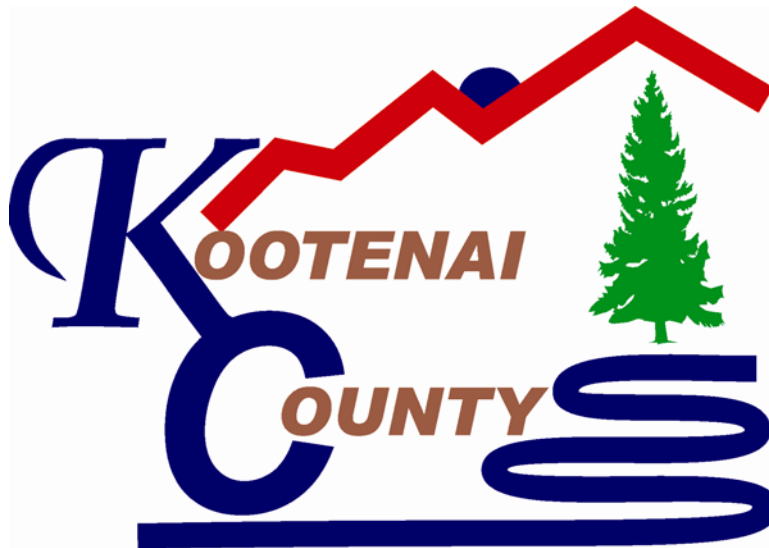


Kootenai County Self-Funded Employee Benefit Plan

Effective November 1, 2006



**Administered by:
Regence BlueShield of Idaho, Inc.**



**Regence
BlueShield
*of Idaho***

An Independent Licensee of the Blue Cross
and Blue Shield Association

**Consultant:
Gary Gustin, Moreton & Company**

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INTRODUCTION

To Our Employees:

This benefit booklet has been prepared to help you understand the benefits provided to you and your enrolled dependents. Please read it carefully. A summary of the benefits is included for referral, but you should also familiarize yourself with such things as waiting periods, exclusions, and other provisions.

It is important to you, your family, and the company that you understand the plan and use it properly and in the most effective manner. Therefore, please familiarize yourself with the information contained in this booklet and keep it for future reference.

Kootenai County has an administrative agreement with Regence BlueShield of Idaho. As our contract administrator, Regence BlueShield of Idaho provides identification cards, processes all claims, and makes benefit payment on our behalf. It is the goal of Regence BlueShield of Idaho to provide you with high quality, low cost health care while maintaining the highest level of service to you and your dependents.

REGENCE BLUESHIELD OF IDAHO DIRECTORY

Please use the following addresses and phone numbers when you need to contact Regence BSI. If you have questions or need general information about your benefits, simply call the appropriate phone number specified below:

Lewiston Office

1602 21st Avenue • P.O. Box 1106
Lewiston, Idaho 83501

General Information Number (208) 746-2671

Boise Office

Pioneer Plaza II
1211 West Myrtle Street, Suite 210
Boise, Idaho 83702

General Information Number (208) 336-2420

Coeur d'Alene Office

610 West Hubbard, Suite 129
Coeur d'Alene, Idaho 83816

General Information Number (208) 667-2761

Pocatello Office

Pocatello Creek Office Park
1175 Call Place, Suite 100
Pocatello, Idaho 83201

General Information Number (208) 234-0020

Twin Falls Office

450 Falls Avenue, Suite 102
Twin Falls, Idaho 83301

General Information Number (208) 736-0755

Other Helpful Phone Numbers:

Toll-Free Number 1-800-632-2022

Hearing Impaired (TDD) Number (208) 798-2074

Preadmission Review Toll-Free Number..... 1-800-351-2370

Web Site Address: www.id.regence.com

SUMMARY OF BENEFITS

This summary provides a brief description of certain benefits and terms of your health care plan. Please review this entire booklet for a complete explanation of benefits, limitations, exclusions, and general provisions.

Maximum Benefits	(In-network and out-of-network combined): \$1,000,000 during a Beneficiary's lifetime with automatic reinstatement up to \$5,000 each calendar year.
Deductible	(In-network and out-of-network combined): \$200 per Beneficiary each calendar year; \$400 per family in the aggregate each calendar year. Benefits payable after the deductible has been met.
Out-of-Pocket Expense	(In-network and out-of-network combined): \$2,000 per Beneficiary each calendar year (plus deductible); no family shall be obligated to meet more than \$4,000 in the aggregate in any calendar year.
Human Organ and Tissue Transplants	\$250,000 maximum during a Beneficiary's lifetime.

Benefits	Network Provider Services You Pay	Services not provided by a Network Provider You Pay
Ambulance Services (prior review required for air ambulance)	20% coinsurance	40% coinsurance
Blood and Blood Plasma	20% coinsurance	40% coinsurance
Chemical Dependency and Mental Health	50% coinsurance	50% coinsurance
<ul style="list-style-type: none"> • Outpatient services (20 visits calendar year maximum) • Inpatient services (6 days calendar year maximum) 	20% coinsurance	40% coinsurance
Chiropractic Services (\$500 calendar year maximum)	20% coinsurance	40% coinsurance
Contraceptives (enrolled employee, spouse, and dependent children) <ul style="list-style-type: none"> • Oral contraceptive prescription drugs • Diaphragms and intrauterine devices • Injectable contraceptives (Depo Provera) • Norplant insertion 	Not subject to the deductible Subject to prescription drug benefit \$25 copayment per device \$20 copayment per injection \$100 copayment per implant	Subject to prescription drug benefit 40% coinsurance 40% coinsurance 40% coinsurance
Diabetic Education (\$400 calendar year maximum; \$1,200 lifetime maximum)	20% coinsurance	40% coinsurance
Diabetic Supplies (blood sugar diagnostic, lancets, swabs, and urine test strips)	20% coinsurance	40% coinsurance
Durable Medical Equipment; Orthotics; and Prosthetic Devices	20% coinsurance	40% coinsurance
Home Health Care (\$5,000 calendar year maximum)	20% coinsurance	40% coinsurance
Home Infusion Therapy	20% coinsurance	40% coinsurance
Hospice Care (limited to \$5,000 and a maximum of 6 months from the initial date covered care is provided)	20% coinsurance	40% coinsurance
Hospital Care <ul style="list-style-type: none"> • Outpatient services (surgery, laboratory and x-ray charges, surgery suite, and ambulatory surgical center) • Emergency room charge for treatment of injury or illness • Inpatient services (room and board and general nursing care, cardiac or intensive care units, ancillary services and supplies, and routine newborn care) 	20% coinsurance 20% coinsurance 20% coinsurance	40% coinsurance 40% coinsurance 40% coinsurance

Benefits	Network Provider Services You Pay	Services not provided by a Network Provider You Pay
Human Growth Hormone Therapy (\$25,000 calendar year maximum)	20% coinsurance	40% coinsurance
Injury to a Sound Natural Tooth (12 months from date of accident; limited to a maximum of \$500 per occurrence)	20% coinsurance	40% coinsurance
Laboratory Testing and X-ray Facilities	20% coinsurance	40% coinsurance
Mammography Services	20% coinsurance	40% coinsurance
Mental Health (see Chemical Dependency)		
Physician/Provider Services (office, home, and outpatient/inpatient hospital visits, surgical services, laboratory and x-ray charges, surgical opinions, maternity care, and routine newborn care)	20% coinsurance	40% coinsurance
Prescription Drugs (per each 34-day supply. Mail-order program network only benefit: one copayment per 90-day supply, limited to 90-day supply.) <ul style="list-style-type: none"> • Network pharmacist and mail-order program <ul style="list-style-type: none"> √ Generic √ Formulary brand √ Non-formulary brand name • Nonnetwork pharmacy 	Not subject to the deductible 25% copayment, up to a \$25 maximum 25% copayment, up to a \$100 maximum 50% copayment, up to a \$200 maximum	Not subject to the deductible \$25 copayment, plus 50% of the remaining balance
Preventive Care (\$300 calendar year maximum for network services only) <ul style="list-style-type: none"> • Routine physical examinations • Laboratory and x-ray charges • Outpatient well baby care, including immunizations (limited to first 24 months of life) • Immunizations for Beneficiaries over age 2 (not subject to \$300 maximum) 	Not subject to the deductible \$15 copayment per visit No coinsurance required \$15 copayment per visit \$5 copayment per injection	20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance
Rehabilitation <ul style="list-style-type: none"> • Inpatient services (\$15,000 calendar year maximum) • Outpatient services <ul style="list-style-type: none"> √ Physical therapy (\$1,000 calendar year maximum) √ Speech therapy (\$1,000 calendar year maximum) √ Occupational therapy (\$1,000 calendar year maximum) √ Respiratory therapy (\$1,000 calendar year maximum) √ Cardiac rehabilitation therapy (\$1,000 calendar year maximum) 	20% coinsurance 20% coinsurance	40% coinsurance 40% coinsurance
Skilled Nursing Facility (30 days calendar year maximum)	20% coinsurance	40% coinsurance

HOW TO FILE YOUR CLAIM

PARTICIPATING PROVIDERS

By presenting your Regence BSI identification card at the time you receive services the provider's staff will assist you in completing any forms that may be required.

Claims for services of providers who have contracted with Regence BSI or a Blue Cross and/or Blue Shield plan in the state where the provider practices will usually be submitted directly to Regence BSI.

NONPARTICIPATING PROVIDERS

If you receive services from a provider who has not contracted with Regence BSI or a Blue Cross and/or Blue Shield plan in the state where that provider practices, you may be required to submit the claim to Regence BSI yourself. In this case, send an itemized copy of the billing to Regence BSI along with your receipt of payment. The itemized bill needs to identify the patient's name, the provider's name, the date or dates of service, and a complete itemization of services rendered.

Because the provider has not contracted with Regence BSI or another Blue Cross and/or Blue Shield plan, you may be required to pay the bill yourself. Regence BSI will reimburse you directly for covered services.

WHAT SHOULD I DO IF MY CLAIM FOR BENEFITS IS DENIED?

Should your claim be denied in whole or in part you will receive written notification. If you disagree with any part of Regence BSI's decision on your medical expense claim, you have the right to appeal. Please refer to the section in this booklet entitled Claims Appeal Process for specific details.

HOSPITAL ADMISSION REVIEW

WHAT IS HOSPITAL ADMISSION REVIEW?

Hospital admission review is Regence BSI's program to make certain your benefit plan pays only for medically necessary care and helps employers contain health care costs. Hospital admission review is prior authorization for medical necessity of inpatient stays in a hospital, skilled nursing facility, or psychiatric/chemical dependency treatment facility.

If your condition requires additional days for further treatment exceeding the days originally scheduled, Regence BSI will authorize additional days based on information provided by the hospital or your doctor.

HOSPITAL ADMISSION REVIEW OFFERS SEVERAL BENEFITS:

- It insures you know the health care alternatives available to you;
- It assures you in advance that you meet the requirements for benefits; and
- It gives you the opportunity to receive care in the most appropriate setting.

HOW DOES HOSPITAL ADMISSION REVIEW WORK?

When your doctor recommends a stay in a hospital of 24 hours or longer, simply call Regence BSI's toll-free number, 1-800-351-2370. This telephone line is available 24 hours a day, 7 days a week. If an answering system receives your call, you will be asked to leave your name, identification number from your Regence BSI card, daytime telephone number, and any other helpful information.

Regence BSI should be notified within two (2) business days of the admission. For scheduled admissions, please call as soon as you know the admission date. For a maternity stay, call when you know your expected delivery date. For emergency admissions, you should notify Regence BSI when you are stabilized and physically able. All admissions should be reviewed by Regence BSI. Review of an admission does not guarantee benefit payments. Benefit payments will be made based upon the Plan provisions and eligibility criteria.

Regence BSI will accept calls from anyone; however, it is ultimately the patient's and/or family's responsibility to initiate prior review. The final medical decision regarding your care is between you and your doctor.

Rising health care costs affect us all. **Remember, it's your health care dollar; please spend it wisely.**

MISCELLANEOUS PLAN INFORMATION

DEFINITIONS

The following are definitions of terms used in this Plan:

Group: Kootenai County (hereinafter referred to as the Group).

Claims Administrator: Regence BlueShield of Idaho (hereinafter referred to as Regence BSI).

BENEFITS

The benefits payable under this Plan and the conditions for receipt of such benefits shall be governed by the provisions set forth in the Group Benefit Plan, a copy of which is attached hereto.

Regence BSI is the Claims Administrator of this Plan, but does not insure the benefits provided under this Plan except for stop-loss coverage.

ADMINISTRATION

The Group is the Administrator of this Plan as the term is used in the "Employee Retirement Income Security Act of 1974 (ERISA)." The Group is the named fiduciary who has the authority to control and manage the administration and operation of this Plan. It may adopt rules and regulations under this Plan and interpret this Plan text. The Group will discharge its duties under this Plan in accordance with the standards set forth in Section 404(A) (1) of "ERISA." It may engage the services of other persons to render advice with regard to its responsibilities under this Plan and to assist in the administration of this Plan. These persons may include (without limitation) accountants, attorneys, claim administrators, and consultants.

The Group may also assign any of its fiduciary responsibilities under this Plan to other persons in a written instrument which specifies the responsibilities assigned to each of the other persons. Any person may serve in more than one (1) fiduciary capacity.

FUNDING POLICY AND PAYMENTS TO AND FROM THIS PLAN

This Plan shall be funded by, and benefits under this Plan shall be paid from, contributions made by the Group.

AMENDMENT AND TERMINATION OF THIS PLAN

The Group reserves the right at any time and from time to time to alter, modify, or amend, in whole or in part, any or all of the provisions of this Plan by a written instrument signed by an officer of the Group acting on its behalf. In addition, the Group may discontinue this Plan at any time.

Payment of Claims

All benefits payable under this Plan will be paid to the employee or Provider immediately upon receipt of the due written proof.

Verification

Regence BSI shall retain the right to verify the existence, nature, and extent of any claim for medical benefits by whatever means are necessary in its opinion.

Legal Proceedings

No action at law or in equity shall be brought to recover under this Plan prior to the expiration of sixty (60) days after proof of claim has been furnished in accordance with the requirements of this Plan, nor shall any such action be brought at all unless commenced within three (3) years from the expiration of the time within which proof of claim is required by the provision thereof.

Independent Association Affiliation

The Group hereby expressly acknowledges its understanding that this Agreement is solely between the Group and Regence BlueShield of Idaho (Regence BSI), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Plans, (the "Association") permitting Regence BSI to use the Blue Shield Service Mark in the state of Idaho and Asotin and Garfield counties in the state of Washington, and that Regence BSI is not the agent of the Association. The Group further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Regence BSI representatives and that no person, entity, or organization other than Regence BSI shall be held accountable or liable to the Group for any of Regence BSI's obligations under this Agreement.

This paragraph shall not create any additional obligations whatsoever on the part of Regence BSI other than those obligations created under other provisions of this Agreement.

GROUP BENEFIT PLAN

This Plan is to be administered as of this **1st day of November, 2006**, by **Regence BlueShield of Idaho, Inc.**, a nonprofit Idaho corporation, hereinafter called Regence BSI, on behalf of **Kootenai County**, hereinafter called the Group, acting solely as agent for its Employees or Beneficiaries, hereinafter called Enrolled Employees, and their duly enrolled spouses and Dependent children, hereinafter called Dependents.

Regence BSI agrees to furnish to eligible Enrolled Employees and their Dependents Necessary Medical, Surgical, and Hospital Services as hereinafter described, subject to all of the terms, conditions, exclusions, and limitations contained in this Plan.

GENERAL PROVISIONS

1. DEFINITIONS

Allowable Charge means the lesser of the submitted charge, the allowance established by Regence BSI, or if services were rendered outside the state of Idaho, the allowance established by a Blue Cross Blue Shield Association affiliate in the area where the service was rendered, for all such services covered under the terms of this Plan. This allowance is determined based upon many factors, including: the charge(s) of the Provider; the charge(s) of Providers with similar training and experience within a particular geographic area; pre-negotiated payment amounts; diagnostic related groupings (DRG); relative value scales; and/or the cost of providing the service or supply.

Ambulatory Surgical Center (ASC) means any free-standing entity that operates exclusively for the purpose of providing surgical services that do not require Inpatient hospitalization.

Assisted Reproductive Technology (ART) means any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART, include but are not limited to donor sperm utilized for artificial insemination or extraordinary procedures to induce fertilization with professional or technical assistance, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, and pronuclear stage tubal transfer.

Beneficiary means any person who satisfies the Enrollment Qualifications and is enrolled for coverage under this Plan.

Chemical Dependency means an illness, other than a Mental or Neuropsychiatric Condition, characterized by physiological or psychological dependency, or both, on any chemical substance, including alcohol. It is further characterized by a frequent or intense pattern of pathological use to the extent the individual exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the substance is reduced or discontinued; and the individual's health is substantially impaired or endangered.

Chiropractor means a doctor of chiropractic licensed to practice as such by the state where the service was rendered.

Coinsurance means the sharing of health care expenses for Covered Services between Regence BSI and its enrolled Beneficiaries. The Coinsurance payable by Regence BSI after the Beneficiary's Deductible requirement is satisfied is expressed as a percentage amount in the Schedule of Benefits. The remaining percentage, determined by subtracting the percentage paid by Regence BSI from one hundred percent (100%), is the responsibility of the Beneficiary.

Copayment means that portion of the cost of a Covered Service for which a Beneficiary is financially responsible. Copayment amounts cannot be applied to a Beneficiary's Deductible nor be paid under any benefit provision of this Plan.

Cosmetic means any surgical procedure that primarily improves or changes appearance and does not primarily improve physical bodily function. Cosmetic Surgery does not include procedures done to correct deformities resulting from disease, trauma, previous therapeutic process, or congenital anomalies.

Covered Service means a treatment, commodity, or supply specified in this Plan for which benefits will be provided when rendered by a Physician or Provider.

Custodial Care means care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial Care includes, but is not limited to,

help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications not requiring constant attention of trained medical personnel.

Deductible means the amount of charges, up to the Allowable Charge, for Covered Services payable by a Beneficiary to an appropriately licensed health care Provider who is recognized for payment under this Plan before Regence BSI will assume any liability for all or part of the remaining Covered Services.

Dentist means a person who has received a degree in Dentistry and is duly licensed to practice Dentistry by governmental authority having jurisdiction over the licensing and practice of Dentistry where said Dentist practices his or her profession.

