2025 Benefit Summary and Medical Program Document

J.R. Simplot Company
Group Health and Welfare Plan
Medical Program

Contract Administrator: Blue Cross of Idaho Health Service, Inc.

HSA Preferred Provider Organization (PPO)

Effective Date: January 1, 2025

Benefit Period: January 1 through December 31

Blue Cross of Idaho

SIMPLOT MEDICAL PROGRAM BENEFITS OUTLINE AND MEDICAL PROGRAM DOCUMENT

IMPORTANT INFORMATION ABOUT THIS OUTLINE

This booklet is a description of the benefits covered by the J.R. Simplot Company Group Health and Welfare Plan Medical Program and serves as the Medical Program Document. This Document, together with the J.R. Simplot Company Group Health and Welfare Plan Summary Plan Description Booklet (SPD), constitute the summary plan description for the Medical Program. Together, they describe in detail the rights and obligations of both the Participant and the Plan. It is important that you read the SPD and this Medical Program Document carefully. If you receive this document electronically, you may request a paper copy at any time at no additional charge by contacting the Contract Administrator (Blue Cross of Idaho) Customer Service.

Throughout this Document references to Blue Cross of Idaho (BCI) are referring to the Contract Administrator. For Covered Services under the terms of the Medical Program, Maximum Allowance is the amount established as the highest level of compensation for a Covered Service. There is more detailed information on how Maximum Allowance is determined and how it affects out-of-state coverage in the Definitions Section.

Note: ***In order to receive maximum benefits, some Covered Services require Emergency Admission Notification, Non-Emergency Preadmission Notification, and/or Prior Authorization. Please review the Inpatient Admission Notification Section, Prior Authorization Section and Attachment A of this Benefits Outline for more details.***

Participants should check with the Contract Administrator) to determine if the treatment or service being considered requires Prior Authorization. All Inpatient Admissions and Emergency Admissions require Inpatient Notification Review or Emergency Admission Review, as appropriate. For more information, please visit the Contract Administrator's Website at www.bcidaho.com or call the Customer Service Department at 855-216-6850.

To locate an In-Network Provider in your area, please visit the Contract Administrator's Website at www.bcidaho.com. You may also call the Customer Service Department at 208-286-3813 or 855-216-6850 for assistance in locating a Provider.
If you cannot locate an In-Network Provider within fifty (50) miles of your primary residence, call the Customer Service Department. The Plan will provide In-Network benefits when a Participant cannot locate an In-Network Provider within fifty (50) miles of their primary residence.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's Copayments, Cost Sharing and/or Deductible.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care Provider, you may owe certain Out-of-Pocket costs, like Copayment, Cost Sharing, or Deductible. You may have additional costs or have to pay the entire bill if you see a Provider or visit a health care facility that isn't in your health plan's network.

"Out-of-Network" means Providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-Network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than In-Network costs for the same service and might not count toward your plan's Deductible or annual Out-of-Pocket Limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network Provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

YOU'RE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an Emergency Medical Condition and get emergency services from an Out-of-Network Provider or facility, the most they can bill you is your plan's In-Network Cost Sharing amount (such as Copayments, Cost Sharing, and Deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an In-Network Hospital or Ambulatory Surgical Center

When you get services from an In-Network Hospital or Ambulatory Surgical Center, certain Providers there may be Out-of-Network. In these cases, the most those Providers can bill you is your plan's In-Network Cost Sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these In-Network facilities, Out-of-Network Providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get Out-of-Network care. You can choose a Provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THESE PROTECTIONS:

- You're only responsible for paying your share of the cost (like the Copayments, Cost Sharing, and Deductibles that you would pay if the Provider or facility was In-Network). Your health plan will pay any additional costs to Out-of-Network Providers and facilities directly.
- Generally, your health plan must:
- Cover emergency services without requiring you to get approval for services in advance (also known as "Prior Authorization").
- Cover emergency services by Out-of-Network Providers.
- Base what you owe the Provider or facility (Cost Sharing) on what it would pay an In-Network Provider or facility and show that amount in your explanation of benefits.

- Count any amount you pay for emergency services or Out-of-Network services toward your In-Network Deductible and Out-of-Pocket Limit.

If you think you've been wrongly billed, you may contact the U.S. Department of Health & Human Services (HHS) by calling toll-free 1 (800) 985-3059. This telephone line is being operated in coordination with the Department of Treasury, Department of Labor, and the Office of Personnel Management, and HHS will route complaints to the appropriate federal agency.

Visit www.cms.gov/nosurprises for more information about the No Surprises Act and your rights under federal law with respect to payment disputes.

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho and Blue Cross of Idaho Care Plus, Inc., (collectively referred to as Blue Cross of Idaho) complies with applicable Federal civil rights laws and does not discriminate, exclude or treat less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)).

Blue Cross of Idaho:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho Civil Rights Coordinator at 1-800-627-1188 (TTY: 711).

If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance at:

Civil Rights Coordinator
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: ***grievancesandappeals@bcidaho.com***
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf***, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html .***

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY:711).

Arabic انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1-800-627-1188 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY：711)。

Farsi توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (TTY:711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188（TTY:711）まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

Nepali: ध्यान दनिुहोस्: तपाईंले नेपाली बोलनुहुनछ भने तपाईंको नमिति भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिविइ: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711).

Form No. 3-1187 (05-24)

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE:
The Women's Health and Cancer Rights Act of 1998 requires health plans to provide the following mastectomy-related services.

1. Reconstruction of the breast on which the mastectomy/lumpectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy/ lumpectomy, including lymphedemas.

OBSTETRIC OR GYNECOLOGICAL CARE NOTICE:
You do not need Prior Authorization from the Contract Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please visit our Website at www.bcidaho.com. You may also call our Customer Service Department at 208-286-3813 or 855-216-6850 for assistance in locating a Provider.

ELIGIBILITY AND ENROLLMENT
Please refer to the J.R. Simplot Group Health and Welfare Plan Summary Plan Description Booklet for information regarding Eligibility and Enrollment.

EXPANDED CHRONIC CARE

Services are classifiable as Expanded Chronic Care when prescribed for a Participant with the corresponding listed Chronic Condition, as described in IRS Notice 2019-45. For certain items a certification from your Provider may be required.

For In-Network Covered Services Plan pays 100% of Maximum Allowance (Deductible does not apply)
For Out-of-Network Covered Services Plan pays 60% of Maximum Allowance after Deductible

COVERED SERVICES	CHRONIC CONDITION	CHRONIC CARE COVERED
Durable Medical Equipment	Hypertension	• Blood pressure monitor
	Asthma	• Peak flow meter
	Diabetes	• Glucometer
Medical Benefits	Diabetes	• Retinopathy screening • Hemoglobin A1c testing
	Liver disease and/or bleeding disorders	• International Normalized Ratio (INR) testing
	Heart disease	• Low-density Lipoprotein (LDL) testing

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Deductibles: *(The Medical Program has a calendar year Deductible for Medical and Prescription Services)*		
Individual	Participant pays the first $1,800 of In-Network Services for eligible expenses per Benefit Period.	Participant pays the first $3,300 of Out-of-Network Services for eligible expenses per Benefit Period.
Family	Participants pay the first $3,400 of In-Network Services for eligible expenses for all Participants under the same Family Coverage per Benefit Period, regardless of which individual Participant, or combination of Participants, meets the Deductible requirement.	Participants pay the first $6,400 of Out-of-Network Services for eligible expenses for all Participants under the same Family Coverage per Benefit Period, regardless of which individual Participant, or combination of Participants, meets the Deductible requirement.
With the exception of certain Preventive Care services and Preventive Prescription Drugs, no payment is due from the Plan until the Deductible is met. In-Network Services do not apply to the Out-of-Network Deductible and Out-of-Network Services do not apply to the In-Network Deductible. *See General Benefit Information section, item I for other services that do not apply to the Deductible.*		
Out of Pocket Limits: *(The Medical Program has a calendar year Out-of-Pocket Limit for Medical and Prescription Services. Includes applicable Deductible, Copayments and Cost Sharing. See General Benefit Information section, item II for services that do not apply to the limit.)*		
Individual Coverage	Participant pays first $4,300 of In-Network eligible expenses per Benefit Period.	Participant pays first $8,300 of Out-of-Network eligible expenses per Benefit Period.
Family Coverage		
Individual	Participant pays first $6,850 of In-Network eligible expenses per Benefit Period.	
Family *(No Participant may contribute more than the Individual Out-of-Pocket amount toward the Family Out-of-Pocket Limit)*	Participants pay a combination of $8,400 of In-Network eligible expenses for all Participants under the same Family Coverage per Benefit Period, regardless of which individual Participant, or combination of Participants, meets the Out-of-Pocket requirement.	Participants pay a combination of $16,400 of Out-of-Network eligible expenses for all Participants under the same Family Coverage per Benefit Period, regardless of which individual Participant, or combination of Participants, meets the Out-of-Pocket requirement.
When the Out-of-Pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for services as listed in the General Benefit Information section, item II that do not apply. In-Network Services do not apply to the Out-of-Network Out of Pocket Limit. Out-of-Network Services will apply to the In-Network Out of Pocket Limit. **Be aware that your actual costs for services provided by an Out-of-Network Provider may exceed the Plan's Out-of-Pocket Limit for Out-of-Network services. Except as provided by the No Surprises Act, Out-of-Network Providers can bill you for the difference between the amount charged by the Provider and the amount allowed by the Contract Administrator, and that amount is not counted toward the Out-of-Network Out-of-Pocket Limit.**		

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Ambulance Transportation Services • **Ground Ambulance Services** • **Air Ambulance Services** *Payment for Out-of-Network Air Ambulance Services is based on the Qualifying Payment Amount. Out-of-Network Air Ambulance Services accumulate towards the In-Network Out-of-Pocket Limit.*	Plan pays 80% of Maximum Allowance after Deductible Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible Plan pays 80% of Maximum Allowance after In-Network Deductible
Ancillary Provider Services	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Breastfeeding Support and Supply Services *(Includes rental and/or purchase of manual or electric breast pumps. Limited to one (1) breast pump purchase per Benefit Period, per Participant.)*	Plan pays 100% of Maximum Allowance *(Deductible does not apply)*	Plan pays 60% of Maximum Allowance after Deductible
Alternative Therapy Services • **Chiropractic Care** • **Acupuncture** • **Therapeutic Massage**	Plan pays 80% of Maximum Allowance after Deductible	**Chiropractic Care Services:** Plan pays 60% of Maximum Allowance after Deductible **Acupuncture and Therapeutic Massage:** Plan pays 80% of Maximum Allowance after Deductible
	Up to a combined total of 30 visits per Participant, per Benefit Period.	
Dental Services – Related to Accidental Injury and completed within 12 months of the accident	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Diabetes Self-Management Education Services – Outpatient	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Diagnostic Services *(Includes diagnostic mammograms)*	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Emergency Services – Facility and Professional Services *Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount.*	Plan pays 80% of Maximum Allowance after In-Network Deductible. Emergency Services accumulate towards the In-Network Out-of-Pocket Limit.	
Gender Affirming Services	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Hearing Aids *(For Eligible Dependent Children Only. Benefits are limited to one (1) device per ear, every three (3) years, and includes forty-five (45) speech therapy visits during the first twelve (12) months after delivery of the covered device. Refer to Outpatient Speech Therapy section for benefit details.)*	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Hearing Services *(Includes screening and diagnostic Audiogram examinations)*	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Home Health Skilled Nursing Services	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
	Up to a combined total of 100 days per Participant, per Benefit Period.	
Home Intravenous Therapy	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Hospice Services	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Hospital Services • Inpatient • Outpatient Surgery at a Licensed General Hospital • Outpatient Surgery at an Ambulatory Surgical Facility	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Infertility and Advanced Reproductive Technology (ART) Treatment Services ***For Enrollee and Enrolled Eligible Dependent spouse only***	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
	Up to a combined Lifetime Benefit Limit of $5,000, per Participant	
Inpatient Rehabilitation or Habilitation Services	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Maternity Services and/or Complications of Pregnancy	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Medical Nutritional Therapy	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Medical Services • Inpatient • Outpatient	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Mental Health and Substance Use Disorder Inpatient and Outpatient Services *(Facility and Professional Services)*	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Outpatient Applied Behavioral Analysis (ABA)	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Treatment for Autism Spectrum Disorder	Covered the same as any other illness, depending on the services rendered. Please see the appropriate section of the Benefits Outline. Visit limits do not apply to Treatments for Autism Spectrum Disorder, and related diagnoses.	
Morbid Obesity Surgical Services *(Services must be provided at a Blue Distinction Center for Bariatric Surgery)*	Plan pays 80% of Maximum Allowance after Deductible	No benefits
	Up to a Lifetime Benefit Limit of one procedure per Participant	
Outpatient Cardiac and Pulmonary Rehabilitation Services	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Outpatient Habilitation Therapy Services: • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
	Up to a combined total of 40 visits per Participant, per Benefit Period	
Outpatient Rehabilitation Therapy Services: • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
	Up to a combined total of 40 visits per Participant, per Benefit Period	
Palliative Care Services	Plan pays 80% of the Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Physician Office Visits	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Post-Mastectomy/Lumpectomy Reconstructive Surgery	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Prescribed Contraceptive Services *(Includes diaphragms, intrauterine devices (IUDs), implantables, injections, and tubal ligation.)*	Plan pays 100% of Maximum Allowance *(Deductible does not apply)*	Plan pays 60% of Maximum Allowance after Deductible
Skilled Nursing Facility	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
	Up to a combined total of 120 days per Participant, per Benefit Period.	
Surgical Services	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Telehealth Services provided by Teledoc (Online Care Group) **The Teledoc (Online Care Group) benefits described in this section are administered only by Teledoc and are not subject to the other terms and conditions of this Document. Contract Administrator is not responsible for, and makes no representations or warranties regarding, these benefits. All requests and questions should be directed to Teledoc or the Plan Sponsor.**	Telehealth services provided by Teledoc (Online Care Group). Covered Services will be subject to the applicable cost share percentages for services rendered. The Teledoc Diabetes Prevention Program is covered at 100% as a Preventive Care Service for those who qualify. To request a consultation, call 1-800-TELADOC.	
Telehealth Virtual Care Services (Providers other than Teledoc (Online Care Group))	Telehealth Virtual Care Services are available for any category of covered outpatient services. The amount of payment and other conditions for in-person services will apply to Telehealth Virtual Care Services. Please see the appropriate section of the Benefits Outline for those terms.	
Therapy Services *(Includes Radiation, Chemotherapy, Renal Dialysis and Growth Hormone.)*	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Transplant Services	Plan pays 80% of Maximum Allowance after Deductible *(Plan pays 100% of Maximum Allowance after Deductible for specific Transplant Services received at a Blue Distinction Center for Transplants (BDCT))*	Plan pays 60% of Maximum Allowance after Deductible
Urgent Care Clinic	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible

PREVENTIVE CARE BENEFITS		
	In-Network	**Out-of-Network**
Preventive Care Services For specifically listed services *Annual adult physical examinations; routine or scheduled well-baby and well-child examinations including hearing screenings; Developmental/Autism Screening; Screening for Visual Impairment in Children; Dental fluoride application for Participants age 5 and under; Bone Density; Chemistry Panels; Cholesterol Screening; Colorectal Cancer Screening; Complete Blood Count (CBC); Diabetes Screening; Pap Test; PSA Test; Rubella Screening; Screening EKG; Screening Mammogram; Thyroid Stimulating Hormone (TSH); Transmittable Diseases Screening (Chlamydia, Gonorrhea, Human Immunodeficiency Virus (HIV), Human papillomavirus (HPV); Syphilis, Tuberculosis (TB)); Hepatitis B Virus Screening; Sexually Transmitted Infections assessment; HIV assessment; Screening and assessment for interpersonal and domestic violence; Urinalysis (UA); Abdominal Aortic Aneurysm Screening and Ultrasound; Unhealthy Alcohol and Drug Use Assessment; Breast Cancer (BRCA) Risk Assessment and Genetic Counseling and Testing for High Risk Family History of Breast or Ovarian Cancer; Newborn Metabolic Screening (PKU, Thyroxine, Sickle Cell); Health Risk Assessment for Depression and/or self-harm; Anxiety Screening; Newborn Hearing Test; Lipid Disorder Screening; Nicotine, Smoking and Tobacco use Cessation Counseling Visit; Dietary Counseling for Adults at Higher Risk for Chronic Disease and Physical Activity Behavioral Counseling; Behavioral Counseling for Participants who are overweight or obese; Screening examinations for school or sports physicals; Preventive Lead Screening; Lung Cancer Screening for Participants age 50 and over; Hepatitis C Virus Infection Screening; Urinary Incontinence Screening; Urine Culture for Pregnant Women; Iron Deficiency Screening for Pregnant Women; Rh (D) Incompatibility Screening for Pregnant Women; Diabetes Screening for Pregnant Women; Perinatal Depression Counseling and Intervention; Behavioral Counseling for Healthy Weight and Weight Gain in Pregnancy.* *The specifically listed Preventive Care Services may be adjusted accordingly to coincide with federal government changes, updates, and revisions.*	Plan pays 100% of Maximum Allowance (Deductible does not apply)	Plan pays 60% of Maximum Allowance after Deductible
Services not Specifically Listed	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible

	In-Network	Out-of-Network
Immunizations *Acellular Pertussis, Anthrax, COVID-19, Cholera, Dengue, Diphtheria, Haemophilus Influenza B, Hepatitis A, Hepatitis B, Human papillomavirus (HPV), Inactivated Poliovirus, Influenza, Japanese Encephalitis, Measles, Meningococcal, Mumps, Pneumococcal (pneumonia), Rabies, Rotavirus, RSV, Rubella, Tetanus, Typhoid, Varicella (Chicken Pox), and Zoster.* *All Immunizations are limited to the extent* ***recommended*** *by the Advisory Committee on Immunization Practices (ACIP) and may be adjusted accordingly to coincide with federal government changes, updates and revisions.* Other immunizations not specifically listed may be covered at the discretion of the Contract Administrator, on behalf of the Plan Administrator, when Medically Necessary.	Listed immunizations require no Deductible or Cost Sharing Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible Plan pays 60% of Maximum Allowance after Deductible
Catapult Health –Preventive Assessment Employer sponsored virtual in home preventive assessment, including a clinical consultation via two-way live video conferencing. Please visit SimplotBenefits.com [simplotbenefits.com] for more information.	Plan pays 100% of Maximum Allowance for services performed by Catapult Health (Deductible does not apply)	No benefits

PRESCRIPTION DRUG BENEFITS • The Standard Formulary is available at www.bcidaho.com, and is available to any Participant on request by contacting the Contract Administrator's Customer Service Department at 208-286-3813 or 855-216-6850. • Except for Prescribed Contraceptives, each non Specialty Prescription Drug shall not exceed a 90 day supply at one (1) time. • Each Specialty Prescription Drug shall not exceed a 30 day supply at one (1) time. • Prescription Drug Services apply to the Out-of-Pocket Limits.	
PARTICIPATING RETAIL OR MAIL ORDER PHARMACIES *No benefits available for Prescription Drugs purchased at a Non-Participating Pharmacy*	
Tier 1	Plan pays 80% of Maximum Allowance after the Individual/Family Deductible is met
Tier 2	Plan pays 80% of Maximum Allowance after the Individual/Family Deductible is met
Tier 3	Plan pays 70% of Maximum Allowance after the Individual/Family Deductible is met
HSA Preventive Prescription Drugs	Participant pays $0 Copayment for HSA Preventive Prescription Drugs as specifically listed on the Contract Administrator's Formulary on the Contract Administrator's Website, www.bcidaho.com; Deductible does not apply.
ACA Preventive Prescription Drugs	Plan pays 100% for ACA Preventive Prescription Drugs as specifically listed on the Contract Administrator's Formulary on the Contract Administrator's Website, www.bcidaho.com; Deductible does not apply.
Prescribed Contraceptives	Plan pays 100% for Women's Preventive Prescription Drugs and devices as specifically listed on the Contract Administrator's Formulary on the Contract Administrator's Website, www.bcidaho.com; Deductible does not apply. The day supply allowed shall not exceed a six (6) month supply at one (1) time, as applicable to the specific contraceptive drug or supply. A Participant may request an exception for any FDA-approved, cleared or granted contraceptive not included on the Contract Administrator's formularies or one that is included with Cost Sharing. Under the exceptions process, if a Participant's attending Provider recommends a particular FDA-approved, cleared or granted contraceptive based on a determination of Medical Necessity with respect to that Participant, the Plan will cover that service or item without Cost Sharing. Contact Customer Service at the telephone number listed on the back of the Enrollee's Identification Card to obtain the appropriate request form.
Smoking Cessation Drugs *(Includes prescription and over the counter smoking cessation drugs)*	Plan pays 100% for Smoking Cessation Drugs for up to two ninety (90) day treatment regimens when dispensed pursuant to a written prescription.
Breast Cancer Prevention Drugs	Plan pays 100% for Breast Cancer Prevention Prescription Drugs for women who have been determined to be at increased risk for breast cancer.
Infertility Prescription Drugs ***For Enrollee and Enrolled Eligible Dependent spouse only***	Up to a combined Lifetime Benefit Limit of $5,000, per Participant

Attachment A:

SERVICES REQUIRING PRIOR AUTHORIZATION

What is Prior Authorization?
As part of your health plan coverage, we provide services to help you save money by avoiding unnecessary costs. When you and your doctor are making decisions about your health care and how your benefits will work, we can help.

