retired employee (or as that employee's dependent). If the Plan which covers that person has not adopted this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
- (4) Dependent children of parents not separated or divorced or unmarried parents living together: the plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent and if as a result the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- (5) Dependent children of separated or divorced parents or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:
- (a) The plan of the parent with custody pays first;
  - (b) The plan of the spouse of the parent with custody (the step-parent) pays next;
  - (c) The plan of the parent without custody pays next; and
  - (d) The plan of the spouse of the non-custodial parent pays last.

Notwithstanding the above provisions, if there is a court decree that would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan that covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

- (6) If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

#### **Right to Receive and Release Necessary Information**

For the purpose of determining the applicability of and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, this Plan may, without notice to any person, release to or obtain from any insurance company or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan such information as may be necessary to implement this provision.

#### **Facility of Payment**

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

#### **Right of Recovery**

Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

#### **Recovery of Payments**

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions or should otherwise not have been paid by the Plan. This Plan may also inadvertently pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the person or entity to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment.

A Covered Person, provider, another benefit plan, insurer or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand.

The Plan Administrator shall have discretion in deciding whether to obtain payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for any other Injury or Illness) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for any other Injury or Illness) under any other group benefits plan maintained by the Idaho Independent Intergovernmental Authority Trust. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, most recent edition of the ICD or CPT standards, Medicare guidelines, HCPCS standards or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, a Covered Person and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns ("Plan Participants") shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s) or damages arising from another party's act or omission for which the Plan has not already been reimbursed.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

- (1) In error;
- (2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- (3) Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
- (4) With respect to an ineligible person;
- (5) In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation, Third Party Recovery and Reimbursement provisions; or
- (6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to the Covered Person.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

#### **Medicaid Coverage**

You or your Dependent's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of you or your Dependent. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of such person, as required by the

state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

#### **Coordination of Benefits with Medicaid**

In all cases, benefits available through a state or federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

#### **Coordination of Benefits with Medicare**

When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare. If you did not elect coverage under Medicare Parts A and/or B when eligible, the Plan will be secondary and coordinate with benefits that would have been provided by Medicare.

When you, your Spouse or Dependents (as applicable) are eligible for or entitled to Medicare and covered by the Plan, the Plan at all times will be operated in accordance with any applicable Medicare secondary payer and non-discrimination rules. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over and rules concerning working disabled individuals (as discussed below).

When Medicare is the primary payor, the Plan will pay secondary to the extent the benefit is a Covered Expense under the Plan (meaning that the Plan will base its payment upon benefits allowable by Medicare).

The following rules apply in determining whether Medicare or Plan coverage is primary health care coverage:

- (1) **The Working Aged Rule:** Medicare benefits are secondary to benefits payable under the Plan for individuals entitled to Medicare due to being age 65 or over and who have Plan coverage as a result of his or her current employment status (or the current employment status of a Spouse). When you or your Spouse become eligible for Medicare due to the attainment of age 65, you or your Spouse may still be eligible for benefits provided under the Plan based on your current employment status.

If, as a result, you have or your Spouse has primary coverage under the Plan, the Plan will pay the portion of your incurred expenses that are normally covered by the Plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have Plan coverage.

- (2) **The Working Disabled Rule:** Medicare benefits are secondary to benefits payable under the Plan for covered individuals under age 65 entitled to Medicare on the basis of disability (other than end-stage renal disease) and who are covered under the Plan as a result of current employment status with an employer. That is, if you or your dependents are covered by the Plan based on your current employment status, Medicare benefits are secondary for you or your covered Dependents entitled to Medicare on the basis of disability (other than end-stage renal disease). In this case the Plan is primary.
- (3) **End-Stage Renal Disease Rule:** Medicare benefits are secondary to benefits payable under the Plan for covered individuals eligible for or entitled to Medicare benefits on the basis of end-stage renal disease ("ESRD"), for a period not to exceed 30 months generally beginning the first day of the month of eligibility or entitlement to Medicare due to ESRD. (Special rules apply if you were entitled to Medicare based on age or disability prior to becoming eligible for Medicare due to ESRD.) Because an ESRD patient can have up to a three-month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to three months. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. Your Employer can provide you with more detailed information on how this rule works.

