Employer Plan

2026 Summary Plan Document for:

Plan Name: Boise Municipal Health Care Trust
Employee Benefit Plan
Plan Sponsor: City of Boise
Trust: Boise Municipal Health Care Trust
Contract Administrator: Blue Cross of Idaho Health Service, Inc.

ASC Vision

Effective Date: January 1, 2026

Benefit Period: January 1 through December 31

This is a self-funded plan and is not an insurance policy and the Boise Municipal Health Care Trust does not participate in the Idaho Life and Health Guaranty Association.

Form No. BMHCT-VISION-010126

BENEFITS OUTLINE

This Summary Plan Document constitutes a part of your benefits guide, benefits booklet, summary plan description, or other similar governing plan document (as the case may be) that provides a summary of the Plan. To the extent there is any conflict between such governing Plan documents of the Employer and this Summary Plan Document, this Summary Plan Document shall be the governing document upon which the Contract Administrator shall administer claims. Notwithstanding any provision in this document to the contrary, if the resolution of a benefit claim is tied to an individual's eligibility for coverage under the Plan, such eligibility determination shall be resolved by the Plan Sponsor.

IMPORTANT INFORMATION ABOUT THIS OUTLINE

This Benefits Outline describes the benefits in general terms. It is important to read the Summary Plan Document in full for specific and detailed information that includes additional exclusions and limitations on benefits. Your manager of employee benefits should be able to help if you have questions. If Participants receive this document and/or any other Plan notices electronically, Participants have the right to receive paper copies of the electronic documents, including summary plan descriptions and plan amendments, upon request at no additional charge.

Throughout this document references to Blue Cross of Idaho (BCI) are referring to the Contract Administrator. For Covered Services under the terms of the Plan, Maximum Allowance is the amount established by the Vision Care Services Vendor (VCSV) 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.

DISCRIMINATION IS AGAINST THE LAW

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.

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 ***https://www.hhs.gov/ocr/complaints/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 बोलनुहुन्छ भने तपाईंको नमिर्ता 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).

Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

HEALTHY SIGHT VISION CARE BENEFITS (VCSV)
BENEFITS OUTLINE
Visit our Website at www.bcidaho.com to locate a Participating Provider

*The Participating Provider is responsible for verifying benefits with the VCSV prior to rendering services. A Participant must provide the Participating Provider sufficient information to verify eligibility. Failure of the Participant to provide sufficient information may delay services and may affect benefit payment under the Plan.

For Covered Providers and Services **Copayment**	Participant pays $25 per eye exam and/or $0 per Frame and Lenses or Medically Necessary Contact Lenses
Service Frequency Limitations	Participant may receive: • one (1) eye exam per Benefit Period. • one (1) pair of Lenses or one (1) pair of Medically Necessary Contact Lenses (in lieu of eyeglasses) or one (1) pair of Elective Contact Lenses (in lieu of eyeglasses) per Benefit Period. • one (1) Frame per Benefit Period. If Contact Lenses are chosen, Participant will be eligible for a Frame the following Benefit Period.

In-Network Services (*Participating Providers)
***Payment for Services Rendered and Allowances*:**

Exam—Participant pays Copayment, as applicable, then Plan pays 100% of Maximum Allowance.

Prescription Glasses—Participant pays Copayment, as applicable, then Plan pays 100% of Maximum Allowance for Basic Lenses and Medically Necessary Contact Lenses (in lieu of glasses). Includes Frame allowance of $250.

Elective Contact Lenses—Includes a Contact Lens fitting and evaluation and $250 allowance for materials in place of benefits for Prescribed Lenses and Frame.

Out-of-Network Services (Nonparticipating Providers)
Reimbursement Allowances:

Professional Fees
Eye Exam: Plan pays up to $45
Materials—Lenses per pair
Frame: Plan pays up to $70
Single Vision Lenses: Plan pays $30
Lined Bifocals Lenses: Plan pays up to $50
Lined Trifocals Lenses: Plan pays up to $65
Progressives Lenses: Plan pays up to $65

Contact Lenses per pair: $105
Medically Necessary, up to Maximum Allowance: $210

Elective Contact Lenses—includes a Contact Lens fitting and evaluation and an allowance for materials in place of benefits for Prescribed Lenses and Frame.

Boise Municipal Health Care Trust Employee Benefit Plan

Effective Date: January 1, 2026

Blue Cross of Idaho has been hired as the Contract Administrator by the Trust 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 Contract Administrator's designated Vision Care Services Vendor (VCSV), Vision Service Plan (VSP) in order to receive benefits for Covered Services. There are two (2) ways for a Participant to submit a claim:

1. The vision service Provider can file the claim for the Participant. In-Network (Participating) Providers will submit a claim on a Participant's behalf if the Participant shows them the identification card before services are rendered and tells them they have coverage through VSP.

2. The Participant can send the claim to VSP.

To File a Participant's Own Claims
In-Network (Participating) vision service Providers will submit a claim for the Participant. This will ensure the Participant receives the highest benefits from the Plan. If the Participant receives services from an Out-of-Network (Nonparticipating) vision service Provider, the Participant can file the claim directly to VSP. To submit an Out-of-Network claim:

1. The Participant can visit VSP's Website at www.vsp.com and sign in as a Member. Click on the "Benefits" link and then the "Submit a Claim" under the heading "Oops! Did You Go Out of Network" Instructions for completing the form are described. Once completed, mail the form to VSP at the address listed below.

2. Include a copy of the itemized billing statement or receipts and be sure to include the following information:
   a. Doctor's name or office name
   b. Name of patient
   c. Date of Service
   d. Each service received and the amount paid

   Mail to:

   Vision Service Plan
   Attention: Claims Services
   PO Box 385018
   Birmingham, AL 35238-5018

For assistance with claims the Participant can call VSP Customer Service at 1-844-348-0848 Monday through Friday 6 a.m. – 7 p.m. MT.

Notice of Claim Time Limit and Documentation
The Contract Administrator will process claims for benefits on behalf of the Employer according to the Administrative Services Agreement between the parties. A claim for Covered Services must be submitted within one year from the date of service and must include all the information necessary for the Contract Administrator, on behalf of the Plan Administrator, to determine benefits.

How the Participant is Notified
If the Participant receives services from an In-Network Provider (Participating), the Provider will provide a statement explaining the cost of the services. If the Participant receives services from an Out-of-Network Provider (Nonparticipating), VSP will provide a statement of costs to the Participant with a reimbursement check.

CONTACT INFORMATION FOR THE CONTRACT ADMINISTRATOR

For general information, please contact the Contract Administrator's office:

Meridian
Customer Service Department
3000 East Pine Avenue
Meridian, ID 83642

Mailing Address
PO Box 7408
Boise, ID 83707
(208) 331-7347 (Boise Area)
1-800-627-1188

ELIGIBILITY AND ENROLLMENT SECTION

I. Eligibility and Enrollment

The Employer decides which categories of its Employees and Dependents will have the opportunity to apply for coverage under this Summary Plan Document in accordance with the Employer's employee handbook. The Employer will determine if there are certain probationary periods that must be satisfied before a new Eligible Employee can qualify for coverage under this Summary Plan Document. Please contact your manager of employee benefits for the probationary period and any other restrictions applicable.

A. Eligible Employee

To qualify as an Eligible Employee under this Summary of Health Care Benefits, a person must be and remain (i) a full-time employee of the Employer who regularly works at least 20 hours per week and is paid on a regular, periodic basis through the Employer's payroll system; (ii) an employee on an approved leave of absence who has been designated by the Employer as eligible for coverage; (iii) an elected official; or (iv) a retiree of the Employer who has been designated by the Employer as eligible for coverage.

B. Eligible Dependent

To qualify as an Eligible Dependent, a person must be and remain one (1) of the following:

1. The Enrollee's spouse under a legally valid marriage provided said spouse is not an Eligible Employee of the Employer and enrolled in any other healthcare plan offered by the Employer.
2. The Enrollee's or the Enrollee's spouse's natural child, stepchild, legally adopted child, child placed with the Enrollee for adoption, or child for whom the Enrollee or the Enrollee's spouse has court-appointed guardianship or custody. The child must be under the age of twenty-six (26).
3. A child as described in the first sentence of subparagraph two (2) who has attained age twenty-six (26) provided:
    a) The child is medically certified as incapable of self-sustaining employment due to an intellectual disability or physical handicap that began prior to age twenty-six (26);
    b) The child is chiefly dependent upon the Enrollee or the Enrollee's spouse for support and maintenance; and
    c) The Enrollee submits proof of such child's incapacity and dependency as described in this subparagraph three (3) within thirty-one (31) days of such child's attainment of age twenty-six (26) and as subsequently required by the Contract Administrator and/or the Employer at reasonable intervals.
4. A child under a QMCSO is also eligible.

A child whose coverage has terminated coverage under this Summary Plan Document due to reaching the age limit, and then becomes disabled, is not eligible to re-enroll as a disabled Dependent child under this Summary Plan Document.

An Enrollee must notify the Boise Municipal Health Care Trust within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate on the last day of the month in which the change in eligibility occurred.

C. Annual Open Enrollment Periods

Applications for coverage for an Eligible Employee will only be accepted during the Employer's annual Open Enrollment Period, during the Eligible Employee's Initial Enrollment Period, or during a Special Enrollment Period as described in this section. If an Eligible Employee does not apply for coverage during these time periods, they must wait until the next Open Enrollment Period or Special Enrollment Period.

D. Initial Enrollment Period

The Initial Enrollment Period is thirty (30) days for Eligible Employees and Eligible Dependents. The Initial Enrollment Period begins on the date the Eligible Employee or Eligible Dependent first becomes eligible for coverage under this Summary Plan Document.

E. Enrollment of Eligible Dependents

1. For an Eligible Employee to enroll themself and any Eligible Dependents for coverage under this Summary Plan Document (or for an Enrollee to enroll Eligible Dependents for coverage) the Eligible Employee or Enrollee, as the case may be, must complete an application and submit it to the Employer.

2. Newborn/Adoption---When a newborn child is added and the monthly Contribution changes, a full month's Contribution is required for the child if their date of birth falls on the first (1st) through the fifteenth (15th) day of the month. No Contribution is required if the child's date of birth falls on the sixteenth (16th) through the last day of the month. An Enrollee's newborn Dependent, including adopted newborn children who are placed with the adoptive Enrollee within sixty (60) days of the adopted child's date of birth, are covered under the Plan from and after the date of birth for sixty (60) days.