Ahead of certain services, we ask your doctor to consult with our medical and pharmacy teams to discuss and agree on the course of treatment. This helps to be sure you're getting the right care and to know that your procedure or medication will be covered. Be sure your doctor gets the following services approved in advance (also called Prior Authorization). You may be responsible to pay for the services that are not approved.

When will I need to obtain Prior Authorization?
The Medical Program does not require Prior Authorization for all services. For example, it is not required for a visit to your primary care provider, going to the emergency room or for many other covered services. If you have questions about services that do not require Prior Authorization, you may call customer service and they will help you obtain the answers you need.

Below is the complete list of services that require Prior Authorization. The complete list of services that require Prior Authorization under the categories below can also be found on the Contract Administrator's Website, www.bcidaho.com. You may also request that the Contract Administrator mail you a copy of the complete list, at no charge, by calling (855) 216-6850. Services that are not on this list, do not require Prior Authorization and will not be reviewed by the Contract Administrator prior to completion of the services.

The following services require Prior Authorization:

Procedures:

- Radiation therapy
- Dental Surgery related to an accident
- Treatment of veins
- Reconstructive and plastic Surgery, including breast, eyelid, jaw and sinus
- Surgery for snoring or sleep problems
- Transplants (organ, tissue, etc.)
- Gender affirming services
- Breast reduction surgery
- Other Inpatient and Outpatient surgical procedures
- Certain genetic and laboratory testing
- Wound Care and Hyperbaric Oxygen (HCO)

Services:

- Acute Inpatient hospitalization
- Long-term acute care hospital (LTACH) admissions
- Rehabilitation and long-term care facility admissions
- Skilled nursing facility admissions
- Sub-acute and transitional care admissions
- Non-emergency ambulance transport
- Surgical Treatment of Morbid Obesity
- Behavioral Health Services
  - Psychological testing/neuropsychological evaluation testing
  - Electroconvulsive therapy (ECT)
  - Intensive outpatient program (IOP)
  - Partial hospitalization program (PHP)
  - Residential treatment center (RTC)
  - Transcranial Magnetic Stimulation (TMS)
- Advanced Imaging Specialty Health Services:
  - Sleep therapy including studies, appliances and treatment
  - Magnetic Resonance Imaging (MRI)
  - Computed Tomography (CT)

- Positron Emission Tomography (PET) scan
- Pain management
- Musculoskeletal procedures for spine and joints

Durable Medical Equipment:

- Certain equipment with costs of more than one thousand dollars ($1,000) (including rent-to-purchase items)
- Certain Orthotic Devices and Prosthetic Appliances with costs of more than one thousand dollars ($1,000)

Pharmacy

- Certain Prescription Drugs (find a full list at ***members.bcidaho.com***)
- Chimeric antigen receptor (CAR) T-cell Therapy
- Growth hormone therapy
- Outpatient intravenous (IV) therapy for infusion drugs (find a list at ***members.bcidaho.com***)

***How do I obtain a Prior Authorization*?**

You or your treating Provider may submit a Prior Authorization request only for the services specifically listed. This may be completed by telephone call or in writing and must include the information necessary to establish that the proposed services are Covered Services under the Medical Program. The Contract Administrator will respond to a request for Prior Authorization within seventy two (72) hours for an expedited request or fourteen (14) days for a standard request of the receipt of the medical information necessary to make a determination.

Note: Prior Authorization is not a guarantee of payment. It is a pre-service determination of Medical Necessity based on information provided to the Contract Administrator at the time the Prior Authorization request is made. The Contract Administrator, on behalf of the Plan Sponsor, retains the right to review the Medical Necessity of services, eligibility of services and benefit limitations and exclusions after services are received.

For additional information, please check with your Provider, call Customer Service at (855) 216-6850 or check the Contract Administrator's Website at www.bcidaho.com.

TRAVEL AND LODGING BENEFITS

The travel benefits described in this section are administered only by Healthbase and are not subject to the other terms and conditions of this this Document. Contract Administrator is not responsible for, and makes no representations or warranties regarding, these benefits. All requests and questions should be directed to Healthbase or the Plan Sponsor.

<table>
<tr><th>COVERED SERVICES</th><th>IN-NETWORK</th><th>OUT-OF-NETWORK</th></tr>
<tr><td rowspan="2">Travel and Lodging Reimbursement</td><td>Plan pays 100% of Maximum Allowance after Deductible</td><td>Plan pays 100% of Maximum Allowance after Deductible</td></tr>
<tr><td colspan="2">Reimbursement is limited to a combined $5,000 per Benefit Period, per Participant</td></tr>
</table>

The Plan provides reimbursement for the Participant and one adult companion (age eighteen (18) and over) for reasonable travel and lodging expenses necessary to receive Covered Services that are unavailable within a three hundred (300) mile drive from or six hundred (600) mile drive round trip of the Participant's primary home address. Reimbursement is limited to transportation (air or mileage), lodging, and rental car expenses. Travel and lodging are limited to $50.00, per night, per traveler in accordance with the 2025 IRS reimbursement guidelines. Traveler reimbursement is limited to the Participant and one (1) caregiver. Please see the Benefits Outline for Cost Sharing information and annual Benefit Period limit.

Mileage is reimbursed in accordance with the 2025 IRS medical mileage reimbursement guidelines of $0.21 per mile. Mileage reimbursement will automatically be updated to coincide with any IRS mileage reimbursement guidelines. Meals and other items not listed in this section are not eligible for reimbursement.

Reimbursements received are considered taxable income to the Participant.

The travel benefits described in this section are administered only by Healthbase and are not subject to the other terms and conditions of this Document. Contract Administrator is not responsible for, and makes no representations or warranties regarding, these benefits. All requests and questions should be directed to Healthbase or the Plan Sponsor.

J.R. SIMPLOT COMPANY GROUP HEALTH AND WELFARE PLAN
MEDICAL PROGRAM DOCUMENT

Blue Cross of Idaho has been hired as the Contract Administrator by the Plan Administrator to perform claims processing and other specified administrative services in relation to the Plan. Blue Cross of Idaho is a trade name for Blue Cross of Idaho Health Service, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

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HOW TO SUBMIT CLAIMS

A Participant must submit a claim to the Medical Program's Contract Administrator, in order to receive benefits for Covered Services. There are two ways for a Participant to submit a claim:

1. The Provider can file the claim for the Participant. Most Providers will submit a claim on a Participant's behalf if the Participant shows them the identification card and asks them to send the Contract Administrator the claim, or
2. The Participant can send the Contract Administrator the claim.

To File a Participant's Own Claims

If a Provider prefers that a Participant file the claim, here is the procedure the Participant needs to follow:

1. Ask the Provider for an itemized billing. This should show each service received and its procedure code, the date it was furnished, and the charge for each service. The Contract Administrator cannot accept billings that only say "Balance Due," "Payment Received," or some similar statement.
2. Obtain a Member Claim Form from the Contract Administrator's Website, www.bcidaho.com, from the Provider or any of the Contract Administrator's offices, and follow the instructions. Use a separate billing and Member Claim Form for each patient involved.
3. Attach the billing to the Member Claim Form and send it to:

   Blue Cross of Idaho Claims Control
   Blue Cross of Idaho
   PO Box 7408
   Boise, ID 83707

For assistance with claims or health information, please call the Contract Administrator Customer Service at 208-286-3813 or 855-216-6850.

How the Participant is Notified

The Contract Administrator makes its claim payment decisions based on the information it has when a claim is received. The Contract Administrator makes every effort to process claims as quickly as possible. The Contract Administrator will send a Participant an Explanation of Benefits (EOB) by mail or electronically, if the Participant has consented to electronic delivery, once the claim is processed. The Explanation of Benefits will show all of the payments the Contract Administrator made on behalf of the Plan and to whom the Contract Administrator sent the payment. It will also explain any charges the Contract Administrator did not pay in full. See the Inquiry and Appeals Procedures section for information on how to appeal charges the Contract Administrator did not pay in full. If a Participant would like a paper copy of their EOB, they may request one from the Contract Administrator's Customer Service.

CONTACT INFORMATION

For assistance with claims or benefit information, please contact Blue Cross of Idaho Customer Service.

Phone:	855-216-6850 or 208-286-3813
Mail:	Blue Cross of Idaho PO Box 7408 Boise, ID 83707
Physical address:	Blue Cross of Idaho 3000 East Pine Avenue Meridian, ID 83642
Online:	www.bcidaho.com

For assistance with Pharmacy claims or benefit information, please contact Blue Cross of Idaho, or CarelonRx:

Phone:	CarelonRx 855-839-5205
Mail Order:	CarelonRx 855-839-5205
Specialty Drugs:	CarelonRx Specialty Pharmacy 833-419-0528 or www.carelonrx.com
Online:	www.bcidaho.com for formulary and mail order

DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout this Medical Program Document ("Document"). Other terms may be defined where they appear in this Document. Definitions in this Document shall control over any other definition or interpretation unless the context clearly indicates otherwise.

Accidental Injury—an objectively demonstrable impairment of bodily function or damage to part of the body caused by trauma from a sudden, unforeseen external force or object, occurring at a reasonably identifiable time and place, and without a Participant's foresight or expectation, which requires medical attention at the time of the accident. The force may be the result of the injured party's actions, but must not be intentionally self-inflicted unless caused by a medical condition or domestic violence. Contact with an external object must be unexpected and unintentional, or the results of force must be unexpected and sudden.

Acute Care—Medically Necessary Inpatient treatment in a Licensed General Hospital or other Facility Provider for sustained medical intervention by a Physician and Skilled Nursing Care to safeguard a Participant's life and health. The immediate medical goal of Acute Care is to stabilize the Participant's condition, rather than upgrade or restore a Participant's abilities.

Admission—begins the first day a Participant becomes a registered Hospital bed patient or a Skilled Nursing Facility patient and continues until the Participant is discharged.

Adverse Benefit Determination—any denial, reduction, rescission of coverage, or termination of, or the failure to provide payment for, a benefit for services or ongoing treatment under the Medical Program.

Advisory Committee on Immunization Practices (ACIP)—a committee consisting of immunization field experts who provide guidance to the Center for Disease Control (CDC) and the Department of Health and Human Services (HHS), on the effective control of vaccine-preventable diseases in the United States. The committee develops written recommendations for the routine administration of vaccines to children and adults; to include dose, route, frequency of administration, precautions and contraindications.

Air Ambulance—medical transport by rotary wing air ambulance or fixed wing air ambulance as those terms are used in Medicare Regulations, including transportation that is certified as either a fixed wing or rotary wing air ambulance and such services and supplies as may be Medically Necessary.

Alcoholism—a behavioral or physical disorder manifested by repeated excessive consumption of alcohol to the extent that it interferes with a Participant's health, social, or economic functioning.

Alcoholism Or Substance Use Disorder Treatment—a Provider that is acting under the scope of its license, where required, that is primarily engaged in providing detoxification and Rehabilitative care for Alcoholism, or Substance Use Disorder, or Addiction.

Ambulatory Surgical Facility (Surgery Center)—a Facility Provider that is Medicare Certified and/or otherwise acting under the scope of its license, where required, with a staff of Physicians, which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis.
2. Provides treatment by or under the supervision of Physicians and provides Skilled Nursing Care while the Participant is in the facility.
3. Does not provide Inpatient accommodations.
4. Is not primarily a facility used as an office or clinic for the private practice of a Physician or other Professional Provider.

American Psychiatric Association—an organization composed of medical specialists who work together to ensure effective treatment for all persons with a mental disorder.

American Psychological Association—a scientific and professional organization that represents psychology in the United States.

Ancillary Provider Services—services typically provided at a Facility Provider by Professional Providers who are not employed by the Facility Provider, e.g. anesthesia, radiology, pathology and are not included in the services provided by the Facility Provider.

Applied Behavior Analysis (ABA)—the process of systematically applying interventions based upon the principles of learning theory to make changes to socially significant behavior to a meaningful degree, and to demonstrate the interventions are responsible for the improvement in behavior.

Approved Clinical Trial—a Registered National Institute of Health (NIH) and Food and Drug Administration (FDA) approved phase I, phase II, phase III, or phase IV clinical trial conducted in relation to prevention, detection, or treatment of cancer or other life-threatening condition.

Artificial Organs—permanently attached or implanted man-made devices that replace all or part of a Diseased or nonfunctioning body organ, including, but not limited to, artificial hearts and pancreases.

Autism Spectrum Disorder—means any of the pervasive developmental disorders or autism spectrum disorders, or related diagnoses, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Autotransplant (or Autograft)—the surgical transfer of an organ or tissue from one location to another within the same individual.

Benefit Period—the specified period of time in which a Participant's benefits for incurred Covered Services accumulate toward annual benefit limits, Deductible amounts and Out-of-Pocket Limits. The Benefit Period for the Plan is a calendar year from January 1 through December 31.

Benefits Outline—a listing of certain Covered Services specifying Cost Sharing, Copayments, Deductibles, and benefit limitations and maximums under the Medical Program.

BlueCard—a program to process claims for most Covered Services received by Participants outside of the Contract Administrator's service area while capturing the local Blue Cross and/or Blue Shield plan's Provider discounts.

Blue Distinction Centers for Transplants (BDCT)—the BDCT are major Hospitals and research institutions located throughout the United States that are designated for Transplants.

Certified Nurse-Midwife—an individual licensed to practice as a Certified Nurse Midwife.

Certified Registered Nurse Anesthetist—a licensed individual registered as a Certified Registered Nurse Anesthetist.

Chiropractic Care—services rendered, referred, or prescribed by a Chiropractic Physician.

Chiropractic Physician—an individual licensed to practice chiropractic.

Clinical Laboratory Improvement Amendments (CLIA)—a Centers for Medicare & Medicaid Services (CMS) program which regulates all human performed laboratory testing in the United States to ensure quality laboratory testing.

Clinical Nurse Specialist—an individual licensed to practice as a Clinical Nurse Specialist.

Clinical Psychologist—an individual licensed to practice clinical psychology.

Continuous Crisis Care—Hospice Nursing Care provided during periods of crisis in order to maintain a terminally ill Participant at home. A period of crisis is one in which the Participant's symptom management demands predominantly Skilled Nursing Care.

Contract Administrator—BCI has been hired as the Contract Administrator by the Plan Administrator to perform claims processing and other specified administrative services in relation to the Plan. The Contract Administrator is not an insurer of health benefits under the Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Contract Administrator is not responsible for Plan financing and does not guarantee the availability of Plan benefits.

Contracting Provider—a Provider that has entered into a written agreement with BCI regarding payment for Covered Services rendered to a Participant under a PPO program. This is not the same as an In-Network Provider whose definition is later in this document.

Copayment—a designated dollar and/or percentage amount, separate from Cost Sharing, that a Participant is financially responsible for and must pay to a Provider at the time certain Covered Services are rendered, under the Prescription Drug Benefit.

Cost Effective—a requested or provided medical service or supply that is Medically Necessary in order to identify or treat a Participant's health condition, illness or injury and that is:

1. Provided in the most cost-appropriate setting consistent with the Participant's clinical condition and the Provider's expertise. For example, when applied to services that can be provided in either an Inpatient hospital setting or Outpatient hospital setting, the Cost Effective setting will generally be the outpatient setting. When applied to services that can be provided in a hospital setting or in a physician office setting, the Cost Effective setting will generally be the physician office setting.
2. Not more costly than an alternative service or supply, including no treatment, and at least as likely to produce an equivalent result for the Participant's condition, Disease, Illness or injury.

Cost Sharing—the percentage of the Maximum Allowance or the actual charge, whichever is less, a Participant pays Out-of-Pocket for Covered Services after satisfaction of any applicable Deductibles or Copayments, or both.

Covered Service—when rendered by a Provider, a service, supply, or procedure specified in this Document for which benefits will be provided to a Participant.

Custodial Care—care designated principally to assist a Participant in engaging in the activities of daily living, or services which constitute personal care, such as help in walking and getting in and out of bed, assistance in eating, dressing, bathing, and using the toilet; preparation of special diets; and supervision of medication, which can usually be self-administered and does not require the continuing attention of trained medical or paramedical personnel. Custodial Care is normally, but not necessarily, provided in a nursing home, convalescent home, rest home, or similar institution.

Deductible—the amount a Participant pays Out-of-Pocket per Benefit Period before the Medical Program begins to pay benefits for most Covered Services. The amount credited to the Deductible is based on the Maximum Allowance or the actual charge, whichever is less.

Dentist—an individual licensed to practice Dentistry.

Dentistry or Dental Treatment—the treatment of teeth and supporting structures, including, but not limited to, the replacement of teeth.

Diagnostic Imaging Provider—a person or entity that is licensed, where required, and/or Medicare Certified (and/or otherwise acting under the scope of license) to render Covered Services.

Diagnostic Service—a test or procedure performed on the order of a Physician or other Professional Provider because of specific symptoms, in order to identify a particular condition, Disease, Illness, or Accidental Injury. Diagnostic Services include, but are not limited to:

1. Radiology services.
2. Laboratory and pathology services.
3. Cardiographic, encephalographic, and radioisotope tests.

Disease—any alteration in the body or any of its organs or parts that interrupts or disturbs the performance of vital functions, thereby causing or threatening pain, weakness, or dysfunction. A Disease can exist with or without a Participant's awareness of it, and can be of known or unknown cause(s).

Durable Medical Equipment—items which can withstand repeated use, are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of Accidental Injury, Disease, or Illness, and are appropriate for use in the Participant's home.

Durable Medical Equipment Supplier—a business that is licensed, where required, and/or Medicare Certified (and/or otherwise acting under the scope of license) to sell or rent Durable Medical Equipment.

Effective Date—the date when coverage for a Participant begins under the Medical Program.

Electroconvulsive Therapy (ECT)—Electroconvulsive Therapy (ECT) is a treatment for severe forms of depression, bipolar disorder, schizophrenia and other serious mental illnesses that uses electrical impulses to induce a convulsive seizure.

Eligible Dependent—a person eligible for enrollment under an Enrollee's coverage as specified in the Plan's Summary Plan Description booklet. For the purposes of this Medical Program, the child of a Surrogate will not be considered an Eligible Dependent of the Surrogate or her spouse.

Eligible Employee—an employee who is eligible to become an Enrollee.

Emergency Admission Notification—notification by the Participant to the Contract Administrator of an Emergency Inpatient Admission resulting in an evaluation conducted by the Contract Administrator, on behalf of the Plan Administrator, to determine the Medical Necessity of a Participant's Emergency Inpatient Admission and the accompanying course of treatment.

Emergency Inpatient Admission—Medically Necessary Inpatient admission to a Licensed General Hospital or other Inpatient Facility due to the sudden, acute onset of a medical condition, Mental or Nervous Condition, Substance Use Disorder or Addiction, or an Accidental Injury which requires immediate medical treatment to preserve life or prevent severe, irreparable harm to a Participant.

Emergency Medical Condition—a condition reflected by sudden and unexpected symptoms that are severe enough that a reasonably prudent layperson with average knowledge of health and medicine would expect extreme consequences to result without immediate medical care. These consequences include placing the health of the individual (or, regarding a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Emergency Medical Conditions, include but are not limited to, heart attacks, cerebrovascular accidents, poisonings, loss of consciousness or respiration, and convulsions, Mental or Nervous Condition, or Substance Use Disorder or Addiction.