Dentistry means the treatment or repair of the teeth, bones, and tissues of the mouth and defects of the human jaws and associated structures. Dentistry shall include, but not be limited to surgical procedures involving mandible and maxilla where performed for the purpose, at least in part, of preparing such boney structure for dentures or the attachment of teeth, artificial or natural. Dentistry shall also include the administration of anesthetic in connection with any of the foregoing.

Dependent means: (1) The legal spouse of the Enrolled Employee and/or (2) the unmarried child of an Enrolled Employee or Enrolled Employee's spouse, up to the age of nineteen (19), age twenty-three (23) if enrolled as a full-time student in a university, college, or vocational school, or pursuing a General Equivalency Diploma (GED). The term "children" includes natural children, step-children, adopted children, or children in the process of adoption from the time placed with the Enrolled Employee. The term "children" also includes children legally dependent upon the Enrolled Employee or Enrolled Employee's spouse for support where a normal parent-child relationship exists with the expectation that the Enrolled Employee will continue to rear that child to adulthood. However, if one or both of that child's natural parents live in the same household with the Enrolled Employee, a parent-child relationship shall not be deemed to exist, even though the Enrolled Employee or the Enrolled Employee's spouse provides support.

Durable Medical Equipment means an item or items which are primarily used to serve a medical purpose, ordered by the attending Physician, can withstand repeated use, are generally not useful to a person in the absence of Illness or Injury, and are appropriate for use by a Beneficiary who is not confined as an Inpatient.

Effective Date means the first day of the Beneficiary's coverage under this Plan, or if the Enrolled Employee must satisfy a probationary period before coverage is effective under this Plan, the Effective Date for the Enrolled Employee and Dependents is the first day of the Enrolled Employee's probationary period. The Effective Date of a Late Enrollee is always the first day of the Beneficiary's coverage under this Plan.

Elective Surgical Procedure means a Surgery that is not emergency Surgery or Surgery which, if not performed expeditiously, might endanger the health or life of a Beneficiary.

Enrolled Employee means an eligible person who applied for coverage, satisfied the Enrollment Qualifications, is accepted and enrolled for coverage, and in whose name the identification card is issued.

Family means two (2) or more persons related by blood, marriage, or law who are enrolled under the same identification number.

Formulary means a list of brand name prescription drugs selected on the basis of their effectiveness and cost. A list of the formulary and non-formulary prescription drugs is available by contacting Regence BSI.

Hospital means: (1) a facility duly licensed as such in the state where located which provides service primarily for Inpatient surgical and medical diagnosis, treatment, and care of injured and ill persons by or under the supervision of a staff of licensed Physicians, or (2) a specialized Inpatient facility licensed and approved as such by the state where located for mental or neuropsychiatric treatment. A Hospital under this definition is not, other than incidentally, a place for rest, a nursing home, or a facility for convalescence.

Illness means a bodily disorder or disease other than an Injury. All such bodily disorders existing concurrently, which are due to the same cause or pathologically related causes, shall be considered to be one (1) Illness. Successive Illnesses resulting from the same cause, or from treatment or complications thereof, shall be considered as the same Illness.

Injury means a physical Injury caused by an unexpected occurrence, independent of disease or bodily infirmity, or caused by ingestion of toxic substances. All bodily disorders sustained in the same mishap or accident or from treatment or complications thereof or pathologically related thereto shall be considered as one (1) Injury. Bodily disorders resulting from allergies shall not be considered as Injuries.

Inpatient means a Beneficiary who is admitted to a Hospital for treatment and who is so confined in such Hospital for a period of twenty-four (24) hours or more and/or for whom a room charge is made.

Investigative Treatment means the use of any treatment, procedure, facility, equipment, drug, device, or commodity, regardless of its medical necessity, deemed by Regence BSI to be either investigative, experimental, or in the early developmental stage of medical technology. The determination by Regence BSI will be based on objective data and information obtained by Regence BSI and reviewed, by competent medical personnel, according to the following criteria:

- 1) The technology must have final approval from the appropriate government regulatory bodies.
- 2) The scientific data and data obtained through actual medical experience regarding the technology must be sufficiently comprehensive to permit Regence BSI medical personnel to reach well-substantiated conclusions concerning the effect of the technology or health outcomes.
- 3) The technology's overall beneficial effects on health outweigh the overall harmful effects on health.
- 4) The technology must be as beneficial as any established alternative.
- 5) When used under the usual conditions of medical practice, the technology should be reasonably expected to satisfy the criteria of sections (3) and (4).

The determination referred to herein will be within the exclusive discretion of Regence BSI and may or may not be in accord with some medical experts' opinions on the acceptance of the technology as established medical practice.

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

Late Enrollee means an eligible employee or Dependent who requests enrollment in this Plan following the initial enrollment period during which the individual is entitled to enroll under the terms of this Plan, provided that the initial enrollment period is a period of at least thirty (30) days. However, an eligible employee or Dependent shall not be considered a Late Enrollee if:

- 1) The individual meets each of the following:
 - a) The individual was covered under Qualifying Coverage at the time of the initial enrollment;
 - b) The individual lost coverage under Qualifying Coverage as a result of termination of employment (*whether voluntary or involuntary*) or eligibility, the involuntary termination of the Qualifying coverage; and
 - c) The individual requests enrollment within thirty (30) days after termination of the Qualifying Coverage.

- 2) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;
- 3) A court has ordered coverage be provided for a spouse or minor Dependent child under this Plan and request for enrollment is made within thirty (30) days after issuance of the court order; or
- 4) The individual first becomes eligible.

Medical Emergency means the sudden onset of a medical condition manifesting itself by symptoms of sufficient severity, including but not limited to severe pain, that the absence of immediate attention could reasonably be expected by a prudent person who possesses an average knowledge of health and medicine to result in: permanently placing the Beneficiary's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily parts or organs.

Medicare means Parts A, B, and D of Title XVIII of the Social Security Act of 1965, including amendments thereto, providing certain Physician, Hospital, and other benefits to qualifying individuals. Reference to such act is hereby made, and said act, including amendments thereto, is by reference made a part hereof as if specifically set forth herein. Part A of such act means Hospital Insurance Benefits, Part B means Supplementary Medical Insurance Benefits, and Part D means *Voluntary Prescription Drug Benefit Program* as set forth in the act.

Mental or Neuropsychiatric Condition means an illness, disorder, or condition, regardless of whether organic or nonorganic, biological, nonbiological, genetic, irrespective of cause, basis, or inducement, classified as a mental disorder in the current edition of the International Classification of Disease, Clinical Modification (ICD-CM), or the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Mental or Neuropsychiatric Condition, includes but is not limited to psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, impulsive control disorders, developmental delays, etc. Mental or Neuropsychiatric Condition does not include Chemical Dependency.

Necessary Medical, Surgical, and Hospital Services means those services or supplies provided by a Physician or Provider that are required to identify or treat a Beneficiary's illness or injury and which, as determined by Regence BSI, are: (1) consistent with the symptoms, diagnosis, and/or treatment of the Beneficiary's condition, disease, ailment, or injury; (2) appropriate with regard to standards of good medical practice recognized and approved at the time employed by Physicians practicing within the state of Idaho as accepted medical practice; (3) not primarily for the convenience of a Beneficiary, Physician, or Provider; and (4) the most appropriate supply or level of service which can be safely provided to the Beneficiary. When applied to the care of an Inpatient, it further means that the Beneficiary's medical symptoms or condition require that the services cannot be safely provided to the Beneficiary as an Outpatient. The fact that a Physician or Provider may prescribe, order, recommend, or approve a service or supply does not, of itself, render such service or supply medically necessary or coverable under this Plan.

Network Hospital means a Hospital who has contracted with Regence BSI as a Network Provider and has agreed to accept the Beneficiary's Deductible, Coinsurance, and/or Copayment plus Regence BSI's payment as payment in full.

Network Pharmacist means a pharmacist or pharmacy who/which has contracted with Regence BSI's prescription drug benefit program administrator to provide prescription drugs and medicines to Beneficiaries and to accept the Beneficiary's Deductible, Coinsurance, and/or Copayment plus the Regence BSI prescription drug program administrator's benefit payment as payment in full for his or her charge.

Network Primary Physician means a Physician who has contracted with Regence BSI as a Network Provider and who has agreed to accept the Beneficiary's Deductible, Coinsurance, and/or Copayment plus Regence BSI's payment as payment in full and who practices in the areas of family and general practice, internal medicine, pediatrics, or obstetrics/gynecology.

Network Provider means a Network Primary Physician, a Network Specialist Physician, a Network Hospital, or other Provider who has contracted with Regence BSI as a Network Provider to provide Covered Services to Beneficiaries, and to accept the Beneficiary's Deductible, Coinsurance, and/or Copayment plus Regence BSI's payment as payment in full.

Network Specialist Physician means a Physician who has contracted with Regence BSI as a Network Provider to provide Covered Services to Beneficiaries and is licensed in a specialized area of medicine other than a Network Primary Physician.

Newborn Children means a child or children born during the term of this Plan to a parent who is an Enrolled Employee or spouse of an Enrolled Employee. Newborn Children shall also include adopted newborn infants who are placed with the Enrolled Employee within sixty (60) days of the adopted child's date of birth. For the purposes of this Plan, "placed" shall mean physical placement in the care of the adoptive Enrolled Employee. 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 shall mean when the adoptive Enrolled Employee signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child.

Nonnetwork Pharmacist means a pharmacist or pharmacy who/which has not contracted with Regence BSI's prescription drug benefit program administrator to provide prescription drugs and medicines to Beneficiaries.

Nonparticipating Hospital means: (1) a Hospital, as herein defined, which has not contracted with Regence BSI, or (2) a Hospital located outside the state of Idaho which has not contracted with a local Blue Cross and/or Blue Shield plan in the state where the Hospital is located. No benefit payment shall be made directly to a Nonparticipating Hospital. Any balances remaining after a Beneficiary's Copayment and/or Coinsurance amounts and Regence BSI's payment shall be the financial responsibility of the Beneficiary.

Nonparticipating Physician/Provider means: (1) a Physician/Provider as herein defined located in the state of Idaho who has not contracted with Regence BSI, or (2) a Physician/Provider located outside the state of Idaho who has not contracted with a local Blue Cross and/or Blue Shield plan in the state where the Physician/Provider practices or is located. Any balances remaining after a Beneficiary's Copayment and/or Coinsurance amounts and Regence BSI's payment shall be the financial responsibility of the Beneficiary.

Outpatient means services rendered in the Provider's office, or at the Hospital or other facility when the Beneficiary is not admitted to the Hospital or facility for a period of more than twenty-four (24) hours.

Participating Hospital means: (1) a Hospital as herein defined that has contracted with Regence BSI, or (2) a Hospital located outside the state of Idaho which has contracted with a local Blue Cross and/or Blue Shield plan in the state where the Hospital is located. A Participating Hospital has agreed to provide Covered Services as set forth in this Plan to Beneficiaries and to accept the Beneficiary's Deductible, Coinsurance, and/or Copayment plus Regence BSI's benefit payment as payment in full.

Participating Physician/Provider means: (1) a Physician/Provider as herein defined who has contracted with Regence BSI, or (2) a Physician/Provider located outside the state of Idaho who has contracted with a local Blue Cross and/or Blue Shield plan in the state where the Physician/Provider practices or is located. A Participating Physician/Provider has contracted with the local Blue Cross and/or Blue Shield plan to provide Covered Services to Beneficiaries and to accept the Beneficiary's Deductible, Coinsurance, and/or Copayment plus Regence BSI's benefit payment as payment in full.

Physical Therapy means the treatment of disability or dysfunction by physical agents and methods (i.e., therapeutic exercise, hydro-therapy, various forms of energy) to assist in rehabilitation and restoration of normal body function after disease or Injury.

Physician means a doctor of medicine and Surgery and/or osteopathy duly licensed to practice as such in the state where he or she practices.

Preexisting Condition means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within a six (6) month period immediately preceding the Effective Date of coverage. Genetic information shall not be considered a Preexisting Condition in the absence of a diagnosis of the condition related to such information. A pregnancy existing on the Effective Date of coverage will not be considered a Preexisting Condition.

Provider means a person or entity recognized as a covered Provider by Regence BSI and duly licensed or certified under applicable state law to provide Covered Services as set forth in this Policy.

Qualifying Coverage means coverage provided under: (1) Medicare or Medicaid, TriCare/CHAMPUS, the Indian health service program, the State Children's Health Insurance Program, a state health benefit risk pool, or any other similar publicly sponsored program; (2) A public plan established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of any of them; or (3) Any other group or individual health insurance contract or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a health maintenance organization, hospital or professional service corporation, or a fraternal benefit society.

Rehabilitation/Occupational Therapy means the treatment of disabled persons due to Injury, disease, or developmental delay by means of training in self-care; upper extremity/hand rehabilitation (i.e. strengthening, coordination, range-of-motion, splinting, fluído-therapy), cognitive/perceptual training, and developmental training to promote the restoration of a person's ability to satisfactorily accomplish the necessary tasks of daily living and those required by the person's particular occupational role.

Respiratory Therapy means introduction of dry or moist gasses into the lungs for treatment purposes.

Service Extender means a person who provides services to treat Mental or Neuropsychiatric Conditions under the supervision of a licensed psychologist in conformance with the guidelines for use of Service Extenders contained in the rules and regulations of the Idaho State Board of Psychologist Examiners and who is: (1) a licensed professional counselor with a current license issued by the Idaho State Counselor Licensing Board, or (2) a Certified Social Worker licensed by the Idaho State Board of Social Work Examiners.

Sound Natural Tooth means a healthy tooth or one that has been restored to a sound condition or replaced by a fixed or removable partial denture or bridge.

Speech Therapy means treatment for the correction of a speech impairment resulting from disease; Surgery; Injury; congenital, psychological, and developmental anomalies; or previous therapeutic processes.

Surgery means operative procedures involving cutting, suturing, or incision through the true skin; care of fractures and dislocations; visualization of the hollow organs of the body when accomplished or accompanied by cutting incision or for removal of a foreign body; scoping procedures (entry by endoscope into the hollow organs of body cavities) for excision; treatment of burns; manipulations under general anesthesia; aspirations for drainage; destruction of tissue by electrical, mechanical, or chemical methods; and x-ray and radium therapy, including use of isotopes, when used in lieu of cutting procedures.

Terminal Illness means an illness or condition in which it is medically probable that the patient has less than six (6) months to live, provided such illness or condition continues its normal course. The patient's condition must be certified as terminally ill by his or her attending Physician.

Totally Disabled means a condition resulting from illness or injury in which, as certified by a Physician:

- 1) An Enrolled Employee or spouse is completely unable to perform the substantial duties of any occupation or business for which qualified by reason of education, training, or experience and is not in fact engaged in any occupation for wage or profit; or
- 2) A retiree or Dependent is completely unable to engage in normal duties or activities of a person in good health who is the same gender and age.

2. WAITING PERIODS

Benefits set forth in this Plan will be provided for the conditions set forth below only after completion of minimum continuous periods of coverage under this Plan immediately preceding treatment as follows:

- A. Benefits for Preexisting Conditions will only be provided for services twelve (12) months or more after the Beneficiary's Effective Date under this Plan. This waiting period shall not apply to Newborn Children who shall be covered from the moment of birth, or to adopted children or children in the process of adoption who have been placed with the Enrolled Employee, if such children are enrolled within sixty (60) days of birth, adoption, or placement. A pregnancy existing on the Effective Date of coverage will not be considered a Preexisting Condition.
- B. Regence BSI shall waive any time period applicable to a Preexisting Condition exclusion or limitation period for the period of time an individual was previously covered by Qualifying Coverage, provided that the Qualifying Coverage was continuous to a date not more than sixty-three (63) days prior to the Effective Date of coverage under this Plan.
- C. Benefits for Preexisting Conditions shall be denied until a Late Enrollee has been enrolled for coverage on this Plan for a continuous twelve (12) month period.

3. EXCLUSIONS

Benefits will not be provided in any of the following circumstances or for any of the following conditions under the terms of this Plan:

- 1) Any procedure, treatment, supply, or service not specifically listed as a Covered Service.
- 2) To the extent benefits are provided or covered by any governmental agency, except as otherwise provided by law.
- 3) Expenses for services incurred as a result of any work related Injury or Illness, including any claims that are resolved pursuant to a disputed claim. *The only exception would be if the Beneficiary is exempt from state or federal Workers' Compensation Law. See the Right of Reimbursement and Subrogation section of these General Provisions.*
- 4) Any Injury or Illness resulting from any act of war or from explosion of atomic or similar fissionable materials in war (declared or undeclared) or any Illness or Injury contracted or incurred during military service, including any complications or recurrences thereof, or national disaster.
- 5) Any situation in which no specific medical treatment plan or psychiatric plan is furnished, including but not limited to rest cure, detoxification setup, Custodial Care, etc.
- 6) Hospital benefits when hospitalization is primarily for diagnostic studies or Physical Therapy when such procedures could have been done adequately and safely on an Outpatient basis.
- 7) Pregnancy tests unless provided by a Physician and administered in the Physician's office or in the Hospital.
- 8) Maternity benefits (including Involuntary Complications of Pregnancy) for Dependent children.
- 9) Immunizations required for travel abroad, including but not limited to cholera, plague, typhoid, typhus, and yellow fever.
- 10) Laetrile (amygdalin); acupuncture; Chelation therapy (except for lead poisoning); homeopathic services; naturopathic services; thermography.
- 11) Routine eye refractions; eye glasses; visual therapy or training
- 12) Radial keratotomy (refractive keratoplasty or other surgical procedures to correct refractive errors/ astigmatism).
- 13) Routine hearing examinations; hearing aids.