#### **Medicare and COBRA**

For most COBRA beneficiaries (e.g., the working aged or disabled Medicare beneficiaries), Medicare rules state that Medicare will be primary to COBRA continuation coverage and this would apply to this Plan's Continuation of Benefits (COBRA) coverage. For an ESRD-related Medicare beneficiary, COBRA continuation coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

**Coordination of Benefits with TRICARE**

The Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

## SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

### Payment Condition

- (1) The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns (collectively referred to hereinafter in this section as "Covered Person") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist and medical payment provisions (collectively "coverage").
- (2) The Covered Person, his or her attorney and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts.
- (3) In the event a Covered Person settles, recovers or is reimbursed by any coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
- (4) If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may elect to seek reimbursement, at its discretion.

### Subrogation

- (1) As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.
- (2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person may have against any coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
- (3) The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
- (4) If the Covered Person fails to file a claim or pursue damages against:
  - (a) The responsible party, its insurer or any other source on behalf of that party;
  - (b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
  - (c) Any policy of insurance from any insurance company or guarantor of a third party;
  - (d) Workers' compensation or other liability insurance company; or,



- (e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage;

the Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

#### **Right of Reimbursement**

- (1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
- (2) No court costs, experts' fees, attorneys' fees, filing fees or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
- (3) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
- (4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.
- (5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable illness, injury, disease or disability.

#### **Excess Insurance**

If at the time of Injury, illness, disease or disability, there is available or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as provided for under the Plan's "Coordination of Benefits" section. The Plan's benefits shall be excess to:

- (1) The responsible party, its insurer or any other source on behalf of that party;
- (2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (3) Any policy of insurance from any insurance company or guarantor of a third party;
- (4) Workers' compensation or other liability insurance company; or
- (5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

#### **Separation of Funds**

Benefits paid by the Plan, funds recovered by the Covered Person and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien or the Plan's right to subrogation and reimbursement.

### **Wrongful Death**

In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any coverage, the Plan's subrogation and reimbursement rights shall still apply.

### **Obligations**

- (1) It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:
  - (a) To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including discovery, attending depositions and/or cooperating in trial to preserve the Plan's rights;
  - (b) To provide the Plan with pertinent information regarding the Illness, disease, disability or Injury, including Accident reports, settlement information and any other requested additional information;
  - (c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
  - (d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
  - (e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
  - (f) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan beneficiary may have against any responsible party or coverage.
- (2) If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.
- (3) The Plan's rights to reimbursement and/or subrogation are in no way dependant upon the Covered Persons' cooperation or adherence to these terms.

### **Offset**

Failure by the Covered Person and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person satisfies his or her obligation.

### **Minor Status**

- (1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
- (2) If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

### **Language Interpretation**

The Plan Sponsor retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights. The Plan Sponsor may amend the Plan at any time without notice, subject to the terms and conditions of any relevant collective bargaining agreement.

### **Severability**

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable State subrogation laws.

## DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section provided, however, that any such capitalized word shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this Plan for that information.

**Accident** means a non-occupational sudden and unforeseen event, definite as to time and place or a deliberate act resulting in unforeseen consequences.

**Ambulatory Surgical Center** means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

**Assistant Surgeon** means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have one or two (2) Assistant Surgeons. The technical aspects of the Surgery involved dictate the need for an Assistant Surgeon.

**Birthing Center** means a place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

**Calendar Year** means January 1 – December 31.

**Certificate of Creditable Coverage** means a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

**Close Relative** means a Covered Person's spouse, parent (including step-parents), sibling, child, grandparent or in-law.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

**Complications of Pregnancy** means condition(s) (when the Pregnancy is not terminated) whose diagnosis is distinct from Pregnancy but which is adversely affected by Pregnancy or caused by Pregnancy; such as, acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity.

Complications of Pregnancy also include an ectopic Pregnancy which is terminated or spontaneous termination of Pregnancy which occurs during a period of gestation when a viable birth is not possible; and, pernicious vomiting (hyperemesis gravidarum) and toxemia with convulsions (eclampsia of Pregnancy).

Complications of Pregnancy do not include false labor, occasional spotting, Physician prescribed rest during the period of Pregnancy, morning sickness and similar conditions, which, although associated with the management of a difficult Pregnancy, are not medically classified as distinct Complications of Pregnancy. A cesarean section (C-Section) birth is considered a Complication of Pregnancy.

**Concurrent Review** means the Medical Management Program Administrator will review all Inpatient admissions for a patient's length of stay. The review is based on clinical information received by the Medical Management Program Administrator from the provider or facility.

**Congenital Anomaly** means a physical developmental defect that is present at birth. Congenital Anomaly also means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be Congenital Anomalies.