Employer—J.R. Simplot Company.

Enrollee—an Eligible Employee who has enrolled for coverage and has satisfied the eligibility requirements of the Plan as described in the Plan's Summary Plan Description booklet and who has properly enrolled in the Medical Program through a process determined by the J.R. Simplot Company.

Explanation of Benefits (EOB)—a statement sent to the Participant explaining what medical treatments and/or services were paid for by the Medical Program.

Family Coverage—enrollment of an Enrollee and one or more Eligible Dependent(s) under the Medical Program.

Freestanding Diabetes Facility—a person or entity that is recognized by the American Diabetes Association, and/or otherwise acting under the scope of its license, where required, to render Covered Services.

Freestanding Dialysis Facility—a Medicare Certified Facility Provider, or other Facility Provider acting under the scope of its license, that is primarily engaged in providing dialysis treatment, maintenance, or training to patients on an Outpatient or home care basis.

Freestanding Emergency Department—a health care facility that is geographically distinct and licensed separately from a Hospital under applicable state law and provides emergency services.

Ground Ambulance—a licensed ground vehicle that is specially designed and equipped for transporting the sick and injured.

Habilitation (or Habilitative)—developing skills and functional abilities necessary for daily living and skills related to communication of persons who have never acquired them.

Health Benefit Plan—any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or managed care organization subscriber contract. Health Benefit Plan does not include policies or certificates of insurance for specific Disease, hospital confinement indemnity, accident-only, credit, dental, vision, Medicare supplement, long-term care or disability income insurance, student health benefits-only coverage issued as a supplement to liability insurance, Workers' Compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

Homebound—confined primarily to the home as a result of a medical condition. The term connotes that it is "a considerable and taxing effort" to leave the home due to a medical condition and not because of inconvenience.

Home Health Agency—any agency or organization that provides Skilled Nursing Care services and other therapeutic services.

Home Health Aide—an individual employed by a Hospice, under the direct supervision of a licensed registered nurse (R.N.), who performs, and trains others to perform, intermittent Custodial Care services which include, but are not limited to, assistance in bathing, checking vital signs, and changing dressings.

Home Health Skilled Nursing Care Services—the delivery of Skilled Nursing Care services under the direction of a Physician to a Homebound Participant. Home Health Skilled Nursing is generally intended to transition a Homebound patient from a hospital setting to a home or prevent a hospital stay, provided such nurse does not ordinarily reside in the Participant's household or is not related to the Participant by blood or marriage.

Home Intravenous Therapy Company—a licensed, where required, and/or Medicare Certified (and/or otherwise acting under the scope of its license) pharmacy or other entity that is principally engaged in providing services, medical supplies, and equipment for certain home infusion Therapy Covered Services, to Participants in their homes or other locations outside of a Licensed General Hospital.

Hospice—a Medicare Certified (and/or otherwise acting under the scope of its license, if required) public agency or private organization designated specifically to provide services for care and management of terminally ill patients, primarily in the home.

Hospice Nursing Care—Skilled Nursing Care and Home Health Aide services provided as a part of the Hospice Plan of Treatment.

Hospice Plan of Treatment—a written plan of care that describes the services and supplies for the Medically Necessary care and treatment to be provided to a Participant by a Hospice. The written plan of care must be established and periodically reviewed by the attending Physician.

Hypnosis—an induced passive state in which there is an increased responsiveness to suggestions and commands, provided that these do not conflict seriously with the subject's conscious or unconscious wishes.

Illness—a deviation from the healthy and normal condition of any bodily function or tissue. An Illness can exist with or without a Participant's awareness of it, and can be of known or unknown cause(s).

In-Network Provider—A Contracting Provider or a Non-Contracting Provider whose Preferred Provider Organization discounts are accessed under the Blue Card program.

Injury—damage to a part of the body caused by trauma from a sudden, unforeseen outside force or object, occurring at an identifiable time and place, and without the Participant's foresight or expectation.

In-Network Services—Covered Services provided by an In-Network Provider.

Inpatient—a Participant who is admitted as a bed patient in a Licensed General Hospital or other Facility Provider and for whom a room and board charge is made.

Intensive Outpatient Program—Intensive Outpatient Program (IOP) is a treatment program that includes extended periods of therapy sessions, several times a week for a minimum of three (3) hours per day, a minimum of three (3) days per week and a minimum of nine (9) hours per week. It is an intermediate setting between traditional therapy sessions and partial hospitalization.

Investigational—any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes such as length of life, quality of life, and functional ability. A technology is considered investigational if, as determined by BCI, on behalf of the Plan Administrator, it fails to meet any <u>one</u> of the following criteria:

- <u>The technology must have final approval from the appropriate government regulatory body.</u> This applies to drugs, biological products, devices, and other products/procedures that must have approval from the U.S. Food and Drug Administration (FDA) or another federal authority before they can be marketed. Interim approval is not sufficient. The condition for which the technology is approved must be the same as that the Contract Administrator is evaluating.

- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of current published medical literature and investigations published in peer-reviewed journals. The quality of the studies and consistency of results will be considered. The evidence should demonstrate that the technology can measure or alter physiological changes related to a Disease, Injury, Illness, or condition. In addition, there should be evidence that such measurement or alteration affects health outcomes.
- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives.
- The technology must show improvement that is attainable outside the investigational setting. Improvements must be demonstrated when used under the usual conditions of medical practice.

If a technology is determined to be investigational, all services specifically associated with the technology, including but not limited to associated procedures, treatments, supplies, devices, equipment, facilities or drugs will also be considered investigational, unless services associated with the technology would otherwise be provided if Participant was not receiving Investigational services.

In determining whether a technology is investigational, the Contract Administrator considers the following source documents: Blue Cross Blue Shield Association's Evidence Positioning System assessments, the Blue Cross and Blue Shield Association Medical Policy Reference Manual as adopted by the Contract Administrator, and Blue Cross of Idaho Medical Policies. BCI also considers current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

Keratoconus—a developmental or dystrophic deformity of the cornea in which it becomes cone-shaped due to a thinning and stretching of the tissue in its central area.

Licensed General Hospital—a short term, Acute Care, general hospital that:

1. Is an institution licensed in the state in which it is located, and is lawfully entitled to operate as a general, Acute Care hospital;
2. Is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians for compensation from and on behalf of its patients.
3. Has functioning departments of medicine and Surgery;
4. Provides twenty-four (24)-hour nursing service by or under the supervision of licensed R.N.s.
5. Is not predominantly a:
    a) Skilled Nursing Facility
    b) Nursing home
    c) Custodial Care home
    d) Health resort
    e) Spa or sanatorium
    f) Place for rest
    g) Place for the treatment or Rehabilitative care of Mental or Nervous Conditions
    h) Place for the treatment or Rehabilitative care of Alcoholism or Substance Use Disorder or Addiction
    i) Place for Hospice care
    j) Residential Treatment Center
    k) Transitional Living Center

Licensed Marriage and Family Therapist (LMFT)—a licensed individual providing diagnosis and treatment of Mental or Nervous Conditions.

Licensed Pharmacist—an individual licensed to practice pharmacy.

Licensed Rehabilitation Hospital—a Facility Provider principally engaged in providing diagnostic, therapeutic, and Physical Rehabilitation Services to Participants on an Inpatient basis.

Lifetime Benefit Limit—the greatest aggregate amount payable by the Contract Administrator and on behalf of a Participant for specified Covered Services during all periods in which the Participant has been continuously enrolled or covered under any agreement, certificate, contract, or plan administered on behalf of the Plan Sponsor.

Maximum Allowance—for Covered Services under the terms of the Plan, Maximum Allowance is the lesser of the billed charge or the amount established by the Contract Administrator as the highest level of compensation for a Covered Service. If the Covered Services are rendered outside the state of Idaho by a Contracting Provider with a Blue Cross and/or Blue Shield affiliate in the location of the Covered Services, the Maximum Allowance is the lesser of the billed charge or the amount established by the affiliate as compensation.

The Maximum Allowance may be determined using many factors, as applicable, including pre-negotiated payment amounts; diagnostic related groupings (DRGs); a resource based relative value scale (RBRVS); ambulatory payment classifications (APCs); the Provider's charge(s); the charge(s) of Providers with similar training and experience within a particular geographic area; Medicare reimbursement amounts; Qualifying Payment Amount, amount determined under an Independent Dispute Resolution (IDR) in accordance with surprise medical billing requirements under the federal No Surprises Act, and/or the cost of rendering the Covered Service. Moreover, Maximum Allowance may differ depending on whether the Provider is Contracting or Noncontracting.

In addition, Maximum Allowance for Covered Services provided by Contracting or Noncontracting Dentists is determined using many factors, including pre-negotiated payment amounts, a calculation of charges submitted by Contracting Idaho Dentists, and/or a calculation of the average charges submitted by all Idaho Dentists.

Medicaid—Title XIX (Grants to States for Medical Assistance Programs) of the United States Social Security Act as amended.

Medical Food—a food which is formulated to be consumed or administered orally or enterally under the supervision of a Physician.

Medical Program—the self-funded program of the J.R. Simplot Group Health and Welfare Plan that provides medical and prescription benefits for eligible Participants on the terms and conditions set forth in this Medical Program Document and in the Plan's Summary Plan Description booklet.

Medically Necessary (Or Medical Necessity)—the Covered Service or supply recommended by the treating Provider to identify or treat a Participant's condition, Disease, Illness or Accidental Injury and which is determined by the Contract Administrator, on behalf of the Plan Administrator, to be:

1. The most appropriate supply or level of service, considering potential benefit and harm to the Participant.
2. Proven to be effective in improving health outcomes:
    a. For new treatment, effectiveness is determined by peer reviewed scientific evidence; or
    b. For existing treatment, effectiveness is determined first by peer reviewed scientific evidence, then by professional standards, then by expert opinion.
3. Not primarily for the convenience of the Participant or Provider.
4. Cost Effective for this condition.

The fact that a Provider may prescribe, order, recommend, or approve a service or supply does not, in and of itself, necessarily establish that such service or supply is Medically Necessary under the Medical Program.

The term Medically Necessary as defined and used in this Document is strictly limited to the application and interpretation of this Document, and any determination of whether a service is Medically Necessary hereunder is made solely for the purpose of determining whether services rendered are Covered Services.

In determining whether a service is Medically Necessary, the Contract Administrator considers the medical records and, the following source documents: Blue Cross Blue Shield Association's Evidence Positioning System assessments, the Blue Cross and Blue Shield Association Medical Policy Reference Manual as adopted by the Contract Administrator, and Blue Cross of Idaho Medical Policies. The Contract Administrator also considers current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

Medicare—Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

Medicare Certified—Centers for Medicare and Medicaid Services (CMS) develops standards that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These minimum health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries.

These standards are the minimum health and safety requirements that providers and suppliers must meet in order to be Medicare and Medicaid Certified.

Mental or Nervous Conditions—means and includes mental disorders, mental Illnesses, psychiatric Illnesses, mental conditions, and psychiatric conditions (whether organic or inorganic, whether of biological, nonbiological, chemical or nonchemical origin and irrespective of cause, basis, or inducement). Mental and Nervous Conditions, include but are not limited to: psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

Morbid Obesity—a condition where an individual's body mass index (BMI) is over 40 kg/meter squared, or the BMI is over 35 kg/meter squared with at least one clinically significant obesity-related disease: diabetes mellitus, obstructive sleep apnea, coronary artery disease, or hypertension.

Neuromusculoskeletal Treatment—means and includes diagnosis and treatment in the form of manipulation and adjustment of the vertebrae, disc, spine, back, neck and adjacent tissues in an Outpatient office or clinic setting and for acute or Rehabilitative purposes.

Noncontracting Provider—a Professional Provider or Facility Provider that has not entered into a written agreement with the Contract Administrator regarding payment for Covered Services rendered to a Participant under a PPO program.

Nurse Practitioner—an individual licensed to practice as a Nurse Practitioner.

Occupational Therapist—an individual licensed to practice occupational therapy.

Office Visit—any direct, one-on-one examination and/or exchange, conducted in the Provider's office, between a Participant and a Provider, or members of their staff for the purposes of seeking care and rendering Covered Services. For purposes of this definition, a Medically Necessary visit by a Physician to a Homebound Participant's place of residence may be considered an Office Visit.

Optometrist—a person who is licensed and specializes in optometry to examine, measure and treat certain visual defects by means of corrective lenses or other methods that do not require a license as a physician.

Organ Procurement—Diagnostic Services and medical services to evaluate or identify an acceptable donor for a recipient and a donor’s surgical and hospital services directly related to the removal of an organ or tissue for such purpose. Transportation for a donor or for a donated organ or tissue is not an Organ Procurement service.

Orthotic Devices—any rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or Diseased body part.

Out-of-Network Provider—a Provider who meets both of the following criteria:

- A Noncontracting Provider, and
- A Provider who does not participate in a Preferred Provider Organization who is accessed through the Blue Card program.

Out-of-Network Services—any Covered Services rendered by a Noncontracting Provider.

Out-of-Pocket Expenses—Cost Sharing expenses that a Participant is responsible for, and actually pays. These include only the Participant’s Deductible, Copayments, and Cost Sharing for eligible Covered Services. They do not include amounts reimbursed from other sources, e.g. a Prescription Drug discount card or coupon.

Out-of-Pocket Limit—the maximum amount of Out-of-Pocket Expenses incurred during one (1) Benefit Period that a Participant is responsible for paying.

Outpatient—a Participant who receives services or supplies while not an Inpatient.

Palliative Care—is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening Illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical and psychosocial.

Partial Hospitalization Program—Partial Hospitalization Program (PHP) is a treatment program that provides interdisciplinary medical and psychiatric services. Partial Hospitalization Program (PHP) involves a prescribed course of

psychiatric treatment provided on a predetermined and organized schedule and provided in lieu of hospitalization for a patient who does not require full-time hospitalization.

Participant—an Enrollee or an enrolled Eligible Dependent covered under the Medical Program**.**

Physical Rehabilitation—Medically Necessary, non-acute therapy rendered by qualified health care professionals. Physical Rehabilitation is intended to restore a Participant's physical health and well-being as close as reasonably possible to the level that existed immediately prior to the occurrence of a condition, Disease, Illness, or Accidental Injury.

Physical Therapist—an individual licensed to practice physical therapy.

Physician—a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) licensed to practice medicine.

Physician Assistant—an individual licensed to practice as a Physician Assistant.

Plan—the J.R. Simplot Company Group Health and Welfare Plan.

Plan Administrator—the Plan Administrator, J.R. Simplot Company, the sole fiduciary of the Plan, has all discretionary authority to interpret the provisions and control the operation and administration of the Plan within the limits of the law.

Plan Sponsor—J.R. Simplot Company.

Podiatrist—an individual licensed to practice podiatry.

Post-Service Claim—any claim for a benefit under the Medical Program that does not require Prior Authorization before services are rendered.

Post-Stabilization Care Services—any additional items and services that are Covered Services after a Participant is stabilized and as part of Outpatient observation or Inpatient or Outpatient stay with respect to the visit in which the emergency services are furnished.

Preadmission Testing—tests and studies required in connection with a Participant's Inpatient admission to a Licensed General Hospital that are rendered or accepted by the Licensed General Hospital on an Outpatient basis. Preadmission tests and studies must be done prior to a scheduled Inpatient admission to the Licensed General Hospital, provided the services would have been available to an Inpatient of that hospital. Preadmission Testing does not include tests or studies performed to establish a diagnosis.

Preferred Blue PPO—a preferred provider organization product offered through the Contract Administrator.

Prescription Drugs—drugs, biologicals, and compounded prescriptions that are FDA approved and can be dispensed only according to a written prescription given by a Physician and/or duly licensed provider, that are listed with approval in the *United States Pharmacopoeia, National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that are prescribed for human consumption, and that are required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription."

Pre-Service Claim—any claim for a benefit that requires Prior Authorization before services are rendered.

Primary Care Giver—a person designated to give direct care and emotional support to a Participant as part of a Hospice Plan of Treatment. A Primary Care Giver may be a spouse, relative, or other individual who has personal significance to the Participant. A Primary Care Giver must be a volunteer who does not expect or claim any compensation for services provided to the Participant.

Prior Authorization—the Provider's or the Participant's request to the Contract Administrator or delegated entity, on behalf of the Plan Administrator, for a Medical Necessity determination of a Participant's proposed treatment. The Contract Administrator or the delegated entity may review medical records, test results and other sources of information to make the determination. Prior Authorization is not a determination of benefit coverage. Benefit coverage and eligibility for payment is determined by the Contract Administrator, on behalf of the Plan Administrator.

Prosthetic and Orthotic Supplier—a person or entity that is licensed, where required, and Medicare Certified (or otherwise acting under the scope of its license) to render Covered Services.

Prosthetic Appliances—Prosthetic Appliances are devices that replace all or part of an absent body organ, including contiguous tissue, or replace all or part of the function of a permanently inoperative or malfunctioning body organ.

Provider—a person or entity that is licensed, certified, accredited and/or registered, where required, to render Covered Services. Providers include any facility or individual who provides a Covered Service while operating within the scope of their license, certification, accreditation and/or registration under applicable state law, unless exempted by federal law.

Psychiatric Hospital—a Facility Provider principally engaged in providing diagnostic and therapeutic services and Rehabilitation Services for the Inpatient treatment of Mental or Nervous Conditions, Alcoholism or Substance Use Disorder or Addiction. These services are provided by or under the supervision of a staff of Physicians, and continuous nursing services are provided under the supervision of a licensed R.N.

Qualifying Payment Amount—the median contracted rates recognized by the Contract Administrator as the maximum payment for the same or similar Covered Services provided by a Provider in same or similar specialty, in the same geographic area (increased by the consumer price index) in accordance with surprise medical billing requirements under the federal No Surprises Act.

Radiation Therapy Center—a Facility Provider that is primarily engaged in providing Radiation Therapy Services to patients on an Outpatient basis.

Recognized Transplant Center—a Licensed General Hospital that meets any of the following criteria:

1. Is approved by the Medicare program for the requested Transplant Covered Services.
2. Is included in the Blue Cross and Blue Shield System's National Transplant Network.
3. Has an arrangement(s) with another Blue Cross and/or Blue Shield Plan for the delivery of the requested Transplant Covered Services, based on appropriate approval criteria established by that Plan.
4. Is approved by the Contract Administrator based on the recommendation of the Contract Administrator's Medical Director.

Registered Dietitian—a professional trained in foods and the management of diets (dietetics) who is credentialed by the Commission on Dietetic Registration of the American Dietetic Association or otherwise acting under the scope of their license, where required.

Rehabilitation (or Rehabilitative)—restoring skills and functional abilities necessary for daily living and skills related to communication that have been lost or impaired due to disease, illness or injury.

Rehabilitation or Habilitation Plan of Treatment—a written plan established and reviewed periodically by an attending Physician which describes the services and supplies for the Rehabilitation or Habilitation care and treatment to be provided to a Participant.

Residential Treatment Center—a Facility Provider licensed by the appropriate state/local authorities as a Residential Treatment Center that is primarily engaged in providing twenty-four (24) hour level of care, including twenty-four (24) hour onsite or on call nursing services and a defined course of therapeutic intervention and special programming in a controlled environment. Care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential Treatment Center does not include Custodial Care, outdoor behavioral health programs, half-way houses, supervised living, group homes, boarding houses or other similar facilities providing primarily a supportive and/or recreational environment, even if Mental Health or Substance Use Disorder counseling is provided in such facilities.

Respite Care—care provided to a Homebound Participant as part of a Hospice Plan of Treatment. The purpose of Respite Care is to provide the Primary Care Giver a temporary period of rest from the stress and physical exhaustion involved in caring for the Participant at home.

Skilled Nursing Care—nursing service that must be rendered by or under the direct supervision of a licensed R.N. to maximize the safety of a Participant and to achieve the medically desired result according to the orders and direction of an attending Physician. The following components of Skilled Nursing Care distinguish it from Custodial Care that does not require professional health training:

1. The observation and assessment of the total medical needs of the Participant.
2. The planning, organization, and management of a treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired result.