   A. Contribution for the first sixty (60) days of coverage is due not less than thirty-one (31) days following receipt of a billing for the required Contribution. In order to continue coverage beyond the sixty (60) days outlined above, the Enrollee must complete an enrollment application within sixty (60) days of date of birth and submit the required Contribution, for the first sixty (60) days, within thirty-one (31) days of the date monthly billing is received and a notice of Contribution is provided to the Enrollee from the Employer.

   B. If the date of adoption or the date of placement for adoption of a child is more than sixty (60) days after the child's date of birth, the Effective Date of coverage will be the date of adoption or the date of placement for adoption. In this Summary Plan Document, 'child' means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. In this Summary Plan Document, "placed for adoption" means physical placement in the care of the adoptive Enrollee, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Enrollee signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

F. Effective Dates of Coverage

Subject to receiving the applicable Contribution payment:

1. If the Eligible Employee or Eligible Dependent enrolled during their Initial Enrollment Period or the Employer's Open Enrollment Period, the Effective Date of coverage for an Eligible Employee and any Eligible Dependents listed on the Eligible Employee's application is the Employer's Plan Date if the application is submitted to the Contract Administrator by the Employer on or before the Plan Date.

2. Except as provided otherwise in this section, if enrollment is requested during an Initial Enrollment Period or annual Open Enrollment Period, the Effective Date of coverage for an Eligible Employee or an Eligible Dependent will be the first day of the month following the month of enrollment.

3. If enrollment is requested during a Special Enrollment Period due to the loss of Minimum Essential Coverage or marriage, the Effective Date of coverage will be the first day of the month following the marriage or loss of coverage.

4. The Effective Date of coverage for enrollment requested during a Special Enrollment Period will be the date of birth for a newborn natural child or a newborn child adopted or placed for adoption within sixty (60) days of the child's date of birth.

5. For other enrollment requested though a Special Enrollment Period, if the application is received between the first and fifteenth day of the month, coverage will begin on the first day of the following month. If the application is received between the sixteenth day and the last day of the month, coverage will begin on the first day of the second month.

G. Late Enrollee

If an Eligible Employee or Eligible Dependent does not enroll during the applicable initial enrollment period described in Paragraph D. of this section, or during a special enrollment period described in Paragraph H. of this section, the Eligible Employee or Eligible Dependent is a Late Enrollee. Following the receipt and acceptance of a completed enrollment application, the Effective Date of coverage for a Late Enrollee will be the date of the Employer's next Plan Date.

H. Special Enrollment Periods

Outside of the Eligible Employee's Initial Enrollment Period or annual Open Enrollment Period, an Eligible Employee or Eligible Dependent will not be considered a Late Enrollee and may enroll for coverage, unless otherwise noted, within thirty (30) days of the occurrence of one of the following events:

1. The Eligible Employee or Eligible Dependent meets each of the following:
   a) The individual was covered under Minimum Essential Coverage at the time of the initial enrollment period.
   b) The individual involuntarily lost coverage under Minimum Essential Coverage.
   c) The individual requests enrollment within thirty (30) days after termination of the Minimum Essential Coverage.
2. Addition of an Eligible Dependent through marriage, birth, adoption or placement of adoption and coverage is requested no later than sixty (60) days after the event.
3. A court has issued a Qualified Medical Child Support Order (QMCSO) requiring that coverage be provided for an Eligible Dependent by an Enrollee, and application for enrollment is made within thirty (30) days after issuance of the QMCSO.
4. The Eligible Employee and/or Eligible Dependent become eligible for financial assistance under Medicaid or the Children's Health Insurance Program (CHIP) and coverage is requested no later than sixty (60) days after the date the Eligible Employee and/or Eligible Dependent is determined to be eligible for such assistance.
5. Coverage under Medicaid or CHIP for an Eligible Employee and/or Eligible Dependent is terminated as a result of loss of eligibility for such coverage, and coverage is requested no later than sixty (60) days after the date of termination of such coverage.

II. Leave Of Absence

If the Employer grants a temporary leave of absence to an Eligible Employee in accordance with the Employer's written policies and procedures, the Eligible Employee and their Eligible Dependents may continue to be enrolled for so long as the leave is approved by the Employer, provided the Employer maintains regular monthly payments for the coverage with the regular Employer billing. The Employer must notify the Contract Administrator of the Enrollee's date of departure for, and return from, the leave of absence. Military personnel called into active duty will continue to be covered to the extent required by the Uniformed Services Employment and Reemployment Rights Act (USERRA) or other applicable law.

LEAVE OF ABSENCE (Special Circumstances)

Family and/or Medical Leave (FMLA)

In general, to be eligible for FMLA, an employee must have worked for their employer for at least 12 months, met the 1,250 hours of service requirement in the twelve (12) months prior to the leave, and worked at a location where the employer employed at least fifty (50) employees within seventy-five (75) miles. If the employee is eligible for FMLA the employee is entitled by law to up to twelve (12) weeks each year (in some cases, up to twenty-six (26) weeks) of unpaid family or medical leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care of a Spouse, child or parent who is seriously ill, or for the employee's own serious illness.

For the calculation of the twelve (12) month period used to determine employee eligibility for FMLA, the Plan uses a rolling twelve (12) month period measured backward in time from the date the employee uses any FMLA leave.

While you are officially on such a family or medical leave, you can keep health coverage for yourself and your Dependents in effect during that family or medical leave period by continuing to pay your Contributions during that leave period.

- Since you will not be paid while you are on family or medical leave, you may pay your Contributions as they come due on the dates you would have been paid (or on some other schedule agreed to by you and your Employer) had you not taken family or medical leave, in which case your Contributions will be made on an after-tax basis.

- Whether or not you keep your coverage while you are on family or medical leave, if you return to work promptly at the end of that leave, your health care coverage will be reinstated without any additional limits or restrictions imposed on account of your leave. This is also true for any of your Dependents who were covered by the Plan at the time you took your leave.

- Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that leave will apply to you and your Dependents in the same way they apply to all other employees and their Dependents. To find out more about your entitlement to family or medical leave as required by federal and/or state law, and the terms on which you may be entitled to it, contact your Human Resources department.

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

USERRA CONTINUATION COVERAGE IS ADMINISTERED BY THE TRUST. THE CONTRACT ADMINISTRATOR DOES NOT ADMINISTER USERRA CONTINUATION COVERAGE. PLEASE CONTACT YOUR GROUP ADMINISTRATOR FOR USERRA INFORMATION.

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA? USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee's coverage under this Summary Plan Document will terminate when the employee enters active duty in the uniformed services.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working.

- If the employee goes into active military service for **up to thirty-one (31) days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Summary Plan Document during that leave period if the employee continues to pay the appropriate Contributions for that coverage during the period of that leave.

Duty to Notify the Plan: The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the employee in writing that they have been called to active duty in the uniformed services and provides a copy of the orders. The employee must notify the Plan Administrator as soon as possible but no later than sixty (60) days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage: Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact your Human Resources department to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Paying for USERRA Coverage:

- If the employee goes into active military service for up to **thirty-one (31) days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Summary Plan Document during that leave period if the employee continues to pay the appropriate Contributions for that coverage during the period of that leave.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **twenty-four (24) months** measured from the last day of the month in which the employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and Contributions for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA chapter for more details.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Summary Plan Document's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- Ninety (90) days from the date of discharge from the military if the period of services was more than one hundred eighty (180) days;
  or
- Fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more but less than one hundred eighty (180) days;
  or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight (8) hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated. Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to your Human Resources department.

III. Changing Your Coverage During the Year (Mid-Year Change of Status/Election Change)

Government regulations generally require that your Plan coverages remain in effect throughout the Plan Year (from January 1 through December 31), but you may be able to make some changes during the year (mid-year) if the Plan Administrator or its designee determines that you have a permissible **change** in your status (as permitted by the IRS) affecting your benefit needs. Generally, proof of the change of status event will be required. The following changes are the only ones permitted under the Plan:

1. **Change in employee's legal marital status**, including gaining a Spouse through marriage, or losing a Spouse through divorce, legal separation (where permissible by law), annulment or death.

2. **Change in number of employee's Dependents**, including gaining a child through birth, adoption, or placement for adoption, or losing a child such as through death.

3. **Change in your, your Spouse's or Dependent Child's employment status or work schedule IF it impairs (or creates) your, your Spouse's or your Dependent Children's eligibility for benefits**, including the start or termination of employment, an increase or decrease in hours of employment (including a switch in part-time and full-time employment), a strike or lock-out, the start of or return from an unpaid leave of absence that is either required by law (such as FMLA and military leave or, other leave permitted by your employer), or a change of work-site.

4. **Change in Dependent status that satisfies or ceases to satisfy the Plan's eligibility requirements**, including changes due to attainment of age, or a change affecting a requirement described under the definition of Dependent in this document.

5. **Change of residence or worksite that allows or impairs** your, your Spouse's or Dependent Child's eligibility for benefits.

6. **Change required under the terms of a Qualified Medical Child Support Order (QMCSO),** including a change necessary to add the child as a covered Dependent as specified in the order, or to cancel coverage for the child if the order requires your former Spouse to provide that coverage.

7. **Change consistent with your right to Special Enrollment** as described in the section dealing with Special Enrollment in the Eligibility chapter of this document.

8. **Change consistent with entitlement to (or loss of eligibility for) Medicare or Medicaid** affecting you, your Spouse or Dependent Child (except for coverage solely under the program for distribution of pediatric vaccines), including prospective cancellation of coverage of the person entitled to Medicare/Medicaid following such entitlement or prospective reinstatement or election of coverage following loss of eligibility for Medicare/Medicaid.

9. **Automatic Change in the Cost of Coverage**. If the cost of a qualified benefits plan increases or decrease during the Plan year and under the terms of the Plan employees are required to make a corresponding change in their payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected employees' elective Contribution for the Plan.