**Copay** has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

**Cosmetic** means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

**Covered Expense** means:

- (1) An item or service listed in the Plan as an eligible medical expense for which the Plan provides coverage.
- (2) For prescription drug expenses, any prescription drugs or medicines eligible for coverage under the Prescription Drug Card Program.

**Covered Person** means, individually, a covered Employee and each of his or her Dependents who are covered under the Plan.

**Creditable Coverage** means coverage of an individual under a qualified health plan as follows:

- (1) A group health plan;
- (2) Health insurance coverage;
- (3) Medicare;
- (4) Medicaid;
- (5) TRICARE;
- (6) An Indian Health Service plan or tribal organization plan;
- (7) A state risk pool coverage;
- (8) A federal employee's health insurance coverage;
- (9) A public health plan (this includes plans established or maintained by a state, the U.S. government, a foreign country, a state or federal penitentiary, U.S. Veterans Administration or any political subdivision of a state, the U.S. government or a foreign country that provides health coverage to individuals who are enrolled in the Plan);
- (10) A Peace Corps plan;
- (11) The State Children's Health Insurance Program.

To the extent that further clarification is needed with respect to the sources of Creditable Coverage listed in the prior sentence, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a), which is incorporated by reference.

**Custodial Care** means care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

**Dentist** means an individual who is duly licensed to practice dentistry or to perform oral Surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

**Dependent** is a Covered Person, other than the Employee, who is covered by the Plan pursuant to the terms and conditions set forth in the "Eligibility for Participation" section of the Plan.

**Durable Medical Equipment** means equipment that:

- (1) Can withstand repeated use;
- (2) Is primarily and customarily used to serve a medical purpose;
- (3) Generally is not useful to a person in the absence of an Illness or Injury; and
- (4) Is appropriate for use in the home.

**Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (2) Serious impairment to bodily functions; or
- (3) Serious dysfunction of any bodily organ or part.

**Emergency Services** means, with respect to an Emergency Medical Condition:

- (1) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- (2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to Stabilize the individual.

**Employee** is defined in the "Eligibility for Participation" section of the Plan.

**Employer** means your employer.

**Enrollment Date** means the earlier of first day of coverage or, if there is a waiting period, the first day of the eligibility waiting period.

**ERISA** means the Employee Retirement Income Security Act of 1974, as may be amended from time to time.

**Essential Health Benefit** has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as may be further defined by the Secretary of the United States Department of Health and Human Services. Essential Health Benefits includes the following general categories and the items and services covered within such categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); Prescription Drugs; rehabilitative and habilitative services and devices; laboratory service; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

**Experimental and/or Investigational** means services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

The Plan Administrator must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

- (1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or
- (2) If the drug, device, medical treatment or procedure or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function or if federal law requires such review or approval, then it is deemed to be Experimental and/or Investigational; or
- (3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational; or
- (4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the FDA for general use.

Expenses related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

- (1) The named drug is not specifically excluded under the General Limitations of the Plan; and
- (2) The named drug has been approved by the FDA; and
- (3) The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and
- (4) If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or NCCN Drugs and Biologics Compendium recognize it as an appropriate treatment for that form of cancer.

Expenses for drugs, devices, services, medical treatments or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

**FMLA** means the Family and Medical Leave Act of 1993, as may be amended from time to time.

**Genetic Information** means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility); (2) establishing contribution or premium accounts for coverage under the Plan and (3) applying the Pre-Existing Condition rule under the Plan.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

**Home Health Care Agency** means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

**Hospice** means an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides 24-hour-a-day, seven days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with four years of full-time clinical experience, at least two of which involved caring for terminally ill patients; (5) has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded and it provides malpractice and malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

**Hospital** means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat illnesses or injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders or Substance Use Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home or a similar institution.

**Illness** means a non-occupational bodily disorder, disease, physical sickness, Pregnancy (including childbirth and miscarriage), Mental Disorder or Substance Use Disorder.

**Incurred** means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

**Injury** means physical damage to the body, caused by an external force and which is due directly and independently of all other causes, to an Accident.

**Inpatient** means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

**Intensive Care Unit** means a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special life saving equipment which is immediately available at all times; (3) at least two (2) beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

**Late Enrollee** is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 30-day eligibility period.

**Lifetime Maximum** means the maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan may provide for a Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable Schedule of Benefits or the applicable covered expenses section of the Plan.