3. Rendering to the Participant, direct nursing services that require specialized training.

Skilled Nursing Facility—a licensed Facility Provider primarily engaged in providing Inpatient Skilled Nursing Care to patients requiring convalescent care rendered by or under the supervision of a Physician. Other than incidentally, a Skilled Nursing Facility is not a place or facility that provides minimal care, Custodial Care, ambulatory care, or part-time care services; or care or treatment of Mental or Nervous Conditions, Alcoholism, or Substance Use Disorder or Addiction.

Sleep Study—the continuous monitoring of physiological parameters, such as brain and breathing activity of the Participant during sleep.

Sound Natural Tooth—for avulsion or traumatic tooth loss, a Sound Natural Tooth is considered to be one in which the existing conditions of the tooth and its supporting structures did not influence the outcome of the Injury in question, is without impairment, including but not limited to periodontal or other conditions, and is not in need of the treatment provided for any reason other than the Accidental Injury.

For injuries related to fracture of the coronal surface, a Sound Natural Tooth is considered to be one which has not been restored by, including but not limited to, a crown, inlay, onlay or porcelain restoration, or treated by endodontics.

Special Care Unit—a designated unit within a Licensed General Hospital that has concentrated facilities, equipment, and support services to provide an intensive level of care for critically ill patients.

Substance Use Disorder or Addiction—a behavioral or physical disorder manifested by repeated excessive use of a drug or alcohol to the extent that it interferes with a Participant's health, social, or economic functioning.

Surgery—within the scope of a Provider's license, the performance of:
1. Generally accepted operative and cutting procedures;
2. Endoscopic examinations and other invasive procedures using specialized instruments;
3. The correction of fractures and dislocations.
4. Customary preoperative and postoperative care.

Surrogate—a woman who agrees to become pregnant and give birth to a child for another individual or couple (the "Intended Parents") in order to give the child to the Intended Parents whether or not the Surrogate is the genetic mother of the child and whether or not the Surrogate does so for compensation.

Telehealth Virtual Care Services—health care services conducted with technology that includes live audio and video communication between the Participant and a Provider in compliance with state and federal laws. No benefits are available for visits conducted by (a) audio-only communication when treatment by such method is not permitted under applicable law at the time of visit, (b) e-mail or (c) fax.

Temporomandibular Joint (TMJ) Syndrome—jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves, and other tissues relating to that joint.

Therapy Services—Therapy Services include only the following:
1. Radiation Therapy—treatment of Disease by x-ray, radium, or radioactive isotopes.
2. Chemotherapy—treatment of malignant Disease by chemical or biological antineoplastic agents.
3. Renal Dialysis—treatment of an acute or chronic kidney condition, which may include the supportive use of an artificial kidney machine.
4. Physical Therapy—treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, or devices to relieve pain, restore maximum function, or prevent disability following a condition, Disease, Illness, Accidental Injury, or loss of a body part.
5. Occupational Therapy—treatment that employs constructive activities designed and adapted for a physically disabled Participant to help satisfactorily accomplish the ordinary tasks of daily living and tasks required by the Participant's particular occupational role.
6. Speech Therapy—corrective treatment of a speech impairment resulting from a condition, Illness, Disease, Surgery, or Accidental Injury; or from congenital anomalies, or previous therapeutic processes.
7. Growth Hormone Therapy—treatment administered by intramuscular injection to treat children with growth failure due to pituitary disorder or dysfunction.
8. Home Intravenous Therapy (Home Infusion Therapy)—treatment provided in the home of the Participant or other locations outside of a Licensed General Hospital, that is administered via an intravenous, intraspinal, intra-arterial,

intrathecal, subcutaneous, enteral, or intramuscular injection or access device inserted into the body, at or under the direction of a Home Health Agency or other Provider acting under the scope of their license.

Transplant—surgical removal of a donated organ or tissue and the transfer of that organ or tissue to a recipient.

Treatments for Autism Spectrum Disorder—means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder, or related diagnoses, by a licensed Physician or a licensed psychologist, including but not limited to behavioral health treatment, pharmacy care, psychiatric care, psychological care, and therapeutic care.

Urgent Care Clinic—a facility offering immediate medical care for non life-threatening injuries and illnesses.

INPATIENT NOTIFICATION SECTION

This section describes procedures that should be followed in order for Participants to receive the maximum benefits available for Covered Services. As specified, Non-Emergency Preadmission Notification or Emergency Admission Notification is required for all Inpatient services.

NOTE: Some Inpatient services also require the Provider to obtain Prior Authorization. Please refer to the Prior Authorization Section.

I. Non-Emergency Preadmission Notification

Non-Emergency Preadmission Notification is a notification to the Contract Administrator by the Participant and is required for all Inpatient admissions except Covered Services subject to Emergency or Maternity delivery Admission Notification. A Participant should notify the Contract Administrator of all proposed Inpatient admissions as soon as they know they will be admitted as an Inpatient. The notification should be made before any Inpatient admission. Non-Emergency Preadmission Notification informs the Contract Administrator, or a delegated entity, of the Participant's proposed Inpatient admission to a Licensed General Hospital, Alcohol or Substance Use Disorder Treatment Facility, Psychiatric Hospital, or any other Facility Provider. This notification alerts the Contract Administrator of the proposed stay. When timely notification of an Inpatient admission is provided by the Participant to the Contract Administrator, payment of benefits is subject to the specific benefit levels, limitations, exclusions and other provisions of the Medical Program.

For Non-Emergency Preadmission Notification call the Contract Administrator at the telephone number listed on the back of the Enrollee's Identification Card.

II. Emergency Admission Notification

When an Emergency Admission occurs for Emergency Medical Conditions and notification cannot be completed prior to admission due to the Participant's condition, the Participant, or their representative, should notify the Contract Administrator within seventy-two (72) hours of the admission. If the admission is on a weekend or legal holiday, the Contract Administrator should be notified by the end of the next working day after the admission.

This notification alerts the Contract Administrator to the emergency stay.

III. Continued Stay Review

The Contract Administrator will contact the hospital utilization review department and/or the attending Physician regarding the Participant's proposed discharge. If the Participant will not be discharged as originally proposed, the Contract Administrator will evaluate the Medical Necessity of the continued stay and approve or disapprove benefits, on behalf of the Plan Administrator, for the proposed course of Inpatient treatment. Payment of benefits is subject to the specific benefit levels, limitations, exclusions and other provisions of the Medical Program.

IV. Discharge Planning

The Contract Administrator will provide information about benefits for various post-discharge courses of treatment.

PRIOR AUTHORIZATION SECTION

What is Prior Authorization?
As part of your health plan coverage, we provide services to help you save money by avoiding unnecessary costs. When you and your doctor are making decisions about your health care and how your benefits will work, we can help.

Ahead of certain services, we ask your doctor to consult with our medical and pharmacy teams to discuss and agree on the course of treatment. This helps to be sure you're getting the right care and to know that your procedure or medication will be covered. Be sure your doctor gets the following services approved in advance (also called Prior Authorization). You may be responsible to pay for the services that are not approved.

When will I need to obtain Prior Authorization?
The Medical Program does not require Prior Authorization for all services. For example, it is not required for a visit to your primary care provider, going to the emergency room or for many other covered services. If you have questions about services that do not require Prior Authorization, you may call customer service and they will help you obtain the answers you need.

***How do I obtain a Prior Authorization*?**
You or your treating Provider may submit a Prior Authorization request only for the services specifically listed. This may be completed by telephone call or in writing and must include the information necessary to establish that the proposed services are Covered Services under the Medical Program. The Contract Administrator will respond to a request for Prior Authorization within seventy two (72) hours for an expedited request or fourteen (14) days for a standard request of the receipt of the medical information necessary to make a determination.

Note: Prior Authorization is not a guarantee of payment. It is a pre-service determination of Medical Necessity based on information provided to the Contract Administrator at the time the Prior Authorization request is made. The Contract Administrator, on behalf of the Plan Sponsor, retains the right to review the Medical Necessity of services, eligibility of services and benefit limitations and exclusions after services are received.

Please refer to Attachment A of the Benefits Outline, check the Contract Administrator's Website at www.bcidaho.com, or call Customer Service at (855) 216-6850 to determine if the Participant's proposed services require Prior Authorization.

GENERAL BENEFIT INFORMATION

This section specifies the benefits a Participant is entitled to receive for Covered Services described, or conditions that must be satisfied to qualify for benefits, subject to the other provisions of the Plan.

I. Deductibles

The Deductible amounts are determined by election of Individual or Family Coverage and are stated in the Benefits Outline. Covered Services provided by an In-Network Provider apply only towards the In-Network Deductible and Covered Services provided by an Out-of-Network Provider apply only towards the Out-of-Network Deductible. Expenses incurred for noncovered services are not applicable to any of the Deductibles.

A. *Individual coverage:* An enrolled individual's Deductible, as specified in the Benefits Outline, consists of the total dollars contributed toward eligible Covered Services per Benefit Period.

B. *Family Coverage:* An enrolled family's Deductible, as specified in the Benefits Outline, consists of the total dollars contributed toward eligible Covered Services per Benefit Period for all Participants covered under the same Family Coverage, regardless of which individual Participant, or combination of Participants, meets the Deductible requirement.

For prescription drugs where mandatory generic substitution applies (see Prescription Drug Benefits section, item V.) the difference between the price of the Generic and Brand Name Drug shall not apply to the Deductible.

The Deductible contributions made under the *Individual coverage* are not applicable to the *Family Coverage* Deductible requirements, and vice versa, unless a Participant transfers from one option to the other.

II. Out-of-Pocket Limits

The Out-of-Pocket Limits for *Individual coverage* and *Family Coverage* are stated in the Benefits Outline. The Out-of-Pocket Limit shall be based upon a Participant's eligible Out-of-Pocket expenses incurred during one Benefit Period. Eligible Out-of-Pocket expenses shall include only the Participant's Copayments, Deductible and Cost Sharing for eligible Covered Services. Out-of-Pocket expenses applied to the Out-of-Network Out-of-Pocket Limit will also apply towards the In-Network Out-of-Pocket Limit.

Out-of-Pocket expenses associated with the following are not included in the Out-of-Pocket Limit:

A. Amounts that exceed the Maximum Allowance.

B. Amounts that exceed benefit limits.

C. Services covered under a separate Plan, if any.

D. Noncovered services or supplies.

For prescription drugs where mandatory generic substitution applies (see Prescription Drug Benefits section, item V.) the difference between the price of the Generic and Brand Name Drug shall not apply to the Out-of-Pocket Limit.

III. Additional Amount of Payment

Except as specified elsewhere in this Document, the Medical Program will pay benefits for Covered Services after a Participant has satisfied their individual Deductible or, if applicable, the family Deductible has been satisfied:

A. For In-Network Services: Unless stated otherwise, for Covered Services furnished in the state of Idaho, the Medical Program will pay or otherwise satisfy a percentage of the Maximum Allowance (shown in the Benefits Outline) if the Covered Services were rendered by a Provider. Several Providers are paid at different rates and/or have different benefit limitations as described in that specific benefit section and in the Benefits Outline.

For Out-of-Network Services: Unless stated otherwise, for Covered Services rendered in the state of Idaho, the Medical Program will pay or otherwise satisfy a percentage of the Maximum Allowance (shown in the Benefits Outline) if the Covered Services were rendered by a Provider. Several Providers are paid at different rates and/or have different benefit limitations as described in that specific benefit section and in the Benefits Outline.

B. For Covered Services furnished outside the state of Idaho by a Provider, the Medical Program shall provide the benefit payment levels specified in this section according to the following:

1. If the Provider has a PPO agreement for claims payment with the Blue Cross and/or Blue Shield plan in the area where the Covered Services were rendered, the Medical Program will base the payment on the local plan's Preferred Provider Organization payment arrangement and allow In-

Network benefits. The Provider shall not make an additional charge to a Participant for amounts in excess of the Medical Program's payment except for Deductibles, Cost Sharing, and noncovered services.

2. If the Provider does not have a PPO agreement for claims payment with the Blue Cross and/or Blue Shield plan in the area where the Covered Services are rendered, the Medical Program will base payment on the Maximum Allowance and allow Out-of-Network benefits. Except as provided by the federal No Surprises Act, the Provider is not obligated to accept the Medical Program's payment as payment in full, and the Medical Program is not responsible for the difference, if any, between the Medical Program's payment and the actual charge.

C. A Contracting Provider rendering Covered Services shall not make an additional charge to a Participant for amounts in excess of the Medical Program's payment made through the Contract Administrator except for Deductibles, Cost Sharing, and noncovered services.

D. The Medical Program is not responsible for the difference, if any, between the Medical Program's payment and the actual charge, unless otherwise specified. Except as provided by the federal No Surprises Act, Participants are responsible for any such difference, including Deductibles, Cost Sharing, charges for noncovered services, and the amount charged by the Noncontracting Provider that is in excess of the Maximum Allowance.

IV. Providers

All Providers and Facilities must be licensed, certified, accredited and/or registered, where required, to render Covered Services. For the purposes of this Medical Program, Providers include any facility or individual who provides a Covered Service while operating within the scope of their license, certification, accreditation and/or registration under applicable state law, unless exempted by federal law.

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MEDICAL BENEFITS SECTION

Note: In order to receive benefits, some Covered Services require Prior Authorization. Please review the Prior Authorization Section for more details.

To be eligible for benefits, Covered Services must be Medically Necessary and must be provided to an eligible Participant under the terms of the Plan.

The Benefits Outline, incorporated into this Document, is an easy reference document that contains general payment information and a descriptive list of Covered Services. Benefits for Covered Services may be subject to Copayments, Deductibles, Cost Sharing, and other limits as specified in this Document.

I. Ambulance Transportation Services

Ambulance transportation services are covered for Medically Necessary transportation of a Participant within the local community by Ambulance under the following conditions:

1. From a Participant's home or scene of Accidental Injury or Emergency Medical Condition to a Licensed General Hospital.
2. Between Licensed General Hospitals.
3. Between a Licensed General Hospital and a Skilled Nursing Facility.
4. From a Licensed General Hospital to the Participant's home.
5. From a Skilled Nursing Facility to the Participant's home.

For purposes of 1., 2. and 3. above, if there is no facility in the local community that can provide Covered Services appropriate to the Participant's condition, then Ambulance Transportation Service means transportation to the closest facility that can provide the necessary service.

Air Ambulance transportation services are covered only when Medically Necessary when geographic restraints prevent Ground Ambulance transportation to the nearest facility that can provide Covered Services appropriate to the Participants condition, or ground transportation would put the health and safety of the Participant at risk.

Ground Ambulance and Air Ambulance services that are not for an Emergency Medical Conditions must be Medically Necessary and require Prior Authorization.

II. Applied Behavioral Analysis (ABA) - Outpatient

Benefits are covered for ABA services by Providers, including those rendered by a Provider who has obtained a Board Certified Behavioral Analysis (BCBA) certification issued by the Behavioral Analyst Certification Board.

III. Approved Clinical Trial Services

Coverage is available for routine patient costs associated with an Approved Clinical Trial. Routine patient costs include but are not limited to Office Visits, diagnostic, laboratory tests and/or other services related to treatment of a medical condition. Routine patient costs are items and services that typically are Covered Services for a Participant not enrolled in an Approved Clinical Trial, but do not include:

1. An Investigational item, device, or service that is the subject of the Approved Clinical Trial;
2. Items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Participant; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

IV. Breastfeeding Support and Supply Services

The lesser of the Maximum Allowance or billed charge for rental, (but not to exceed the lesser of the Maximum Allowance or billed charge for the total purchase price) or, at the option of the Contract Administrator, on behalf of the Plan Administrator, the purchase of breastfeeding support and supplies. The breastfeeding support and supplies must be prescribed by an attending Physician or other Professional Provider within the scope of license and must be supplied by a Provider. If the Participant and her Provider have chosen a more expensive item than is determined to be the standard and most economical by the Contract Administrator, on behalf of the Plan Administrator, the excess charge is solely the responsibility of the Participant. Supply items considered to be personal care items or common household items are not covered.

V. Chiropractic Care Services

A. Benefits are limited to Chiropractic Care Services related to a significant medical condition necessitating appropriate Medically Necessary evaluation and Neuromusculoskeletal Treatment services. Benefits are limited to the annual maximum visits as listed in the Benefits Outline. Chiropractic Care Services are covered when:

1. Services are directly related to a written treatment regimen prepared and performed by a Chiropractic Physician.
2. Services must be related to recovery or improvement in function, with reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time.

B. No benefits are provided for:

1. Surgery as defined in this Document to include injections.
2. Laboratory and pathology services.
3. Range of motion and passive exercises that are not related to restoration of a specific loss of function.
4. Massage therapy, if not performed in conjunction with other modalities or manipulations.
5. Maintenance, palliative or supportive care.
6. Preventive or wellness care.
7. Facility-related charges for Chiropractic Care Services, health club dues or charges, or Chiropractic Care Services provided in a health club, fitness facility, or similar setting.
8. General exercise programs.
9. Diagnostic Services, except for x-rays to assist in the diagnosis and Neuromusculoskeletal Treatment plan as defined in this Document.

V. Dental Services Related to Accidental Injury

Dental services which are rendered by a Physician or Dentist and required as a result of Accidental Injury to the jaw, Sound Natural Tooth, mouth, or face. Such services are covered only for the twelve (12) month period immediately following the date of Injury providing the Medical Program remains in effect during the twelve (12) month period. Temporomandibular Joint (TMJ) Syndrome and injuries as a result of chewing or biting are not considered Accidental Injuries, unless the source of the injury is an act of domestic violence. No benefits are available under this section for Orthodontia services.

Benefits are provided for repair of damage to a Sound Natural Tooth, lips, gums, and other portions of the mouth, including fractures of the maxilla or mandible. Repair or replacement of damaged dentures, bridges, or other dental appliances is not covered, unless the appliance must be modified or replaced due to Accidental Injury to a Sound Natural Tooth which are abutting the bridge or denture.

Benefits for dental services related to Accidental Injury under this provision shall be secondary to dental benefits available to a Participant under another benefit section of this Document, the Dental Program of the Plan, or available under a dental policy of insurance, contract, or underwriting plan that is separate and distinct from the Plan.

VI. Diabetes Self-Management Education Services - Outpatient

Diabetes Self-Management Education includes instruction in the basic skills of diabetes management through books/educational material as well as an individual or group consultation with a certified diabetes educator, nurse, or dietitian in an American Diabetes Association (ADA) or American Association of Diabetes Educators (AADE) certified program, or other provider acting, where required, under the scope of their license.

VII. Diagnostic Services

Diagnostic Services include mammograms. Tests to determine pregnancy and Pap tests are covered regardless of results. Benefits for Medically Necessary genetic testing are only available when Prior Authorization has been completed and approved by the Contract Administrator, on behalf of the Plan Administrator.

VIII. Durable Medical Equipment (DME)

The lesser of the Maximum Allowance or billed charge for rental, (but not to exceed the lesser of the Maximum Allowance or billed charge for the total purchase price) or, at the option of the Contract Administrator, on behalf of the Plan Administrator, the purchase of Medically Necessary Durable Medical Equipment required for therapeutic use. The Durable Medical Equipment must be prescribed by an attending Physician or other Professional Provider within the scope of license. Benefits shall not exceed the cost of the standard, most economical Durable Medical Equipment that is consistent, according to generally accepted medical treatment practices, with the Participant's condition. If the Participant and their Provider have chosen a more expensive treatment than is determined to be the standard and most economical by the Contract Administrator, on behalf of the Plan Administrator, the excess charge is

solely the responsibility of the Participant. Equipment items considered to be common household items are not covered.

Due to ongoing service requirements and safety issues relating to oxygen equipment, the Medical Program will not limit the cost of oxygen and the rental of oxygen delivery systems to the purchase price of the system(s).

IX. Gender Affirming Services

Gender Affirming Covered Services include non-surgical and surgical procedures, drugs and treatments. Gender reassignment Surgical Services and certain Prescription Drugs may require Prior Authorization and/or require a documented diagnosis of gender dysphoria (gender identity disorder).

A. Non-surgical Covered Services include but are not limited to:

1. Hormone therapy
2. Puberty suppression therapy
3. Electrolysis or laser permeant hair removal may be covered for up to twelve (12) sessions for certain skin graft.