- 14) Humidifiers; vaporizers; air conditioners; or any other air filtration or purification unit or system.
- 15) Physical fitness or Physical Therapy equipment including, but not limited to, whirlpools, spas, hot tubs; weight lifting equipment; charges in or by health spas; weight reduction programs.
- 16) Heating pads, contour chairs, and therapeutic beds (not including certified, standard model hospital beds which will be paid under the Durable Medical Equipment section).
- 17) Cosmetic or reconstructive procedures and attendant hospitalization, except for Newborn Children or due to trauma or disease, done for aesthetic purposes and not to restore an impaired function of the body. Cosmetic procedures will not be covered regardless of the fact that the lack of correction causes emotional or psychological effects. Complications or subsequent Surgery related in any way to any previous Cosmetic procedure shall not be covered, even if the procedure is a Necessary Medical, Surgical, and Hospital Service.
- 18) Investigative Treatment as determined by Regence BSI pursuant to the Definitions section of these General Provisions.
- 19) Routine foot care (including removal of corns or calluses or trimming of nails); foot impression casting including x-rays incidental to casting; orthopedic shoes; arch supports and other supportive devices for the feet.
- 20) Benefits which are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to or makes benefits available to the Beneficiary, whether or not application is duly made therefore.
- 21) Procedures related to sex transformations.
- 22) Procedures related to reversal of sterilization.
- 23) Charges for services related to surrogate pregnancy.
- 24) Any Assisted Reproductive Technology (ART) procedure including associated services and supplies.
- 25) Vasectomies (male sterilization) will be covered for Physician services only.
- 26) Speech, occupational, rehabilitation, or neurodevelopmental therapy, except as specifically provided under rehabilitation benefits.
- 27) Medical or surgical treatment for obesity and manifestations thereof, or for reversal or revisions of Surgery for obesity.
- 28) Benefits in connection with transplants, except as set forth in the Schedule of Benefits for Preauthorized Human Organ and Tissue Transplants and Bone Marrow Reinfusion.
- 29) Benefits in connection with harvesting and reinfusion of bone marrow for the treatment of any illness, except as set forth in the Preauthorized Human Organ and Tissue Transplants and Bone Marrow Reinfusion.
- 30) Any services, chemotherapy, radiation therapy (or any therapy that damages the bone marrow), supplies, drugs, and aftercare for or related to bone marrow transplant, stem cell support or peripheral stem cell support procedures for a condition not set forth in the Schedule of Benefits for Preauthorized Human Organ and Tissue Transplants and Bone Marrow Reinfusion.
- 31) Prescription drugs and medicines for smoking cessation.
- 32) Fertility drugs (Pergonal, etc.)
- 33) Services connected with nonemergency, nonmaternity Hospital admissions on Fridays or Saturdays, unless Surgery is performed the day of admission or the day following admission.
- 34) Elective abortions, except to preserve the life of the female Enrolled Employee or spouse upon whom the abortion is performed.
- 35) Treatment to correct malocclusion (bad closure of the jaw); to correct vertical dimension (the distance between two [2] points on the face, one [1] above and one [1] below the mouth); to restore occlusion

(including splinting, orthodontic treatment, or dental appliances); and for Dentistry, oral Surgery, or dental implants whether resulting from accident, disease, or dental treatment.

- 36) Treatment of temporomandibular joint (TMJ) disorders and/or orthognathic conditions.
- 37) Benefits for counseling in the absence of Illness or Injury including, but not limited to premarital or marital counseling; Family counseling; educational, social, behavioral, or recreational therapy; bereavement counseling; sex or interpersonal relationship counseling; or counseling with the Beneficiary's friends, employer, school counselor or school teacher.
- 38) Charges for services and supplies: (1) for which a Beneficiary is not required to make payment, (2) that are made only because benefits are available under this Plan, or (3) for which a Beneficiary would have no legal obligation to pay in the absence of this or any similar coverage.
- 39) Expenses for services furnished by a Provider who is related to the Beneficiary by blood or marriage or who resides in the Beneficiary's household.
- 40) Charges for telephone or internet consultations; missed appointments; claim form completion; interest charges; legal services; obtaining medical records; setup and delivery of Durable Medical Equipment; or Provider travel and/or lodging expenses.
- 41) Convenience items such as telephones; television; guest trays or meals; personal hygiene items or services; or homemaker or housekeeping services, except by home health aides as ordered in a hospice treatment plan.
- 42) Drugs and supplies not requiring a prescription order, including but not limited to aspirin, antacid, benzyl peroxide preparations, cosmetics, medicated soaps, food supplements, syringes, and bandages; Antabuse, Methadone, Minoxidil, or Rogaine hair preparations; experimental drugs including those labeled, "Caution-Limited by Federal Law to Investigational Use"; and prescription medications related to health care services which are not covered under this Plan.
- 43) Diet and weight monitoring, and educational services.
- 44) Special foods or diets, vitamins, minerals, dietary and nutritional supplements, and nutritional therapy.
- 45) Any services, supplies, or charges which result from the treatment of any direct or indirect complication of any Illness or condition for which coverage is not or was not provided.

4. LIMITATIONS

- 1) Total benefits paid for covered preauthorized human organ and tissue transplant and bone marrow reinfusion services shall be limited to a maximum of \$250,000 during a Beneficiary's lifetime.
- 2) Total Outpatient benefits paid for the treatment of Mental or Neuropsychiatric Conditions and Chemical Dependency shall be limited to a maximum of twenty (20) visits per Beneficiary each calendar year.
- 3) Total Inpatient benefits paid for the treatment of Mental or Neuropsychiatric Conditions and Chemical Dependency shall be limited to a maximum of six (6) days per Beneficiary each calendar year.
- 4) Total benefits paid for Physical Therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.
- 5) Total benefits paid for Speech Therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.
- 6) Total benefits paid for occupational therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.
- 7) Total benefits paid for Respiratory Therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.
- 8) Total benefits paid for cardiac rehabilitation therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.

- 9) Total benefits paid for Inpatient rehabilitation services shall be limited to a maximum of \$15,000 per Beneficiary each calendar year.
- 10) Total benefits paid for services of a Chiropractor shall be limited to a maximum of \$500 per Beneficiary each calendar year.
- 11) Total benefits paid for home health care visits shall be limited to a maximum of \$5,000 per Beneficiary each calendar year.
- 12) Total benefits paid for hospice care services shall be limited to a maximum of \$5,000 and a maximum of six (6) months from the initial date covered hospice care is provided.
- 13) Total benefits paid for extended care in a skilled nursing facility shall be limited to a maximum of thirty (30) days per Beneficiary each calendar year.
- 14) Total benefits paid for diabetic education shall be limited to a maximum of \$400 per Beneficiary each calendar year up to a maximum of \$1,200 during a Beneficiary's lifetime when education services are provided through a Regence BSI-approved diabetic education program.
- 15) Total benefits paid for human growth hormone therapy shall be limited to a maximum of \$25,000 per Beneficiary each calendar year.
- 16) Total benefits paid for Injury to a Sound Natural Tooth services shall be limited to a maximum of \$500 per occurrence for up to twelve (12) months from the date of accident.
- 17) Total Network benefits for routine well baby care, including immunizations, shall be limited to a maximum of \$300 per Beneficiary each calendar year. Benefits shall be limited to the first twenty-four (24) months of life.
- 18) Total Network benefits paid for routine physical examinations and covered routine laboratory and x-ray charges shall be limited to a maximum of \$300 per Beneficiary each calendar year.
- 19) Claims submitted to Regence BSI more than twelve (12) months after the last day on which Covered Services were rendered shall be ineligible for payment, unless it can be shown to the satisfaction of Regence BSI that there was unusual and justifiable cause for such late submission.

5. INDIVIDUAL CASE MANAGEMENT

Regence BSI may authorize benefits in an individual case for specific services which would not ordinarily be Covered Services if it appears to Regence BSI that use of such services will reduce costs without compromising the quality of care. Regence BSI shall advise the Beneficiary and the Providers in writing when, and to what extent, such benefits will be provided. Providing such benefits shall not constitute an amendment to this Plan.

6. ENROLLMENT QUALIFICATIONS

In order for an applicant or Beneficiary to become entitled to or continue the benefits of this Plan, the following qualifications must be met:

- A. An Enrolled Employee hereunder is any employee of the Group as to whom the following qualification exists:
 - 1) The employee must be employed on a regular basis at least thirty-five (35) hours per week and be eligible for Federal and FICA withholding.

Enrolled Employees hired on or after the effective date of this Plan who meet the qualification above, will be eligible for coverage after satisfying probationary periods as agreed upon by Regence BSI and the Group.
- B. An unmarried Dependent child may continue to receive the benefits afforded Dependents hereunder to age nineteen (19), or up to age twenty-three (23) when eligibility is met as defined in the definition of a Dependent.
- C. Employees and Dependents have thirty (30) days from the date they first became eligible to submit an application for coverage. An employee or Dependent whose application is not received with the Group's initial enrollment or

within thirty (30) days from the date he or she first became eligible to submit an application may be a Late Enrollee. Refer to page 14 for a definition of Late Enrollee.

- D. In the absence of fraud, all statements made by applicants, policyholders, or by a Beneficiary shall be deemed representations and not warranties. No statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless such statement is contained in a written instrument signed by the Group or the Beneficiary.
- E. Enrollment shall be effective the first day of the month following the last day of the probationary period, if the application has been accepted and approved by Regence BSI. Newborn Children's enrollment shall be effective from moment of birth provided application is made within sixty (60) days following date of birth and the appropriate premium (if any) is received. Enrollment for adopted Newborn Children placed within sixty (60) days of the child's date of birth shall be effective from the date of birth. Enrollment for adopted children placed after sixty (60) days of the child's date of birth shall be effective from the date of placement. Enrollment as described is only effective provided application is made within sixty (60) days following date of placement with the Enrolled Employee and the appropriate premium (if any) is received. If date of birth for the Newborn Child or date of placement for the adopted child is on or before the fifteenth (15th) of the month, premium will be billed for the entire month. If date of birth or date of placement is after the fifteenth (15th), premium will commence with the first day of the month following birth or placement.
- F. Prior to legal finalization of an adoption, the coverage provided herein shall continue until the first of the following events occurs: (1) the date the child is removed permanently from placement, or (2) the date the Enrolled Employee rescinds, in writing, the agreement of adoption and the agreement assuming financial responsibility. If one (1) of the foregoing events occurs, coverage shall terminate on the last day of the calendar month in which such event occurs.
- G. A new spouse shall have sixty (60) days from the date of marriage to become enrolled under this Plan. Enrollment shall be effective not later than the first day of the month following acceptance and approval of the application.
- H. If both a husband and wife are employed by the Group and are eligible for benefits, each Enrolled Employee must be covered as only an Enrolled Employee and may not additionally be covered as a Dependent of his or her spouse under this Plan. Dependent children may only be enrolled under the coverage of one parent under this Plan.
- I. Any unmarried enrolled child, who is or becomes incapable of self-sustaining employment by reason of developmental disability or physical handicap prior to reaching the age of nineteen (19) and who is primarily dependent upon the Enrolled Employee for support and maintenance, shall not be terminated so long as this Plan remains in force and the Dependent remains in such condition, if the Enrolled Employee has, within thirty-one (31) days of such Dependent's reaching the age of nineteen (19), submitted proof of such Dependent's incapacity as herein described. Regence BSI may require subsequent proof of the Dependent's disability and dependency, but not more frequently than once each year.
- J. Coverage for any Beneficiary will terminate on the last day of the calendar month in which the Beneficiary ceases to be eligible for coverage.
- K. *An open enrollment period shall take place each plan year during the months of September 1 through October 31 to be effective November 1st of the following plan year. All employees and their dependents will be eligible to enroll for the first time or make changes to their existing coverage without being treated as a late enrollee.*

7. FAMILY MEDICAL LEAVE ACT

This Plan shall be administered to accommodate the specific requirements of the Family and Medical Leave Act of 1993 (Public Law 103-3), the Act. Any term or provision of this Plan relating to eligibility for coverage which contradicts or conflicts with the express terms of the Act is hereby declared null and void.

The Group will keep Regence BSI advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by the Act.

8. COORDINATION OF BENEFITS, OTHER INSURANCE

If a Beneficiary is covered under any other individual or group medical contract or policy, including blanket insurance policy whether or not an individual certificate or policy is issued under the individual or group or blanket policy (hereinafter referred to as "Other Plan"), the benefits under this Plan and those of the Other Plan will be coordinated in accordance with the provisions of this section of these General Provisions.

Plan shall not include any group or group-type hospital indemnity benefits that equal \$200 per day or less, school accident-type coverages covering accidents only, long term care insurance policies for non-medical services, limited benefit health coverage, any state plan under Medicaid, any plan when, by state or federal law, its benefits are excess to those of an private insurance program or other non-governmental program, Medicare Supplement policies, a state plan under Medicaid, medical benefits coverage in individual automobile "no fault" and traditional automobile "fault" type contracts, or non-renewable short term coverages issued for a period of twelve (12) months or less.

In no event shall benefits payable by Regence BSI and the Other Plan exceed the allowable charges for such benefits.

If Regence BSI shall have made payment under this Plan in excess of the amount required by this provision, then upon such excess being established, Regence BSI shall be entitled to recover from the patient, the patient's assignee or beneficiary, or from the Other Plan on request.

If the Other Plan contains a provision coordinating its benefits with the benefits of this Plan, the following rules shall apply to establish the order of benefit payment under this Plan and the Other Plan:

- A. A group plan shall always be primary to an individual plan.
- B. The benefits of a plan which cover the Beneficiary other than as a Dependent shall be primary.
- C. Where a Dependent child is covered by more than one plan, the following rules shall apply:
 - 1) When the parents are married or not separated, the benefits of the plan of the parent whose birthday (day and month only) falls earlier in a year are determined before those of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan which has covered the parent for the longer period of time shall be primary.
 - 2) Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
 - 3) When the parents are separated or divorced and the Custodial Parent of the child has not remarried, the benefits of a plan which cover the child as a Dependent of the Custodial Parent of the child will be determined before the benefits of a plan which cover the child as a Dependent of the parent without custody.
 - 4) When the parents are divorced and the Custodial Parent of the child has remarried, the benefits of a plan which cover the child as a Dependent of the Custodial Parent shall be determined before the benefits of a plan which cover that child as a Dependent of the step-parent. The benefits of a plan which cover that child as a Dependent of the step-parent will be determined before the benefits of a plan which cover that child as a Dependent of the parent without custody.
 - 5) When the parents are divorced and the court awards joint custody without specifying which parent is financially responsible for the child's health care expenses, the benefits of the Plan of the parent whose birthday (day and month only) falls earlier in a year are determined before those of the parent whose birthday falls later in that year, but if both parents have the same birthday, the benefits of the plan which has covered the parent for the longer period of time shall be primary.
 - 6) When the parents are not married or are separated (whether or not they ever have been married) or are divorced and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parent and the parent's spouse (if any) is:
 - a) The plan of the Custodial Parent;

- b) The plan of the spouse of the Custodial Parent;
 - c) The plan of the noncustodial parent; or
 - d) The plan of the spouse of the noncustodial parent.
- D. Active/inactive employees: The plan that covers the individual as an employee who is neither laid off nor retired (or as that employee's Dependent) is primary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.
- E. Continuation coverage: The plan which covers the individual as an employee or retired employee, or as that employee's Dependent will be primary over the plan that is providing continuation coverage. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.
- F. Longer/shorter length of coverage: If none of the above rules determines the order of benefits, the plan that covered the individual as an employee or retired employee, or as that employee's Dependent, for a longer period of time is primary.
- 1) To determine the length of time a person has been covered under a plan, two (2) plans shall be treated as one (1) if the person was eligible under the second within twenty-four (24) hours after the first ended.
 - 2) The start of a new plan does not include:
 - a) A change in the amount of scope of a plan's benefits;
 - b) A change in the entity that pays, provides, or administers the plan's benefits;
 - c) A change from one type of plan to another (such as from a single employer plan to that of a multiple employer plan).
 - 3) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.
- G. If the above rules do not establish an order of benefit priority, the allowable expenses of each plan shall be shared equally.

9. MEDICARE

In certain situations, this Plan is primary to Medicare. This means that when a Beneficiary is enrolled in Medicare and this Plan at the same time, Regence BSI will pay benefits for Covered Services first and Medicare pays second. Those situations are:

- A. When the Enrolled Employee or spouse is age sixty-five (65) or over and by law Medicare is secondary to the employer group health plan;
- B. When the Beneficiary incurs Covered Services for kidney transplant or kidney dialysis and by law Medicare is secondary to this Plan; and
- C. When the Beneficiary is entitled to benefits under Medicare disability and by law Medicare is secondary to this Plan.

In addition, if the Beneficiary is Medicare eligible, Regence BSI will not pay the Beneficiary or the Beneficiary's provider for any part of expenses incurred from the Beneficiary's provider if the Beneficiary's provider does not participate with Medicare. In all other instances, Regence BSI will not cover any part of a Covered Service to the extent the Covered Service is actually paid or would have been paid under Medicare Part A, B, or D had the Beneficiary properly applied for benefits.

10. COMPLIANCE WITH LAW AND COURT ORDERS

Regence BSI administers all health insurance policies in compliance with applicable Idaho and federal law. In the event a court of competent jurisdiction enters a Qualified Medical Child Support Order (QMCSO) or other order regarding enrollment of or payment of medical expenses for a Dependent child or alternate recipient, a copy of such order must be provided to Regence BSI. Regence BSI shall comply with any such order to the extent possible.

11. MODIFICATION REQUIRED BY CHANGE IN LAW

In the event of a change in federal or state law, Regence BSI will administer this Plan according to the change in law at the time such law becomes effective. Unless a prior notice is otherwise required by such change in federal or state law, Regence BSI may choose to incorporate the change in law by amendment to this Plan or reissue a plan document to the Group as modified by such change, upon the Group's renewal date.

12. RIGHT OF REIMBURSEMENT AND SUBROGATION

This Plan excludes any medical, prescription drug, or time loss benefits for any Injury or Illness, if the costs associated with the Injury or Illness may be recoverable from a third party or through worker's compensation or from any other source. This includes first party payer payments for any automobile Personal Injury Protection or Medical Payments and Uninsured or Underinsured Motorist coverages. Regence BSI may choose, at its discretion, reimbursement or subrogation as a means of recovery.

If the Beneficiary has a potential right of recovery for an Illness or Injury for which a third party may have legal responsibility, Regence BSI may advance benefits pending the resolution of the claim upon the following condition:

By accepting or claiming benefits, the Beneficiary agrees that Regence BSI is entitled to reimbursement of the full amount of benefits that Regence BSI has paid, out of any settlement or recovery from any source, including any judgment, settlement, disputed claim settlement, uninsured motorist payment, or any other recovery related to the Injury or Illness for which Regence BSI has provided benefits.

This right applies without regard to the characterization as payment for medical expenses, or other designation of the recovery by the affected Beneficiary and/or any third party or the recovery source. Regence BSI's right to reimbursement, however, will not exceed the amount of recovery.