10. **Significant Change in the Cost of Coverage**. If the cost charged to an employee for a benefit package significantly increases or significantly decreases during the Plan year, the Plan may permit the employee to make a corresponding change in election under the Plan. In such a case the employee may start coverage in the Plan option with the decreased cost; or, revoke coverage in the Plan option with an increased cost and elect, on a prospective basis, coverage under another plan option providing similar coverage, if one is available, or drop the coverage if no other such plan option is available.

11. **Significant curtailment without loss of coverage**. If the employee or employee's Spouse or Dependent child has a significant curtailment of coverage under a plan during the Plan year that is not a loss of coverage, the Plan may permit the employee who has been participating in the Plan to revoke his/her election for that coverage and elect to receive, on a prospective basis, coverage under another

benefit package option providing similar coverage, or to drop coverage if no similar benefit package option is available. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to participants under the Plan so as to constitute reduced coverage to participants generally.

12. **Addition or elimination of a benefit package option providing similar coverage**. If during a Plan Year, the Plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option) the Participant may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.

13. **Addition or significant improvement of any Plan option under the employer's Health Care Programs or the Spouse's employer's health care plans or programs**. In such a case, a Participant may revoke coverage in the current plan and either elect, on a prospective basis, coverage under a new or improved plan option.

14. **Change in coverage under another employer's plan or program** that permits Participants to make an election change that would be permitted by these mid-year changes, or that permits Participants to make an election for a period of coverage that is different from the Plan Year of this Summary Plan Document (e.g. Spouse's employer coverage has different open enrollment/Plan year). In such a case, a Participant may elect, on a prospective basis, the same change in coverage under this Summary Plan Document that was available under the other plan.

15. **Reduction of Hours.** An employee who was expected to average at least 30 hours of service per week may prospectively drop group health plan coverage midyear if the employee's status changes so that the employee is expected to average <u>less than</u> 30 hours of service, even if the reduction of hours does not result in loss of eligibility for the plan. However, the mid-year change must correspond to the employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in other minimum essential coverage (MEC). The new MEC coverage must be effective no later than the first day of the second month following the month in which the original coverage is dropped. For example, other minimum essential coverage could mean intended enrollment in Health Insurance Marketplace coverage, minimum essential coverage through the spouse's group health plan, to change to a different medical plan option of the employee's own employer or to enroll in Medicaid/CHIP.

16. **Exchange Coverage.** An employee who is eligible to enroll in Marketplace coverage (during a Marketplace special enrollment or open enrollment period) may prospectively drop the Trust's group health plan coverage midyear, but only if the change corresponds to the employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in Marketplace coverage that is effective no later than the day after the last day of the original coverage. This means that the Trust's group health plan coverage is not to be terminated until Marketplace coverage takes effect.

These rules apply to making changes to your benefit coverage(s) during the year:

1. Any change you make to your benefits must be determined by the Plan Administrator or its designee to <u>be necessary, appropriate to and consistent with the change in status</u>; *(For example, if mid-year, the employee and Spouse deliver a newborn child they can add that child to this Summary Plan Document but it would be inconsistent with a birth event to drop the Spouse from coverage at this time)* **and**

2. You must notify the Plan in writing within 31 days of the change in status, otherwise, the request will not be considered to be made on account of your change of status and you will have to wait until the next Open Enrollment period to make your changes in coverage. (You have 60 days from the loss of eligibility for Medicaid or CHIP to request to enroll in this Summary Plan Document as discussed under Special Enrollment); **and**

3. If you have a permissible change in status, you are only allowed to make changes to your coverage that are consistent with the change of status event. <u>Generally only coverage for the individual who has lost eligibility as a result of a change of status (or who has gained eligibility elsewhere and</u>

actually enrolled for that coverage) can be dropped mid-year from this Summary Plan Document. Generally, proof of the change of status event will be required; **and**

4. If you will be adding an eligible individual to the Plan, **coverage changes associated with a mid-year change of status opportunity for benefits-eligible persons must be prospective** and are therefore effective the first day of the month following the change, provided you submit a completed enrollment change form to your Human Resources department, except for:

- Newborns, who are effective on the date of birth and
- Children adopted or placed for adoption, who are effective on the date of adoption or placement for adoption.

A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan

Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code. Generally, proof of the change of status event will be required. This chart is only a summary of some of the permitted medical plan changes and is not all inclusive.

This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).

If you experience the following Event...	You may make the following change(s) within 31 days of the Event.	YOU MAY NOT make these types of changes...
REMINDER: *Failure to notify the Plan within 60 days of the date of a divorce or the date a child loses eligibility will cause the individuals losing coverage to forfeit the right to elect COBRA continuation coverage.*		
Family Events		
Marriage	• Enroll yourself, if applicable • Enroll your new Spouse and other eligible dependents • Drop health coverage (to enroll in your Spouse's plan) • Change health plans, when options are available	• Drop health coverage and not enroll in Spouse's plan.
Divorce	• Remove your Spouse from your health coverage • Enroll yourself (and your children) if you or they were previously enrolled in your Spouse's plan	• Change health plans • Drop health coverage for yourself or any other covered individual
Gain a child due to birth or adoption	• Enroll yourself, if applicable • Enroll the eligible child and any other eligible dependents • Change health plans, when options are available	• Drop health coverage for yourself or any other covered individuals
Child requires coverage due to a QMCSO	• Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Change health plans, when options are available, to accommodate the child named on the QMCSO	• Make any other changes, except as required by the QMCSO
Loss of a Dependent's eligibility (*e.g.,* child reaches the maximum age for coverage)	• Remove the Dependent from your health coverage • Dependent will be offered COBRA. You may pay for dependent's COBRA coverage on a pre-tax basis.	• Change health plans • Drop health coverage for yourself or any other covered individuals

A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan

Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code. Generally, proof of the change of status event will be required. This chart is only a summary of some of the permitted medical plan changes and is not all inclusive.

This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).

If you experience the following Event...	You may make the following change(s) within 31 days of the Event.	YOU MAY NOT make these types of changes...
Death of a dependent (Spouse or child)	• Remove the dependent from your health coverage • Change health plans, when options are available	• Drop health coverage for yourself or any other covered individuals
Covered person has become entitled to (or lost entitlement to) Medicaid or Medicare	• Drop coverage for the person who became entitled to Medicare or Medicaid. • Add the person who lost Medicare/Medicaid entitlement.	• Drop health coverage for yourself or any other covered individuals
Employment Status Events		
Spouse becomes eligible for health benefits in another group health plan	• Remove your Spouse from your health coverage, with proof of Spouse's other new plan coverage • Remove your children from your health coverage, with proof of children's other new plan coverage • Drop coverage for yourself only with proof that Spouse added you to the Spouse's new group health plan	• Change health plans • Add any eligible dependents to your health coverage
Spouse loses employment or otherwise becomes ineligible for health benefits in another plan	• Enroll your Spouse and, if applicable, eligible children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your Spouse's plan • Change health plans, when options are available	• Drop health coverage for yourself or any other covered dependents
You lose employment or otherwise become ineligible for health benefits	• Enroll in your Spouse's plan, if available • Elect temporary COBRA coverage for the Qualified Beneficiaries (you and your covered Dependents)	
Proof of a status change may be required to make a corresponding change in coverage/enrollment.		

IV. Employer Contribution and Enrollment Requirements

A. All applications submitted to the Contract Administrator by the Employer now or in the future, will be for Eligible Employees or Eligible Dependents only.

B. The Trust agrees to be responsible for and make the total required payment to the Contract Administrator as provided in the Administrative Services Agreement. The Trust further agrees that no other hospital, medical or surgical group coverage will be offered to employees during the term of this Summary Plan Document, unless required by State or Federal law.

C. The Trust agrees it will pay one hundred percent (100%) of the amount paid in benefits for all Participants under this Summary Plan Document, except as modified by the Administrative Services Agreement.

D. Before the Effective Date of the change, the Employer shall submit all eligibility changes for Enrollees and Eligible Dependents on the Contract Administrator's usual forms. It is the Employer's responsibility to verify that all Participants are eligible for coverage as specified in this Summary Plan Document. The Contract Administrator shall have the right to audit the Employer's employment, payroll, and eligibility records to ensure that all Participants are eligible and properly enrolled and to ensure that the Employer meets enrollment requirements.

V. Qualified Medical Child Support Order

A. If this Summary Plan Document provides for Family Coverage, the Contract Administrator will comply with a Qualified Medical Child Support Order (QMCSO) according to applicable federal or state laws. A medical child support order is any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a child of an Enrollee or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under this Summary Plan Document**,** or
2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.

B. A medical child support order meets the requirements of a QMCSO if such order clearly specifies:

1. The name and the last known mailing address (if any) of the Enrollee and the name and mailing address of each child covered by the order.
2. A reasonable description of the type of coverage to be provided by this Summary Plan Document to each such child, or the manner in which such type of coverage is to be determined.
3. The period to which such order applies.

C. 1. Within fifteen (15) days of receipt of a medical child support order, the Contract Administrator will notify the party who sent the order and each affected child of the receipt and of the criteria by which the Contract Administrator determines if the medical child support order is a QMCSO. In addition, the Contract Administrator will send an application to each affected child. The application must be completed by or on behalf of the affected child and promptly returned to the Contract Administrator. With respect to a medical child support order, affected children may designate a representative for receipt of copies of notices sent to each of them.

2. Within thirty (30) days after receipt of a medical child support order and a completed application, the Contract Administrator will determine if the medical child support order is a QMCSO and will notify the Enrollee, the party who sent the order, and each affected child of such determination.

D. The Contract Administrator, on behalf of the Plan Administrator, will make benefit payments to the respective party for reimbursement of eligible expenses paid by an enrolled affected child or by an enrolled affected child’s custodial parent, legal guardian, or the Idaho Department of Health and Welfare.

VISION CARE BENEFITS SECTION

This section specifies the benefits a Participant is entitled to receive for the Covered Services described, subject to the other provisions of this Summary Plan Document.

I. Copayment and Limitations on Frequency of Services

The Copayment amount and limitations on frequency of services are shown in the Benefits Outline.

II. Covered Providers

The following are Covered Providers under this section:

- Optometrist (OD)
- Ophthalmologist (MD)

III. Procedures for Obtaining Covered Services

A. A Participant must contact the Vision Care Services Vendor (VCSV) Participating Provider to make an appointment to receive Covered Services. No preauthorization or special benefit form is required. The doctor is responsible for verifying eligibility and obtaining the necessary authorization from the VCSV prior to the delivery of service. Each authorization is valid for fifteen (15) days. A Participant must provide the VCSV Participating Provider sufficient information to verify eligibility. Failure of the Participant to provide sufficient information may delay services and may affect benefit payment under the Plan.