B. Surgical Covered Services include but are not limited to:

1. Genital Surgery
2. Breast or chest Surgery (such as augmentation or reduction)

X. Hearing Aids

Hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for the fitting for congenital or acquired hearing loss if without intervention may result in cognitive or speech development deficits are a Covered Service for Eligible Dependent Children. Benefits are limited to one (1) device per ear, every three (3) years, and includes forty-five (45) speech therapy visits during the first twelve (12) months after delivery of the covered device.

XI. Hearing Services

Tests to determine an individual's sharpness of hearing, ability to hear sounds, and to distinguish different speech sounds are covered when performed by a qualified technician.

XII. Home Health Skilled Nursing Care Services

The delivery of Skilled Nursing Care services under the direction of a Physician to a Homebound Participant, provided such provider does not ordinarily reside in the Participant's household or is not related to the Participant by blood or marriage. The services must not constitute Custodial Care. Services must be provided by a Medicare certified Home Health Agency or other Provider acting under the scope of their license and limited to intermittent Skilled Nursing Care. The patient's Physician must review the care at least every thirty (30) days. Services are limited to the annual maximum days as shown in the Benefits Outline. No benefits are provided during any period of time in which the Participant is receiving Hospice Services covered by the Medical Program.

XIII. Hospice Services

A. Conditions

A Participant must specifically request Hospice benefits and must meet the following conditions to be eligible:

1. The attending or primary Physician must certify that the Participant is a terminally ill patient with a life expectancy of six months or less.
2. The Participant must live within the Hospice's local geographical area.
3. The Participant must be formally accepted by the Hospice.
4. The Participant must have a designated volunteer Primary Care Giver at all times.

B. Exclusions and Limitations

No benefits are provided for:

1. Hospice services not included in a Hospice Plan of Treatment and not provided or arranged and billed through a Hospice.
2. Continuous Skilled Nursing Care except as specifically provided as a part of Respite Care or Continuous Crisis Care.
3. Hospice benefits provided during any period of time in which a Participant is receiving Home Health Skilled Nursing Care benefits.

XIV. Hospital Services - Inpatient

The following are Covered Services:

A. Room, Board and General Nursing Services

Room and board, special diets, the services of a dietician, and general nursing service when a Participant is an Inpatient in a Licensed General Hospital is covered as follows:

1. A room with two (2) or more beds is covered. If a private room is used, the benefit provided in this section for a room with two (2) or more beds will be applied toward the charge for the private room. Any difference between the charges is a noncovered expense and is the sole responsibility of the Participant.
2. If isolation of the Participant is: (a) required by the law of a political jurisdiction, or (b) required to prevent contamination of either the Participant or another patient by the Participant, then payment for approved private room isolation charges shall be in place of the benefits for the daily room charge stated in paragraph one (1).
3. Benefits for a bed in a Special Care Unit shall be in place of the benefits for the daily room charge stated in paragraph one (1).
4. A bed in a nursery unit is covered.

B. Ancillary Services

Licensed General Hospital services and supplies, including:

1. Use of operating, delivery, cast, and treatment rooms and equipment.
2. Prescription Drugs administered while the Participant is an Inpatient.
3. Administration and processing of whole blood and blood products when the whole blood or blood products are actually used in a transfusion for a Participant; whole blood or blood plasma that is not donated on behalf of the Participant or replaced through contributions on behalf of the Participant.
4. Anesthesia, anesthesia supplies, and services rendered by the Licensed General Hospital as a regular Hospital service and billed by the Licensed General Hospital in conjunction with a procedure that is a Covered Service.
5. All medical and surgical dressings, supplies, casts, and splints that have been ordered by a Physician and furnished by a Licensed General Hospital; specially constructed braces and supports are not a Covered Service under this section.
6. Oxygen and administration of oxygen.
7. Patient convenience items essential for the maintenance of hygiene provided by a Licensed General Hospital as a regular hospital service in connection with a covered hospital stay. Patient convenience items include, but are not limited to, an admission kit, disposable washbasin, bedpan or urinal, shampoo, toothpaste, toothbrush, and deodorant.
8. Diagnostic Services and Therapy Services.

   If Diagnostic Services or Therapy Services furnished through a Licensed General Hospital are provided in part or in full by a Physician under contract with the Licensed General Hospital to perform such services, and the Physician bills separately for such services, the Physician's services shall be a Covered Service.

XV. Hospital Services - Outpatient

The following are Covered Services:

A. Emergency Services

Medical care to treat an Emergency Medical Condition or an Accidental Injury. Emergency room services include:

- Emergency room Physician and Facility services;
- Freestanding Emergency Department;
- Post-Stabilization Care Services;
- Equipment, supplies and drugs used in the emergency room;
- Inpatient Admission that is necessary even after Stabilization;
- Services and exams for Stabilization of an Emergency Medical Condition; and
- Equipment and devices, telemedicine services, Diagnostic Services, preoperative and postoperative services, and other items and services, rendered during the Emergency room visit.

For purposes of this section, Stabilization means that no material deterioration of the Emergency Medical Condition is likely to result from or occur during the transfer of the Participant from a facility.

B. Surgery

Licensed General Hospital or Ambulatory Surgical Facility services and supplies including removal of sutures, anesthesia, anesthesia supplies, and services rendered by an employee of the Licensed General Hospital or Ambulatory Surgical Facility who is not the surgeon or surgical assistant, in conjunction with a procedure that is a Covered Service.

XVI. Hospital Services - Special Services

A. Preadmission Testing

Tests and studies required with the Participant's admission and accepted or rendered by a Licensed General Hospital on an Outpatient basis prior to a scheduled admission as an Inpatient, if the services would have been available to an Inpatient of a Licensed General Hospital. Preadmission Testing does not include tests or studies performed to establish a diagnosis.

Preadmission Testing benefits are limited to Inpatient admissions for Surgery. Preadmission Testing must be conducted within seven (7) days prior to a Participant's Inpatient admission.

Preadmission Testing is a Covered Service only if the services are not repeated when the Participant is admitted to the Licensed General Hospital as an Inpatient, and only if the tests and charges are included in the Inpatient medical records.

No benefits for Preadmission Testing are provided if the Participant cancels or postpones the admission to the Licensed General Hospital as an Inpatient. If the Licensed General Hospital or Physician cancels or postpones the admission then benefits are provided.

B. Dental Related Services

Hospital benefits may be provided for dental extractions, or other dental procedures if certified by a Physician that a non-dental medical condition requires hospitalization to safeguard the health of the Participant. Non-dental conditions that may receive hospital benefits are:

1. Brittle diabetes.
2. History of a life-endangering heart condition.
3. History of uncontrollable bleeding.
4. Severe bronchial asthma.
5. Children under ten (10) years of age who require general anesthetic.
6. Other non-dental life-endangering conditions that require hospitalization, subject to approval by the Contract Administrator, on behalf of the Plan Administrator.

XXXVII. Infertility Treatment and Advanced Reproductive Technology (ART) Services

A. Covered Services

1. Assisted Fertility Services**:** Intrauterine Insemination (IUI).
2. Artificial Reproductive Technologies: In Vitro Fertilization (IVF), Intracytoplasmic Sperm Injections (ICSI), specialized sperm retrieval, and procedures to retrieve oocytes.

B. Eligibility

1. Eligibility is limited to the Enrollee and Enrolled Eligible Dependent spouse only.
2. Participants must meet the medical criteria of a received a diagnosis from a Physician as having a medical condition that renders conception improbable through sexual intercourse or have undergone one year of medical based and supervised methods of conception, including artificial insemination, which a physician has determined to have failed and are not likely to lead to a successful pregnancy.

C. Exclusions and Limitations

No benefits are provided for:

1. Reversal of sterilization (Reversals of tubal ligations or vasectomies).
2. Surrogate costs.
3. Egg or sperm donor.
4. Embryo transfer, except for fresh embryo transfer.
5. Expenses, procedures or services related to Surrogate pregnancy/delivery or donor eggs.
6. Any diagnosis or treatment for enrolled Eligible Dependent children.

XVIII. Inpatient Rehabilitation or Habilitation Services

Benefits are provided for Rehabilitation or Habilitation Services subject to the following:

A. Admission for Inpatient Physical Rehabilitation must occur within one hundred twenty (120) days of discharge from an Acute Care Licensed General Hospital.

B. Continuation of benefits is contingent upon approval by the Contract Administrator, on behalf of the Plan Administrator, of a Rehabilitation or Habilitation Services Plan of Treatment and documented evidence of patient progress submitted to the Contract Administrator at least twice each month.

XIX. Maternity Services and/or Involuntary Complications of Pregnancy

Diagnostic x-ray and laboratory services related to pregnancy, childbirth or miscarriage are covered.

Nursery care of a newborn infant is not a maternity service.

A. Normal Pregnancy

Normal pregnancy includes all conditions arising from pregnancy or delivery, including any condition usually associated with the management of a difficult pregnancy that is not defined below as a complication of pregnancy.

B. Complications of Pregnancy

Complications of Pregnancy include, but are not limited to:

1. Cesarean section delivery, ectopic pregnancy which is terminated, spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia, and toxemia; and
2. Conditions requiring Inpatient confinement (when the pregnancy is not terminated), the diagnoses of which are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed bed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

C. If you have a birth, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child will include forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a cesarean section delivery. Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours or ninety-six (96) hours as applicable. For stays in excess of forty-eight (48) hours or ninety-six (96) hours, additional benefits may be available under the terms of subsection "Continued Stay Review", found in the Inpatient Notification Section of this Document.

XX. Medical Foods

Medical Foods for inborn errors of metabolism such as Phenylketonuria (PKU) or when a Provider has diagnosed the presence of inadequate nutritional oral intake related to a medical condition or due to a progressive impairment of swallowing or digestion.

XXI. Medical Services - Inpatient

Inpatient medical services rendered by a physician or other Professional Provider to a Participant who is receiving Covered Services in a Licensed General Hospital or Skilled Nursing Facility.

Consultation services when rendered to a Participant as an Inpatient of a Licensed General Hospital by another Physician at the request of the attending Physician. Consultation services do not include staff consultations that are required by Licensed General Hospital rules and regulations.

XXII. Medical Services - Outpatient

The following Outpatient medical services rendered by a Physician or other Professional Provider to a Participant who is an Outpatient, provided such services are not related to pregnancy, Chiropractic Care, Mental or Nervous Conditions and/or Substance Use Disorder or Addiction, except as provided specifically elsewhere in this Document.

A. Home and Other Outpatient Visits

Medical care visits and consultations for the examination, diagnosis, or treatment of a condition, Injury, Disease, or Illness.

B. Physician Office Visits

Medical care visits and consultations for the examination, diagnosis, or treatment of a condition, Injury, Disease, or Illness.

C. Special Therapy Services

Deep Radiation Therapy or Chemotherapy for a malignancy when such therapy is performed in the Physician's office.

D. Other Therapy Services

Other Therapy Services as specified in the Therapy Services section of this Document.

E. Telehealth Virtual Care Services

XXIII. Mental Health and Substance Use Disorder Care Services

A. Covered Mental Health and Substance Use Disorder Services include Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP), Residential Treatment Center, psychological testing/neuropsychological evaluation testing and Electroconvulsive Therapy (ECT).

B. **Inpatient Mental Health and Substance Use Disorder Care—**The benefits provided for Inpatient hospital services and Inpatient medical services in this section are also provided for the care of Mental or Nervous Conditions, Alcoholism, Substance Use Disorder or Addiction, or any combination of these.

C. **Outpatient Mental Health and Substance Use Disorder Care—**The benefits provided for Outpatient Hospital Services and Outpatient Medical Services in this section are also provided for Mental or Nervous Conditions, Alcoholism, Substance Use Disorder or Addiction, or any combination of these. The use of Hypnosis to treat a Participant's Mental or Nervous Condition is a Covered Service.

D. **Outpatient Psychotherapy Services—**Covered Services include professional office visit services, family, individual and/or group therapy.

XXIV. Morbid Obesity Surgical Services

For Covered Services for the treatment of Morbid Obesity, the Medical Program shall pay or otherwise satisfy a percentage of the Maximum Allowance as shown in the Benefits Outline.

Benefits are provided for treatment of Morbid Obesity subject to the following:

1. Surgery for Morbid Obesity is Medically Necessary to control other medical conditions that are eligible for Covered Services under the Medical Program and nonsurgical methods have been unsuccessful in treating the Morbid Obesity; or
2. Surgery for Morbid Obesity is considered Medically Necessary when the Morbid Obesity is the result of persistent and uncontrollable weight gain that constitutes a present or potential threat to life.
3. Benefits are only available when provided at a Blue Distinction Center for Bariatric Surgery.
4. Benefits are limited to a Lifetime Benefit Limit of one procedure per Participant.

XXV. Orthotic Devices

Orthotic Devices include, but are not limited to, Medically Necessary braces, back or special surgical corsets, splints for extremities, and trusses, when prescribed by a Provider. Arch supports, other foot support devices, orthopedic shoes, and garter belts are not considered Orthotic Devices. Benefits shall not exceed the cost of the standard, most economical Orthotic device that is consistent, according to generally accepted medical treatment practices, with the Participant's condition.

For Participants with Diabetes, when prescribed by a Licensed Provider, Covered Services include therapeutic shoes and inserts. Benefits are limited to the following, per Benefit Period: one (1) pair of custom-molded shoes and inserts, (1) one pair of extra-depth shoes, two (2) additional pairs of inserts for custom-molded shoes, and three (3) pairs of inserts for extra-depth shoes.

XXVI. Outpatient Cardiac and Pulmonary Rehabilitation Therapy Services

Cardiac Rehabilitation is a Covered Service for Participants who have a clear medical need and who are referred by their attending Physician and (1) have a documented diagnosis of acute myocardial infarction (MI) within the preceding 12 months; (2) have had coronary artery bypass graft (CABG) Surgery; (3) have percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; (4) have had heart valve Surgery; (5) have had heart or heart-lung transplantation; (6) have current stable angina pectoris; or (7) have compensated heart failure.

Pulmonary Rehabilitation Services are provided as specified in the Benefits Outline, on behalf of the Plan Administrator.

XXVII. Palliative Care Services

A Participant, or a Provider on behalf of the Participant, must specifically request services for Palliative Care. Palliative Care Covered Services are covered when a Provider has assessed that a Participant is in need of Palliative Care for a serious Illness (including remission support), life-limiting injury or end-of-life care, and is limited to the following:

1. Acute Inpatient, Skilled Nursing Facility or Rehabilitation based Palliative Care services.
2. Home Health pain and symptom management services.
3. Home Health psychological and social services including individual and family counseling.
4. Caregiver support rendered by a Provider to a Participant.
5. Advanced care planning limited to face-to-face services between a Provider and a Participant to discuss the Participant's health care wishes if they become unable to make decisions about their care.

XXVIII. Post-Mastectomy/Lumpectomy Reconstructive Surgery

Reconstructive Surgery in connection with a Disease related mastectomy/lumpectomy, including:

A. Reconstruction of the breast on which the mastectomy/lumpectomy was performed;

B. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

C. Prostheses and treatment of physical complications at all stages of the mastectomy/lumpectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the Participant.

XXIX. Prescribed Contraceptive Services

Covered Services include prescribed devices, injectable, insertable and implantable methods of temporary contraception, such as diaphragms, intrauterine devices (IUDs) and injections. Covered Services include tubal ligation.

There are no benefits for:

A. Over-the-counter items including, but not limited to condoms, spermicides, and sponges.

B. Prescribed contraceptives that could otherwise be purchased over-the-counter.

C. Oral contraceptive prescription drugs and other prescription hormonal contraceptives. See Prescription Drug Benefit Section for oral contraceptive benefits.

XXX. Preventive Services

Benefits are provided for:

A. Preventive Care Covered Services—See Benefits Outline for complete list. Preventive Care Covered Services also includes Dietary Counseling, also referred to as "medical nutritional counseling", which includes the assessment of a Participant's overall nutritional status followed by the assignment of individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition. Dietary Counseling is only covered under the Preventive Care Benefit and includes Dietary Counseling for Diabetes.

B. Immunizations—see Benefits Outline for complete list.

XXXI. Prosthetic Appliances

The purchase, fitting, necessary adjustment, repair, and replacement of Prosthetic Appliances including post-mastectomy prostheses.

Benefits for prosthetic appliances are subject to the following limitations:

A. Benefits shall not exceed the cost of the standard, most economical Prosthetic Appliance that is consistent, according to generally accepted medical treatment practices, with the Participant's condition. If the Participant and their Provider have chosen a more expensive treatment than is determined to be the standard and most economical by the Contract Administrator, on behalf of the Plan Administrator, the excess charge is solely the responsibility of the Participant.

B. No benefits are provided for dental appliances or major Artificial Organs, including but not limited to, artificial hearts and pancreases.

C. Following cataract Surgery, benefits for a required contact lens or a pair of eyeglasses are limited to the first contact lens or pair of eyeglasses, which must be purchased within ninety (90) days.

D. Benefits for required contact lens or a pair of eyeglasses for treatment of Keratoconus.

E. No benefits are provided for the rental or purchase of any synthesized, artificial speech or communications output device or system or any similar device, appliance or computer system designed to provide speech output or to aid an inoperative or unintelligible voice, except for voice boxes to replace all or part of a surgically removed larynx.

XXXII. Skilled Nursing Facility

Benefits provided to an Inpatient of a Licensed General Hospital are also provided for services and supplies customarily rendered to an Inpatient of a Skilled Nursing Facility, including twenty-four (24) hour onsite nursing services. If a Participant is admitted for Skilled Nursing Services, the contract terms in effect on the date of the admission will apply to the Skilled Nursing Facility visit for the entire Inpatient stay. However, if a Participant's admission crosses Benefit Periods and the previous Benefit Period limit has been exhausted, the Contract Administrator will credit the new Benefit Period limit without discharge. Skilled Nursing Facility care does not include Custodial Care, supervised living, or other similar facilities providing primarily a supportive and/or recreational environment, even if some Skilled Nursing Care is provided in such facilities.

No benefits are provided when the care received consists primarily of:

A. Room and board, routine nursing care, training, supervisory or Custodial Care.

B. Care for senile deterioration, mental deficiency, or intellectual disability.

C. Care for Mental or Nervous Conditions and/or Substance Use Disorder or Addiction.

D. Maintenance Physical Therapy, hydrotherapy, Speech Therapy, or Occupational Therapy.

XXXIII. Sleep Study Services

Services rendered, referred, or prescribed by a Physician to diagnose a sleep disturbance or disorder. Services may be performed in a sleep laboratory, monitored by a qualified Sleep Study technician or through a home Sleep Study, via a portable recording device.

XXXIV. Surgical Services

A. Surgical Services

1. Surgery performed by a Physician or other Professional Provider.
2. Benefits for multiple surgical procedures performed during the same operative session by one or more Physicians or other Professional Providers shall be calculated based upon the Contract Administrator's Maximum Allowance and payment guidelines.

B. Surgical Supplies

When a Physician or other Professional Provider performs covered Surgery in the office, benefits are available for a sterile suture or Surgery tray normally required for minor surgical procedures.

C. Surgical Assistant

Medically Necessary services rendered by a Physician or other appropriately qualified surgical assistant who actively assists the operating surgeon in the performance of covered Surgery where an assistant is required. The percentage of the Maximum Allowance that is used as the actual Maximum Allowance to calculate the amount of payment under this section for Covered Services rendered by a surgical assistant is 20% for a Physician Assistant and 10% for other appropriately qualified surgical assistants.

D. Anesthesia

In conjunction with a covered procedure, the administration of anesthesia ordered by the attending Physician and rendered by a Physician or other Professional Provider. The use of Hypnosis as anesthesia is not a Covered Service. General anesthesia administered by the surgeon or assistant surgeon is not a Covered Service.

E. Second and Third Surgical Opinion

1. Services consist of a Physician's consultative opinion to verify the need for elective Surgery as first recommended by another Physician.
2. Specifications:
   a) Elective Surgery is covered Surgery that may be deferred and is not an emergency.
   b) Use of a second consultant is at the Participant's option.
   c) If the first recommendation for elective Surgery conflicts with the second consultant's opinion, then a third consultant's opinion is a Covered Service.
   d) The third consultant must be a Physician other than the Physician who first recommended elective Surgery or the Physician who was the second consultant.