Regence BSI may require the Beneficiary to sign and deliver all legal papers and take any other actions Regence BSI may ask to secure the rights of Regence BSI, including an assignment of rights to pursue the Beneficiary's claim if the Beneficiary fails to pursue his or her claim. If Regence BSI asks the Beneficiary to sign a trust agreement or other document to reimburse Regence BSI from the proceeds of any recovery, the Beneficiary may be required to do so as a condition to advancement of any benefits. If benefits were paid before the agreement is signed, the Beneficiary agrees to reimburse Regence BSI upon receipt of recovery in any form from or on behalf of a third party.

The Beneficiary agrees that he or she will do nothing to prejudice Regence BSI's rights and will cooperate fully with Regence BSI, including signing any documents and providing prompt notice of any settlement. The Beneficiary shall notify Regence BSI of any facts which may impact Regence BSI's right to reimbursement or subrogation. This shall include but not necessarily be limited to the following:

- 1) The filing of a lawsuit, or;
- 2) Timely advance notification of settlement negotiations, including but not necessarily limited to a minimum of twenty one (21) days advance notice of the date, time, location, and participants to be involved in any settlement conference or mediations, or;
- 3) A minimum of five (5) business days prior notification of the intent of a third party to make payment of any kind to the benefit of or on behalf of a Beneficiary which is in any manner related to the Injury or Illness which gives rise to Regence BSI's right to reimbursement or subrogation.

The Beneficiary acknowledges that Regence BSI is authorized but not obligated to recover directly from any third party any benefits paid from any party liable to the Beneficiary upon mailing of a written notice to the potential payer and affected Beneficiary or his or her representative.

Regence BSI is entitled to reimbursement from the first dollars received from any recovery. Regence BSI will not reduce the reimbursement or subrogation right due to the Beneficiary not being made whole. Regence BSI shall not be liable for any expenses or fees incurred by the Beneficiary in connection with obtaining a recovery. A Beneficiary, however, may request Regence BSI to pay a proportional share of attorney's fees and costs at the time of any settlement or recovery or to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid by Regence BSI. Regence BSI has discretion whether to grant such requests.

Advancement of payment for otherwise excluded benefits or review of a request for attorney fees are conditioned upon the retention by the Beneficiary's attorney of funds sufficient to satisfy Regence BSI's asserted lien in a client trust account, until such lien is satisfied or released.

In the event that a Beneficiary and/or his/her agent or attorney fails to comply with the terms of these provisions, Regence BSI may recover through legal action, any benefits advanced for any Illness or Injury resulting from the action or omission of a third party.

Any benefits provided by this Plan contrary to the exclusion are provided solely to assist the Beneficiary, and are subject to all clauses herein related to the Beneficiary's obligations regarding reimbursement and subrogation rights of this Plan.

By paying for such benefits Regence BSI is not acting as a volunteer and is not waiving Regence BSI's right to reimbursement or subrogation.

13. RIGHT TO RECOVERY

If for any reason Regence BSI has paid any amount to or on behalf of a Beneficiary in any of the following circumstances:

- 1) For services, supplies or accommodations not covered under this Plan;
- 2) Payments made for or on behalf of a person who is not covered under this Plan;
- 3) Payments which exceed amounts to be paid as benefits under this Plan;
- 4) Duplicate payments; or
- 5) For benefits received from Regence BSI for treatment of an Illness or Injury of a Beneficiary where another person, entity, firm or corporation is legally responsible for payment for the treatment of the Beneficiary,

the Beneficiary agrees to reimburse Regence BSI for any and all above described amounts. Regence BSI shall have three (3) years from the date of loss or in the case of third party responsibility as described in paragraph 5, shall have three (3) years from discovery of the payment to Beneficiary or on the Beneficiary's behalf by the third party through contract, settlement, judgement or any other means, to request reimbursement from the Beneficiary. In the event Regence BSI uses a third party collection agency or attorney to collect the overpayment, the Beneficiary shall be responsible for payment of collection fees incurred, including but not limited to any court costs and attorney fees. Regence BSI's right to recovery includes the right to deduct the amount paid in error from future benefits Regence BSI would provide for the Beneficiary, even if the payment error was not made originally on that Beneficiary's behalf.

This Right to Recovery provision in no way reduces rights to reimbursement or subrogation. Please reference other sections of this Plan specific to third party liability.

14. CHOICE OF LAW

This Plan shall be governed by and construed and enforced in accordance with the laws of the State of Idaho.

Venue:

Any legal action arising out of this Plan must be filed in either state or federal court in Idaho. Venue of any cause of action arising out of this Plan resulting in legal action in state court or in arbitration or mediation shall be in Ada County, Idaho.

Merger:

This Plan contains the entire agreement binding the parties. It is expressly agreed that neither party is bound by any stipulation, representation, or agreements (verbal or otherwise), which is not printed or written in the Plan.

15. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that health information about a Beneficiary may be requested or disclosed by Regence BSI. The information requested or disclosed will be used for the purpose of facilitating health care treatment, payment of claims, or business operations necessary to administer health care benefits; or as required by law.

The information requested or disclosed may be related to treatment or services received from:

- A. A Physician, Dentist, pharmacist or other physical or behavioral health care practitioner;
- B. A clinic, hospital, long-term care or other medical facility;
- C. Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or
- D. An insurance carrier or group health plan.

Health information requested or disclosed by Regence BSI may include, but is not limited to claim records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

NOTE: This provision does not apply to information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services, and genetic testing. A specific authorization will be obtained from the Beneficiary in order for Regence BSI to receive information related to these health conditions.

16. INDEPENDENT CONTRACTORS

It is expressly understood and agreed that Physicians and Providers hereunder are, as to Regence BSI, solely independent contractors and are not agents of Regence BSI for any purpose hereunder. Regence BSI shall have no liability whatsoever for any negligence, act, or failure to act on the part of any such Physician or Provider.

17. LIMITATIONS OF LIABILITY

In no case shall Regence BSI be liable for the negligence or other wrongful act or omission of any Physician or Provider or his or her employees or any other person. Regence BSI shall not be liable to any person or entity for the inability or failure to procure or provide the benefits of this Plan by reason of epidemic, disaster, or other cause or condition beyond the control of Regence BSI.

18. VESTING OF PLANS

Under no circumstances does a Beneficiary acquire a vested interest in continued receipt of a particular benefit or level of benefits. If benefits for a service or supply are eliminated or modified for a new Plan year, benefits will not be provided for those services or supplies rendered after the effective date of the elimination or modification. No oral statements or representations by any person, including employers, agents, or representatives of Regence BSI, can change, alter, delete, add, or otherwise modify the express written terms of this Plan or a validly executed endorsement to this Plan.

19. NONASSIGNABILITY

The benefits hereunder shall not, by the Beneficiary or any person entitled thereto, be pledged, hypothecated, encumbered, or assigned without the express written consent of Regence BSI.

20. CLAIMS APPEAL PROCESS

This section describes the Appeal Process in the event a Beneficiary or a Beneficiary's Representative (any representative authorized by the Beneficiary) has a complaint or grievance regarding a claim denial or other action by Regence BSI under this Plan and wishes to have it reviewed. A request for appeal must be submitted to Regence BSI within 180 days of the claim denial or other action giving rise to the complaint or grievance. Failure to appeal within this time period will preclude all further rights to appeal or contest the action in any forum.

NOTE: In the event a Beneficiary or a Beneficiary's Representative reasonably believes that a utilization management decision denying preauthorization of a pre-service claim could jeopardize the Beneficiary's life, health, or ability to regain maximum function or according to a Physician with knowledge of the Beneficiary's medical condition, would subject the Beneficiary to severe pain that cannot be adequately managed without the disputed care or treatment, the Beneficiary or the Beneficiary's Representative may request an Expedited Appeal. For procedures, see "Expedited Appeal" below.

FIRST LEVEL – Complaint/Grievance/Reconsideration

The Beneficiary may initiate an appeal through either a written or verbal request. Written appeal requests should be mailed to Regence BlueShield of Idaho, 1602 21st Avenue, P.O. Box 1106, Lewiston, Idaho 83501-9932. Oral requests can be made by calling Regence BSI at (208) 746-2671 or toll-free at 1-800-632-2022. Within five (5) working days or seven (7) calendar days, whichever is sooner, of the receipt of request for an appeal, Regence BSI will send an acknowledgement of the request for appeal. If additional information is needed to complete the review, Regence BSI will send notice of the delay within thirty (30) days of receipt of the appeal request. "First Level – Complaint/Grievance/Reconsideration" is a review by a Regence BSI representative who was not involved in the initial decision. In the case of an appeal involving a decision requiring medical judgment, the Regence BSI representative will consult with a Regence BSI Medical Services Physician prior to rendering a decision. A written notice of the decision will be sent within thirty (30) days of receipt of the request for an appeal.

SECOND LEVEL - Internal Appeal

If the Beneficiary disagrees with the decision made in the "First Level – Complaint/Grievance/Reconsideration," the Beneficiary may request further appeal to the "Second Level – Internal Appeal." The appeal request must be made within one hundred eighty (180) days after the Beneficiary receives notice of the decision at the "First Level – Complaint/Grievance/Reconsideration." Failure to request a "Second Level – Internal Appeal" within this time period will preclude the Beneficiary's right to further appeal of the decision in any forum. The appeal request, including any additional information or comments, must be made to Regence BlueShield of Idaho, 1602 21st Avenue, P.O. Box 1106, Lewiston, Idaho 83501-9932. Within five (5) working days or seven (7) calendar days, whichever is sooner, of the receipt of the request for "Second Level – Internal Appeal," Regence BSI will send an acknowledgement of the request for appeal. "Second Level – Internal Appeal" is a review by a Panel comprised of the Appeal Coordinator, a Regence BSI Medical Services Physician, and another officer of Regence BSI, none of whom were involved in the initial denial. The Beneficiary or the Beneficiary's Representative, on the Beneficiary's behalf, will be given a reasonable opportunity to personally appear or participate via telephone, video conference, or other technology, and/or to provide written materials. For appeals involving a post-service investigational or experimental issue, a written notice of the decision will be sent within twenty (20) working days or thirty (30) calendar days, if sooner, of receipt of the "Second Level – Internal Appeal" and within five (5) working days of the decision being made. For appeals involving pre-service preauthorization of a procedure, including a pre-service investigational procedure, a written notice of the decision will be sent within fourteen (14) days of receipt of the "Second Level – Internal Appeal"

and within five (5) working days of the decision being made, except when additional information is needed. In that case, the total review period will not exceed thirty (30) days from receipt of the initial request for "Second Level – Internal Appeal." For all other appeals, a written notice of the decision will be sent within thirty (30) days of receipt of the request for "Second Level – Internal Appeal" and within five (5) working days of the decision being made.

For decisions regarding medical necessity and experimental or investigational appeals, a "Third Level – External Appeal" is available. The "Second Level Appeal" is the final decision regarding benefit determination.

OPTIONAL APPEAL

The following level of Appeal is optional. For a Beneficiary of a Group which is subject to ERISA, such Beneficiary should know that other forums may be utilized as the final level of Appeal to resolve a dispute the Beneficiary has with Regence BSI, including but not limited to civil action under Section 502(a) of ERISA.

OPTIONAL THIRD LEVEL - External Appeal

If the Beneficiary disagrees with the decision regarding medical necessity and experimental or investigational made in the "Second Level – Internal Appeal" (or if the Beneficiary disagrees with the decision made in a "First Level – Expedited Appeal" described below), but preauthorization could no longer be reasonably believed to be clinically urgent (e.g., the service has been provided), the Beneficiary may request further appeal to the "Third Level – External Appeal." The appeal request must be made within one hundred eighty (180) days after the Beneficiary receives notice of the decision at the "Second Level – Internal Appeal." Failure to request a "Third Level – External Appeal" within this time period will preclude the Beneficiary's right to further appeal of the decision through this optional level. The appeal request, including any additional information or comments, must be made to Regence BlueShield of Idaho, 1602 21st Avenue, P.O. Box 1106, Lewiston, Idaho 83501-9932. "Third Level – External Appeal" will be coordinated by the Appeal Coordinator while the decision is made by an Independent Review Organization (IRO). The IRO is an independent Physician review organization which is unbiased, independent, and not controlled by Regence BSI. Within the IRO, there will be clinical expertise, use of evidence-based decision making, maintenance of confidentiality, and adequate administration and training capacity. Within five (5) working days of receipt of the request for a "Third Level – External Appeal," the Appeal Coordinator will send an acknowledgement of the request for appeal. The Appeal Coordinator will provide the IRO with the appeal documentation within three (3) working days. The Appeal Coordinator will send written notice to the Beneficiary of the decision within thirty (30) days of the receipt of request for "Third Level – External Appeal."

FOR ERISA GROUPS

The following level of Appeal is optional. Other forums may be utilized as the final level of Appeal to resolve a dispute the Beneficiary has with Regence BSI, including but not limited to civil action under Section 502(a) of ERISA.

OPTIONAL FOURTH LEVEL - Arbitration

Arbitration is the final level of appeal for a dispute a Beneficiary has with Regence BSI. All other levels of this Appeal Process must be exhausted before arbitration is available. Arbitration will be binding in accordance with the Arbitration provision of this section. Regence BSI will assist the Beneficiary with procedures for initiating and participating in an arbitration.

FOR NON-ERISA GROUPS

FOURTH LEVEL - Arbitration

Arbitration is the final level of appeal for a dispute a Beneficiary has with Regence BSI. All other levels of this Appeal Process must be exhausted before arbitration is available. Arbitration will be binding in accordance with the Arbitration provision of this section. Regence BSI will assist the Beneficiary with procedures for initiating and participating in an arbitration.

EXPEDITED APPEALS

FIRST LEVEL - Expedited Appeal

If the Beneficiary or Beneficiary's Representative reasonably believes that a utilization management decision is clinically urgent and that denial by Regence BSI of preauthorization of a pre-service will jeopardize the Beneficiary's life, health, or ability to regain maximum function or according to a Physician with knowledge of the Beneficiary's medical condition, would subject the Beneficiary to severe pain that cannot be adequately managed without the disputed care or treatment, the Beneficiary or the Beneficiary's representative may request an Expedited Appeal. The appeal request must be made verbally or in writing within one hundred eighty (180) days after the Beneficiary receives notice of the initial written preauthorized denial, state the need for a decision on an expedited basis, and include documentation necessary for the appeal decision. The appeal request, including any additional information or comments, must be made to Regence BlueShield of Idaho, 1602 21st Avenue, P.O. Box 1106, Lewiston, Idaho 83501-9932. The "First Level – Expedited Appeal" is a review by a Panel comprised of the Appeal Coordinator, a Regence BSI Medical Service Physician, and another officer of Regence BSI, none of whom were involved in the initial denial. A verbal notice of the decision will be provided to the Beneficiary and the Beneficiary's Representative as soon as possible after the decision, but no later than seventy-two (72) hours of receipt of the request for "First Level – Expedited Appeal," and a written notice will be provided within one (1) working day of providing the verbal notification.

OPTIONAL EXPEDITED APPEAL

The following level of Expedited Appeal is optional. For a Beneficiary of a Group which is subject to ERISA, such Beneficiary should know that other forums may be utilized as the final level of Expedited Appeal to resolve a dispute the Beneficiary has with Regence BSI, including but not limited to civil action under Section 502(a) of ERISA.

OPTIONAL SECOND LEVEL - Expedited Appeal

If the Beneficiary disagrees with the decision made in the "First Level – Expedited Appeal" and the Beneficiary or Beneficiary's Representative reasonably believes that preauthorization remains clinically urgent (pre-service), the Beneficiary may request further appeal to the "Second Level – Expedited Appeal." The appeal request must be made verbally or in writing within one hundred eighty (180) days after the Beneficiary receives either the verbal or written notice of the decision at the "First Level – Expedited Appeal."

Failure to request a "Second Level – Expedited Appeal" within this time period will preclude the Beneficiary's right to further appeal of the decision through this optional level. The appeal request, including any additional information or comments, must be made to Regence BlueShield of Idaho, 1602 21st Avenue, P.O. Box 1106, Lewiston, Idaho 83501-9932. A "Second Level – Expedited Appeal" will be coordinated by the Appeal Coordinator while the decision is made by an Independent Review Organization (IRO). The IRO is an independent Physician review organization which is unbiased, independent, and not controlled by Regence BSI. Within the IRO, there will be clinical expertise, use of evidence-based decision making, maintenance of confidentiality, and adequate administration and training capacity. Immediately upon receipt of the request for a "Second Level – Expedited Appeal," the Appeal Coordinator will provide the IRO with the appeal documentation. A verbal notice of the decision will be provided to the Beneficiary and the Beneficiary's Representative as soon as possible after the decision, but no later than seventy-two (72) hours of receipt of the request for "Second Level – Expedited Appeal," and a written notice will be provided by the IRO within two (2) working day of providing the verbal notification.

FOR ERISA GROUPS

The following level of Appeal is optional. Other forums may be utilized as the final level of Appeal to resolve a dispute the Beneficiary has with Regence BSI, including but not limited to civil action under Section 502(a) of ERISA.

OPTIONAL THIRD LEVEL – Expedited Appeal

Arbitration is available as the final level of appeal for a dispute a Beneficiary has with Regence BSI. All other levels of this Appeal Process must be exhausted before arbitration is available. Choosing arbitration as the final level for the settlement of such disputes will be binding in accordance with the Arbitration provision of this section. Regence BSI will assist the Beneficiary with procedures for initiating and participating in an arbitration.

FOR NON-ERISA GROUPS

THIRD LEVEL – Expedited Appeal

Arbitration is the final level of appeal for a dispute a Beneficiary has with Regence BSI. All other levels of this Appeal Process must be exhausted before arbitration is available. Arbitration will be binding in accordance with the Arbitration provision of this section. Regence BSI will assist the Beneficiary with procedures for initiating and participating in an arbitration.

ARBITRATION (for non-ERISA Groups or if Opted for ERISA Groups)

In the event of any dispute or controversy concerning the construction, interpretation, performance, or breach of the Agreement arising between the Beneficiary or the heir-at-law or the Beneficiary's representative, and Regence BSI, whether involving a claim in tort, contract, or otherwise, the same may be submitted by the Beneficiary as the final level of appeal, to arbitration under the appropriate rules of the American Arbitration Association. All administrative remedies described in this Plan must be exhausted prior to the demand for arbitration. The costs of arbitration, including reasonable filing fees, administrative fees, and arbitrator fees, will be borne by Regence BSI. Other expenses of arbitration, including but not limited to attorney fees, expenses of discovery, witnesses, stenographers, translators, and similar expense, will be borne by the party incurring those expenses. The parties agree that the arbitrator's award will be binding, may include attorney's fees if allowed by state law, and may be enforced in any court having jurisdiction thereof by filing a petition for enforcement of said award. Any arbitration will be conducted in Boise, Idaho, unless mutually agreed otherwise by the parties.