**Long-Term Acute Care Facility/Hospital (LTACH)** means a facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, seven days a week basis. The severity of the LTACH patient's condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; and (5) education for the patient and family to manage their present and future healthcare needs.

**Maintenance Therapy** means medical and non-medical health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel.

**Medically Necessary/Medical Necessity** means treatment is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

- (1) "Proven" means the care is not considered Experimental and/or Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.
- (2) "Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness or a clinical condition.
- (3) "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

**Medicare** means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

**Member Share** is the dollar amount of Covered Expenses for which the Covered Person is responsible for; after satisfaction of the Member Share the Plan will pay eligible charges at the Plan Share percentage level.



**Mental Disorder** means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

**Morbid Obesity** Morbid obesity is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy or musculoskeletal dysfunction.

**Non-Participating Provider** means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

**Participating Employer** means any employer that has, with the consent of the Plan Sponsor, adopted this Plan pursuant to a participation agreement by and between the Plan Sponsor and the employer for the exclusive benefit of its Employees and their eligible Dependents.

**Participating Provider** means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

**Physician** means a legally licensed Physician who is acting within the scope of their license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes, but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Speech Therapist, Speech Pathologist and Licensed Midwife. An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

**Plan** means the Idaho Independent Intergovernmental Authority Trust - A Self-Funded Health Plan.

**Plan Administrator** means the Idaho Independent Intergovernmental Authority Trust. The Idaho Independent Intergovernmental Authority Trust may delegate fiduciary and other responsibilities to the Plan Administrator.

**Plan Share** means a share percentage of Covered Expenses paid by the Plan and Covered Person after satisfaction of any Member Share amounts. Once the total Plan Share amount has been satisfied, the Plan will pay Covered Expenses at 100% for the balance of the Calendar Year.

**Plan Sponsor** means Idaho Independent Intergovernmental Authority Trust or any successor thereto.

**Plan Year** means the period from October 1 - September 30 each year.

**Prescription Drug** means any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription," (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

**Primary Care Physician** means a licensed Physician practicing in one of the following fields: (1) family practice; (2) general practice; (3) internal medicine; (4) obstetrics and gynecology; or (5) pediatrics.

**Reconstructive Surgery** means Surgery that is incidental to an Injury, Illness or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

**Rehabilitation Facility** means a facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a

lower level of care; (7) twenty-four (24) hour nursing services are available; and (8) the confinement is not for Custodial Care or maintenance care.

**Security Standards** mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

**Semi-Private Room** means a Hospital room shared by two or more patients.

**Significant Break in Coverage** means a period of 63 consecutive days during each of which an individual does not have any Creditable Coverage.

**Skilled Nursing Facility** is a facility that meets all of the following requirements:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally disabled, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

**Special Enrollee** is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 30-day eligibility period and who later enrolls in the Plan due to a Special Enrollment Event or Status Change Event.

**Specialist** means a licensed Physician that provides services to a Covered Person within the range of their specialty (e.g. cardiologist, neurologist, etc.).

**Stabilize** means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions and (1) there is inadequate time to effect a safe transfer to another Hospital before delivery or (2) transfer may pose a threat to the health or safety of the woman or her unborn child; to deliver (including the placenta).

**Substance Use Disorder** means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

**Surgery or Surgical Procedure** means any of the following:

- (1) The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound;
- (2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

- (3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
- (4) The induction of artificial pneumothorax and the injection of sclerosing solutions;
- (5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
- (6) Obstetrical delivery and dilation and curettage; or
- (7) Biopsy.

**Third Party Administrator** means Meritain Health, Inc., P.O. Box 27267, Minneapolis, MN 55427-0267.

**Urgent Care Facility** means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

**USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as may be amended from time to time.

**Usual and Customary Charge (U&C)** means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual will be subject to a Usual and Customary determination. Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any medical or dental complications or unusual circumstances which require additional time, skill or experience. Limitations for Usual and Customary Charges are not applicable to Participating Providers.

## PLAN ADMINISTRATION

### Delegation of Responsibility

The Idaho Independent Intergovernmental Authority Trust is a named fiduciary of the Plan with full discretionary authority for the control and management of the operation and administration of the Plan. The Idaho Independent Intergovernmental Authority Trust may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

### Authority to Make Decisions

The Plan is administered by the Plan Administrator in accordance with rules of the State of Idaho. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Idaho Independent Intergovernmental Authority Trust to be Plan Administrator and serve at the convenience of the Idaho Independent Intergovernmental Authority Trust. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved or is removed from the position, the Idaho Independent Intergovernmental Authority Trust will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights and to decide questions of Plan interpretation and those of fact and law relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that you and/or your Dependent (as applicable) are entitled to them.