XXXV. Therapy Services

Benefits for Therapy Services include:

A. Chemotherapy

B. Growth Hormone Therapy

C. Home Intravenous Therapy (Home Infusion Therapy)

Benefits are limited to medications, services and/or supplies provided to or in the home of the Participant, including but not limited to, hemophilia-related products and services and IVIG products and services that are administered via an intravenous, intraspinal, intra-arterial, intrathecal, subcutaneous, enteral, or intramuscular injection or access device inserted into the body.

D. Occupational Therapy

1. Payment is limited to Occupational Therapy services related to Habilitative and Rehabilitative care where there is a reasonable expectation that the services will produce measurable improvements in the Participant's condition in a reasonable period of time. Occupational Therapy Services are covered when performed by:
   a) A Physician.
   b) A non-Physician Provider provided the Covered Services are related directly to a written treatment regimen prepared by a Licensed Occupational Therapist or other Provider acting within the scope of their license and approved by a Physician.

2. No benefits are provided for:
   a) Facility-related charges for Outpatient Occupational Therapy Services, health club dues or charges, or Occupational Therapy Services provided in a health club, fitness facility, or similar setting.
   b) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Occupational Therapist.
   c) Maintenance, palliative or supportive care.
   d) Behavioral modification services.

E. Physical Therapy

1. Payment is limited to Physical Therapy services related to Habilitative and Rehabilitative care where there is a reasonable expectation that the services will produce measurable improvements in the Participant's condition in a reasonable period of time. Physical Therapy Services are covered when performed by:
   a) A Physician;
   b) A non-Physician Provider provided the Covered Services are related directly to a written treatment regimen prepared by a Physical Therapist, or other Provider acting within the scope of their license.
   c) A Podiatrist.
2. No benefits are provided for:
   a) The following Physical Therapy services when the specialized skills of a Licensed Physical Therapist are not required:
      (1) Range of motion and passive exercises that are not related to the restoration of a specific loss of function but are useful in maintaining range of motion in paralyzed extremities.
      (2) Assistance in walking, such as that provided in support for feeble or unstable patients.
   b) Facility-related charges for Outpatient Physical Therapy services, health club dues or charges, or Physical Therapy services provided in a health club, fitness facility, or similar setting; or
   c) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Physical Therapist.
   d) Maintenance, palliative or supportive care.
   e) Behavioral modification services.

F. Radiation Therapy

G. Renal Dialysis

H. Speech Therapy

1. Benefits shall be limited to Speech Therapy services related to Habilitative and Rehabilitative care and cochlear implant therapy, where there is a reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time.
2. Speech Therapy services are covered when performed by:
   a) A Physician.
   b) A non-Physician Provider provided the services are related directly to a written treatment regimen designed by a Speech Therapist or other Provider acting within the scope of their license.
3. No benefits are provided for:
   a) Maintenance or supportive care.
   b) Behavioral modification services.

XXXVI. Transplant Services

A. Autotransplants

Autotransplants of arteries, veins, ear bones (ossicles), cartilage, muscles, skin, hematopoietic, CAR T-Cell, and tendons; teeth or tooth buds, and other autotransplants as Medically Necessary.

The applicable benefits provided for Hospital services and Surgical Services are provided only for a recipient of Medically Necessary Autotransplant services. Autologous blood transfusion, FDA approved mechanical or biological heart valves and implanting of artificial pacemakers are not considered Transplants and are a Covered Service if Medically Necessary.

B. Transplants

Transplants of corneas, kidneys, bone marrow, livers, hearts, lungs, pancreas, islet tissue, hematopoietic, heart-lung and pancreas-kidney combinations, and other solid organ or tissue Transplants or combinations, and other Transplants as Medically Necessary.

1. The applicable benefits provided for Hospital services and surgical services are provided for a recipient of Medically Necessary Transplant services.
2. The Transplant(s) must be performed at a Facility Provider that has appropriate licensing to perform the Transplant service to be eligible for Benefits.
3. If the recipient is eligible to receive benefits for these Transplant services, Organ Procurement charges are paid for the donor, even if the donor is not a Participant. Benefits for the donor will be charged to the recipient's coverage.

Travel and living and tissue or organ transport expenses up to $5,000 to cover costs of the transplant recipient and/or a companion traveler's hotel, transportation and other expenses incurred if travel is necessary to receive Transplant Services at a Blue Distinction Center for Transplant (BDCT) or in the case of a kidney transplant from a Recognized Transplant Center. Transplant Services must be Prior Authorized by the Contract Administrator. The Participant will be notified of their eligibility for this travel allowance upon Prior Authorization of the scheduled Transplant services.

C. Exclusions and Limitations

In addition to any other exclusions and limitations of the Medical Program, the following exclusions and limitations apply to Transplant or Autotransplant services:

No benefits are available for the following services:

a) Transplants of brain tissue or brain membrane, intestine, pituitary and adrenal glands, hair Transplants, or any other Transplant not specifically named as a Covered Service in this Document; or for Artificial Organs, including, but not limited to, artificial hearts or pancreases.
b) Any eligible expenses of a donor related to donating or transplanting an organ or tissue unless the recipient is a Participant who is eligible to receive benefits for Transplant services.
c) The cost of a human organ or tissue that is sold rather than donated to the recipient.
d) Transportation costs, including, but not limited to, Ambulance Transportation service or air service for the donor or to transport a donated organ or tissue, unless listed as a Covered Service in this Document.
e) Living expenses for the recipient, donor, or family members, unless listed as a Covered Service in this Document.
f) Costs covered or funded by governmental, foundation, or charitable grants or programs; or Physician fees or other charges if no charge is generally made in the absence of health coverage or insurance coverage.
g) Any complication to the donor arising from a donor's Transplant Surgery is not a covered benefit under the Participant Transplant recipient's benefit under the Medical Program. If the donor is also a Participant, Covered Services related to medical complications to the donor arising from Transplant Surgery will apply to the donor's benefit under the Medical Program.
h) Costs related to the search for a suitable donor.
i) No benefits are available for services, expenses, or other obligations of or for a deceased donor (even if the donor is a Participant).

XXXVII. Treatment for Autism Spectrum Disorder

Treatment for Autism Spectrum Disorder, and related diagnoses.

PRESCRIPTION DRUG BENEFITS

This Prescription Drug Benefits Section specifies the benefits a Participant is entitled to receive for Covered Services, including Covered Prescription Drugs, described in this section, subject to all of the other provisions of the Medical Program.

I. Prescription Drug Copayment/Cost Sharing/Deductible/Out-of-Pocket

For the types and levels of benefits coverage regarding Prescription Drugs, see the Benefits Outline.

Prescription Drugs:
For a thirty (30) day or less supply of a Prescription Drug, the Participant is responsible for paying one (1) Copayment and/or Cost Sharing amount.

For a thirty-one (31) day to sixty (60) day supply of a Prescription Drug, the Participant is responsible for paying two (2) Copayment and/or Cost Sharing amounts.

For a sixty-one (61) day to ninety (90) day supply of a Prescription Drug, the Participant is responsible for paying three (3) Copayment and/or Cost Sharing amounts.

Diabetic Supplies:
Insulin syringes/needles have no Copayment if purchased within ninety (90) days of insulin purchase. All other supplies will be subject to applicable Cost Sharing, Copayment and/or Deductible.

II. Providers

The following are Providers under this section:
Licensed Pharmacist
Participating Pharmacy/Pharmacist
Physician

III. Dispensing Limitations

Retail: Each covered prescription for a Prescription Drug is limited to no more than a ninety (90) day supply. Specialty Drugs are limited to no more than a thirty (30) day supply. However, certain prescriptions and Prescription Drugs may be subject to more restrictive day-supply and allowed quantity limitations.

Mail Order/Specialty Pharmacy: Each covered prescription for a Prescription Drug is limited to no more than a ninety (90) day supply. Specialty Drugs are limited to no more than a thirty (30) day supply and must be obtained through a designated Specialty Pharmacy. However, certain prescriptions and Prescription Drugs may be subject to more restrictive day-supply and allowed quantity limitations. In addition, certain Prescription Drugs may not be available under the Medical Program by mail order due to circumstances such as unstable shelf life, and required special storage conditions.

IV. Amount of Payment

the Contract Administrator, on behalf of the Plan Administrator, or its designated Pharmacy Benefits Manager (PBM), will provide the following benefits for Covered Services:

A. The amount of payment for a covered Prescription Drug dispensed by a Participating Pharmacist is the balance remaining after subtracting the Prescription Drug Copayment, Cost Sharing and/or Deductible, if applicable from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

B. The amount of payment for a covered Prescription Drug dispensed by an approved mail order Participating Pharmacy is the balance remaining after subtracting the Prescription Drug Copayment, Cost Sharing and/or Deductible, if applicable, from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

C. Submission of a prescription to a pharmacy is not a claim. If a Participant receives Covered Services from a pharmacy and believes that the Copayment, Cost Sharing or other amount is incorrect, the Participant may then submit a written claim to the Contract Administrator requesting reimbursement of any amounts the Participant believes were incorrect. Refer to the Inquiry and Appeals Procedures in the General Provisions Section of this Document.

V. Mandatory Generic Drug Substitution

Certain Prescription Drugs are restricted to Generics for payment by the Medical Program. Even if the Participant, the Physician or other duly licensed Provider requests the Brand Name Drug, the Participant is responsible for the difference between the price of the Generic and Brand Name Drug, plus any applicable Brand Name Drug

Deductible/Copayment/Cost Sharing. The difference between the price of the Generic and Brand Name Drug shall not apply to the applicable Deductible and/or Out of Pocket Limits.

VI. Utilization Review

Prescription Drug benefits include utilization review of Prescription Drug usage for the Participant's health and safety. If there are patterns of over-utilization or misuse of drugs the Participant's Physician(s) and Pharmacist may be notified. The Medical Program reserves the right to limit benefits to prevent over-utilization or misuse of Prescription Drugs.

VII. Preauthorization

Certain Prescription Drugs may require preauthorization. If the Participant's Physician or other Provider prescribes a drug, which requires preauthorization, the Participant will be informed by the Provider or Pharmacist. To obtain preauthorization the Participant's Physician must notify the Contract Administrator or its designated agent, describing the Medical Necessity for the prescription. The Contract Administrator or its designated agent, on behalf of the Plan Administrator, will respond to a request for Prior Authorization received from either the Participant's Physician or the Participant within seventy-two (72) hours for an expedited request or fourteen (14) days for a standard request of the receipt of the medical information necessary to make a determination.

VIII. Covered Prescription Drugs

Generic and Brand Name Prescription Drugs, certain over-the-counter medications, certain allowed Compound Drugs and Diabetic Supplies as listed on the Contract Administrator's Formulary. The drugs or medicines must be directly related to the treatment of an Illness, Disease, medical condition or Accidental Injury and must be dispensed pursuant to a written prescription by a Licensed Pharmacist or Physician on or after the Participant's Effective Date. Benefits for Prescription Drugs are available up to the dispensing limitations stated in Item III. of this section.

Smoking cessation Prescription Drugs are a Covered Service.

Ovulation induction with ovulatory stimulant infertility Prescription Drugs are a Covered Service.

IX. Definitions

A. **Allowed Charge**—the amount payable for a Prescription Drug dispensed to a Participant based on the reimbursement formula determined between the Contract Administrator and its PBM plus the dispensing fee for a Prescription Drug dispensed by a retail pharmacy.

B. **Brand Name Drug**—a Prescription Drug, approved by the FDA, that is protected by a patent and is marketed and supplied under the manufacturer's patented/trademarked name.

C. **Compound Drug**—a customized medication derived from two or more raw chemicals, powders or devices, of which at least one ingredient is a federal legend drug, prepared by a Pharmacist according to a prescriber's specifications.

D. **Diabetic Supplies**—supplies that can be purchased at a Participating Pharmacy using the Participant's pharmacy benefit. Includes: insulin syringes, insulin pen needles, lancets, test strips (blood glucose and urine), and insulin pump supplies (reservoirs and syringes, administration sets, and access sets).

E. **Formulary**—a list of Covered Prescription Drugs approved by the Contract Administrator's Pharmacy and Therapeutics Committee clinical review. This list is managed and subject to periodic review and amendment by the Contract Administrator and the Pharmacy and Therapeutics Committee. Prescription Drugs covered by the Prescription Drug Benefit are organized into tiers. Generally, lower tiers contain Prescription Drugs that are more Cost Effective and provide a greater value when considering both clinical and financial attributes while higher tiers contain Prescription Drugs that are generally more expensive. Prescription Drugs on lower tiers may include a greater proportion of Preferred and Non-Preferred Generic Drugs while Prescription Drugs on higher tiers may include more Preferred and Non-Preferred Brand Name Drugs and Specialty Prescription Drugs.

ACA Preventive Drugs—are mandated by the Affordable Care Act to be provided at no cost, are also found on the formulary.

F. **Generic Drug**—a Prescription Drug, approved by the FDA, that has the same active ingredients, strength, and dosage as its Brand Name Drug counterpart.

G. **Nonparticipating Pharmacy/Pharmacist**—a Licensed Pharmacist, a retail, mail-order or Specialty Pharmacy that has not entered into a contract with the Contract Administrator's PBM for the purpose of providing Prescription Drug Covered Services to Participants under the Medical Program.

H. **Participating Pharmacy/Pharmacist**—a Licensed Pharmacist, a retail, mail-order or Specialty Pharmacy that has a contract with the Contract Administrator's PBM for the purpose of providing Prescription Drug Covered Services to Participants.

I. **Pharmacy and Therapeutics Committee**—a committee of Physicians and Licensed Pharmacists established by the Contract Administrator that recommends policy regarding the evaluation, selection, and therapeutic use of various drugs. The Committee also decides, on behalf of the Plan Administrator, which drugs are eligible for benefits.

J. **Prescription Drugs**—drugs, biologicals and Compounded prescriptions that are FDA approved and can be dispensed only according to a written prescription given by a Physician and/or duly licensed Provider, that are listed and accepted in the *United States Pharmacopoeia, National Formulary,* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that are prescribed for human consumption, and that are required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription."

K. **Specialty Drugs**—are injectable and non-injectable medications that are typically used to treat complex conditions and meet one or more of the following criteria:

a. are biotech-derived or biological in nature;
b. are significantly higher cost than traditional medications;
c. are used in complex treatment regimens; require special delivery, storage and handling;
d. require special medication-administration training for patients;
e. require on-going monitoring of medication adherence, side effects, and dosage changes;
f. are available through limited-distribution channels; and
g. may require additional support and coordinated case management.

L. **Specialty Pharmacy**—a duly licensed Pharmacy that primarily dispenses Specialty Drugs.

M. **Usual Charge**—the lowest retail price being charged by a Licensed Pharmacist for a Prescription Drug at the time of purchase by a Participant.

X. Prescription Drug Exclusions and Limitations

In addition to any other exclusions and limitations of the Medical Program, the following exclusions and limitations apply to this section and throughout this Document, unless otherwise specified.

The Cost Sharing components of the Plan, e.g., Deductibles, Cost Sharing and Copayments, are intended to address actual Out-of-Pocket Expenses. Participants are required to notify the Contract Administrator if, at the point of service, a Prescription Drug discount card or coupon through a manufacturer, store or other discount program is utilized so that Cost Sharing amounts, e.g., Deductibles, Cost Sharing and Copayments can be properly adjusted.

No benefits are provided for the following:

1. Drugs used for the termination of early pregnancy, and complications arising therefrom, except when required to correct a~~n~~ immediately life-endangering condition.
2. Over-the-counter drugs other than those listed on the Contract Administrator formulary, even if prescribed by a Physician. Notwithstanding this exclusion, the Plan Administrator, through the determination of the Contract Administrator Pharmacy and Therapeutics Committee may choose to cover certain over-the-counter medications when Prescription Drug benefits are provided under the Medical Program. Such approved over-the-counter medications must be identified by the Contract Administrator in writing and will specify the procedures for obtaining benefits for such approved over-the-counter medications. Please note that the fact a particular over-the-counter drug or medication is covered does not require the Medical Program to cover or otherwise pay or reimburse the Participant for any other over-the-counter drug or medication.
3. Charges for the administration or injection of any drug, except for vaccinations listed on the Prescription Drug Formulary.
4. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, and other non-medicinal substances except Diabetic Supplies, regardless of intended use.
5. Drugs labeled "Caution—Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made to the Participant.
6. Immunization agents, except for vaccinations listed on the Prescription Drug Formulary, biological sera, blood or blood plasma. Benefits may be available under the Covered Services section.
7. Medication that is to be taken by or administered to a Participant, in whole or in part, while the Participant is an Inpatient in a Licensed General Hospital, rest home, sanatorium, Skilled Nursing Facility, extended care facility, convalescent hospital, nursing home, or similar institution which operates or allows to operate on its premises, a facility for dispensing pharmaceuticals.
8. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order (may be shorter depending on the drug's DEA schedule).

9. Any Prescription Drug, biological or other agent, which is:
    a) Prescribed primarily to aid or assist the Participant in weight loss, including all anorectics, whether amphetamine or nonamphetamine.
    b) Prescribed primarily to retard the rate of hair loss or to aid in the replacement of lost hair.
    c) Prescribed primarily for personal hygiene, comfort, beautification, or for the purpose of improving appearance.
    d) Prescribed primarily to increase growth.
    e) Provided by or under the direction of a Home Intravenous Therapy Company, Home Health Agency or other Provider. Benefits are available for this Therapy Service under the Medical Benefits Section, and only as preauthorized and approved when Medically Necessary.
10. Lost, stolen, broken or destroyed medications, except in the case of loss due directly to a natural disaster.

GENERAL EXCLUSIONS AND LIMITATIONS

In addition to the exclusions and limitations listed elsewhere in the Medical Program, the following exclusions and limitations apply, unless otherwise specified.

I. General Exclusions and Limitations

There are no benefits for services, supplies, drugs, or other charges that are:

A. Not Medically Necessary. If services requiring Prior Authorization are performed by a Contracting Provider and benefits are denied as not Medically Necessary, the cost of said services are not the financial responsibility of the Participant. However, the Participant could be financially responsible for services found to be not Medically Necessary when provided by a Noncontracting Provider.

B. In excess of the Maximum Allowance.

C. For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an Accidental Injury and within twelve (12) months of the Accidental Injury or unless an attending Physician certifies in writing that the Participant has a non-dental, life-endangering condition which makes hospitalization necessary to safeguard the Participant's health and life.

D. Not prescribed by or upon the direction of a Physician or other Professional Provider; or which are furnished by any individuals or facilities other than Licensed General Hospitals, Physicians, and other Providers.

E. Investigational in nature.

F. Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Participant is entitled to benefits under occupational coverage, obtained or provided by or through the Employer under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Participant claims such benefits or compensation or recovers losses from a third party.

G. Provided or paid for by any federal governmental entity or unit except when payment under the Medical Program is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefore would vary, or are or would be affected by the existence of coverage under the Medical Program.

H. Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.

I. Furnished by a Provider who is related to the Participant by blood or marriage and who ordinarily dwells in the Participant's household.

J. Received from a dental, vision, or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.

K. For Surgery intended mainly to improve appearance or for complications arising from Surgery intended mainly to improve appearance, except for:

1. Reconstructive Surgery necessary to treat an Accidental Injury, when performed within eighteen (18) months of the Accidental Injury; or
2. Reconstructive Surgery necessary to treat an infection or other Disease of the involved part; or
3. Reconstructive Surgery to correct congenital anomalies in a Participant who is a dependent child; or
4. Post-Mastectomy/Lumpectomy Reconstructive Surgery as described as Covered Service in this document.

L. Rendered prior to the Participant's Effective Date.

M. For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance) even if prescribed by a Physician.

N. For exercise or relaxation items or services even if prescribed by a Physician, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs, spas, hot tubs, whirlpool baths, waterbeds or swimming pools.

O. For convenience items including but not limited to Durable Medical Equipment such as bath equipment, cold therapy units, duplicate items, home traction devices, or safety equipment.

P. For relaxation or exercise therapies, including but not limited to, educational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, homeopathic, or naturopathic, massage, or music even if prescribed by a Physician, except as specified as a Covered Service.

Q. Recreational therapy or therapeutic recreation programs, which can include, but are not limited to, diabetes camps, adventure therapy, and/or wilderness therapy (which can include, but are not limited to, programs for outdoor behavioral health, childhood diabetes, and childhood cancer).