21. BLUECARD PROGRAM

All Blue Cross and Blue Shield Plans participate in the BlueCard Program. When a Beneficiary obtains Covered Services outside the geographic area Regence BSI serves and the claim is processed through the BlueCard Program, the amount the Beneficiary pays for Covered Services is usually calculated from the lower of: (1) the provider's billed charges for the Covered Services; or (2) the negotiated price that the on-site Blue Cross and/or Blue Shield organization ("Host Blue") passes on to Regence BSI. Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated final price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with the provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with the provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may be prospectively adjusted to correct for over- or underestimation of past prices. However, the amount the Beneficiary pays is considered a final price.

In addition, statutes in a small number of states may require the Host Blue to use a basis for calculating a Beneficiary's liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statute mandate a Beneficiary's liability calculation method that differs from the usual BlueCard method noted in the paragraph above or require a surcharge, Regence BSI would then calculate a Beneficiary's liability for Covered Services using that state's statutory method in effect at the time the Beneficiary received Covered Services.

IN-NETWORK SCHEDULE OF BENEFITS

ELIGIBILITY FOR BENEFITS

22. DEDUCTIBLE ACCUMULATION

From and after the effective date of this Plan, the benefits shall apply commencing with the first day of an Illness, Injury, or physical disability for which Covered Services are provided hereunder, after the following conditions have been fulfilled:

- A. Before a Beneficiary shall qualify for the benefits of this Plan, such Beneficiary must have paid, subsequent to the Effective Date of coverage under this Plan, the Deductible amount of \$200 for each calendar year, In-Network and Out-of-Network combined, in which the benefits of this Plan apply. In calculating whether the Deductible requirements have been fulfilled, only amounts, up to the Allowable Charge of Covered Services actually paid by the Beneficiary for medical, surgical, and Hospital care during the current calendar year shall be considered.
- B. No Family shall be obligated to meet more than \$400 in the aggregate in any calendar year.
- C. Charges for services payable by the Beneficiary due to a reduction of benefits, denial of benefits, or amounts charged in excess of allowable charges are the financial responsibility of the Beneficiary and shall not be considered as an eligible expense for application towards the Deductible amount.
- D. If a Beneficiary is hospitalized on the last day of the calendar year for which the Deductible requirement has been fulfilled and such hospitalization continues uninterrupted into the succeeding calendar year, such period of continuous hospitalization shall be considered a part of the calendar year in which it originated, and the Deductible requirement for the succeeding calendar year shall not apply until the day following the Beneficiary's discharge from the Hospital.
- E. To qualify for the benefits of this Plan, the Beneficiary shall submit proof to Regence BSI that the applicable Deductible amount for the calendar year involved has been incurred including name of Provider, diagnosis, and itemized statements.

IN-NETWORK SERVICES SCHEDULE OF BENEFITS

Medical, Surgical and Hospital Benefits for Services Provided by a Network Provider

After a Beneficiary has otherwise qualified and fulfilled the Deductible requirement above, Regence BSI will provide such Beneficiary with benefits for Necessary Medical, Surgical, and Hospital Services actually incurred subject to the maximum lifetime benefit limits and the terms, waiting periods, exclusions, limitations, and general provisions set forth in this Plan, as follows:

23. PREVENTIVE CARE (NOT SUBJECT TO THE DEDUCTIBLE)

- A. Benefits shall be provided at one hundred percent (100%) of the Allowable Charge, subject to a \$15 Copayment per visit, for services provided by a Network Primary physician or Network Specialist Physician for routine physical examinations for the evaluation and management of a healthy individual in the absence of patient complaints or symptoms associated with Illness or Injury. Benefits shall be limited to \$300 per Beneficiary each calendar year.
- B. Benefits shall be provided at one hundred percent (100%) of the Allowable Charge for routine laboratory and x-ray charges associated with routine physical examination as limited herein when services are provided by a Network Primary Physician or Network Specialist Physician. Covered routine laboratory and x-ray charges shall be limited to the following: mammograms, unilateral, bilateral, or bilateral screening mammography services; chemistry panel; urinalysis; stool guaic; complete blood count; prostate specific antigen; tuberculosis skin or tine testing; papanicolaou stain (pap smear), cytopathology by a technician under Physician supervision, cytopathology requiring interpretation by a Physician, or cytopathology with definitive hormonal evaluation; PKU (phenylketonuria) testing; and/or electrocardiogram.
- C. Benefits for immunizations shall be provided at one hundred percent (100%) of the Allowable Charge, subject to a \$5 Copayment per injection, for Enrolled Employees and Dependents over two (2) years of age. Benefits for immunizations are not subject to the \$300 calendar year maximum.
- D. Benefits shall be provided at one hundred percent (100%) of the Allowable Charge, subject to a \$15 Copayment, for Outpatient well baby care, including immunizations. Benefits paid shall be limited to the first twenty-four (24) months of life and a maximum of \$300 per calendar year.
- E. Once an Enrolled Employee or Dependent has reached the \$300 calendar year maximum, benefits shall be provided at eighty percent (80%) of the Allowable Charge, subject to the Deductible, for any additional preventive services.

24. NETWORK PRIMARY PHYSICIAN AND NETWORK SPECIALIST PHYSICIAN

Benefits of this section shall apply to all office, home, and Hospital services when such services are provided by a Network Primary Physician or Network Specialist Physician.

Laboratory testing and x-ray examination services provided at a Hospital or other facility, regardless of whether the Beneficiary was referred to the Hospital or facility by a Network Primary Physician or Network Specialist Physician, shall be provided under the applicable section of this Schedule of Benefits depending upon the person, entity, or facility providing the service.

Benefits for services of a Network Primary Physician or Network Specialist Physician as outlined below shall be provided at eighty percent (80%) of the Allowable Charge:

- A. Office, home, and Outpatient Hospital visits for treatment of Illness or Injury either in the Network Primary Physician's office, Network Specialist's office, or as an Outpatient in the Hospital.
- B. Injections and related supplies.
- C. Hospital visits for Illness or Injury while necessarily hospitalized as an Inpatient.
- D. Surgical services, including services of assistant surgeon and anesthesiologist.
- E. Laboratory testing and x-ray services.
- F. Routine newborn nursing care for an enrolled Newborn Child while the Newborn Child is necessarily hospitalized as an Inpatient following birth.
- G. Second and third surgical consultative opinions to confirm the need for Elective Surgical Procedures as first recommended by the attending Physician. A second opinion consultant shall not be the same Physician who recommended elective Surgery and a third opinion consultant shall not be the same Physician who recommended elective Surgery or rendered the second opinion. Use of a second opinion is at the Beneficiary's option. If the second opinion conflicts with the first, then a third opinion is a Covered Service.

25. HOSPITAL ADMISSION REVIEW

A Beneficiary, his or her representative, or the facility should notify Regence BSI of all Inpatient Hospital and skilled nursing facility admissions, including Inpatient admission for cochlear implant, within two (2) business days of admission. For emergency admissions, the Beneficiary should notify Regence BSI when stabilized and physically able. All admissions should be reviewed by Regence BSI. Review of an admission does not guarantee benefit payments. Benefit payments will be made based upon Plan provisions and eligibility criteria.

26. INPATIENT HOSPITAL

A period of hospitalization shall begin the first day a Beneficiary becomes registered as an Inpatient at a Hospital and shall continue until a Beneficiary is discharged from the Hospital. Benefits provided by a Network Hospital for Inpatient hospitalization as outlined below shall be provided at eighty percent (80%) of the Allowable Charge:

- A. Room and board and general nursing care in a Hospital room of two (2) or more beds. Allowance shall be made for the day of admission or the day of discharge but not for both.
- B. Hospital cardiac or intensive care units.
- C. Hospital ancillary services and supplies.
- D. Hospital benefits as set forth above for cases of dental Surgery when performed by a Dentist and upon certification by a Physician that hospitalization is necessary because of nondental health impairment such as hemophilia, heart disease, etc.
- E. Routine room and board, general nursing care, and ancillary services for an enrolled Newborn Child while the Newborn Child is necessarily hospitalized as an Inpatient following birth.

27. OUTPATIENT HOSPITAL

Benefits for Outpatient services provided by a Network Hospital as outlined below shall be provided at eighty percent (80%) of the Allowable Charge:

- A. Regence BSI-approved Outpatient Hospital services, including but not limited to Surgery, diagnostic laboratory, and x-ray, provided in an Outpatient Hospital, Ambulatory Surgical Center, or Surgery suite.

- B. Use of the emergency room for the treatment of Illness or Injury.
- C. Hospital benefits as set forth above for cases of dental Surgery when performed by a Dentist and upon certification by a Physician that Outpatient Hospital care is necessary because of nondental health impairment such as hemophilia, heart disease, etc.

28. MATERNITY CARE

- A. Benefits for medical and surgical services consequential upon pregnancy, including Involuntary Complications of Pregnancy provided by a Network Primary Physician or Network Specialist Physician, for the eligible female Enrolled Employee or spouse shall be provided at eighty percent (80%) of the Allowable Charge.
- B. Benefits for room and board and general nursing care in a hospital room of two (2) or more beds, and ancillary services for maternity care, including Involuntary Complications of Pregnancy provided by a Network Hospital shall be provided at eighty percent (80%) of the Allowable Charge.
- C. Maternity benefits (including Involuntary Complications of Pregnancy) are not provided for Dependent children.
- D. No coverage will be provided for elective abortions, except to preserve the life of the female Enrolled Employee or spouse upon whom the abortion is performed.
- E. Routine newborn nursery care is not considered a maternity service. See the Network Primary Physician, Network Specialist Physician, and Inpatient Hospital sections above for benefits.
- F. Involuntary Complications of Pregnancy shall be covered as any other Illness.

29. MENTAL OR NEUROPSYCHIATRIC CONDITIONS AND CHEMICAL DEPENDENCY

- A. Benefits shall be provided at eighty percent (80%) of the Allowable Charge for services for the treatment of Mental or Neuropsychiatric Conditions or Chemical Dependency while the Beneficiary is necessarily hospitalized as an Inpatient in an approved Hospital or nonfederal institution specializing in the treatment of such Illnesses when such services are provided by a Network Provider.
- B. Benefits shall be provided at eighty percent (80%) of the Allowable Charge for room and board, general nursing care, and ancillary services in a Hospital room of two (2) or more beds for the treatment of Mental or Neuropsychiatric Conditions or Chemical Dependency when such services are provided by a Network Hospital. Allowance shall be made for the day of admission or the day of discharge, but not for both.
- C. Benefits shall be provided at fifty percent (50%) of the Allowable Charge for Outpatient Physician services for the treatment of Mental or Neuropsychiatric Conditions or Chemical Dependency when such services are provided by a Network Provider.
- D. Benefits shall be provided at fifty percent (50%) of the Allowable Charge for Outpatient Hospital services for the treatment of Mental or Neuropsychiatric Conditions or Chemical Dependency when such services are provided by a Network Hospital.
- E. Total Outpatient benefits paid for the treatment of Mental or Neuropsychiatric Conditions and Chemical Dependency shall be limited to a maximum of twenty (20) visits per Beneficiary each calendar year.
- F. Total Inpatient benefits paid for the treatment of Mental or Neuropsychiatric Conditions and Chemical Dependency shall be limited to a maximum of six (6) days per Beneficiary each calendar year.

30. MAMMOGRAPHY SERVICES

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for screening or diagnostic mammography services for any woman desiring a mammogram.

31. BLOOD AND BLOOD PLASMA

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for blood and blood plasma, if not replaced by donors.

32. DURABLE MEDICAL EQUIPMENT

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for the following:

Subject to prior authorization by Regence BSI, the rental (but not to exceed the total cost of purchase) or, at the option of Regence BSI, the purchase of Durable Medical Equipment when prescribed by a Physician or Provider and required for therapeutic use. Regence BSI shall reserve the right to contract with Providers as necessary to provide covered Durable Medical Equipment for its Beneficiaries. Items secured under the provisions of this paragraph shall be limited to the standard model of such appliance or medical equipment (no benefits for electronic or cosmetic appliances). Repairs or maintenance costs will be covered. Replacement costs will be covered only if the equipment was used by the Beneficiary in the manner and for the purpose for which the equipment was intended, and the replacement costs are necessarily incurred due to normal wear and tear of the equipment. See the Exclusions section of the General Provisions for other items not covered.

33. PROSTHETIC DEVICES

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for the purchase, fitting, necessary adjustment, repairs and replacements of prosthetic devices, and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding artificial hearts, dental appliances, and the replacement of cataract lenses except when new cataract lenses are needed because of prescription change). Replacement costs will be covered only if the prosthetic appliance was used by the Beneficiary in the manner and for the purpose for which such appliance was intended, and the replacement costs are necessarily incurred due to normal wear and tear of the appliance. Regence BSI shall reserve the right to contract with Providers as necessary to provide covered prosthetic appliances for its Beneficiaries.

34. ORTHOTICS

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for the purchase of an ankle-foot orthotic, and/or a knee-ankle-foot orthotic used to support, align, prevent, or correct deformities or improve function of movable parts of the body when required for therapeutic use for treatment of neurological or circulatory conditions. Regence BSI shall reserve the right to contract with Providers as necessary to provide covered orthotics for its Beneficiaries. Items secured under the provisions of this paragraph shall be limited to the standard and/or most cost effective model of such orthotic (no benefits for electronic or cosmetic devices). Maintenance costs will not be covered. Repairs and replacement costs will be covered only if the orthotic was used by the Beneficiary in the manner and for the purpose for which the orthotic was intended, and the replacement costs are necessarily incurred due to normal wear and tear of the orthotic.

35. AMBULANCE SERVICES

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for ambulance service within the local community by means of a specially designed and equipped vehicle used primarily for transporting the sick and injured:

- A. From a Beneficiary's home or scene of Injury or Medical Emergency to an approved Hospital,
- B. Between approved Hospitals, or
- C. Between an approved Hospital and skilled nursing facility, if such facility is the closest institution that can provide Covered Services appropriate to the Beneficiary's condition. If there is no facility in the local community that can

provide Covered Services appropriate to the Beneficiary's condition, ambulance service will extend to the closest facility outside the local community that can provide the necessary service.

Air ambulance will be provided only when ground transportation is not feasible. Prior review must be obtained from Regence BSI to be eligible for this benefit unless an emergency situation existed which precluded obtaining prior approval.

36. SKILLED NURSING FACILITY

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for extended care in an approved skilled nursing facility for charges covering room and board and ancillary services. A Beneficiary, his or her representative, or the facility must notify Regence BSI of skilled nursing facility admissions. To be eligible for this benefit the following qualifications must be met: (1) the patient's admittance to the skilled nursing facility must be ordered by the attending Physician; (2) the illness or injury must require skilled nursing care on a continuing basis; and (3) skilled nursing facility confinement must be for circumstances reflecting the need for convalescence from an illness, treatment of a terminal condition, or a long term illness and must not be for Custodial Care. Total benefits provided for extended care in a skilled nursing facility shall be limited to a maximum of thirty (30) days per Beneficiary each calendar year.

37. CHIROPRACTIC SERVICES

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for professional services rendered by a Chiropractor, practicing within the scope of his or her license. Chiropractic benefits shall not be provided under the Out-of-Pocket provision or for the treatment of orthognathic conditions and/or temporomandibular joint (TMJ) disorders. Total benefits paid for services of a Chiropractor shall be limited to a maximum of \$500 per Beneficiary each calendar year.

38. DIAGNOSTIC LABORATORY TESTING AND/OR X-RAY FACILITIES

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for services of Regence BSI-approved diagnostic laboratory and x-ray facilities.

39. HUMAN GROWTH HORMONE THERAPY

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for human growth hormone therapy for: (1) growth hormone deficiency in children, (2) growth failure in children secondary to chronic renal insufficiency, (3) Turner's Syndrome, or (4) the promotion of wound healing for patients with severe, acute burns. Human growth hormone therapy for the above listed conditions will only be covered when authorized by Regence BSI in advance. Benefits for covered human growth hormone therapy shall be limited to a maximum of \$25,000 per Beneficiary each calendar year.

40. INJURY TO A SOUND NATURAL TOOTH

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for professional services rendered by a Physician or Dentist for the treatment of a fractured jaw or for Injury to a Sound Natural Tooth. Services needed as a result of chewing or biting shall not be considered services required as a result of an Injury. Total benefits paid for Injury to a Sound Natural Tooth shall be limited to a maximum of \$500 per occurrence up to twelve (12) months from the date of accident.

41. DIABETIC SUPPLIES

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for blood sugar diagnostics, lancets, swabs, and urine test strips.

42. DIABETIC EDUCATION

Benefits for diabetic education as outlined below shall be provided at eighty percent (80%) of the Allowable Charge:

- A. The Beneficiary must have a diagnosis of diabetes confirmed by a Physician through diagnostic laboratory testing and clinical findings.
- B. Diabetic education must be prescribed by a Physician.
- C. The program must be:
 - 1) Recognized by the American Diabetes Association (ADA);
 - 2) Conducted by a certified diabetes educator (CDE) or registered dietician; or
 - 3) Equivalent in experience and education to the requirements above and be approved by the Regence BSI Medical Director.
- D. No benefits shall be provided for the following:
 - 1) Inpatient services;
 - 2) Books and/or tapes; and
 - 3) Prescription or nonprescription drugs, medications, or supplies.
- E. Total benefits paid for diabetic education shall be limited to a maximum of \$400 per Beneficiary each calendar year up to a maximum of \$1,200 during a Beneficiary's lifetime when education services are provided through a Regence BSI-approved diabetic education program.