The duties of the Plan Administrator include the following:

- (1) To administer the Plan in accordance with its terms;
- (2) To determine all questions of eligibility, status and coverage under the Plan;
- (3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- (4) To make factual findings;
- (5) To decide disputes which may arise relative to a Covered Person's rights;
- (6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- (7) To keep and maintain the Plan documents and all other records pertaining to the Plan;
- (8) To appoint and supervise a Third Party Administrator to pay claims;
- (9) To perform all necessary reporting as required by Federal or State law;
- (10) To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;
- (11) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- (12) To perform each and every function necessary for or related to the Plan's administration.

**Amendment or Termination of Plan**

The Idaho Independent Intergovernmental Authority Trust expects to maintain this Plan indefinitely; however, the Idaho Independent Intergovernmental Authority Trust may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part, subject to the terms and conditions of any relevant collective bargaining agreements.

The Idaho Independent Intergovernmental Authority Trust may, in its sole discretion, at any time, amend, suspend or terminate by operation of law, as a result of changes in law which are required to affect provisions in the Plan.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Idaho Independent Intergovernmental Authority Trust.

## MISCELLANEOUS INFORMATION

### **Assignment Of Benefits**

No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in ERISA Section 609(a) and in the Plan's QMCSO procedures.

### **Clerical Error**

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to you and/or your Dependents have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

### **Conformity with Applicable Laws**

This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

### **Cost of the Plan**

The Idaho Independent Intergovernmental Authority Trust is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Idaho Independent Intergovernmental Authority Trust is free to determine the manner and means of funding the Plan, including, but not limited to, payment of Plan expenses from the Employer's general assets. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Idaho Independent Intergovernmental Authority Trust, in its sole discretion.

### **Interpretation of this Document**

The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this Plan applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

### **No Contract of Employment**

This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for or an inducement or condition of, the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

### **Release of Information**

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

### **Worker's Compensation**

This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any workers' compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive workers' compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from workers' compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

- (1) The workers' compensation benefits are in dispute or are made by means of settlement or compromise;
- (2) No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment;
- (3) The amount of workers' compensation benefits due specifically to health care expense is not agreed upon or defined by you or the workers' compensation carrier; or
- (4) The health care expense is specifically excluded from the workers' compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when you file a claim for coverage under workers' compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through workers' compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

## HIPAA PRIVACY PRACTICES

The following is a description of certain uses and disclosures that may be made by the Plan of your health information:

### **Disclosure of Summary Health Information to the Idaho Independent Intergovernmental Authority Trust**

In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "privacy standards"), the Plan may disclose summary health information to the Idaho Independent Intergovernmental Authority Trust, if the Idaho Independent Intergovernmental Authority Trust requests the summary health information for the purpose of:

- (1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- (2) Modifying, amending or terminating the Plan.

"Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

### **Disclosure of Protected Health Information ("PHI") to the Idaho Independent Intergovernmental Authority Trust for Plan Administration Purposes**

In order that the Idaho Independent Intergovernmental Authority Trust may receive and use PHI for Plan administration purposes, the Idaho Independent Intergovernmental Authority Trust agrees to:

- (1) Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
- (2) Ensure that any agents, including a subcontractor, to whom the Idaho Independent Intergovernmental Authority Trust provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Idaho Independent Intergovernmental Authority Trust with respect to such PHI;
- (3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Idaho Independent Intergovernmental Authority Trust, except pursuant to an authorization which meets the requirements of the privacy standards;
- (4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Idaho Independent Intergovernmental Authority Trust becomes aware;
- (5) Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
- (6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
- (7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
- (8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS") or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
- (9) If feasible, return or destroy all PHI received from the Plan that the Idaho Independent Intergovernmental Authority Trust still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and



(10) Ensure that adequate separation between the Plan and the Idaho Independent Intergovernmental Authority Trust, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

- (a) The Idaho Independent Intergovernmental Authority Trust shall only allow certain named employees or classes of employees or other persons under control of the Idaho Independent Intergovernmental Authority Trust who have been designated to carry out plan administration functions, access to PHI. You may contact the Idaho Independent Intergovernmental Authority Trust for a list of those persons. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Idaho Independent Intergovernmental Authority Trust performs for the Plan.
- (b) In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Idaho Independent Intergovernmental Authority Trust only upon receipt of a certification by the Idaho Independent Intergovernmental Authority Trust that:

- (1) The Plan documents have been amended to incorporate the above provisions; and
- (2) The Idaho Independent Intergovernmental Authority Trust agrees to comply with such provisions.