R. For telephone consultations, and all computer or Internet communications, except as in connection with Telehealth Virtual Care Services or specified as a Covered Service.

S. For failure to keep a scheduled visit or appointment; for completion of a claim form; for interpretation services; or for personal mileage, transportation, food or lodging expenses, unless specified as a Covered Service in the Plan, or for mileage, transportation, food or lodging expenses billed by a Physician or other Professional Provider.

T. For Inpatient admissions that are primarily for Diagnostic Services or Therapy Services; or for Inpatient admissions when the Participant is ambulatory and/or confined primarily for bed rest, special diet, behavioral problems, environmental change or for treatment not requiring continuous bed care.

U. For Inpatient or Outpatient Custodial Care; or for Inpatient or Outpatient services consisting mainly of educational therapy, behavioral modification, self-care or self-help training, except as specified as a Covered Service.

V. For any cosmetic foot care, including but not limited to, treatment of corns, calluses, and toenails (except for surgical care of ingrown or Diseased toenails).

W. Related to Dentistry or Dental Treatment, even if related to a medical condition, unless specified as a Covered Service.

X. Related to orthoptics, eyeglasses or contact Lenses, or the vision examination for prescribing or fitting eyeglasses or contact Lenses, unless specified as a Covered Service.

Y. For hearing aids or examinations for the prescription or fitting of hearing aids, or except as specified as a Covered Service.

Z. For any treatment of sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence, even if related to a medical condition.

AA. Made by a Licensed General Hospital for the Participant's failure to vacate a room on or before the Licensed General Hospital's established discharge hour.

AB. Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.

AC. Furnished by a facility that is primarily a nursing home, a convalescent home, or a rest home.

AD. For Acute Care, Rehabilitative care, diagnostic testing except as specified as a Covered Service in this Document; for Mental or Nervous Conditions and Substance Use Disorder or Addiction services not recognized by the American Psychiatric and American Psychological Associations.

AE. For any of the following:

1. For appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a Covered Service;

2. For implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies;
3. For alveolectomy or alveoloplasty when related to tooth extraction.

AF. For weight control or treatment of obesity or morbid obesity, even if Medically Necessary, except as specified as a Covered Service. For reversals or revisions of Surgery for obesity, except when required to correct a life-endangering condition.

AG. For use of operating, cast, examination, or treatment rooms or for equipment located in a Provider's office or facility, except for emergency room facility charges in a Licensed General Hospital unless specified as a Covered Service.

AH. For the reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties.

AI. Except as specifically listed, treatment for reproductive procedures, including but not limited to, ovulation induction procedures and pharmaceuticals, intrauterine insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance a Participant's reproductive ability, including but not limited to laboratory services, radiology services or similar services related to treatment for reproductive procedures.

AJ. Any expenses, procedures or services related to Surrogate pregnancy, delivery or donor eggs.

AK. For Transplant services and Artificial Organs, except as specified as a Covered Service.

AL. For acupuncture, except as specified as a Covered Service.

AM. For surgical procedures that alter the refractive character of the eye, including but not limited to, radial keratotomy, myopic keratomileusis, Laser-In-Situ Keratomileusis (LASIK), and other surgical procedures of the refractive-keratoplasty type, to cure or reduce myopia or astigmatism, even if Medically Necessary, unless specified as a Covered Service. Additionally, reversals, revisions, and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.

AN. For Hospice, except as specified as a Covered Service.

AO. For pastoral and spiritual, counseling.

AP. For homemaker and housekeeping services or home-delivered meals.

AQ. Payment for items or services not permitted under applicable state law or for the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.

AR. For treatment or other health care of any Participant in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Participant to Covered Services under the Medical Program, if and to the extent those benefits are payable to or due the Participant under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's, or other similar policy of insurance, contract, or underwriting plan.

In the event the Medical Program, for any reason makes payment for or otherwise provides benefits excluded by the above provisions, the Plan shall succeed to the rights of payment or reimbursement of the compensated Provider, the Participant, and the Participant's heirs and personal representative against all insurers, underwriters, self-insurers or other such obligors contractually liable or obliged to the Participant, or their estate for such services, supplies, drugs or other charges so provided by the Medical Program in connection with such Illness, Disease, Accidental Injury or other condition.

AS. For which a Participant would have no legal obligation to pay in the absence of coverage under the Medical Program or any similar coverage; or for which no charge or a different charge is usually made in the absence

of health coverage or insurance coverage or charges in connection with work for compensation or charges; or for which reimbursement or payment is contemplated under an agreement with a third party.

AT. For a routine or periodic mental or physical examination or laboratory test that is not connected with the care and treatment of an actual Illness, Disease or Accidental Injury; or for an examination or laboratory test required for any employment-related purpose; or related to an occupational injury; for a marriage license; or for insurance, school or camp application; or for sports participation physicals; or a screening examination including routine hearing examinations, except as specified as a Covered Service.

AU. For immunizations, except as specified as a Covered Service.

AV. For breast reduction Surgery or Surgery for gynecomastia, except as specified as a Covered Service in this Document.

AW. For nutritional supplements.

AX. For replacements or nutritional formulas except, when administered enterally due to impairment in digestion and absorption of an oral diet and is the sole source of caloric need or nutrition in a Participant, or except as specified as a Covered Service.

AY. For vitamins and minerals, unless required through a written prescription and cannot be purchased over the counter.

AZ. For an elective abortion, except to preserve the life of the Participant upon whom the abortion is performed.

AAA. For alterations or modifications to a home or vehicle.

AAB. For special clothing, including shoes (unless permanently attached to a brace).

AAC. Provided to a person enrolled as an Eligible Dependent, but who no longer qualifies as an Eligible Dependent due to a change in eligibility status that occurred after enrollment.

AAD. Furnished by a Provider outside the scope of the Provider's license under state law, unless exempted by federal law.

AAE. For Outpatient pulmonary and/or Outpatient cardiac Rehabilitation, except as specified as a Covered Service in this Document.

AAF. For complications arising from the acceptance or utilization of services, supplies or procedures that are not a Covered Service.

AAG. For the use of Hypnosis, as anesthesia or other treatment, except as specified as a Covered Service in this Document.

AAH. For dental implants, appliances (with the exception of sleep apnea devices), and/or prosthetics, and/or treatment related to Orthodontia, even when Medically Necessary unless specified as a Covered Service.

AAI. For arch supports, orthopedic shoes, and other foot devices, except as specified as a Covered Service.

AAJ. For surgical removal of excess skin that is the result of weight loss or gain, including but not limited to association with prior weight reduction (obesity) Surgery.

AAK. For the purchase of Therapy or Service Dogs/Animals and the cost of training/maintaining said animals.

AAL. For procedures including but not limited to breast augmentation, liposuction, Adam's apple reduction, rhinoplasty, facial reconstruction and other procedures considered cosmetic in nature, unless Medically Necessary.

AAM. Any newly FDA approved Prescription Drug, biological agent, or other agent until it has been reviewed and implemented by the Contract Administrator's Pharmacy and Therapeutics Committee.

AAN. For the treatment of injuries sustained while operating a motor vehicle under the influence of alcohol and/or narcotics. For purposes of the Plan exclusion, "Under the influence" as it relates to alcohol means having a whole blood alcohol content of .08 or above or a serum blood alcohol content of .10 or above as measured by a laboratory approved by the State Police or a laboratory certified by the Centers for Medicare and Medicaid Services. For purposes of the Plan exclusion, "Under the influence" as it relates to narcotics means impairment of driving ability caused by the use of narcotics not prescribed or administered by a Physician, as determined by applicable law.

AAO. Rendered after exhaustion of an established benefit limit, unless authorized at the discretion of the Plan Administrator and in accordance with specific medical criteria established by the Contract Administrator.

AAP. All services, supplies, devices and treatment that are not FDA approved.

AAQ. Any services, interventions occurring within the framework of an educational program or institution; or provided in or by a school/educational setting; or provided as a replacement for services that are the responsibility of the educational system.

GENERAL PROVISIONS

I. Participant/Provider Relationship

A. The choice of a Provider is solely the Participant's.

B. The Contract Administrator does not render Covered Services but only makes payment for Covered Services received by Participants. The Contract Administrator and the Plan Administrator are not liable for any act or omission or for the level of competence of any Provider, and have no responsibility for a Provider's failure or refusal to render Covered Services to a Participant.

C. The use or nonuse of an adjective such as Contracting or Noncontracting is not a statement as to the ability of the Provider.

II. Coordination of Benefits

The intent of this Coordination of Benefits provision is to provide that the sum of benefit payments from all "Other Plans" and the Medical Program will not exceed the normal benefit allowance from Medical Program when no Other Plan(s) are involved.

A. Definitions, as used in this section:

1. **This Plan** will mean the Medical Program.
2. **Other Plans** will mean any medical or dental expense benefits provided under:
   a. Any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association;
   b. Any program required or established by federal or state law, including Medicare Parts A, B, C and D; and
   c. Any program sponsored by or arranged through a school or other educational agency. (Note: the term "Other Plan" will not include benefits provided under a student accident policy, nor will the term "Other Plan" include benefits provided under a state medical assistance program where eligibility is based on financial need.)

   If the Other Plan contains several programs and some of those programs dictate rules for Coordination of Benefits and other programs do not dictate rules for Coordination of Benefits, Coordination of Benefits will apply separately.
3. **Primary Plan/Secondary Plan** describes the order of how payments are made according to benefit determination rules when more than one plan covers the person. When this Plan is Primary, its benefits are determined before those of any Other Plan and without considering any Other Plan's benefits. When this Plan is Secondary, its benefits are determined after those of any Other Plan and may be reduced because of the Primary.
4. **Allowable Expense** will mean a health care Covered Service or expense, including Deductibles and Copayments, if any, that is covered at least in part by any of the plans covering the person for whom benefits are claimed. When a plan provides benefits in the form of Services, the reasonable cash value of each Service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an Allowable Expense.

B. Order of Benefit Determination

Benefits payable by a plan that does not have a Coordination of Benefits provision as described in this section will be determined before a plan that does have such a provision except as described below in the "Medicare Exception—Order of Benefit Determination" subsection. In all other instances, the order of determination will be:

1. Non-Dependent/Dependent. The benefits of a plan that covers the person for whom benefits are claimed as an Enrollee (non-dependent) are determined before the benefits of a plan that covers the person as an Eligible Dependent.
2. Dependent Child
   a. Parents not Separated or Divorced—The benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the plan that covered a parent longer are determined before those of the plan that covered the other parent for a shorter period of time. However, if another plan does not have the rule described above, but instead has a rule based on 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.

b. Separated or Divorced Parents—Single Custody. If two or more plans cover an Eligible Dependent child of divorced or separated parents, benefits for the child are determined in this order:
   1) First, the plan of the parent with custody of the child;
   2) Then, the plan of the spouse of the parent with custody of the child; and
   3) Finally, the plan of the parent not having custody of the child.
   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any period during which any benefits are actually paid or provided before the entity has that actual knowledge.

c. Separated or Divorced Parents—Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules for Eligible Dependent children of parents who are not separated or divorced.

d. Active/Inactive Employee. The benefits of a plan that covers a person as an Enrollee who is neither laid off nor retired, or as that active Enrollee's Eligible Dependent, are determined before the benefits of a plan that covers that person as a laid-off or retired Enrollee or as that inactive Enrollee's Eligible Dependent. 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 will not apply.

e. Continuation of Coverage. If coverage is provided for a person under a right of continuation according to federal or state law and the person is also covered under the Other Plan, the following will be the order of benefit determination:
   1) First, the benefits of a plan covering the person as an active (non-COBRA participant (or as that person's dependent);
   2) Second, the benefits under the continuation coverage.
   3) If the Other Plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

f. Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the plan that covered a person longer are determined before those of the plan that covered that person for the shorter time.

g. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the plans. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

C. Medicare Exception—Order of Benefit Determination

This Plan will be primary over Medicare only when federal law requires it to be primary. This Plan will be secondary to Medicare to the fullest extent allowed by federal law.

The rules governing coordination of benefits with Medicare are set by the federal government and are quite complex. The summary that follows is not a comprehensive account of those rules nor is it intended to change the basic Medicare rule described in the previous paragraph.

1. Medicare is primary for a person who is eligible for Medicare on the basis of age or disability unless the person is covered under this Plan because of his/her current employment status or that of their spouse. COBRA continuation coverage is not considered coverage based on current employment status, i.e., Medicare is primary for a person who is eligible for Medicare on the basis of age or disability and has COBRA continuation coverage under this Plan.

2. Medicare is primary for a person who is eligible for Medicare on the basis of end stage renal disease (ESRD) after the thirtieth (30) month of Medicare eligibility unless Medicare was already primary on the basis of age or disability on the date the person became eligible on the basis of ESRD.

Medicare is secondary during that 30-month period, known as a coordination period. When this Plan is primary, it pays benefits based on the Plan terms, and you pay your share as required under Plan terms. In certain circumstances, such as when you use a non-participating provider, you may be responsible for

amounts charged in excess of what the Plan will pay, known as "balance billing" (see item III.C in General Benefit Information). Medicare does not typically permit balance billing from Medicare providers, when it is primary. You should contact Medicare for more information about your options.

When this Plan would be secondary to Medicare, it will reduce benefits based on what Medicare would pay under Part A and Part B, even if you or your Dependent are not enrolled in Part A or Part B. The Claims Administrator may make a good faith estimate of the amount Medicare would pay. This estimate will be deemed a benefit paid for purposes of determining benefits.

D. Effect on Benefits

Benefits payable by this Plan will not duplicate benefits already paid by any Other Plan(s) for Allowable Expenses.

Benefits payable under this Plan will be adjusted appropriately by the benefits payable under the Other Plan(s), if the Other Plan(s) benefits are determined to be primary payers before this Plan.

When this Plan is secondary, the regular benefit payment will be calculated. If the Other Plan's payment is less than this Plan's normal benefit allowance, then this Plan will pay the difference up to the normal benefit allowance for this Plan.

Example 1:	**Allowable Expense**	**Plan Pays**	**Benefit**
Other Plan (Primary Plan)	$100	70%	$70
This Plan (Secondary Plan)	$100	80%	$80
Difference Paid by Simplot Plan		$10	

If the Other Plan's payment is equal to or more than this Plan's normal benefit allowance, then this Plan pays no additional benefits.

Example 2:	**Allowable Expense**	**Plan Pays**	**Benefit**
Other Plan (Primary Plan)	$100	80%	$80
This Plan (Secondary Plan)	$100	80%	$80
Difference Paid by this Plan		$0	

Deductibles, maximums and other benefit limits of this Plan will be adjusted as if benefits had been paid.

E. General Coordination of Benefits Provisions

1. Exchange of Information. Any person who claims benefits under this Plan is required, upon request, to provide all information that is needed to coordinate benefits. In addition, all information that is needed to coordinate benefits may be exchanged with other companies, organizations, or persons.

2. Plan Reimbursement. The Plan may reimburse any Other Plan if:
   a. Benefits were paid by that Other Plan; but
   b. Should have been paid under this Plan in accordance with this section.
   In such instances, the reimbursement amounts will be considered benefits paid under this Plan and, to the extent of those amounts, will discharge this Plan from liability.

3. Integration with Individual Medical Expense Automobile Policies. The amount payable under this Plan for covered medical and dental expenses shall be reduced by the amounts payable for such Services under an individual medical expense automobile policy.
4. Right of Recovery. If it is determined that benefits paid under this Plan should have been paid by any Other Plan or policy, this Plan will have the right to recover those payments from:
   a. The person to or for whom the benefits were paid; and/or

b. The other companies or organizations liable for the benefit payments.

F. Prescription Drug Benefit

This Plan shall not pay additional prescription drug benefits secondary to another plan, regardless of whether a claim is made to the primary plan.

III. Inquiry and Appeals Procedures

If the Participant's claim for benefits is denied and an Adverse Benefit Determination, the Participant must first exhaust any applicable internal appeals process described below prior to pursuing legal action. Any legal action must be filed within two (2) years after the final internal appeal decision and must be filed in Federal court in Boise, Idaho.

A. Informal Inquiry

For any initial questions concerning a claim, a Participant should call or write the Contract Administrator's Customer Service Department. The Contract Administrator's phone number and address is listed on the Explanation of Benefits (EOB) form and in the Contact Information section of this Document.

B. Formal Appeal

A Participant, or their authorized representative as defined by the Plan, who wishes to formally appeal a Pre-Service Claim decision may do so through the following process:

1. A Participant may have an authorized representative pursue a benefit claim or an appeal of an Adverse Benefit Determination on their behalf. The Plan Administrator requires that a Participant execute the Contract Administrator's "Appointment of Authorized Representative" form before the Contract Administrator, on behalf of the Plan Administrator determines that an individual has been authorized to act on behalf of the Participant. The form can be found on the Contract Administrator's Website at www.bcidaho.com.

2. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and the documents in support of such appeals may be submitted by phone or facsimile. The appeal should set forth the reasons why the Participant contends the decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

3. After receipt of the appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by a Contract Administrator's Medical Director or physician designee. For non-urgent claim appeals, the Contract Administrator will mail a written reply to the Participant within fifteen (15) days after receipt of the written appeal. Urgent claim appeals will be notified orally within seventy-two (72) hours. If the original decision is upheld, the reply will state the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible taking into account the medical exigencies of each claim.

4. Furthermore, the Participant or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.

5. If the original, non-urgent claim decision is upheld upon reconsideration, the Participant, or their authorized representative, may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within thirty (30) days of the Contract Administrator's mailing of the initial reconsideration decision. The Contract Administrator Medical Director who is not subordinate to the Medical Director or physician designee who decided the initial appeal will review and make a recommendation to the Plan Administrator who will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt. There are no further internal appeals available for urgent claims.

C. A Participant, or their authorized representative as defined by the Plan, who wishes to formally appeal a Post-Service Claims decision may do so through the following process:

1. A Participant may have an authorized representative pursue a benefit claim or an appeal of an Adverse Benefit Determination on their behalf. The Plan Administrator requires that a Participant execute an "Appointment of Authorized Representative" form before the Contract Administrator, on

behalf of the Plan Administrator determines that an individual has been authorized to act on behalf of the Participant. The form can be found on the Contract Administrator's Website at www.bcidaho.com.

2. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. This written appeal should set forth the reasons why the Participant contends the decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

3. After receipt of the written appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by the Contract Administrator's Medical Director, or physician designee if the appeal requires medical judgment. The Contract Administrator shall mail a written reply to the Participant within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will list the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible.

4. Furthermore, the Participant or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.

5. If the original decision is upheld upon reconsideration, the Participant or their authorized representative may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within sixty (60) days of the Contract Administrator's mailing of the initial reconsideration decision. If the appeal requires medical judgment, a Medical Director of the Contract Administrator who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will review and make a recommendation to the Plan Administrator, who will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within thirty (30) days of its receipt.

D. Participant's Rights to an Independent External Review

Please read this carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with the Contract Administrator or the Plan Administrator. If a Participant or their authorized representative (as defined by the Plan) requests an independent external review of a claim, the decision made by the independent reviewer will be binding and final on the Plan Administrator. The Participant or their authorized representative will have the right to further review the claim by a court, arbitrator, mediator or other dispute resolution entity under the Employee Retirement Income Security Act of 1974 (ERISA).

If the Contract Administrator, on behalf of the Plan Administrator, issues a final Adverse Benefit Determination of a Participant's request to provide or pay for a health care service or supply, a Participant or their authorized representative may have the right to have the decision reviewed by health care professionals who have no association with the Contract Administrator or the Plan Administrator. A Participant has this right only if the denial decision involved:

- The Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Participant's health care service or supply, or
- Determination that a Participant's health care service or supply was Investigational.

A Participant or their authorized representative must first exhaust the Plan's internal appeal processes described in this Document. Exhaustion of that process includes completing all levels of appeal. Exhaustion of the appeals process is not required if the Contract Administrator failed to respond to a standard appeal within thirty-five (35) days in writing or to an urgent appeal within three business days of the date the Participant filed the appeal, unless the Participant or their authorized representative requested or agreed to a delay. The Plan Administrator may also agree to waive the exhaustion requirement for an external review request. The Participant or their authorized representative may file for an internal urgent appeal with the Contract Administrator and for an expedited external review with the Idaho Department of Insurance at the same time if the Participant's request qualifies as an "urgent care request" defined below.