43. PRESCRIPTION AND MAIL-ORDER MAINTENANCE DRUGS (NOT SUBJECT TO THE DEDUCTIBLE)

- A. For covered prescription drugs dispensed by a Network Pharmacist or through Regence BSI's prescription mail-order Provider, the Beneficiary shall be responsible for a:
 - 1) 25% Coinsurance up to a maximum of \$25 for generic prescription drugs;
 - 2) 25% Coinsurance up to a maximum of \$100 for Formulary brand name prescription drugs; or
 - 3) 50% Coinsurance up to a maximum of \$200 for non-Formulary brand name prescription drugs and prescription medications newly approved by the Federal Food and Drug Administration (FDA).Regence BSI shall be responsible for the remaining balance of the prescription drug program administrator's Maximum Allowable Cost (MAC) rates. Covered drugs are for the specific and direct treatment of the covered Illness or Injury. Insulin and insulin syringes/needles when prescribed and dispensed at the same time as the insulin are covered.
- B. Each prescription dispensed shall not exceed a thirty-four (34) day supply.
- C. Each prescription dispensed through Regence BSI's mail-order provider shall not exceed a ninety (90) day supply. The Beneficiary shall be responsible for a Coinsurance for each ninety (90) day supply.
- D. Prescription drugs may require preauthorization by Regence BSI.
- E. A list of prescription medications newly approved by the Federal Food and Drug Administration (FDA) is provided to pharmacies and is available to the Beneficiary upon written request or on Regence BSI's web site at (www.id.regence.com).
- F. Noncovered items include: (1) Birth control devices purchased through Regence BSI's mail-order provider; (2) Fertility drugs; (3) Nonlegend prescription drugs other than insulin; (4) Charges for administration or injection of any drugs; (5) Therapeutic devices or appliances such as hypodermic syringes, support garments, and similar items; (6) Experimental drugs; (7) Immunization agents, biological sera, blood or blood plasma; (8) Medication received as an Inpatient in a licensed Hospital or other facility; (9) Prescription drugs for smoking cessation; and (10) Prescription drugs for the treatment of obesity.

- G. Included as part of this prescription drug benefit is a drug utilization review program. Utilizing a database of information on every Beneficiary, Physician, and Network Pharmacist prescription, the program alerts a dispensing pharmacist of potential conflicts in drug therapy, duplicate drugs and overuse before the Beneficiary obtains the medication. Prescription claims telecommunicated on-line by the pharmacist are analyzed with the Beneficiary's active drug profile for potential drug problems. Claims which are identified to be excessive utilization will be denied.

44. CONTRACEPTIVES (NOT SUBJECT TO THE DEDUCTIBLE)

- A. Benefits provided for covered oral contraceptive prescription drugs for the Beneficiary shall be subject to the prescription drug benefit and dispensing limit.
- B. Benefits shall be provided for diaphragms and intrauterine devices for the Beneficiary at one hundred percent (100%) of the Allowable Charge, subject to a \$25 Copayment per device.
- C. Benefits shall be provided for injectable contraceptives (Depo Provera, etc.) for the Beneficiary at one hundred percent (100%) of the Allowable Charge, subject to a \$20 Copayment per injection.
- D. Benefits shall be provided for Norplant insertion for the purpose of contraception for the Beneficiary at one hundred percent (100%) of the Allowable Charge, subject to a \$100 Copayment per implant.

Removal for conception and reinsertion following delivery is not covered.

Coverage for implants will be limited to once each five (5) years.

45. PREAUTHORIZED HUMAN ORGAN AND TISSUE TRANSPLANTS AND BONE MARROW REINFUSION

- A. Covered Services related to human organ and tissue transplants and bone marrow transplants shall be provided at eighty percent (80%) of the Allowable Charge. In addition to the exclusions and limitations set forth in the General Provisions, human organ and tissue transplants shall be further subject to all of the conditions and limitations set forth below:

- 1) Benefits for any organ or tissue transplant or bone marrow reinfusion authorized by Regence BSI will be paid up to a lifetime maximum of \$250,000 for each Beneficiary. All costs incurred by the Beneficiary in connection with the organ transplant process shall be counted against the lifetime maximum, including but not limited to: All pre-transplant procedures, post-transplant Outpatient care related to the transplant (except drug costs); re-transplantation costs; any complications directly attributable to transplantation or reinfusion.
- 2) Organ or tissue transplants must be given by one (1) human being to another (except in the case of autologous bone marrow reinfusion). No benefits will be paid for artificial, nonhuman, or mechanical transplants regardless of whether implantation is a temporary measure while awaiting an available human organ.
- 3) No benefits will be paid for donor or organ procurement services and costs incurred outside the United States, unless specifically approved by Regence BSI.
- 4) Benefits are not provided for selection, transportation, or storage costs when donor or organ procurement benefits are available through other group coverage, when government funding is available, or if funds are available from any other source.
- 5) No benefits will be paid for the purchase of any organ or tissue.
- 6) No benefits will be provided for any services or supplies related to transplant procedures other than those specifically listed as covered.
- 7) No benefits will be provided for any services, chemotherapy, radiation therapy (or any therapy that damages the bone marrow), supplies, drugs, and aftercare for or related to bone marrow transplant, stem cell support, or peripheral stem cell support procedures for a condition not specifically listed below as covered.

- B. In addition to the provisions listed above, benefit payments related to the expenses incurred by the donor and the recipient of any organ or tissue transplant are also subject to the following additional provisions:

- 1) Organ procurement services means those diagnostic or medical services to evaluate, select, store, identify, or test that organ or tissue which is actually used in a transplant. It also means the donor's surgical and Hospital services directly related to the removal of an organ or tissue which is actually used in a transplant. Organ procurement costs also include those expenses incurred by recipients in the medical process to locate a compatible donor. Transportation of the donor or for the donated organ or tissue is not an organ procurement service.
 - 2) Benefits paid for organ procurement services shall be limited to a maximum of \$15,000 during a Beneficiary's lifetime. Organ procurement service benefits will only be paid if the donor organ is actually used for a transplant. The benefits paid for organ procurement services will be counted against the \$250,000 lifetime maximum.
 - 3) When both the donor and recipient are covered by this Plan, benefits for the recipient's expenses will be paid according to the terms of this Plan, subject to the \$250,000 and \$15,000 lifetime maximums.
 - 4) When both the donor and recipient are covered by this Plan, benefits for the donor's expenses are limited to the payment of organ procurement services subject to the following:
 - a) No donor expenses will be paid unless the donor's organ is actually used in the transplant.
 - b) Medical complications and unforeseen medical effects of the donation will be covered as any other illness regardless of whether the organ is actually used in the transplant.
 - c) Organ procurement expenses incurred by the donor will be credited against the donor's \$15,000 lifetime maximum.
 - 5) When only the recipient is a Beneficiary under this Plan, only the recipient receives the benefits listed herein. No expenses incurred by the non-insured donor will be paid, except as otherwise permitted by the payment of organ procurement services under the recipient's Plan. No benefits whatsoever are available to a non-insured recipient.
 - 6) When only the donor is a Beneficiary of this Plan, benefits for the donor's expenses are limited to the payment of organ procurement services subject to the following:
 - a) No donor expenses will be paid unless the donor's organ is actually used in the transplant.
 - b) Medical complications and unforeseen medical effects of the donation will be covered as any other illness regardless of whether the organ is actually used in the transplant.
 - c) Organ procurement expenses incurred by the donor will be credited against the donor's \$15,000 lifetime maximum.
- C. In addition to the \$250,000 lifetime maximum there shall be a benefit of up to \$5,000 in maximum lifetime benefits payable for the transportation, lodging, meals, and other incidental expenses incurred as a direct result of the transplant. The benefit will be paid upon the following terms and conditions:
- 1) The benefits will be paid only for the listed expenses incurred by the recipient or the recipient's immediate Family members.
 - 2) The benefits will be reimbursed upon the submission to Regence BSI of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service Provider.
 - 3) The listed expenses will not be reimbursed unless such expenses are incurred between the time period of five (5) days prior to the transplant to 120 days after the transplant.
 - 4) Regence BSI reserves the exclusive right to deny payment of any such expenses it deems inappropriate, excessive, or not in keeping with the intent of this provision.
- D. Human organ and tissue transplants covered under this Plan are limited to:
- 1) Heart

- 2) Single/bilateral/lobar lung
- 3) Lung in conjunction with heart transplant
- 4) Cornea
- 5) Kidney
- 6) Liver
- 7) Pancreas
- 8) Islet cell autotransplantation when undergoing total pancreatectomy for chronic pancreatitis
- 9) Small bowel
- 10) Small bowel/liver
- 11) Small bowel/liver/multivisceral
- 12) Autologous bone marrow transplant and/or autologous peripheral stem cell transplant only for the treatment of the following conditions:
 - a) Lymphoma
 - b) Hodgkin's disease
 - c) Neuroblastoma
 - d) Acute leukemia
 - (1) Lymphocytic
 - (2) Myelogenous
 - e) Germ cell tumor
 - f) Ewing's sarcoma, recurrent or refractory
 - g) Medulloblastoma, recurrent or refractory
 - h) Wilm's tumor, high risk or recurrent
 - i) Primitive neuroectodermal tumor
 - j) Multiple myeloma
- 13) Allogeneic bone marrow transplant only for the treatment of the following conditions:
 - a) Aplastic anemia
 - b) Acute leukemia
 - (1) Lymphocytic
 - (2) Myelogenous
 - c) Severe combined immunodeficiency (not AIDS)
 - d) Infantile malignant osteopetrosis
 - (1) Albers - Schonberg syndrome
 - (2) Marble bone disease
 - e) Chronic myelogenous leukemia
 - f) Lymphoma
 - g) Wiskott-Aldrich Syndrome
 - h) Neuroblastoma
 - i) Homozygous beta-thalassemia (thalassemia major)
 - j) Hodgkin's disease
 - k) Myelodysplastic syndrome

- l) Mucopolysaccharidoses
- m) Mucopolipidoses
- n) Myeloproliferative disorders
- o) Sickle cell anemia
- p) Kostmann's syndrome
- q) Leukocyte adhesion deficiencies
- r) X-linked lymphoproliferative syndrome
- s) Wilm's tumor, high risk or recurrent
- t) Ewing's sarcoma, recurrent or refractory

14) and other transplants determined by Regence BSI to be a covered transplant since this Plan was issued.

E. No benefits will be provided unless written preauthorization is obtained from Regence BSI prior to covered transplant-related services. Regence BSI will determine whether to preauthorize a proposed transplant based on: (1) the Beneficiary's medical condition, (2) medical appropriateness of the proposed transplant, (3) the Physician who will perform the transplant procedure, (4) the facility in which the transplant procedure will be performed, and (5) the terms and conditions of this transplant provision. Regence BSI reserves the right, at its sole option, to contract with specific facilities to perform these transplant services and to base benefit payments upon the terms and conditions of such third party contracts.

46. HOME INFUSION THERAPY

Benefits for home infusion therapy shall be provided at eighty percent (80%) of the Allowable Charge for medically necessary services and supplies when provided by a Regence BSI-approved home infusion therapy provider. Covered Services shall include the following:

- A. Professional skilled nursing services of a nurse (RN or LPN) required for: (1) training the Beneficiary and/or alternative caregiver; (2) the administration of therapy; and (3) monitoring the intravenous therapy treatment.
- B. Medical and surgical supplies, and equipment, which are customarily furnished by the home infusion therapy agency and which are medically necessary to administer the home infusion therapy treatment.
- C. Prescribed drugs furnished by the home infusion therapy agency, which is a part of the home infusion therapy treatment. The administration of such drugs must require the professional skills of a nurse (RN or LPN) at the time the Beneficiary is receiving nursing services as set forth above. This does not include prescribed drugs that are self-administered or administered by a non-professional caregiver.

No benefits will be provided unless the Beneficiary obtains preauthorization from Regence BSI prior to receiving home infusion therapy treatment. Regence BSI must receive information sufficient for its determination of medical necessity.

47. HOME HEALTH CARE

Benefits for home health care services as outlined below shall be provided at eighty percent (80%) of the Allowable Charge when provided by a Regence BSI-approved home health agency. All of the following conditions must be met to qualify for this benefit:

- 1) Services are provided in lieu of in-hospital or necessary skilled nursing facility services.
- 2) The services are prescribed by a Physician.
- 3) The services are provided by a R.N. or L.P.N. on a part-time visiting basis of no more than four (4) hours in duration per visit.

- 4) The services are provided by a Hospital or state-licensed community health care agency approved by Regence BSI.
- 5) Notification to Regence BSI of treatment and plan of care is required.

No benefits will be paid for services provided where no specific medical treatment is furnished. Services provided by a relative, volunteer, or by a person who normally resides with the patient will not be covered.

Total benefits paid for home health care visits shall be limited to a maximum of \$5,000 per Beneficiary each calendar year.

48. HOSPICE CARE

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for hospice services and supplies as listed below when such services and supplies are included in the hospice treatment plan and provided and billed by a hospice licensed by the Department of Health and Welfare to a Beneficiary who is terminally ill and homebound. Notification of the Physician's treatment and plan of care must be provided to Regence BSI.

Benefits for hospice care shall be limited to a maximum of \$5,000 and a maximum of six (6) months from the initial date covered care is provided. Regence BSI may, in its sole discretion, grant limited extensions if it is determined that continued hospice care is medically appropriate.

Home Care Visits - Visits by a registered or licensed practical nurse; a physical, occupational, or speech therapist; MSW (Masters of Social Work); or a home health aide. A visit must be for intermittent, medically necessary, or palliative care of not more than four (4) hours in duration.

Hospice Inpatient Care - Up to twelve (12) days in the six (6) month benefit period. Benefits shall be subject to the \$5,000 benefit maximum. Prior approval by Regence BSI is required.

Respite Care - Up to 120 hours of care per three (3) month period in the most appropriate setting.

Exclusions - Hospice benefits do not cover the following:

- 1) Services provided to other than the terminally ill Beneficiary, including bereavement counseling for Family members.
- 2) Pastoral and spiritual counseling.
- 3) Services performed by Family members or volunteer workers.
- 4) Homemaker or housekeeping services, except by home health aides, as ordered in the hospice treatment plan.
- 5) Supportive environmental materials, including but not limited to handrails, ramps, air conditioners, and telephones.
- 6) Normal necessities of living, including but not limited to food, clothing, and household supplies.
- 7) Food service, such as "Meals on Wheels."
- 8) Separate charges for reports, records, or transportation.
- 9) Legal and financial counseling services.
- 10) Services and supplies not included in the hospice treatment plan or not specifically set forth as a hospice benefit.
- 11) Services and supplies in excess of the stated limitations or services and supplies provided more than six (6) months after the initial date of covered hospice care, unless specifically approved by Regence BSI.

49. INPATIENT REHABILITATION

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for Inpatient rehabilitation services and supplies provided and billed by a licensed acute rehabilitation Hospital with accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facility (CARF), or a Medicare-approved rehabilitation facility. Benefits are provided to restore a Beneficiary who was Totally Disabled as the result of a covered Illness, Injury, condition, or disease, as outlined below, to a level of function which allows that Beneficiary to live as independently as possible.

All of the applicable requirements below must be met to qualify for this benefit:

- A. The rehabilitation facility's program must be closely supervised by a psychiatrist or Physician with experience in rehabilitation. The facility must provide twenty-four (24) hour rehabilitative nursing care and rehabilitative therapy with the availability of a registered nurse having specialized training or experience in rehabilitation.
- B. The facility must provide a plan of treatment to Regence BSI including current evaluations showing potential for improvement of the Beneficiary's function.
- C. Conditions for Inpatient rehabilitation services covered under this Plan must be acute in nature. The benefits of this section will not be payable if the Beneficiary has been previously treated for the same condition or received any multi-level rehabilitative treatment in a medical rehabilitation center for the same condition. Covered conditions are limited to the following:
 - 1) Extensive intracranial Injury
 - a) Cerebral laceration and contusions
 - b) Subarachnoid, subdural extradural hemorrhage following Injury
 - c) Intracranial bleeding following Injury
 - d) Other intracranial Injury
 - 2) Extensive spinal cord Injury
 - 3) Extensive crushing Injury involving multiple fractures
 - a) Lower extremity amputation due to trauma or new amputation due to Illness
 - 4) Inflammatory diseases of the central nervous system resulting in marked neurological/neuromuscular deficiency limited to the following:
 - a) Meningitis
 - b) Encephalitis
 - c) Intracranial and intraspinal abscess
 - 5) Disorders of the central nervous system limited to the following:
 - a) Hemiplegia
 - b) Paraplegia
 - 6) Acute cerebrovascular accidents
 - 7) Neoplasms resulting in marked neurological and/or neuromuscular deficit limited to the following:
 - a) Spinal cord compression due to neoplasm
 - b) Intracranial neoplasm

Diagnosis alone does not justify benefit application for Inpatient rehabilitation.
- D. The medical condition of the Beneficiary must meet the following criteria for benefit consideration. This information must be documented in writing:
 - 1) The Beneficiary must be considered medically stable to tolerate rehabilitative therapy.

- 2) Physical Therapy or cognitive therapy (upon approval following review) must be the main focus of rehabilitation.
 - 3) The Beneficiary must be able to tolerate at least three (3) hours of therapy per day.
 - 4) Severe physical, neuromuscular, neurological impairment necessitating the need for twenty four (24) hour nursing care must be present.
 - 5) The Beneficiary must be responsive to verbal and visual stimuli.
 - 6) No other medical, surgical, or psychological impairing condition shall be present which may limit rehabilitation progress.
 - 7) The Beneficiary must show potential for rehabilitation.
- E. No benefits will be provided unless the Beneficiary obtains written preauthorization from Regence BSI prior to Inpatient admission for rehabilitation. Regence BSI reserves the right to review all requests for prior approval based on: (1) the Beneficiary's medical condition, (2) the Physician who will supervise the treatment, and (3) the facility in which the rehabilitation will be performed. Regence BSI must receive information sufficient for its determination of Plan and benefit application. Regence BSI reserves the right, at its sole option, to contract with specific facilities to perform rehabilitation services and to base benefit payments upon the terms and conditions of such third party contracts.

Total benefits paid for Inpatient rehabilitation services shall be limited to a maximum of \$15,000 per Beneficiary each calendar year.

Exclusions - Inpatient rehabilitation benefits do not cover the following:

- 1) Custodial Care;
- 2) Maintenance care;
- 3) Vocational rehabilitation;
- 4) Driver's education;
- 5) Communication devices;
- 6) Services to reduce or training to reduce debilitating chronic pain;
- 7) Pain management/clinics;
- 8) Rehabilitation for post Inpatient Hospital stays for orthopaedic or reconstructive surgeries;
- 9) Sensory stimulation for coma patients;
- 10) Cardiac and pulmonary rehabilitation;
- 11) Services for polyarthritis (including rheumatoid), neurological disorders, and/or deconditioning due to long illness;
- 12) Prosthetic devices;
- 13) Educational materials;
- 14) Services, supplies, medication, or care of any kind, other than those directly related to rehabilitation care;
- 15) Charges from a transitional care/subacute rehabilitation unit.