B. Should the Participant obtain services from a Provider who is not a VCSV Participating Provider, the Participant is responsible for making payment in full to the Provider and will be reimbursed by the VCSV in accordance with the benefits available for Covered Services under this section.

IV. Covered Services

When rendered by a Covered Provider, benefits are provided for the following services:

A. Eye Examination
B. Frame
C. Single Vision Lenses
D. Lined Bifocal Lenses
E. Lined Trifocal Lenses
F. Contact Lens fitting and evaluation and Contact Lenses in place of eyeglasses

A. Eye Examination

An eye vision examination regardless of its Medical Necessity, including but not limited to, the following services:

(NOTE: Each test may not be indicated for every patient.)

1. **Comprehensive Examination**—evaluation of the complete visual system with or without cycloplegia or mydriasis.
2. **Intermediate Examination**—brief or limited routine check-up or vision survey.
3. **Vision Analysis**—various tests for prescription Lenses.
4. **Tonometry**—measurement of eye tension for glaucoma.
5. **Biomicroscopy**—examination of the living eye tissue.
6. **Central and/or Peripheral Field Study**—measurement of visual acuity in the central and/or peripheral field of vision.
7. **Dilation—**allows for a better view inside the eye, i.e., optic nerve blood vessels, etc.

B. Prescribed Lenses and Frames

When an eye examination indicates that new Lenses or a new Frame or both are necessary for the proper visual health and welfare of a Participant, they will be supplied, together with such professional services as necessary, which include but are not limited to:

1. Prescribing and ordering proper Lenses.
2. Assisting in the selection of a Frame.
3. Verifying the accuracy of the finished Lenses.
4. Proper fitting and adjustment of the eyeglasses.

The VCSV reserves the right to limit the cost of Frames provided by a Participating Provider. The allowance is published periodically by the VCSV to its Participating Providers and is set at a level to cover the majority of Frames in common use. If a Participant wishes to select a more expensive Frame than allowed in this section, the difference in cost is not the responsibility of the VCSV, the Contract Administrator or the Plan Administrator.

C. Contact Lenses

1. **Medically Necessary Contact Lenses**—Medically Necessary Contact Lenses are covered for Participants when specific benefit criteria are satisfied and when prescribed by Participant's doctor.

   When the Participating Provider receives prior approval for such cases, they are fully covered by the VCSV and are in place of the benefits described for Prescribed Lenses and Frames.

   Medically Necessary Contact Lenses may be prescribed only for certain medical conditions.

2. **Elective Contact Lenses**—if a Participant chooses Contact Lenses from a Participating Provider for reasons other than those mentioned above, benefits are provided as follows: The initial basic examination will be covered in full (as described under Eye Examination) and an allowance will be paid toward a contact lens evaluation fee, fitting costs, and materials in place of the benefits described for Prescribed Lenses and Frames. The allowance amount is shown in the Benefits Outline.

3. **Reimbursement Allowance**—For Covered Services rendered by a Provider who is not a Participating Provider, a determination of Medically Necessary versus Elective Contact Lenses will be consistent with Participating Provider services. Reimbursement allowances for Medically Necessary and Elective Contact Lenses include a contact lens evaluation fee, fitting costs, and materials and is in place of all other benefits for materials, including eyeglass Lenses and Frame.

V. Additional Amount of Payment Provisions

A. The Participant must pay the Copayment, if any, to the Participating Provider for Covered Services and must pay for any additional services received not covered by the Plan. The VCSV will pay the Participating Provider in accordance with the agreement between the VCSV and the Participating Provider.

Subject to the applicable Copayment(s), the VCSV will pay or otherwise secure the discharge of the cost of Covered Services rendered by a Participating Provider. A Participating Provider shall not make an additional charge to a Participant for amounts in excess of the VCSV's payment except for Copayments, noncovered services, and amounts above the allowance for elective Contact Lenses.

B. If Covered Services are rendered by a Provider who is not a VCSV Participating Provider:

1. The Participant is responsible for paying the Provider in full. The Participant will be reimbursed in accordance with the benefits available, if any, as shown in the Benefits Outline.

2. The Nonparticipating Provider is not obligated to accept the VCSV's payment as payment in full. The VCSV and the Contract Administrator, or the Plan Administrator are not responsible for the difference, if any, between the VCSV's payment and the actual charge, any such difference is the Participant's responsibility.

3. Benefits for Covered Services are subject to the same time limits and Copayments as those described for Covered Services received from a Participating Provider. Covered Services obtained from a Nonparticipating Provider are in place of obtaining services from a Participating Provider.

C. The amounts shown in the Benefits Outline under Payment for services rendered by a Nonparticipating Provider are maximums. The actual amount paid in reimbursement to the Participant is either the amount indicated in the Benefits Outline or the amount actually charged, whichever is less.

VI. Enrollee's Options

When a Participant selects any of the following options, the VCSV pays the basic cost of the allowed Lenses, and the Participant is responsible for paying the additional costs for the following options:

1. Blended Lenses.
2. Contact Lenses, except as provided in this section.
3. Oversize Lenses.
4. Progressive multi-focal Lenses.
5. Coating of the lens or Lenses.
6. Laminating of the lens or Lenses.
7. A Frame that costs more than the VCSV's allowance.
8. Cosmetic Lenses.
9. Optional cosmetic processes.
10. UV (ultraviolet) protected Lenses.
11. Polycarbonate Lenses (except for Eligible Dependent Children).
12. Low vision aids.
13. Lens materials other than plastic or glass.

DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout the Plan. Other terms may be defined where they appear in this Summary Plan Document. All Providers and Facilities must be licensed, certified, accredited and/or registered, where required, to render Covered Services. For the purposes of this Summary Plan Document, 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. Definitions in this Summary Plan 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.

Administrative Services Agreement—a formal agreement between the Contract Administrator and the Plan Administrator outlining responsibilities, general administrative services and benefit payment services.

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

Amendment (Amend)—a formal document signed by the representatives of Boise Municipal Health Care Trust. The Amendment adds, deletes or changes the provisions of the Plan and applies to all covered persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.

Benefit Period—the specified period of time in which a Participant's benefits for incurred Covered Services accumulate toward annual benefit limits and Out-of-Pocket Limits.

Benefits Outline—a listing of certain Covered Services specifying Cost Sharing, Copayments and Benefit limitations and maximums under this Summary Plan Document.

Blended Lenses—bifocals that do not have a visible dividing line.

Coated Lenses—a substance added to a finished lens on one (1) or both surfaces.

Contact Lenses—ophthalmic corrective Lenses (either glass or plastic, ground or molded). They must be prescribed by an Optometrist or Ophthalmologist/Physician to be directly fitted to the Participant's eye.

Congenital Anomaly—a condition existing at or from birth, which is a significant deviation from the common form or function of the body, whether caused by a hereditary or a developmental defect or Disease. In this Summary of Health Care Benefits, the term significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be Congenital Anomalies.

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

Contribution—the amount paid or payable by the Employer or Eligible Employee into the Trust fund.

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.

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 Covered 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 is responsible to pay Out-of-Pocket for Covered Services after satisfaction of any applicable Copayments. In this Summary Plan Document, the term Cost Sharing is used instead of the term coinsurance and is defined the same.

Covered Provider—a Provider specified in this Summary Plan Document from whom a Participant must receive Covered Services in order to be eligible to receive benefits.

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

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).

Effective Date—the date when coverage for a Participant begins under this Summary Plan Document.

Eligible Dependent—a person eligible for enrollment under an Enrollee's coverage.

Eligible Employee—an employee, sole proprietor or partner of the Employer who is entitled to apply as an Enrollee.

Employer—City of Boise.

Enrollee—an Eligible Employee who has enrolled for coverage and has satisfied the requirements of the Eligibility and Enrollment Section.

Family Coverage—the enrollment of an Enrollee and two (2) or more Eligible Dependents under the Plan.

Frame—a standard eyeglass Frame adequate to hold Lenses.

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).

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 a Participating Provider.

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 the VCSV, 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.

Lenses—ophthalmic corrective Lenses (either glass or plastic, ground or molded). They must be prescribed by an Optometrist or Ophthalmologist to improve visual acuity or performance and to be fitted to a Frame. Amounts payable are based on a lens blank not more than sixty-one (61) millimeters in diameter, tinted no darker than the equivalent of Pink #1 or #2 and without photosensitive or anti-reflective properties.

Maximum Allowance—for Covered Services under the terms of the Plan, Maximum Allowance is the lesser of the billed charge or the amount established as the highest level of compensation for a Covered Service as established by the VCSV.

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

Medically Necessary (or Medical Necessity)—the Covered Service or supply recommended by the treating Covered Provider to identify or treat a Participant's condition, Disease, Illness or Accidental Injury and which is determined by the Contract 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 Covered Provider.
4. Cost Effective for this condition.

The fact that a Covered 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 this Summary Plan Document.

The term Medically Necessary as defined and used in the Plan is strictly limited to the application and interpretation of the Plan, 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.

Nonparticipating Provider—a Provider that has not entered into a written agreement with the VCSV regarding payment for Covered Services rendered to a Participant under the Plan.

Ophthalmologist—a doctor of medicine (M.D.) who is both a medical doctor and a surgeon. The ophthalmologist is licensed to exam, diagnose and treat disorders and diseases of the eye and visual system of the brain, as well as prescribe corrective lenses (glasses or contacts).

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.

Orthoptics—the teaching and training process for improvement of visual perception and coordination of the two (2) eyes for efficient and comfortable binocular vision.

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

Out-of-Pocket Limit—the amount of Out-of-Pocket expenses incurred during one (1) Benefit Period that a Participant is responsible for paying. Eligible Out-of-Pocket expenses include only the Participant's Cost Sharing for eligible Covered Services.

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

Participant—an Enrollee or an enrolled Eligible Dependent covered under the Plan.

Participating Provider—a Provider that has entered into a written agreement with the VCSV regarding payment for Covered Services rendered to a Participant under the Plan.