A Participant or their authorized representative 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, www.doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

A Participant may act as their own representative in a request or a Participant may name another person, including a Participant's treating health care provider, to act as an authorized representative for a request. If a Participant wants someone else to represent them, a Participant must include a signed "Appointment of an Authorized Representative" form with the request before the Contract Administrator, on behalf of the Plan Administrator, determines that an individual has been authorized to act on behalf of the Participants. The form can be found on the Contract Administrator's Website www.bcidaho.com. A Participant's written external review request to the Idaho Department of Insurance must include a completed form authorizing the release of any 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 a Participant's completed authorization form. If the request qualifies for external review, the Plan Administrator's final adverse benefit determination will be reviewed by an independent review organization selected by the Idaho Department of Insurance. The Plan Administrator will pay the costs of the review.

Standard External Review Request: A Participant or their authorized representative must file a written external review request with the Idaho Department of Insurance within four (4) months after the date the Contract Administrator, on behalf of the Plan Administrator, issues a final notice of denial.

1. Within seven (7) days after the Idaho Department of Insurance receives the request, the Idaho Department of Insurance will send a copy to the Contract Administrator who will notify the Plan Administrator.
2. Within fourteen (14) days after the Contract Administrator receives the request from the Idaho Department of Insurance, the Contract Administrator and the Plan Administrator will review the request for eligibility. Within five (5) business days after the Contract Administrator and the Plan Administrator complete that review, the Contract Administrator will notify the Participant and the Idaho Department of Insurance in writing if the request is eligible or what additional information is needed. If the Plan Administrator denies the eligibility for review, the Participant or their authorized representative may appeal that determination to the Department.
3. If the request is eligible for review, the Idaho Department of Insurance will assign an independent review organization to your review within seven (7) days of receipt of the Contract Administrator's notice. The Idaho Department of Insurance will also notify the Participant in writing.
4. Within seven (7) days of the date you receive the Idaho Department of Insurance's notice of assignment to an independent review organization, the Participant or their authorized representative may submit any additional information in writing to the independent review organization that they want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to the Participant, the Contract Administrator, on behalf of the Plan Administrator, and to the Idaho Department of Insurance within forty-two (42) days after receipt of an external review request.

Expedited External Review Request: A Participant or their authorized representative may file a written "urgent care request" with the Idaho Department of Insurance for an expedited external review of a pre-service or concurrent service denial. The Participant or their authorized representative may file for an internal urgent appeal with the Contract Administrator and for an expedited external review with the Idaho Department of Insurance 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 Claim 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 Participant or the ability of the Participant to regain maximum function;
2. In the opinion of the Provider with knowledge of the covered person's medical condition, would subject the Participant 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 Idaho Department of Insurance will send your request to the Contract Administrator. The Contract Administrator and the Plan Administrator will determine, no later than the second (2nd) full business day, if the request is eligible for review. The Contract Administrator, on behalf of the Plan Administrator, will notify the Participant and the Idaho Department of Insurance no later than one (1) business day after the Plan Administrator's decision if the request is eligible. If the Plan Administrator denies the eligibility for review, the Participant or their authorized representative may appeal that determination to the Idaho Department of Insurance.

If the request is eligible for review, the Idaho Department of Insurance will assign an independent review organization to the review upon receipt of the Contract Administrator's notice. The Idaho Department of Insurance will also notify the Participant. The independent review organization must provide notice of its decision to the Participant, the Contract Administrator, on behalf of the Plan Administrator, and to the Idaho Department of Insurance within seventy-two (72) hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within forty-eight (48) hours of notice of its decision. If the decision reverses the Plan Administrator's denial, the Contract Administrator will notify the Participant and the Idaho Department of Insurance of the Medical Program's intent to pay for the covered benefit as soon as reasonably practicable, but not later than one (1) business day after receiving notice of the decision.

Binding Nature of the External Review Decision:
The Plan is subject to the federal Employee Retirement Income Security Act (ERISA) and therefore the external review decision by the independent review organization will be final and binding on the Plan Administrator. The Participant may have additional review rights provided under federal ERISA laws.

IV. Reimbursement of Benefits Paid by Mistake

If the Contract Administrator, on behalf of the Plan Administrator, mistakenly makes payment for benefits on behalf of an Enrollee or their Eligible Dependent(s) that the Enrollee or their Eligible Dependent(s) is not entitled to under the Medical Program, the Enrollee must reimburse the erroneous payment to the Contract Administrator, on behalf of the Plan Administrator.

The reimbursement is due and payable as soon as the Contract Administrator notifies the Enrollee and requests reimbursement. the Contract Administrator, on behalf of the Plan Administrator, may also recover such erroneous payment from any other person or Provider to whom the payments were made. If reimbursement is not made in a timely manner, The Contract Administrator, on behalf of the Plan Administrator, may reduce benefits or reduce an allowance for benefits as a set-off toward reimbursement.

Even though the Contract Administrator, on behalf of the Plan Administrator, may elect to continue to provide benefits after mistakenly paying benefits, the Contract Administrator, on behalf of the Plan Administrator, may still enforce this provision with respect to benefits paid before discovery of the mistake. This provision is in addition to, not instead of, any other remedy the Contract Administrator, on behalf of the Plan Administrator, may have at law or in equity.

V. Subrogation and Reimbursement Rights

The benefits of the Medical Program will be available to a Participant when the Participant is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereinafter referred to as "third party"). To the extent that such benefits for Covered Services are provided or paid for by the Contract Administrator, on behalf of the Plan Administrator under the Medical Program, the Contract Administrator, on behalf of the Plan Administrator shall be subrogated and succeed to the rights of the Participant or, in the event of the Participant's death, to the rights of their heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Services in such an event, the Participant or their personal representative shall furnish the Contract Administrator in writing with the names, addresses, and contact information of the third party or parties that caused or are responsible, or may have caused or may be responsible for such injury, harm or loss, and all facts and information known to the Participant or their personal representative concerning the injury, harm or loss. In addition, the Participant shall furnish the name and contact information of the liability insurer and its adjuster of the third party, including the policy number, of any liability insurance that covers, or may cover, such injury, harm, or loss.

The Contract Administrator, on behalf of the Plan Administrator may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

Subrogation is taking over the Participant's right to receive payments from other parties. The Participant or their legal representative will transfer to the Contract Administrator, on behalf of the Plan Administrator any rights the Participant may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Participant. Thus, the Contract Administrator, on behalf of the Plan Administrator may initiate litigation at the Plan Administrator's sole discretion, in the name of the Participant, against any third party or parties. Furthermore, the Participant shall fully cooperate with the Contract Administrator in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice the Plan's subrogation rights and efforts. The Contract Administrator, on behalf of the Plan Administrator will be reimbursed in full for all benefits paid even if the Participant is not made whole or fully compensated by the recovery. Moreover, the Contract Administrator and the Plan Administrator are not responsible for any attorney's fees, other expenses or costs incurred by the Participant without the prior written consent of the Contract Administrator and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by the Contract Administrator, on behalf of the Plan Administrator.

Additionally, the Contract Administrator, on behalf of the Plan Administrator may at its option elect to enforce the Plan's right of reimbursement from the Participant, or their legal representative, of any benefits paid from monies recovered as a result of the injury, harm or loss. The Participant shall fully cooperate with the Contract Administrator in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice the Plans reimbursement rights and efforts.

The Participant shall pay the Contract Administrator, on behalf of the Plan Administrator, as the first priority, and the Contract Administrator, on behalf of the Plan Administrator, shall have a constructive trust and an equitable lien on, all amounts from any recovery by suit, settlement or otherwise from any third party or parties or from any third party's or parties' insurer(s), indemnitor(s) or underwriter(s), to the extent of benefits provided by the Contract Administrator, on behalf of the Plan Administrator under the Plan, regardless of how the recovery is allocated *(i. e.,* pain and suffering) and whether the recovery makes the Participant whole. Thus, the Contract Administrator, on behalf of the Plan Administrator, will be reimbursed by the Participant, or their legal representative, from monies recovered as a result of the injury, harm or loss, for all benefits paid even if the Participant is not made whole or fully compensated by the recovery. Moreover, the Contract Administrator and the Plan Administrator are not responsible for any attorney's fees, other expenses or costs incurred by the Participant without the prior written consent of the Contract Administrator and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by the Contract Administrator, on behalf of the Plan Administrator.

To the extent that the Contract Administrator, on behalf of the Plan Administrator provides or pays benefits for Covered Services, the Plan's rights of subrogation and reimbursement extend to any right the Participant has to recover from the Participant's insurer, or under the Participant's "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions, and workers' compensation benefits.

The Contract Administrator, on behalf of the Plan Administrator shall have the right, at the Plan Administrator's option, to seek reimbursement from, or enforce its right of subrogation against, the Participant, the Participant's personal representative, a special needs trust, or any trust, person or vehicle that holds any payment or recovery from or on behalf of the Participant including the Participant's attorney.

The Plan's subrogation and reimbursement rights shall take priority over the Participant's rights both for benefits provided and payments made by the Contract Administrator, on behalf of the Plan Administrator, and for benefits to be provided or payments to be made by the Contract Administrator on behalf of the Plan Administrator, in the future on account of the injury, harm or loss giving rise to the Plan's subrogation and reimbursement rights. Further, the Plan

Administrator's subrogation and reimbursement rights for such benefits and payments provided or to be provided are primary and take precedence over the rights of the Participant, even if there are deficiencies in any recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Participant and the Plan Administrator.

Collections or recoveries made by a Participant for such injury, harm or loss in excess of such benefits provided and payments made shall first be allocated to such future benefits and payments that would otherwise be owed by the Plan on account of the injury, harm or loss giving rise to the Plan's subrogation and reimbursement rights, and shall constitute a special Deductible applicable to such future benefits and payments that would otherwise be owed by the Plan, or any subsequent group health plan provided by the Plan Sponsor. Thereafter, the Contract Administrator, on behalf of the Plan Administrator, shall have no obligation to provide any further benefits or make any further payment until the Participant has incurred medical expenses in treatment of such injury, harm or loss equal to such special Deductible.

VI. Individual Benefits Management

Individual Benefits Management allows the Contract Administrator, on behalf of the Plan Administrator, to provide alternative benefits in place of specified Covered Services when alternative benefits allow the Participant to achieve optimum health care in the most cost-effective way.

The decision to allow alternative benefits will be made by the Plan Administrator in its sole and absolute discretion on a case-by-case basis. The Contract Administrator, on behalf of the Plan Administrator, may allow alternative benefits in place of specified Covered Services when a Participant, or the Participant's legal guardian and their Physician concur in the request for and the advisability of alternative benefits. The Plan Administrator reserves the right to modify, limit, or cease providing alternative benefits at any time.

A determination to cover alternative benefits for a Participant shall not be deemed to waive, alter, or affect the Plan Administrator's right to reject any other requests or recommendations for alternative benefits.

VII. Health Care Providers Outside the United States

The benefits available under the Medical Program are also available to Participants traveling or living outside the United States. The Inpatient Notification and Prior Authorization requirements will apply. If the Provider is a Contracting Provider with BlueCard, the Contracting Provider will submit claims for reimbursement on behalf of the Participant. Reimbursement for Covered Services will be made directly to the Contracting Provider. If the Health Care Provider does not participate with BlueCard, the Participant will be responsible for payment of services and submitting a claim for reimbursement to the Contract Administrator. The Contract Administrator will require the original claim along with an English translation. It is the Participant's responsibility to provide this information.

The Medical Program will reimburse covered Prescription Drugs purchased outside the United States by Participants who live outside the United States where no suitable alternative exists. Reimbursement will also be made in instances where Participants are traveling and new drug therapy is initiated for acute conditions or where emergency replacement of drugs originally prescribed and purchased in the United States is necessary. The reimbursable supply of drugs in travel situations will be limited to an amount necessary to assure continuation of therapy during the travel period and for a reasonable period thereafter.

VIII. Payment of Benefits

The Contract Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

A. The Contract Administrator, on behalf of the Plan Administrator, is authorized by the Participant to make payments directly to Providers rendering Covered Services to the Participant for benefits provided under the Plan. Notwithstanding this authorization, the Contract Administrator, on behalf of the Plan Administrator, reserves and shall have the right to make such payments directly to the Participant. Except as provided by law, the Contract Administrator's right, on behalf of the Plan Administrator, to pay a Participant directly is not assignable by a Participant nor can it be waived without the Contract Administrator's concurrence, on behalf of the Plan Administrator, nor may the right to receive benefits for Covered Services under this Document be transferred or assigned, either before or after Covered Services are rendered. Payments will also be made in accordance with any assignment of rights required by state Medicaid plan.

B. Once Covered Services are rendered by a Provider, the Contract Administrator, on behalf of the Plan Administrator, shall not be obliged to honor Participant requests not to pay claims submitted by such Provider, and the Contract Administrator, on behalf of the Plan Administrator, shall have no liability to any

person because of its rejection of such request; however, in its sole discretion, for good cause, the Contract Administrator, on behalf of the Plan Administrator, may nonetheless deny all or any part of any Provider claim.

IX. Out-of-Area Services

Overview

The Contract Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Participants access healthcare services outside the geographic area served by the Contract Administrator, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area served by the Contract Administrator, Participants obtain care from healthcare Providers that have a contractual agreement ("participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Participants may obtain care from healthcare Providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating Providers") with the Host Blue. The Contract Administrator remains responsible for fulfilling its contractual obligations to you. The Contract Administrator payment practices in both instances are described below.

This disclosure describes how claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that Dental Care Benefits, except when not paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by the Contract Administrator to provide the specific service or services are not processed through Inter-Plan Arrangements.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Participants access Covered Services within the geographic area served by a Host Blue/outside the geographic area served by the Contract Administrator, the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare Providers. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim – In General

a. Participant Liability Calculation

Unless subject to a fixed dollar copayment, the calculation of the Participant liability on claims for Covered Services will be based on the lower of the participating Provider's billed charges for Covered Services or the negotiated price made available to the Contract Administrator by the Host Blue.

b. The Plan Sponsor Liability Calculation

The calculation of the Plan Sponsor liability on claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to the Contract Administrator by the Host Blue under the contract between the Host Blue and the Provider. Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its participating healthcare Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, the Plan Sponsor may be liable for the excess amount even when the Participant's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the billed charge.

2. Claims Pricing

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's Provider contracts. The negotiated price made available to the Contract Administrator by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its Providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price the Plan Sponsor pay on a specific claim and the actual amount the Host Blue pays to the Provider. However, the BlueCard Program requires that the amount paid by the Participant and the Plan Sponsor is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future claim prices. As a result, the amounts charged to the Plan Sponsor will be adjusted in a following year, as necessary, to account for over- or underestimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from the Plan Sponsor. If the Plan Sponsor terminates, you will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

3. BlueCard Program Fees and Compensation

The Plan Sponsor understands and agrees to reimburse the Contract Administrator for certain fees and compensation which the Contract Administrator are obligated under the BlueCard Program to pay to the Host Blues, to the Association and/or to vendors of BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to the Plan Sponsor are set forth in Appendix A. BlueCard Program Fees and compensation may be revised from time to time as described in section G. below.

B. Special Cases: Value-Based Programs

Value-Based Programs Overview

The Plan Sponsor's Participants may access Covered Services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs under the BlueCard Program
Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways:

The Host Blue may pass these Provider payments to the Contract Administrator, which the Contract Administrator will pass directly on to the Plan Sponsor as either an amount included in the price of the claim or an amount charged separately in addition to the claim.

When such amounts are included in the price of the claim, the claim may be billed using one of the following pricing methods, as determined by the Host Blue:

(i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the claim. These charges are passed to the Plan Sponsor via an enhanced Provider fee schedule.
(ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the claim, they may be billed as follows:

- Per Member Per Month (PMPM) Billings: Per Member Per Month billings for Value- Based Programs incentives/Shared Savings settlements to accounts are outside of the claim system. The Contract Administrator will pass these Host Blue charges directly through to the Plan Sponsor as a separately identified amount on the group billings.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PMPM price methods, described above, are calculated. If the Plan Sponsor terminates, you will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of the Plan.

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated/drawn down over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

Note: Participants will not bear any portion of the cost of Value-Based Programs except when a Host Blue

uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

Care Coordinator Fees

Host Blues may also bill the Contract Administrator for Care Coordinator Fees for Provider services which we will pass on to the Plan Sponsor as follows:

1. PMPM billings; or
2. Individual claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

As part of the Plan, the Contract Administrator and the Plan Sponsor will not impose Participant Cost Sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

If the Contract Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan Sponsor's Participants, the Contract Administrator will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

Exception: For negotiated arrangements, when Control/Home Licensees have negotiated with accounts to waive member Cost Sharing for care coordinator fees, the following provision will apply: As part of this Plan, the Contract Administrator and the Plan Sponsor have agreed to waive Participant Cost Sharing for care coordinator fees.

C. Prepayment Review and Return of Overpayments

If a Host Blue conducts prepayment review activities including, but not limited to, data mining, itemized bill reviews, secondary claim code editing, and DRG audits, the Host Blue may bill the Contract Administrator up to a maximum of 16 percent of the savings identified, unless an alternative reimbursement arrangement is agreed upon by the Contract Administrator and the Host Blue, and these fees may be charged to the Plan Sponsor. If a Host Blue engages a third party to perform these activities on its behalf, the Host Blue may bill the Contract Administrator the lesser of the full amount of the third-party fees or up to 16 percent of the savings identified, unless an alternative reimbursement arrangement is agreed upon by the Contract Administrator and the Host Blue, and these fees may be charged to the Plan Sponsor.

Recoveries from a Host Blue or its participating and nonparticipating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/healthcare Provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to the Contract Administrator they will be credited to the Plan Sponsor account. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to the Plan Sponsor as a percentage of the recovery.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, the Contract Administrator will request the Host Blue to provide full refunds from participating healthcare Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original claim. For Care Coordinator Fees associated with Value-Based Programs, the Contract Administrator will request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements or (c) would jeopardize the Host Blue's relationship with its participating healthcare Providers, notwithstanding to the contrary any other provision of the Plan.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the Contract Administrator will disclose any such surcharge, tax or other fee to the Plan Sponsor, which will be the Plan Sponsor liability.

E. Nonparticipating Providers Outside the Contract Administrator Service Area

Please refer to the Additional Amount of Payment Provisions section in this Document.

F. Blue Cross Blue Shield Global Core

1. General Information

If Participants are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of BCBS Global Core when accessing Covered Services. BCBS Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although BCBS Global Core assists Participants with accessing a network of Inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when Participants receive care from Providers outside the BlueCard service area, the Participants will typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these services.

- **Inpatient Services**

  In most cases, if Participants contact the BCBS Global Core Service Center for assistance, hospitals will not require Participants to pay for covered Inpatient services, except for their deductibles, Cost Sharing, etc. In such cases, the hospital will submit Participant claims to the BCBS Global Core service center to initiate claims processing. However, if the Participant paid in full at the time of service, the Participant must submit a claim to obtain reimbursement for Covered Services. **Participants must contact Blue Cross of Idaho to obtain precertification for non-emergency Inpatient services.**

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require Participants to pay in full at the time of service. Participants must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a BCBS Global Core Claim**

  When Participants pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Participants should complete a BCBS Global Core claim form and send the claim form with the Provider's itemized bill(s) to the BCBS Global Core service center address on the form to initiate claims processing. The claim form is available from Blue Cross of Idaho, the BCBS Global Core service center, or online at www.bcbsglobalcore.com. If Participants need assistance with their claim submissions, they should call the BCBS Global Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

2. BCBS Global Core-Related Fees

The Employer understands and agrees to reimburse Blue Cross of Idaho for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to the Employer under BCBS Global Core are set forth in Appendix A. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in section G. below.

G. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, the Contract Administrator shall provide the Plan Sponsor with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and the Plan Sponsor right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change. If the Plan Sponsor fails to respond to the notice and does not terminate this Agreement during the notice period, the Plan Sponsor will be deemed to have approved the proposed changes, and the Contract Administrator will then allow such modifications to become part of this Agreement.

X. Notice of Claim

The Contract Administrator must receive a written notice of claim for payment for a Covered Service no later than one year from the date a Covered Service is rendered, except if it is not reasonably possible to give notice of proof within this timeframe. The Contract Administrator will deny any claim not received within this time limit.