50. OUTPATIENT REHABILITATION

Benefits shall be provided at eighty percent (80%) of the Allowable Charge for medically necessary Outpatient rehabilitation services and supplies provided and billed by a licensed or certified physical, speech, occupational, cardiac, or respiratory therapist to improve or restore lost bodily function.

Total benefits paid for Physical Therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.

Total benefits paid for Speech Therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.

Total benefits paid for occupational therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.

Total benefits paid for Respiratory Therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.

Total benefits paid for cardiac rehabilitation therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.

Exclusions - Outpatient rehabilitation benefits do not cover the following:

- 1) Inpatient care and services;
- 2) Diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, whether or not that service is provided by a licensed or registered Provider;
- 3) Treatment primarily for Mental or Neuropsychiatric Conditions or Chemical Dependency;
- 4) Services, supplies, medications, or care of any kind, other than those directly related to rehabilitation care;
- 5) Biofeedback, unless rendered as neuromuscular electrical stimulation.

51. WORLD-WIDE COVERAGE

Benefits of this Plan shall be available on a world-wide basis.

52. OUT-OF-POCKET EXPENSE

In the event the total Coinsurance share of Covered Services for one (1) Beneficiary exceeds \$2,000 (plus Deductible) in one (1) calendar year for In-Network and Out-of-Network services combined, the Coinsurance amount payable by Regence BSI on behalf of that Beneficiary shall be increased to one hundred percent (100%) of the Allowable Charge for the remainder of the calendar year in which the excess charges were incurred. Each Beneficiary must meet the out-of-pocket expense amount, however, no Family shall be obligated to meet more than \$4,000 (plus Deductible) in the aggregate in any calendar year.

The following expenses do not apply toward the out-of-pocket expense and are the financial responsibility of the Beneficiary:

- 1) Deductible amounts.
- 2) Copayments.
- 3) Chiropractic Services.
- 4) Expenses in excess of specific benefit limitations.
- 5) Noncovered services.

53. MAXIMUM BENEFITS

Total benefits paid under this Plan, In-Network and Out-of-Network combined, shall not exceed \$1,000,000 during a Beneficiary's lifetime for all Illnesses and Injuries, with automatic reinstatement up to \$5,000 each calendar year.

OUT-OF-NETWORK SCHEDULE OF BENEFITS ELIGIBILITY FOR BENEFITS

54. DEDUCTIBLE ACCUMULATION

From and after the effective date of this Plan, the benefits shall apply commencing with the first day of an Illness, Injury, or physical disability for which Covered Services are provided hereunder, after the following conditions have been fulfilled:

- A. Before a Beneficiary shall qualify for the benefits of this Plan, such Beneficiary must have paid, subsequent to the Effective Date of coverage under this Plan, the Deductible amount of \$200 for each calendar year, In-Network and Out-of-Network combined, in which the benefits of this Plan apply. In calculating whether the Deductible requirements have been fulfilled, only amounts, up to the Allowable Charge of Covered Services actually paid by the Beneficiary for medical, surgical, and Hospital care during the current calendar year shall be considered.
- B. No Family shall be obligated to meet more than \$400 in the aggregate in any calendar year.
- C. Charges for services payable by the Beneficiary due to a reduction of benefits, denial of benefits, or amounts charged in excess of allowable charges are the financial responsibility of the Beneficiary and shall not be considered as an eligible expense for application towards the Deductible amount.
- D. If a Beneficiary is hospitalized on the last day of the calendar year for which the Deductible requirement has been fulfilled and such hospitalization continues uninterrupted into the succeeding calendar year, such period of continuous hospitalization shall be considered a part of the calendar year in which it originated, and the Deductible requirement for the succeeding calendar year shall not apply until the day following the Beneficiary's discharge from the Hospital.
- E. To qualify for the benefits of this Plan, the Beneficiary shall submit proof to Regence BSI that the applicable Deductible amount for the calendar year involved has been incurred including name of Provider, diagnosis, and itemized statements.

OUT-OF-NETWORK SERVICES SCHEDULE OF BENEFITS

For Services not Provided by a Network Provider

After a Beneficiary has otherwise qualified and fulfilled the Deductible requirement above, Regence BSI will provide such Beneficiary with benefits for Necessary Medical, Surgical, and Hospital Services actually incurred subject to the maximum lifetime benefit limits and the terms, waiting periods, exclusions, limitations, and general provisions set forth in this Plan, as follows:

55. PREVENTIVE CARE

- A. Benefits shall be provided at eighty percent (80%) of the Allowable Charge for services provided by a Nonnetwork Primary physician or Nonnetwork Specialist Physician for routine physical examinations for the evaluation and management of a healthy individual in the absence of patient complaints or symptoms associated with Illness or Injury.
- B. Benefits shall be provided at eighty percent (80%) of the Allowable Charge for routine laboratory and x-ray charges associated with routine physical examination as limited herein when services are not provided by a Nonnetwork Primary Physician or Nonnetwork Specialist Physician. Covered routine laboratory and x-ray charges shall be limited to the following: mammograms, unilateral, bilateral, or bilateral screening mammography services; chemistry panel; urinalysis; stool guaic; complete blood count; prostate specific antigen; tuberculosis skin or tine testing; papanicolaou stain (pap smear), cytopathology by a technician under Physician supervision, cytopathology requiring interpretation by a Physician, or cytopathology with definitive hormonal evaluation; PKU (phenylketonuria) testing; and/or electrocardiogram.
- C. Benefits for immunizations shall be provided at eighty percent (80%) of the Allowable Charge for Enrolled Employees and Dependents over two (2) years of age.
- D. Benefits shall be provided at eighty percent (80%) of the Allowable Charge for Outpatient well baby care, including immunizations. Benefits paid shall be limited to the first twenty-four (24) months of life.

56. PHYSICIAN/PROVIDER AND SPECIALIST

Benefits of this section shall apply to all office, home, and Hospital services provided by and billed by a Physician/Provider or Specialist.

Laboratory testing and x-ray examination services provided at a Hospital or other facility, regardless of whether the Beneficiary was referred to the Hospital or facility by a Physician/Provider or Specialist, shall be provided under the applicable section of this Schedule of Benefits depending upon the person, entity, or facility providing the service.

Benefits for services of a Physician/Provider or Specialist as outlined below shall be provided at sixty percent (60%) of the Allowable Charge:

- A. Office, home, and Outpatient Hospital visits for the treatment of an Illness, Injury, or Surgery either in the Physician/Provider's office or as an Outpatient in the Hospital.
- B. Injections and related supplies.
- C. Diagnostic laboratory and x-ray services.
- D. Surgical services, including services of assistant surgeon, and anesthesiologist.
- E. Hospital visits for Illness or Injury while necessarily hospitalized as an Inpatient during coverable periods of hospitalization.

- F. Routine newborn nursing care for an enrolled Newborn Child while the Newborn Child is necessarily hospitalized as an Inpatient following birth.
- G. Second and third surgical consultative opinions to confirm the need for Elective Surgical Procedures as first recommended by the attending Physician. A second opinion consultant shall not be the same Physician who recommended elective Surgery and a third opinion consultant shall not be the same Physician who recommended elective Surgery or rendered the second opinion. Use of a second opinion is at the Beneficiary's option. If the second opinion conflicts with the first, then a third opinion is a Covered Service.

57. HOSPITAL ADMISSION REVIEW

A Beneficiary, his or her representative, or the facility should notify Regence BSI of all Inpatient Hospital and skilled nursing facility admissions, including Inpatient admission for cochlear implant, within two (2) business days of admission. For emergency admissions, the Beneficiary should notify Regence BSI when stabilized and physically able. All admissions should be reviewed by Regence BSI. Review of an admission does not guarantee benefit payments. Benefit payments will be made based upon Plan provisions and eligibility criteria.

58. INPATIENT HOSPITAL

A period of hospitalization shall begin the first day a Beneficiary becomes registered as an Inpatient at a Hospital and shall continue until a Beneficiary is discharged from the Hospital. Benefits for Inpatient hospitalization as outlined below shall be provided at sixty percent (60%) of the Allowable Charge:

- A. Room and board and general nursing care in a Hospital room of two (2) or more beds. Allowance shall be made for the day of admission or the day of discharge but not for both.
- B. Hospital cardiac or intensive care units.
- C. Hospital ancillary services and supplies.
- D. Routine room and board, general nursing care, and ancillary services for an enrolled Newborn Child while the Newborn Child is necessarily hospitalized as an Inpatient following birth.
- E. Hospital benefits as set forth above for cases of dental Surgery when performed by a Dentist and upon certification by a Physician that hospitalization is necessary because of nondental health impairment such as hemophilia, heart disease, etc.

59. OUTPATIENT HOSPITAL

Benefits for Outpatient services as outlined below shall be provided at sixty percent (60%) of the Allowable Charge:

- A. Regence BSI-approved Outpatient Hospital services, including but not limited to Surgery, diagnostic laboratory, and x-ray, provided in an Outpatient Hospital, Ambulatory Surgical Center, or Surgery suite.
- B. Use of the emergency room for the treatment of Illness or Injury.
- C. Hospital benefits as set forth above for cases of dental Surgery when performed by a Dentist and upon certification by a Physician that Outpatient Hospital care is necessary because of nondental health impairment such as hemophilia, heart disease, etc.

60. MATERNITY CARE

- A. Benefits for medical and surgical services consequential upon pregnancy, including Involuntary Complications of Pregnancy, for the eligible female Enrolled Employee or spouse shall be provided at sixty percent (60%) of the Allowable Charge for services of a Physician/Provider or Specialist.

- B. Benefits for room and board and general nursing care in a hospital room of two (2) or more beds, and ancillary services for maternity care, including Involuntary Complications of Pregnancy shall be provided at sixty percent (60%) of the Allowable Charge.
- C. Maternity benefits (including Involuntary Complications of Pregnancy) are not provided for Dependent children.
- D. No coverage will be provided for elective abortions, except to preserve the life of the female Enrolled Employee or spouse upon whom the abortion is performed.
- E. Routine newborn nursery care is not considered a maternity service. See the Physician/Provider and Specialist, and Inpatient Hospital sections above.
- F. Involuntary Complications of Pregnancy shall be covered as any other Illness.

61. MENTAL OR NEUROPSYCHIATRIC CONDITIONS AND CHEMICAL DEPENDENCY

- A. Benefits shall be provided at sixty percent (60%) of the Allowable Charge for services for the treatment of Mental or Neuropsychiatric Conditions or Chemical Dependency while the Beneficiary is necessarily hospitalized as an Inpatient in an approved Hospital or nonfederal institution specializing in the treatment of such Illnesses when such services are not provided by a Network Provider.
- B. Benefits shall be provided at sixty percent (60%) of the Allowable Charge for room and board, general nursing care, and ancillary services in a Hospital room of two (2) or more beds for the treatment of Mental or Neuropsychiatric Conditions or Chemical Dependency when such services are not provided by a Network Hospital. Allowance shall be made for the day of admission or the day of discharge, but not for both.
- C. Benefits shall be provided at fifty percent (50%) of the Allowable Charge for Outpatient Physician services for the treatment of Mental or Neuropsychiatric Conditions or Chemical Dependency when such services are not provided by a Network Provider.
- D. Benefits shall be provided at fifty percent (50%) of the Allowable Charge for Outpatient Hospital services for the treatment of Mental or Neuropsychiatric Conditions or Chemical Dependency when such services are not provided by a Network Hospital.
- E. Total Outpatient benefits paid for the treatment of Mental or Neuropsychiatric Conditions and Chemical Dependency shall be limited to a maximum of twenty (20) visits per Beneficiary each calendar year.
- F. Total Inpatient benefits paid for the treatment of Mental or Neuropsychiatric Conditions and Chemical Dependency shall be limited to a maximum of six (6) days per Beneficiary each calendar year.

62. MAMMOGRAPHY SERVICES

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for screening or diagnostic mammography services for any woman desiring a mammogram.

63. BLOOD AND BLOOD PLASMA

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for blood and blood plasma, if not replaced by donors.

64. DURABLE MEDICAL EQUIPMENT

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for the following:

Subject to prior authorization by Regence BSI, the rental (but not to exceed the total cost of purchase) or, at the option of Regence BSI, the purchase of Durable Medical Equipment when prescribed by a Physician or Provider and required for therapeutic use. Regence BSI shall reserve the right to contract with Providers as necessary to provide covered Durable Medical Equipment for its Beneficiaries. Items secured under the provisions of this paragraph shall be limited to the standard model of such appliance or medical equipment (no benefits for electronic or cosmetic appliances). Repairs or maintenance costs will be covered. Replacement costs will be covered only if the equipment

was used by the Beneficiary in the manner and for the purpose for which the equipment was intended, and the replacement costs are necessarily incurred due to normal wear and tear of the equipment. See the Exclusions section of the General Provisions for other items not covered.

65. PROSTHETIC DEVICES

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for the purchase, fitting, necessary adjustment, repairs and replacements of prosthetic devices, and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding artificial hearts, dental appliances, and the replacement of cataract lenses except when new cataract lenses are needed because of prescription change). Replacement costs will be covered only if the prosthetic appliance was used by the Beneficiary in the manner and for the purpose for which such appliance was intended, and the replacement costs are necessarily incurred due to normal wear and tear of the appliance. Regence BSI shall reserve the right to contract with Providers as necessary to provide covered prosthetic appliances for its Beneficiaries.

66. ORTHOTICS

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for the purchase of an ankle-foot orthotic, and/or a knee-ankle-foot orthotic used to support, align, prevent, or correct deformities or improve function of movable parts of the body when required for therapeutic use for treatment of neurological or circulatory conditions. Regence BSI shall reserve the right to contract with Providers as necessary to provide covered orthotics for its Beneficiaries. Items secured under the provisions of this paragraph shall be limited to the standard and/or most cost effective model of such orthotic (no benefits for electronic or cosmetic devices). Maintenance costs will not be covered. Repairs and replacement costs will be covered only if the orthotic was used by the Beneficiary in the manner and for the purpose for which the orthotic was intended, and the replacement costs are necessarily incurred due to normal wear and tear of the orthotic.

67. AMBULANCE SERVICES

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for ambulance service within the local community by means of a specially designed and equipped vehicle used primarily for transporting the sick and injured:

- A. From a Beneficiary's home or scene of Injury or Medical Emergency to an approved Hospital,
- B. Between approved Hospitals, or
- C. Between an approved Hospital and skilled nursing facility, if such facility is the closest institution that can provide Covered Services appropriate to the Beneficiary's condition. If there is no facility in the local community that can provide Covered Services appropriate to the Beneficiary's condition, ambulance service will extend to the closest facility outside the local community that can provide the necessary service.

Air ambulance will be provided only when ground transportation is not feasible. Prior review must be obtained from Regence BSI to be eligible for this benefit unless an emergency situation existed which precluded obtaining prior approval.

68. SKILLED NURSING FACILITY

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for extended care in an approved skilled nursing facility for charges covering room and board and ancillary services. A Beneficiary, his or her representative, or the facility must notify Regence BSI of skilled nursing facility admissions. To be eligible for this benefit the following qualifications must be met: (1) the patient's admittance to the skilled nursing facility must be ordered by the attending Physician; (2) the Illness or Injury must require skilled nursing care on a continuing basis; and (3) skilled nursing facility confinement must be for circumstances reflecting the need for convalescence from an Illness, treatment of a

terminal condition, or a long term illness and must not be for Custodial Care. Total benefits provided for extended care in a skilled nursing facility shall be limited to a maximum of thirty (30) days per Beneficiary each calendar year.

69. CHIROPRACTIC SERVICES

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for professional services rendered by a Chiropractor, practicing within the scope of his or her license. Chiropractic benefits shall not be provided under the Out-of-Pocket provision or for the treatment of orthognathic conditions and/or temporomandibular joint (TMJ) disorders. Total benefits paid for services of a Chiropractor shall be limited to a maximum of \$500 per Beneficiary each calendar year.

70. DIAGNOSTIC LABORATORY TESTING AND/OR X-RAY FACILITIES

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for services of Regence BSI-approved diagnostic laboratory and x-ray facilities.

71. HUMAN GROWTH HORMONE THERAPY

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for human growth hormone therapy for: (1) growth hormone deficiency in children, (2) growth failure in children secondary to chronic renal insufficiency, (3) Turner's Syndrome, or (4) the promotion of wound healing for patients with severe, acute burns. Human growth hormone therapy for the above listed conditions will only be covered when authorized by Regence BSI in advance. Benefits for covered human growth hormone therapy shall be limited to a maximum of \$25,000 per Beneficiary each calendar year.

72. INJURY TO A SOUND NATURAL TOOTH

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for professional services rendered by a Physician or Dentist for the treatment of a fractured jaw or for Injury to a Sound Natural Tooth. Services needed as a result of chewing or biting shall not be considered services required as a result of an Injury. Total benefits paid for Injury to a Sound Natural Tooth shall be limited to a maximum of \$500 per occurrence up to twelve (12) months from the date of accident.

73. DIABETIC SUPPLIES

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for blood sugar diagnostics, lancets, swabs, and urine test strips.

74. DIABETIC EDUCATION

Benefits for diabetic education as outlined below shall be provided at sixty percent (60%) of the Allowable Charge:

- A. The Beneficiary must have a diagnosis of diabetes confirmed by a Physician through diagnostic laboratory testing and clinical findings.
- B. Diabetic education must be prescribed by a Physician.
- C. The program must be:
 - 1) Recognized by the American Diabetes Association (ADA);
 - 2) Conducted by a certified diabetes educator (CDE) or registered dietician; or
 - 3) Equivalent in experience and education to the requirements above and be approved by the Regence BSI Medical Director.
- D. No benefits shall be provided for the following:
 - 1) Inpatient services;
 - 2) Books and/or tapes; and
 - 3) Prescription or nonprescription drugs, medications, or supplies.

- E. Total benefits paid for diabetic education shall be limited to a maximum of \$400 per Beneficiary each calendar year up to a maximum of \$1,200 during a Beneficiary's lifetime when education services are provided through a Regence BSI-approved diabetic education program.

75. PRESCRIPTION DRUGS (NOT SUBJECT TO THE DEDUCTIBLE)

- A. For covered prescription drugs and prescription medications newly approved by the Federal Food and Drug Administration (FDA) dispensed by a Nonnetwork Pharmacist, the Insured shall be responsible for a \$25 Copayment plus fifty percent (50%) of the remaining balance.