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

Plan(s)—a multiple employer plan under which payment for medical, surgical, hospital, and other services for prevention, diagnosis, or treatment of any disease, injury, or bodily condition of an Eligible Employee is, or is to be, regularly provided for or promised from funds created or maintained in whole or in part by Contributions or payments thereto by the Employer and Eligible Employees.

Plan Administrator—the Plan Administrator, Boise Municipal Health Care Trust, who is 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. All decisions made by the Plan Administrator, including final determination of Medical Necessity, shall be final and binding on all parties. Boise Municipal Health Care Trust also reserves the right to modify eligibility clauses for new Plan participants who join the Plan as a result of a merger, acquisition or for any employee who was covered under a labor agreement plan during a previous period of employment to which Boise Municipal Health Care Trust, contributes, provided that coverage under the Plan begins within thirty-one (31) days of the date coverage under the previous Plan terminates. Boise Municipal Health Care Trust may choose to hire a consultant and/or Contract Administrator to perform specified duties in relation to the Plan. The Plan Administrator also has the right to amend, modify or terminate the Plan at any time or in any manner as outlined in the Administrative Services Agreement.

The administration of the Plan document is under the supervision of the Plan Administrator, Boise Municipal Health Care Trust. The Employee Benefits Department of Boise Municipal Health Care Trust acts on behalf of the Plan Administrator. Boise Municipal Health Care Trust has agreed to indemnify each employee in the Employee Benefits Department for any liability the employee incurs as a result of acting on behalf of the Plan Administrator, except if such liability is due to the employee's gross negligence or misconduct.

Plan Administrator—COBRA—the Contract Administrator is not the Plan Administrator for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments to it. Except for services the

Contract Administrator has agreed to perform regarding COBRA, the Trust is responsible for satisfaction of notice, disclosure, and other obligations if these laws are applicable to the Employer.

Plan Date—the date specified in this Summary Plan Document when coverage commences for the Employer.

Plan Sponsor—City of Boise.

Plano Lenses—lenses with refractive correction of less than ± .50 diopter.

Post-Service Claim—any claim for a benefit under the Plan that does not require prior authorization before services are rendered.

Pre-Service Claim—any claim for a benefit under the Plan that requires prior authorization before services are rendered.

Provider—a person or entity that is licensed, certified, accredited and/or registered, where required, to render Covered Services. For the purposes of this Summary Plan Document, Providers include only Ophthalmologists and Optometrists

Summary Plan Document—this description of the benefits provided under the Plan.

Surgery—within the scope of a Provider's license, the performance of:

1. Generally accepted operative and cutting procedures.
2. Invasive procedures using specialized instruments.
3. Customary preoperative and postoperative care.

Tinted Lenses—Lenses that have an additional substance added to produce constant tint.

Trust—Boise Municipal Health Care Trust.

Trustee—the trustee, whether a single or multiple trustees of the Trust.

Vision Care Services Vendor (VCSV)—an entity contracting with the Contract Administrator to provide Vision Care Services to its Participants.

EXCLUSIONS AND LIMITATIONS SECTION

The following exclusions and limitations apply to the entire Summary Plan Document, unless otherwise specifically listed as a Covered Service in this Summary Plan Document.

I. General Exclusions and Limitations

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

A. Not Medically Necessary.

B. In excess of the Maximum Allowance.

C. Not prescribed by or upon the direction of an Optometrist or Ophthalmologist or other professional Provider; or which are furnished by any individuals or facilities other than Physicians, and other Providers.

D. Investigational in nature.

E. 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.

F. Provided or paid for by any federal governmental entity or unit except when payment under the Plan 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 this Summary Plan Document.

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

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

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

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

K. For telephone consultations, and all computer or Internet communications; 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 or for mileage, transportation, food or lodging expenses billed by a Physician or other Professional Provider.

L. 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.

M. 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 this Summary Plan Document, 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 Contract Administrator for any reason makes payment for or otherwise provides benefits excluded by the above provisions, the Plan Administrator 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 Contract Administrator in connection with such Illness, Disease, Accidental Injury or other condition.

N. For which a Participant would have no legal obligation to pay in the absence of coverage under this Summary Plan Document 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.

O. 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.

P. Provided outside the United States, which if had been provided in the United States, would not be a Covered Service.

Q. Furnished by a Provider or caregiver that is not listed as a Covered Provider.

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

S. Orthoptics or other vision training and any associated supplemental testing.

T. Plano Lenses.

U. Two (2) pair of eyeglasses in place of bifocals.

V. Replacement of Lenses, Frames or Contact Lenses furnished hereunder that are lost or broken (Lenses, Frames or Contact Lenses are only replaced at the normal intervals when Covered Services are otherwise available).

W. Medical or surgical treatment of the eye(s).

X. Any eye examination or any corrective eyewear required by an employer as a condition of employment.

Y. Solutions and/or cleaning products for eyeglasses or Contact Lenses.

Z. For Congenital Anomalies, or for developmental malformations, unless the patient is an Eligible Dependent child.

AA. Contact lens insurance policies or service agreements.

AB. Refitting of Contact Lenses after the initial ninety (90) day fitting period.

AC. Contact lens modification, polishing or cleaning.

AD. Local, state and/or federal taxes, except where the VCSV is required by law to pay.

AE. Professional services associated with Corneal Refractive Therapy (CRT), Orthokeratology, or myopia management.

GENERAL PROVISIONS SECTION

I. Termination or Modification of a Participant's Coverage

A. If an Enrollee ceases to be an Eligible Employee or the Employer does not remit the required Contribution, the Enrollee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day of the last month for which payment was made. If the Employer does not remit the required payments as required by the Administrative Services Agreement and the Contract Administrator elects to terminate this Agreement, the enrollee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day for which the Employer reimbursed the Contract Administrator for the payment of claims and administrative fees.

B. Except as provided in this paragraph, coverage for a Participant who is no longer eligible under this Summary Plan Document will terminate on the date a Participant no longer qualifies as a Participant, as defined in the Eligibility and Enrollment Section. Coverage will not terminate because of age for a Participant who is a dependent child incapable of self-sustaining employment by reason of intellectual disability or physical handicap, who became so incapable prior to reaching the age limit, and who is chiefly dependent on the Enrollee for support and maintenance, provided the Enrollee, within thirty-one (31) days of when the dependent child reaches the age limit, has submitted to the Contract Administrator (at the Enrollee's expense) a Physician's certification of such dependent child's incapacity. The Contract Administrator, on behalf of the Plan Administrator, may require, at reasonable intervals during the two (2) years following when the child reaches the age limit, subsequent proof of the child's continuing disability and dependency. After two (2) years, the Contract Administrator, on behalf of the Plan Administrator, may require such subsequent proof once each year. Coverage for the dependent child will continue so long as the Plan remains in effect, the child's disability and financial dependency exists, and the child has not exhausted benefits.

C. Termination or modification of this Summary Plan Document automatically terminates or modifies all of the Participant's coverage and rights hereunder. It is the responsibility of the Trust to notify all of its Participants of the termination or any modification of this Summary Plan Document, and the Contract Administrator's notice to the Trust, upon mailing or any other delivery, constitutes complete and conclusive notice to the Participants.

D. No benefits are available to a Participant for Covered Services rendered after the date of termination of a Participant's coverage.

E. The Plan Administrator may terminate or retroactively rescind a Participant's coverage under this Summary Plan Document for any intentional misrepresentation, omission, or concealment of fact by, concerning, or on behalf of any Participant that was or would have been material to the Plan Administrator's acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.

F. Prior to legal finalization of an adoption, the coverage provided in this Summary Plan Document for a child placed for adoption with an Enrollee continues as it would for a naturally born child of the Enrollee until the first of the following events occurs:

1. The date the child is removed permanently from placement and the legal obligation terminates, or
2. The date the Enrollee rescinds, in writing, the agreement of adoption or the agreement assuming financial responsibility.

If one (1) of the foregoing events occurs, coverage terminates on the last day of the month in which such event occurs.

G. Coverage under this Summary Plan Document will terminate for an Eligible Dependent on the last day of the month the Participant no longer qualifies as an Eligible Dependent due to a change in eligibility status.

II. When The Plan Can End Your Coverage for Cause

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when Contributions are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan, (for example, failure to timely notify the Plan of a divorce, is not a rescission), as discussed below:

A. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause thirty (30) days after it gives you written notice of its finding that you or your covered Dependent:

1. **engages in an act, practice or omission that constitutes fraud or an intentional misrepresentation of a fact** in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan; or

2. **allowed anyone else to use the identification card** that entitles you or your covered Dependent to coverage, services or benefits under the Plan; or

3. **altered any prescription** furnished by a Physician or other Health Care Practitioner.

If your coverage is terminated for any of the above reasons, it may be terminated retroactively to the date that you or your covered Dependent performed or permitted the acts described above.

For example, you must immediately notify your Human Resource department, in writing, of any change in eligibility status for any Dependent enrolled for coverage under the Plan, such as divorce or other event resulting in a loss of eligibility. A failure to notify the Plan of such a change in status will be deemed an act of omission constituting fraud or an intentional misrepresentation of a fact by the Participant and ineligible Dependent.

B. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause thirty (30) days after it gives you written notice of its finding that you or your covered Dependent(s) engaged in **conduct that was abusive, obstructive, or otherwise detrimental to a Physician or Health Care Practitioner**. If your coverage is terminated for this reason, it will be terminated on a going forward basis.

C. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause fifteen (15) days after it gives you written notice of its finding that you have failed to pay your Contribution payment. In this instance, your coverage may be terminated retroactively to the date of the delinquent Contribution payment. In addition, your coverage may be suspended during the fifteen (15) day notice period.

II. Plan Administrator—COBRA

The Contract Administrator is not the plan administrator for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments to it. Except for services the Contract Administrator has agreed to perform regarding COBRA, the Trust is responsible for satisfaction of notice, disclosure, and other obligations if these laws are applicable to the Employer.

III. Contract Between the Contract Administrator and the Trust—Description of Coverage

This Summary Plan Document is part of the Administrative Services Agreement between the Contract Administrator and the Trust. The Contract Administrator will provide the Trust with copies the Summary Plan Document to give to each Enrollee as a description of coverage or provide electronic access to the Summary Plan Document, but this Summary Plan Document shall not be construed as a contract between the Contract Administrator and any Enrollee. The Contract Administrator's mailing or any electronic delivery of the Plan to the Trust constitutes complete and conclusive issuance and delivery thereof to each Enrollee.