**Disclosure of Certain Enrollment Information to the Idaho Independent Intergovernmental Authority Trust**

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Idaho Independent Intergovernmental Authority Trust information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Idaho Independent Intergovernmental Authority Trust.

**Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage**

The Idaho Independent Intergovernmental Authority Trust hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

**Other Disclosures and Uses of PHI**

With respect to all other uses and disclosures of PHI, the Plan shall comply with the privacy standards.

## HIPAA SECURITY PRACTICES

### **Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Idaho Independent Intergovernmental Authority Trust for Plan Administration Functions**

To enable the Idaho Independent Intergovernmental Authority Trust to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Idaho Independent Intergovernmental Authority Trust agrees to:

- (1) Implement Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- (2) Ensure that adequate separation between the Plan and the Idaho Independent Intergovernmental Authority Trust, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
- (3) Ensure that any agent, including a subcontractor, to whom the Idaho Independent Intergovernmental Authority Trust provides Electronic PHI created, received, maintained or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and
- (4) Report to the Plan any Security Incident of which it becomes aware.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

### **Health Information Technology for Economic and Clinical Health (HITECH) Act**

The Plan will comply with all applicable requirements of final regulations issued by the Department of Health and Human Services pursuant to Subtitle D of the HITECH Act and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan. If there is any conflict between the requirements of Subtitle D of the HITECH Act and any provision of this Plan, applicable law will control. Any amendment or revision or authoritative guidance relating to Subtitle D of the HITECH Act is hereby incorporated into the Plan as of the date that the Plan is required to comply with such guidance.

The Idaho Independent Intergovernmental Authority Trust will promptly report any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

## GENERAL PLAN INFORMATION

**Name of Plan:** Idaho Independent Intergovernmental Authority Trust - A Self-Funded Health Plan

**Plan Sponsor (Named Fiduciary):** Idaho Independent Intergovernmental Authority Trust  
950 West Bannock Street, Suite 520  
Boise, ID 83702  
(208) 331-1968

**Plan Administrator:** Idaho Independent Intergovernmental Authority Trust  
950 West Bannock Street, Suite 520  
Boise, ID 83702  
(208) 331-1968

**Plan Sponsor EIN:** 45-1341997

**Plan Year:** October 1 - September 30

**Plan Number:** 501

**Plan Type:** Welfare benefit plan providing medical and prescription drug benefits.  
  
This Plan is maintained pursuant to one or more collective bargaining agreements. For a copy of such agreement, please contact the Plan Administrator.

**Contributions:** The cost of coverage under the Plan is funded in part by Employee contributions and in part by contributions from the Plan Sponsor and each Participating Employer.

**Third Party Administrator:** Meritain Health, Inc.  
P.O. Box 27267  
Minneapolis, MN 55427-0267  
(800) 925-2272

**COBRA Administrator:** Meritain Health, Inc.  
P.O. Box 27935  
Golden Valley, MN 55427-0935  
Fax No.: (763) 852-5079

**Medical Management Program Administrator:** Meritain Health Medical Management  
100 West Old Wilson Road, 3rd Floor  
Worthington, Ohio 43085  
(800) 242-1199

**Prescription Drug Program Card Administrator:** Caremark  
2211 Sanders Road 10th Floor  
Northbrook, IL 60062  
(866) 475-7589

**Agent for Service of Legal Process:** Idaho Independent Intergovernmental Authority Trust  
950 West Bannock Street, Suite 520  
Boise, ID 83702  
(208) 331-1968

**Trustee(s):**

Moore, Smith, Braxton & Turcke, Chartered  
Stephanie J. Bonney  
950 West Bannock Street, Suite 520  
Boise, ID 83702  
(208) 331-1800

**Opt-Out Provision:**

The Employer has elected to opt-out of the following requirements under Title XXVII of the Public Health Service Act:

Parity in the application of certain limits to Mental Disorder and Substance Use Disorder benefits.

The Plan shall take effect for each Participating Employer as of the Effective Date, unless a different date is set forth above.

The Plan is a legal entity. Legal notice may be filed with and legal process served upon, the Plan Administrator.