IV. Benefits to Which Participants are Entitled

A. Subject to all of the terms of this Summary Plan Document, a Participant is entitled to benefits for Covered Services in the amounts specified in the benefit sections and/or in the Benefits Outline.

B. Benefits will be provided only if Covered Services are prescribed by, or performed by, or under the direction of a Physician or other Professional Provider.

C. Covered Services are subject to the availability of Facility Providers and the ability of the employees of such Providers and of available Physicians to provide such services. The Plan Administrator and/or the Contract Administrator shall not assume nor have any liability for conditions beyond its control which affect the Participant's ability to obtain Covered Services.

D. Boise Municipal Health Care Trust intends the Plan to be permanent, but because future conditions affecting Boise Municipal Health Care Trust cannot be anticipated or foreseen, Boise Municipal Health Care Trust reserves the right to amend, modify, or terminate the Plan at any time, which may result in the termination or modification of the Participants' Coverage. Expenses incurred prior to the Plan modification or termination will be paid as provided under the terms of the Plan prior to its modification or termination. Any material change made to the Plan will be provided in writing within sixty (60) days of the Effective Date of change.

V. Notice of Claim

The Contract Administrator will process claims for benefits on behalf of the Trust according to the Administrative Services Agreement between the parties. A claim for Covered Services must be submitted within one (1) year from the date of service and must include all the information necessary for the Contract Administrator to determine benefits.

VI. Release and Disclosure of Medical Records and Other Information

In order to effectively apply the provisions of the Plan, the Contract Administrator may obtain information from Providers and other entities pertaining to any health related services that the Participant may receive or may have received in the past. The Contract Administrator may also disclose to Providers and other entities, information obtained from the Participant's transactions, Contributions, payment history and claims data necessary to allow the processing of a claim and for other health care operations. To protect the Participant's privacy, the Contract Administrator treats all information in a confidential manner.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2003, a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that certain self-funded health plans sponsored by the Boise Municipal Health Care Trust (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

- **PHI does not include** health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical Leave (FMLA), life insurance, dependent care FSA, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment in the Plan and is also available from your Human Resources department and the employee benefits Website. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Trust (the Board of Trustees for the Boise Municipal Health Care Trust), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Trust**.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Trust for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

- **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

- **Payment** includes activities undertaken by the Plan to obtain Contributions or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

  a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee Contributions for coverage;

  b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and

  c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

- **Health Care Operations** includes, but is not limited to:

  a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

  b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

  c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, Contribution rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

  d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

  e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Trusts, or other customers.

B. **When an Authorization Form is Needed:** Generally the Plan will require that you sign a valid authorization form (available from your Human Resources department) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

C. **The Plan will disclose PHI to the Trust only** upon receipt of a certification from the Trust that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Trust agrees to:

1. Not use or disclose the information other than as permitted or required by the Summary Plan Document or as required by law;

2. Ensure that any agents, including their subcontractors, to whom the Trust provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Trust with respect to such information. The Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;

3. Not use or disclose the information for employment-related actions and decisions;

4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Trust, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);

5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

6. Make PHI available to the individual in accordance with the access requirements of HIPAA;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. Make available the information required to provide an accounting of PHI disclosures;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;

10. If feasible, return or destroy all PHI received from the Plan that the Trust maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

D. **In order to ensure that adequate separation between the Plan and the Trust is maintained** in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

1. Your Human Resources staff charged with administration of the Plan;

2. Business Associates under contract to the Plan including but not limited to the vendors who assist in administering our self-funded health plans such as the Medical plan claims administrator and preferred provider organization network, utilization management company, outpatient prescription drug program, wellness program, Dental and Vision Plan claims administrators and network administrators, COBRA administrator, etc.

E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the Trust performs for the Plan. If these persons do not comply with this obligation, the Trust has designed a mechanism for resolution of noncompliance. **Issues of noncompliance** (including disciplinary sanctions as appropriate) will be investigated and managed by the Trust's Privacy Officer:

If you are a minor and have concerns about the Plan releasing PHI to your parents or guardian, please contact the Privacy Officer.

F. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Trust will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

G. **Hybrid Entity**: For purposes of complying with the HIPAA Privacy rules, the Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self-funded medical plan options, self-funded dental plan options, self-funded vision plan options, wellness program, COBRA administration and Health Flexible Spending Account (FSA) administration.

VII. Exclusion of General Damages

Liability under this Summary Plan Document for benefits conferred hereunder, including recovery under any claim or breach of the Plan, shall be limited to the actual benefits for Covered Services as provided herein and shall specifically exclude any claim for general damages, including but not limited to, alleged pain, suffering or mental anguish, or for economic loss, or consequential loss or damages.

VIII. Payment of Benefits

The Contract Administrator (Blue Cross of Idaho) 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 Summary Plan 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. The Contract Administrator and the Plan Administrator prohibit direct or indirect payment by third parties unless it meets the standards set below.

Family, friends, religious institutions, private, not-for-profit foundations such as Indian tribes, tribal organizations, urban Indian organizations, state and federal government programs or grantees or sub-grantees such as the Ryan White HIV/AIDS Program and other similar entities are not prohibited from paying contribution on behalf of an individual receiving medical treatment. Cost Sharing contributions made from permitted third parties will be applied to the Participants applicable Deductible and/or Out-of-Pocket Limit.

Each of the following criteria must be met for the Contract Administrator or the Plan Administrator to accept a third party payment:

1. the assistance is provided on the basis of the Participant's financial need;
2. the institution/organization is not a healthcare Provider; and
3. the institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

To assist in appropriately applying Cost Sharing contributions made from a permitted third party to the Participants applicable Deductible and/or Out-of-Pocket Limit, the Participant is encouraged to provide notification to the Contract Administrator if they receive any form of assistance for payment of their Contribution, Cost Sharing, Copayment or Deductible amounts.

Contributions submitted in violation of this provision will not be accepted and the Enrollee's Plan may be terminated for non-payment. Cost Sharing contributions made from non-permitted third parties will not be

applied to the Participants applicable Deductible and/or Out-of-Pocket Limit. The Contract Administrator will inform the Participant in writing of the reason for rejecting or otherwise refusing to treat a third party payment as a payment from the Participant.

C. 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. 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 Participating or Nonparticipating is not a statement as to the ability of the Provider.

X. Participating Plan

The Contract Administrator may, in its sole discretion, make an agreement with any appropriate entity (referred to as a Participating Plan) to provide, in whole or in part, benefits for Covered Services to Participants, but it shall have no obligation to do so.

XI. Coordination of the Plan's Benefits with Other Benefits

This Coordination of Benefits (COB) provision applies when a Participant has health care coverage under more than one (1) Contract. Contract is defined below.

The Order of Benefit Determination Rules govern the order in which each Contract will pay a claim for benefits. The Contract that pays first is called the Primary Contract. The Primary Contract must pay benefits in accordance with its terms without regard to the possibility that another Contract may cover some expenses. The Contract that pays after the Primary Contract is the Secondary Contract. The Secondary Contract may reduce the benefits it pays so that payments from all Contracts does not exceed one hundred percent (100%) of the total Allowable Expenses.

A. Definitions

1. A Contract is any of the following that provides benefits or services for medical or dental care or treatment. If separate Contracts are used to provide coordinated coverage for members of a group, the separate Contracts are considered parts of the same Contract and there is no COB among those separate contracts.

   a) Contract includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   b) Contract does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefit for non-medical components of long-term care policies; Medicare supplement policies; Medicare or any other federal governmental plans, unless permitted by law.

   Each Contract for coverage under a) or b) is a separate Contract. If a Contract has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate Contract.

2. This Contract means, in a COB provision, the part of the Contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Contracts. Any other part of the Contract providing health care benefits is separate from this plan. A Contract may apply one (1) COB provision to certain benefits, such as dental benefits,

coordinating only with similar benefits, any may apply under COB provision to coordinate other benefits.

3. The Order of Benefit Determination Rules determine whether This Contract is a Primary Contract or Secondary Contract when the Participant has health care coverage under more than one (1) Contract. When This Contract is primary, it determines payment for its benefits first before those of any other Contract without considering any other Contract's benefits. When This Contract is secondary, it determines its benefits after those of another Contract and may reduce the benefits it pays so that all Contract benefits do not exceed one hundred percent (100%) of the total Allowable Expense.

4. Allowable Expense is a health care expense, including Deductibles, Cost Sharing and Copayments, that is covered at least in part by any Contract covering the Participant. When a Contract 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 that is not covered by any Contract covering the Participant is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

   The following are examples of expenses that are not Allowable Expenses:

   a) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Contracts provides coverage for private hospital room expenses.

   b) If a Participant is covered by two (2) or more Contracts that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

   c) If a Participant is covered by two (2) or more Contracts that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees it not an Allowable Expense.

   d) If a Participant is covered by one (1) Contract that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Contract that provides its benefits or services on the basis of negotiated fees, the Primary Contract's payment arrangement shall be the Allowable Expense for all Contracts. However, if the provider has contracted with the Secondary Contract to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Contract's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Contract to determine its benefits.

   e) The amount of any benefit reduction by the Primary Contract because a covered person has failed to comply with the Contract provisions is not an Allowable Expense. Examples of these types of Contract provisions include second surgical opinions, pre-certificate of admissions, and preferred provider arrangements.

5. Closed Panel Plan is a Contract that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

6. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

B. Order of Benefit Determination Rules

When a Participant is covered by two (2) or more Contracts, the rules for determining the order of benefit payments are as follows:

1. The Primary Contract pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Contract.

2. a) Except as provided in Paragraph 2.b) below, a Contract that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Contracts state that the complying Contract is primary.

   b) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Contract provided by the Contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

3. A Contract may consider the benefits paid or provided by another Contract in calculating payment of its benefits only when it is secondary to that other Contract.

4. Each Contract determines its order of benefits using the first of the following rules that apply:
   a) Non-Dependent or Dependent. The Contract that covers the Participant other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Contract and the Contract that covers the Participant as a dependent is the Secondary Contract. However, if the Participant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Contract covering the Participant as a dependent; and primary to the Contract covering the Participant as other than a dependent (e.g. a retired employee); then the order of benefits between the two Contracts is reversed so that the Contract covering the Participant as an employee, member, policyholder, subscriber or retiree is the Secondary Contract and the other Contract is the Primary Contract.

   b) Dependent Child Covered Under More Than One Contract. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Contract the order of benefits is determined as follows:
      (1) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Contract of the parent whose birthday falls earlier in the calendar year is the Primary Contract; or if both parents have the same birthday, the Contract that has covered the parent the longest is the Primary Contract.
      (2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Contract of that parent has actual knowledge of those terms, that Contract is primary. This rule applies to Contract year commencing after the Contract is given notice of the court decree;
         ii. If a court decree states that both parents are responsible for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) shall determine the order of benefits;
         iii. If a court decree states both parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
         iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            1. The Contract covering the Custodial Parent;
            2. The Contract covering the spouse of the Custodial Parent;
            3. The Contract covering the non-Custodial Parent; and then
            4. The Contract covering the spouse of the non-Custodial Parent.

For a dependent child covered under more than one Contract of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

c) Active Employee or Retired or Laid-off Employee. The Contract that covers a Participant as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Contract. The Contract covering that same Participant as a retired or laid-off employee is the Secondary Contract. The same would hold true if a Participant is a dependent of an active employee and that same Participant is a dependent of a retired or laid-off employee. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

d) COBRA or State Continuation Coverage. If a Participant whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Contract, the Contract covering the Participant as an employee, member, subscriber or retiree or covering the Participant as a dependent of an employee, member, subscriber or retiree is the Primary Contract and the COBRA or state or other federal continuation coverage is the Secondary Contract. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

CONTINUATION OF COVERAGE (COBRA)

Entitlement to COBRA Continuation Coverage

In compliance with a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly called COBRA), eligible employees, eligible retirees and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace** (*the Marketplace helps people without health coverage find and enroll in a health plan. See your state Health Insurance Marketplace or visit the federal Marketplace at* www.healthcare.gov).

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly Contributions for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within thirty (30) days of losing coverage under this Summary Plan Document, even if that other plan generally does not accept late enrollees.

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

This Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person's COBRA rights.

COBRA Administrator: The name, address and telephone number of the COBRA Administrator responsible for the administration of COBRA, is:

Peak One Administration
608 Northwest Boulevard, Suite 200

Coeur d'Alene, ID 83814
877-404-9443 (Toll Free)

IMPORTANT:
This chapter serves as a notice to summarize your rights and obligations under the COBRA Continuation Coverage law. It is provided to all covered employees, retirees, and their covered Spouses and is intended to inform them (and their covered dependents, if any) in a summary fashion about COBRA coverage, when it may become available and what needs to be done to protect the right to receive COBRA coverage. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your Spouse take the time to read this notice carefully and be familiar with its contents.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered employees, and retirees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment and Open Enrollment.

1. **"Qualified Beneficiary"**: Under the law, a Qualified Beneficiary is any Employee, or retiree or the Spouse or Dependent Child of an employee, or retiree who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

    - A child of the covered employee, or retiree who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.

    - A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

2. **"Qualifying Event":** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Summary Plan Document**. If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Summary Plan Document, (*e. g.* employee continues working even though entitled to Medicare) then COBRA is not available.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries[1]		
	Employee	Spouse	Dependent Child(ren)
Employee terminates (for other than gross misconduct), including retirement.	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the health care coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months
Retiree coverage is terminated or coverage is substantially reduced within one year before or after the employer files for bankruptcy reorganization under Chapter 11 of the federal Bankruptcy Act.	Retiree: for Life	Varies[2]	Varies[2]

[1]: *When a covered employee's Qualifying Event (e.g. termination of employment or reduction in hours) occurs within the eighteen (18) month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's covered Spouse and dependent children who are Qualified Beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends thirty-six (36) months after the Medicare entitlement.*

[2]: *Employer's bankruptcy under Title 11 of the US Code may trigger COBRA coverage for certain retirees and their related Qualified Beneficiaries such as COBRA coverage for the life of the retiree. The retiree's Spouse and dependent children are entitled to COBRA for the life of the retiree and if they survive the retiree, for thirty-six (36) months after the retiree's death. If the retiree is not living when the Qualifying Event occurs, but the retiree's surviving Spouse is alive and covered by the group health plan, then that surviving Spouse is entitled to coverage for life.*

Special Enrollment Rights

You have special enrollment rights under federal law that allow you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within thirty (30) days (or as applicable sixty (60) days) after your group health coverage ends because of the Qualifying Events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either eighteen (18) months or thirty-six (36) months, depending on which Qualifying Event occurred, measured from the date the Qualifying Event occurs or loss of Plan coverage (generally the end of the month in which the Qualifying Event occurred).The eighteen (18) month period of COBRA Continuation Coverage may be extended for up to eleven (11) months under certain circumstances (described in another section of this chapter on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this chapter.

Medicare Entitlement

A person becomes entitled to Medicare on the first day of the month in which the Participant attains age sixty-five (65), but only if the Participant submits the required application for Social Security retirement benefits within the time period prescribed by law. Generally a person becomes entitled to Medicare on the first day of the 30th month after the date on which the Participant was determined by the Social Security Administration to be totally and permanently disabled so as to be entitled to Social Security disability income benefits.

Procedure for Notifying the Plan of a Qualifying Event (Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after loss of coverage due to these events: a divorce or legal separation, or a child ceasing to be a "dependent child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than sixty (60) days after that Qualifying Event occurs.**
That written notice should be sent to the COBRA Administrator at:

Peak One Administration
608 Northwest Boulevard, Suite 200
Coeur d'Alene, ID 83814
877-404-9443 (Toll Free)

The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

NOTE: If such a notice is not received by the COBRA Administrator within the sixty (60) day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Officials of the employee's own employer should notify the COBRA Administrator within thirty-one (31) days of these events: an employee's death, termination of employment including retirement, reduction in hours making the employee ineligible for coverage, or entitlement to Medicare (if it causes the employee to be ineligible for coverage). However, **you or your family should also promptly notify the COBRA Administrator in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA Continuation Coverage

When:

a. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to health care coverage under the Plan, you died, have become entitled to Medicare, or

b. **you notify the COBRA Administrator** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

then the COBRA Administrator will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. **Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage.** Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice to elect COBRA Continuation Coverage.

NOTE: If you and/or any of your covered dependents do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Summary Plan Document after the date coverage ends.

The COBRA Continuation Coverage That Will Be Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA Continuation Coverage that appears later in this chapter for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

When COBRA Continuation Coverage of your participation in the health care flexible spending account (Health FSA) is available, it will be on the same terms outlined above for group health coverage, but since the person who elects COBRA will no longer be employed by their Employer, it will not be possible to make Contributions to the health care flexible spending account on a before-tax basis.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

Any person who elects COBRA Continuation Coverage must pay the full cost of the COBRA Continuation Coverage. The Trust is permitted to charge the full cost of coverage for similarly situated active employees and families (including both the employer's and employee's share), plus an additional 2%. If the eighteen (18) month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the eleven (11) month additional COBRA period.
Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time the Participant becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

NOTE: You may not receive an invoice (bill) for the initial COBRA Contribution payment or for the monthly COBRA Contribution payments. You are responsible for making timely payments for COBRA continuation coverage to the COBRA Administrator.

IMPORTANT
There may not be invoices or payment reminders for COBRA Contribution payments. You are responsible for making sure that timely COBRA Contribution payments are made to the COBRA Administrator.

Grace Periods

The **initial payment** for the COBRA Continuation Coverage is due to the COBRA Administrator **no later than 45 days** after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect.

After the initial COBRA payment, **subsequent payments** are due on the first day of each month, but there will be **a thirty (30) day grace period** to make those payments. If payments are not made within the thirty (30) day time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

For Monthly Payments, What If The Full COBRA Contribution Payment Is Not Made When Due?

If the COBRA Administrator receives a COBRA Contribution payment that is not for the full amount due, the COBRA Administrator will determine if the COBRA Contribution payment is short by an amount that is significant or not. A Contribution payment will be

considered to be **significantly short** of the required Contribution payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA Contribution payment.

If there is a **significant shortfall** then COBRA continuation coverage will end as of the date for which the last full COBRA Contribution payment was made.

If there is not a significant shortfall, the COBRA Administrator will notify the Qualified Beneficiary of the deficiency amount and allow a reasonable period of thirty (30) days to pay the shortfall.

- If the shortfall is paid in the thirty (30) day time period then COBRA continuation coverage will continue for the month in which the shortfall occurred.

- If the shortfall is not paid in the thirty (30) day time period then COBRA continuation coverage will end as of the date for which the last full COBRA Contribution payment was made (which may result in a mid-month termination of COBRA coverage).

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Addition of Newly Acquired Dependents

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage, you have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that child for COBRA Continuation Coverage if you do so within thirty-one (31) days after the birth, adoption, or placement for adoption. The child will be entitled to the full duration of COBRA.

If you marry while you are enrolled for COBRA, your spouse is not a Qualified Beneficiary, but the spouse can be added for the remainder of the duration of your existing COBRA coverage.

Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the COBRA Administrator to add a dependent.

Loss of Other Employer Health Plan Coverage

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage your Spouse or dependent loses coverage under another group health plan, you may enroll the Spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the Spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as

a result of employer Contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay Contributions on a timely basis or termination of coverage for cause. You must enroll the Spouse or dependent within thirty-one (31) days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the COBRA Administrator an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an Eighteen (18) Month COBRA Continuation Period

If, during an eighteen (18)-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, become entitled to Medicare (Part A, Part B or both), or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse and/or child is extended to thirty-six (36) months measured from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below).

NOTE: Medicare entitlement is not a Qualifying Event under this Summary Plan Document and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to thirty-six (36) months for Spouses and dependents who are Qualified Beneficiaries.

Notifying the Plan: To extend COBRA when a second Qualifying Event occurs, you must notify the COBRA Administrator in writing within sixty (60) days of a second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event, such as divorce documents.

This extended period of COBRA Continuation Coverage is not available to anyone who became your Spouse after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the eighteen (18) month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of eighteen (18) months (unless the Employee is entitled to an additional period of up to eleven (11) months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA may not be extended beyond eighteen (18) months from the initial Qualifying Event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of thirty-six (36) months (except for retirees who become entitled to COBRA because of a Chapter 11 bankruptcy reorganization proceeding on the part of the employee's employer.)

Extended COBRA Coverage in Certain Cases of Disability During an Eighteen (18)-

Month COBRA Continuation Period

If, prior to the Qualifying Event or during the first sixty (60) days of an eighteen (18) month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child is totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to twenty-nine (29) months (instead of eighteen (18) months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

1. This extension is available only if:

   - the Social Security Administration determines that the individual's disability began at some time before the 60th day of COBRA Continuation Coverage; **and**

   - the disability lasts until at least the end of the eighteen (18) month period of COBRA Continuation Coverage.

Notifying the Plan: you or another family member need to follow this procedure (to notify the Plan) by sending a written notification to the COBRA Administrator of the Social Security Administration determination within sixty (60) days after that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the name of the disabled person, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the COBRA Administrator before the end of the eighteen (18) month COBRA Continuation period.

2. The cost of COBRA Continuation Coverage during the additional eleven (11) month period of COBRA Continuation Coverage may be 50% higher than the cost for coverage during the first eighteen (18) month period.

3. The COBRA Administrator must also be notified within thirty (30) days of the determination by the Social Security Administration that you are no longer disabled.

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

1. The date the Contribution payment amount due for COBRA coverage is **not paid in full and on time**;

2. The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;

3. The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan. IMPORTANT: The Qualified Beneficiary must notify this Summary Plan Document as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator. COBRA coverage under this Summary Plan Document ends on the last day of the month prior to the month in which the Qualified Beneficiary is covered under the other group health plan.

4. During an extension of the maximum COBRA coverage period to twenty-nine (29) months due to the disability of the Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled;

5. The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan).

6. The date the employer no longer provides group health coverage to any of its employees;

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the COBRA Administrator determines that COBRA coverage will terminate early.

Once COBRA coverage terminates early it cannot be reinstated.

No Entitlement to Convert to an Individual Health Plan after COBRA Ends

There is no opportunity to convert to an individual health plan after COBRA ends under this Summary Plan Document.

Appealing an Adverse Determination Related to COBRA

If an individual receives an adverse determination (denial) related to a request for eligibility for COBRA (such as with a Notice of Unavailability of COBRA), a request for extension of COBRA for a disability, a request for extension of COBRA for a second qualifying event, or a notice of early termination of COBRA, the individual is permitted to appeal to the Plan. To request an appeal, follow this process:

a) Send a written request for an appeal to the COBRA Administrator within sixty (60) days of the date you received the adverse determination letter.

b) Explain why you disagree with the adverse determination.

c) Provide any additional information you want considered during the appeal process.

d) Include the most current name and address of each individual affected by the adverse determination.

The COBRA Administrator will respond in writing to this appeal within sixty (60) days of the Plan's receipt of the request for appeal. The appeal response will be sent to the address provided by the individual. This concludes the COBRA appeal process.

Note that a claim for reimbursement of health expenses would follow the Plan's usual claim appeal process for post-service claims.

COBRA Questions or To Give Notice of Changes in Your Circumstances

If you have any questions about your COBRA rights, please contact the COBRA Administrator at:

Peak One Administration
608 Northwest Boulevard, Suite 200
Coeur d'Alene, ID 83814
877-404-9443 (Toll Free)

Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify the COBRA Administrator:

1. within thirty-one (31) days of a **change in marital status (e.g. marry, divorce)**; or have **a new dependent child**; or

2. within sixty (60) days of the date you or a covered dependent Spouse or child has been determined to be **totally and permanently disabled** by the Social Security Administration; or

3. within sixty (60) days if a covered child **ceases to be a "dependent child"** as that term is defined by the Plan; or

4. promptly if an individual has **changed their address, becomes entitled to Medicare, or is no longer disabled**.

FMLA and COBRA: Taking a leave under the Family & Medical Leave Act (FMLA) is not a COBRA Qualifying Event. A Qualifying Event can occur **after** the FMLA period expires, **if** the employee does not return to work and thus loses coverage under their group health plan. Then, the COBRA period is measured from the date of the Qualifying Event—in most cases, the last day of the FMLA leave. Note that if the employee notifies the employer that they are not returning to employment prior to the expiration of the maximum FMLA twelve (12) week (or in some cases twenty-six (26) week) period, a loss of coverage could occur earlier.

e) Longer or Shorter Length of Coverage. The Contract that covered the Participant as an employee, member, policyholder, subscriber, or retiree longer is the Primary Contract and the Contract that covered the Participant the shorter period of time is the Secondary Contract.

f) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Contracts meeting the definition of Contract. In addition, This Contract will not pay more than it would have paid had it been the Primary Contract.

C. Effect on the Benefits of this Contract

1. When This Contract is secondary, it may reduce its benefits so that the total benefits paid or provided by all Contracts during a Contract year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Contract will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Contract that is unpaid by the Primary Contract. The Secondary Contract may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Contract, the total benefits paid or provided by all Contracts for the claim do not exceed the total Allowable Expenses for that claim. In addition, the Secondary Contract shall credit to its Contract deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

2. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Contract and other Closed Panel Plans.

D. Facility of Payment

A payment made under another Contract may include an amount that should have been paid under this Contract. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Contract. The Contract Administrator will not have to pay that amount again. The term "payment made" includes

providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

E. Right of Recovery

If the amount of the payments made by the Contract Administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the Participants it has paid or for whom it has paid; or any other Participant or organization that may be responsible for the benefits or services provided for the covered Participant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

XII. Incorporated by Reference

All of the terms, limitations and exclusions of coverage contained in this Summary Plan Document are incorporated by reference into all sections, endorsements, riders, and Amendments and are as effective as if fully expressed in each one unless specifically noted to the contrary.

XIII. Inquiry and Appeals Procedures

A. Informal Inquiry

The Contract Administrator has delegated certain activities, including Appeals, to the VCSV, though the Contract Administrator retains ultimate responsibility over these activities. For any initial questions concerning a claim, a Participant should call the VCSV phone number 844-348-0848. If the VCSV cannot resolve the Participant's concern to their satisfaction, the Participant or the Participant's authorized representative may submit a written request to the VCSV for review. A written request can be made by completing the form available on www.vsp.com Website or by sending the written request by mail to the VCSV at: Vision Service Plan, Attention: Complaint and Grievance Unit, PO Box 997100, Sacramento, CA 95899-7100. Verbal requests can be made by calling the VCSV phone number.

If the Participant's claim for benefits is denied and an Adverse Benefit Determination is issued, the Participant must first exhaust any applicable internal appeals process described below prior to pursuing legal action.

B. Formal Appeal

A Participant 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 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. 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 the Contract Administrator's Medical Director, physician designee, or a VCSV designee. For non-urgent claim appeals, the Contract Administrator or a VCSV designee 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 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 or its VCSV designee's mailing of the initial reconsideration decision. The Contract Administrator's Medical Director or its VCSV designee who is not subordinate to the Medical Director or physician designee who decided the initial appeal, 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.

C. A Participant 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 Contract Administrator's or a VCSV designee's 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 or a VCSV designee 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 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 (or a VCSV designee's) mailing of the initial reconsideration decision. A Medical Director of the Contract Administrator who is not subordinate to the Medical Director, physician designee, or a VCSV designee who decided the initial appeal, will issue a final decision after consideration of all relevant information, if the appeal requires medical judgment. A final decision on the appeal will be made within thirty (30) days of its receipt. If the appeal does not require medical judgment, a Vice President of the Contract Administrator who did not decide the initial appeal will issue the decision.

D. External Review

At the Contract Administrator's discretion, and on behalf of the Plan Administrator, an additional review is available for Adverse Benefit Determinations based upon medical issues including Medical Necessity and Investigational treatment. A Participant must first exhaust both levels of the formal appeals process before submitting a request for External Review to the Appeals and Grievance Coordinator. A request for External Review must be sent within sixty (60) days of the date of the Contract Administrator's second formal written appeal decision. External Review will be made by an impartial provider, associated with an independent review organization, who practices in the same or a similar specialty as the one involved in the review. The Independent Review Organization will issue a determination within sixty (60) days of receipt of the request for External Review.

Submission of an appeal for External Review is voluntary and does not affect a Participant's rights that may be available following the exhaustion of the formal appeals process, except that the time to file such action shall be tolled while the External Review is pending.

XIV. Reimbursement of Benefits Paid by Mistake

If the Contract 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 this Summary Plan Document, 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. 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.

XV. Subrogation and Reimbursement Rights

The benefits of this Summary Plan Document 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 this Summary Plan Document, agreement, certificate, contract or plan, 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 its 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 Contract Administrator'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 its 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, on behalf of the Plan 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 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 this Summary Plan Document, regardless of how the recovery is allocated *(i. e.,* pain and suffering) and whether the recovery makes the Participant whole. Thus, the Contract 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 Contract Administrator'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 its 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 Contract Administrator's subrogation and reimbursement rights shall take priority over the Participant's rights both for benefits provided and payments made by the Contract Administrator, and for benefits to be provided or payments to be made by the Contract Administrator in the future on account of the injury, harm or loss giving rise to the Contract Administrator'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 Contract 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 Contract Administrator's subrogation and reimbursement rights, and shall constitute a Special Credit applicable to such future benefits and payments that would otherwise be owed by the Plan, or any subsequent group health plan provided by the Trust. Thereafter, the Contract Administrator, on behalf of the Plan Administrator, shall have no obligation to provide any further benefits or make any further payments until the Participant has incurred medical expenses in treatment of such injury, harm or loss equal to such Special Credit.

XVI. Statements

In the absence of fraud, all statements made by an applicant, or the policyholder, or by an enrolled person shall be deemed representations and not warranties, and no statement made for the purpose of acquiring coverage under the Plan shall void such coverage under this Summary Plan Document or reduce benefits unless contained in a written instrument signed by the Trust or the enrolled person.

XVII. Coverage and Benefits Determination

The Contract Administrator is vested with authority and discretion to determine eligibility for coverage and whether a claim for benefits is covered under the terms of this Summary Plan Document, based on all the terms and provisions set forth in this Summary Plan Document, and also to determine the amount of benefits owed on claims which are covered.