Regence BSI shall be responsible for the remaining balance of the prescription drug program administrator's Maximum Allowable Cost (MAC) rates. Covered drugs are for the specific and direct treatment of the covered Illness or Injury. Insulin and insulin syringes/needles when prescribed and dispensed at the same time as the insulin are covered.

- B. Each prescription dispensed shall not exceed a thirty-four (34) day supply.
- C. Prescription drugs may require preauthorization by Regence BSI.
- D. A list of prescription medications newly approved by the Federal Food and Drug Administration (FDA) is provided to pharmacies and is available to the Insured upon written request or on Regence BSI's web site at (www.id.regence.com).
- E. Noncovered items include: (1) Fertility drugs; (2) Nonlegend prescription drugs other than insulin; (3) Charges for administration or injection of any drugs; (4) Therapeutic devices or appliances such as hypodermic syringes, support garments, and similar items; (5) Experimental drugs; (6) Immunization agents, biological sera, blood or blood plasma; (7) Medication received as an Inpatient in a licensed Hospital or other facility; (8) Prescription drugs for smoking cessation; and (9) Prescription drugs for treatment of obesity.
- F. Included as part of this prescription drug benefit is a drug utilization review program. Utilizing a database of information on every Beneficiary, physician, and network pharmacist prescription, the program alerts a dispensing pharmacist of potential conflict in drug therapy, duplicate drugs, and overuse before the Beneficiary obtains the medication. Prescription claims telecommunicated on-line by the pharmacist are analyzed with the Beneficiary's active drug profile for potential drug problems. Claims which are identified to be excessive utilization will be denied.

76. CONTRACEPTIVES

- A. Benefits shall be provided for covered oral contraceptive prescription drugs for the Beneficiary, subject to the prescription drug benefit and dispensing limit, not subject to the Deductible.
- B. Benefits shall be provided at sixty percent (60%) of the Allowable Charge, subject to the Deductible, for diaphragms and intrauterine devices, injectable contraceptives (Depo Provera, etc.) and Norplant insertion for the Beneficiary. Removal for conception and reinsertion following delivery is not covered. Coverage for implants will be limited to once each five (5) years.

77. PREAUTHORIZED HUMAN ORGAN AND TISSUE TRANSPLANTS AND BONE MARROW REINFUSION

- A. Covered Services related to human organ and tissue transplants and bone marrow transplants shall be provided at sixty percent (60%) of the Allowable Charge. In addition to the exclusions and limitations set forth in the General Provisions, human organ and tissue transplants shall be further subject to all of the conditions and limitations set forth below:
 - 1) Benefits for any organ or tissue transplant or bone marrow reinfusion authorized by Regence BSI will be paid up to a lifetime maximum of \$250,000 for each Beneficiary. All costs incurred by the Beneficiary in connection with the organ transplant process shall be counted against the lifetime maximum, including but not limited to:

All pre-transplant procedures, post-transplant Outpatient care related to the transplant (except drug costs); re-transplantation costs; any complications directly attributable to transplantation or reinfusion.

- 2) Organ or tissue transplants must be given by one (1) human being to another (except in the case of autologous bone marrow reinfusion). No benefits will be paid for artificial, nonhuman, or mechanical transplants regardless of whether implantation is a temporary measure while awaiting an available human organ.
 - 3) No benefits will be paid for donor or organ procurement services and costs incurred outside the United States, unless specifically approved by Regence BSI.
 - 4) Benefits are not provided for selection, transportation, or storage costs when donor or organ procurement benefits are available through other group coverage, when government funding is available, or if funds are available from any other source.
 - 5) No benefits will be paid for the purchase of any organ or tissue.
 - 6) No benefits will be provided for any services or supplies related to transplant procedures other than those specifically listed as covered.
 - 7) No benefits will be provided for any services, chemotherapy, radiation therapy (or any therapy that damages the bone marrow), supplies, drugs, and aftercare for or related to bone marrow transplant, stem cell support, or peripheral stem cell support procedures for a condition not specifically listed below as covered.
- B. In addition to the provisions listed above, benefit payments related to the expenses incurred by the donor and the recipient of any organ or tissue transplant are also subject to the following additional provisions:
- 1) Organ procurement services means those diagnostic or medical services to evaluate, select, store, identify, or test that organ or tissue which is actually used in a transplant. It also means the donor's surgical and Hospital services directly related to the removal of an organ or tissue which is actually used in a transplant. Organ procurement costs also include those expenses incurred by recipients in the medical process to locate a compatible donor. Transportation of the donor or for the donated organ or tissue is not an organ procurement service.
 - 2) Benefits paid for organ procurement services shall be limited to a maximum of \$15,000 during a Beneficiary's lifetime. Organ procurement service benefits will only be paid if the donor organ is actually used for a transplant. The benefits paid for organ procurement services will be counted against the \$250,000 lifetime maximum.
 - 3) When both the donor and recipient are covered by this Plan, benefits for the recipient's expenses will be paid according to the terms of this Plan, subject to the \$250,000 and \$15,000 lifetime maximums.
 - 4) When both the donor and recipient are covered by this Plan, benefits for the donor's expenses are limited to the payment of organ procurement services subject to the following:
 - a) No donor expenses will be paid unless the donor's organ is actually used in the transplant.
 - b) Medical complications and unforeseen medical effects of the donation will be covered as any other illness regardless of whether the organ is actually used in the transplant.
 - c) Organ procurement expenses incurred by the donor will be credited against the donor's \$15,000 lifetime maximum.
 - 5) When only the recipient is a Beneficiary under this Plan, only the recipient receives the benefits listed herein. No expenses incurred by the non-insured donor will be paid, except as otherwise permitted by the payment of organ procurement services under the recipient's Plan. No benefits whatsoever are available to a non-insured recipient.

- 6) When only the donor is a Beneficiary of this Plan, benefits for the donor's expenses are limited to the payment of organ procurement services subject to the following:
 - a) No donor expenses will be paid unless the donor's organ is actually used in the transplant.
 - b) Medical complications and unforeseen medical effects of the donation will be covered as any other illness regardless of whether the organ is actually used in the transplant.
 - c) Organ procurement expenses incurred by the donor will be credited against the donor's \$15,000 lifetime maximum.

- C. In addition to the \$250,000 lifetime maximum there shall be a benefit of up to \$5,000 in maximum lifetime benefits payable for the transportation, lodging, meals, and other incidental expenses incurred as a direct result of the transplant. The benefit will be paid upon the following terms and conditions:
 - 1) The benefits will be paid only for the listed expenses incurred by the recipient or the recipient's immediate Family members.
 - 2) The benefits will be reimbursed upon the submission to Regence BSI of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service Provider.
 - 3) The listed expenses will not be reimbursed unless such expenses are incurred between the time period of five (5) days prior to the transplant to 120 days after the transplant.
 - 4) Regence BSI reserves the exclusive right to deny payment of any such expenses it deems inappropriate, excessive, or not in keeping with the intent of this provision.

- D. Human organ and tissue transplants covered under this Plan are limited to:
 - 1) Heart
 - 2) Single/bilateral/lobar lung
 - 3) Lung in conjunction with heart transplant
 - 4) Cornea
 - 5) Kidney
 - 6) Liver
 - 7) Pancreas
 - 8) Islet cell autotransplantation when undergoing total pancreatectomy for chronic pancreatitis
 - 9) Small bowel
 - 10) Small bowel/liver
 - 11) Small bowel/liver/multivisceral
 - 12) Autologous bone marrow transplant and/or autologous peripheral stem cell transplant only for the treatment of the following conditions:
 - a) Lymphoma
 - b) Hodgkin's disease
 - c) Neuroblastoma
 - d) Acute leukemia
 - (1) Lymphocytic
 - (2) Myelogenous
 - e) Germ cell tumor
 - f) Ewing's sarcoma, recurrent or refractory
 - g) Medulloblastoma, recurrent or refractory
 - h) Wilm's tumor, high risk or recurrent

- i) Primitive neuroectodermal tumor
 - j) Multiple myeloma
- 13) Allogeneic bone marrow transplant only for the treatment of the following conditions:
- a) Aplastic anemia
 - b) Acute leukemia
 - (1) Lymphocytic
 - (2) Myelogenous
 - c) Severe combined immunodeficiency (not AIDS)
 - d) Infantile malignant osteopetrosis
 - (1) Albers - Schonberg syndrome
 - (2) Marble bone disease
 - e) Chronic myelogenous leukemia
 - f) Lymphoma
 - g) Wiskott-Aldrich Syndrome
 - h) Neuroblastoma
 - i) Homozygous beta-thalassemia (thalassemia major)
 - j) Hodgkin's disease
 - k) Myelodysplastic syndrome
 - l) Mucopolysaccharidoses
 - m) Mucopolidoses
 - n) Myeloproliferative disorders
 - o) Sickle cell anemia
 - p) Kostmann's syndrome
 - q) Leukocyte adhesion deficiencies
 - r) X-linked lymphoproliferative syndrome
 - s) Wilm's tumor, high risk or recurrent
 - t) Ewing's sarcoma, recurrent or refractory
- 14) and other transplants determined by Regence BSI to be a covered transplant since this Plan was issued.

E. No benefits will be provided unless written preauthorization is obtained from Regence BSI prior to covered transplant-related services. Regence BSI will determine whether to preauthorize a proposed transplant based on: (1) the Beneficiary's medical condition, (2) medical appropriateness of the proposed transplant, (3) the Physician who will perform the transplant procedure, (4) the facility in which the transplant procedure will be performed, and (5) the terms and conditions of this transplant provision. Regence BSI reserves the right, at its sole option, to contract with specific facilities to perform these transplant services and to base benefit payments upon the terms and conditions of such third party contracts.

78. HOME INFUSION THERAPY

Benefits for home infusion therapy shall be provided at sixty percent (60%) of the Allowable Charge for medically necessary services and supplies when provided by a Regence BSI-approved home infusion therapy provider. Covered Services shall include the following:

- A. Professional skilled nursing services of a nurse (RN or LPN) required for: (1) training the Beneficiary and/or alternative caregiver; (2) the administration of therapy; and (3) monitoring the intravenous therapy treatment.
- B. Medical and surgical supplies, and equipment, which are customarily furnished by the home infusion therapy agency and which are medically necessary to administer the home infusion therapy treatment.

- C. Prescribed drugs furnished by the home infusion therapy agency, which is a part of the home infusion therapy treatment. The administration of such drugs must require the professional skills of a nurse (RN or LPN) at the time the Beneficiary is receiving nursing services as set forth above. This does not include prescribed drugs that are self-administered or administered by a non-professional caregiver.

No benefits will be provided unless the Beneficiary obtains preauthorization from Regence BSI prior to receiving home infusion therapy treatment. Regence BSI must receive information sufficient for its determination of medical necessity.

79. HOME HEALTH CARE

Benefits for home health care services as outlined below shall be provided at sixty percent (60%) of the Allowable Charge when provided by a Regence BSI-approved home health care agency. All of the following conditions must be met to qualify for this benefit:

- 1) Services are provided in lieu of in-hospital or necessary skilled nursing facility services.
- 2) The services are prescribed by a Physician.
- 3) The services are provided by a R.N. or L.P.N. on a part-time visiting basis of no more than four (4) hours in duration per visit.
- 4) The services are provided by a Hospital or state-licensed community health care agency approved by Regence BSI.
- 5) Notification to Regence BSI of treatment and plan of care is required.

No benefits will be paid for services provided where no specific medical treatment is furnished. Services provided by a relative, volunteer, or by a person who normally resides with the patient will not be covered.

Total benefits paid for home health care visits shall be limited to a maximum of \$5,000 per Beneficiary each calendar year.

80. HOSPICE CARE

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for hospice services and supplies as listed below when such services and supplies are included in the hospice treatment plan and provided and billed by a hospice licensed by the Department of Health and Welfare to a Beneficiary who is terminally ill and homebound. Notification of the Physician's treatment and plan of care must be provided to Regence BSI.

Benefits for hospice care shall be limited to a maximum of \$5,000 and a maximum of six (6) months from the initial date covered care is provided. Regence BSI may, in its sole discretion, grant limited extensions if it is determined that continued hospice care is medically appropriate.

Home Care Visits - Visits by a registered or licensed practical nurse; a physical, occupational, or speech therapist; MSW (Masters of Social Work); or a home health aide. A visit must be for intermittent, medically necessary, or palliative care of not more than four (4) hours in duration.

Hospice Inpatient Care - Up to twelve (12) days in the six (6) month benefit period. Benefits shall be subject to the \$5,000 benefit maximum. Prior approval by Regence BSI is required.

Respite Care - Up to 120 hours of care per three (3) month period in the most appropriate setting.

Exclusions - Hospice benefits do not cover the following:

- 1) Services provided to other than the terminally ill Beneficiary, including bereavement counseling for Family members.

- 2) Pastoral and spiritual counseling.
- 3) Services performed by Family members or volunteer workers.
- 4) Homemaker or housekeeping services, except by home health aides, as ordered in the hospice treatment plan.
- 5) Supportive environmental materials, including but not limited to handrails, ramps, air conditioners, and telephones.
- 6) Normal necessities of living, including but not limited to food, clothing, and household supplies.
- 7) Food service, such as "Meals on Wheels."
- 8) Separate charges for reports, records, or transportation.
- 9) Legal and financial counseling services.
- 10) Services and supplies not included in the hospice treatment plan or not specifically set forth as a hospice benefit.
- 11) Services and supplies in excess of the stated limitations or services and supplies provided more than six (6) months after the initial date of covered hospice care, unless specifically approved by Regence BSI.

81. INPATIENT REHABILITATION

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for Inpatient rehabilitation services and supplies provided and billed by a licensed acute rehabilitation Hospital with accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facility (CARF), or a Medicare-approved rehabilitation facility. Benefits are provided to restore a Beneficiary who was Totally Disabled as the result of a covered Illness, Injury, condition, or disease, as outlined below, to a level of function which allows that Beneficiary to live as independently as possible.

All of the applicable requirements below must be met to qualify for this benefit:

- A. The rehabilitation facility's program must be closely supervised by a psychiatrist or Physician with experience in rehabilitation. The facility must provide twenty-four (24) hour rehabilitative nursing care and rehabilitative therapy with the availability of a registered nurse having specialized training or experience in rehabilitation.
- B. The facility must provide a plan of treatment to Regence BSI including current evaluations showing potential for improvement of the Beneficiary's function.
- C. Conditions for Inpatient rehabilitation services covered under this Plan must be acute in nature. The benefits of this section will not be payable if the Beneficiary has been previously treated for the same condition or received any multi-level rehabilitative treatment in a medical rehabilitation center for the same condition. Covered conditions are limited to the following:
 - 1) Extensive intracranial Injury
 - a) Cerebral laceration and contusions
 - b) Subarachnoid, subdural extradural hemorrhage following Injury
 - c) Intracranial bleeding following Injury
 - d) Other intracranial Injury
 - 2) Extensive spinal cord Injury
 - 3) Extensive crushing Injury involving multiple fractures
 - a) Lower extremity amputation due to trauma or new amputation due to Illness

- 4) Inflammatory diseases of the central nervous system resulting in marked neurological/neuromuscular deficiency limited to the following:
 - a) Meningitis
 - b) Encephalitis
 - c) Intracranial and intraspinal abscess
- 5) Disorders of the central nervous system limited to the following:
 - a) Hemiplegia
 - b) Paraplegia
- 6) Acute cerebrovascular accidents
- 7) Neoplasms resulting in marked neurological and/or neuromuscular deficit limited to the following:
 - a) Spinal cord compression due to neoplasm
 - b) Intracranial neoplasm

Diagnosis alone does not justify benefit application for Inpatient rehabilitation.

- D. The medical condition of the Beneficiary must meet the following criteria for benefit consideration. This information must be documented in writing:
- 1) The Beneficiary must be considered medically stable to tolerate rehabilitative therapy.
 - 2) Physical Therapy or cognitive therapy (upon approval following review) must be the main focus of rehabilitation.
 - 3) The Beneficiary must be able to tolerate at least three (3) hours of therapy per day.
 - 4) Severe physical, neuromuscular, neurological impairment necessitating the need for twenty-four (24) hour nursing care must be present.
 - 5) The Beneficiary must be responsive to verbal and visual stimuli.
 - 6) No other medical, surgical, or psychological impairing condition shall be present which may limit rehabilitation progress.
 - 7) The Beneficiary must show potential for rehabilitation.
- E. No benefits will be provided unless the Beneficiary obtains written preauthorization from Regence BSI prior to Inpatient admission for rehabilitation. Regence BSI reserves the right to review all requests for prior approval based on: (1) the Beneficiary's medical condition, (2) the Physician who will supervise the treatment, and (3) the facility in which the rehabilitation will be performed. Regence BSI must receive information sufficient for its determination of Plan and benefit application. Regence BSI reserves the right, at its sole option, to contract with specific facilities to perform rehabilitation services and to base benefit payments upon the terms and conditions of such third party contracts.

Total benefits paid for Inpatient rehabilitation services shall be limited to a maximum of \$15,000 per Beneficiary each calendar year.

Exclusions - Inpatient rehabilitation benefits do not cover the following:

- 1) Custodial Care;
- 2) Maintenance care;
- 3) Vocational rehabilitation;
- 4) Driver's education;
- 5) Communication devices;
- 6) Services to reduce or training to reduce debilitating chronic pain;

- 7) Pain management/clinics;
- 8) Rehabilitation for post Inpatient Hospital stays for orthopaedic or reconstructive surgeries;
- 9) Sensory stimulation for coma patients;
- 10) Cardiac and pulmonary rehabilitation;
- 11) Services for polyarthritis (including rheumatoid), neurological disorders, and/or deconditioning due to long illness;
- 12) Prosthetic devices;
- 13) Educational materials;
- 14) Services, supplies, medication, or care of any kind, other than those directly related to rehabilitation care;
- 15) Charges from a transitional care/subacute rehabilitation unit.

82. OUTPATIENT REHABILITATION

Benefits shall be provided at sixty percent (60%) of the Allowable Charge for medically necessary Outpatient rehabilitation services and supplies provided and billed by a licensed or certified physical, occupational, respiratory, or speech therapist to improve or restore lost bodily function.

Total benefits paid for Physical Therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.

Total benefits paid for Speech Therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.

Total benefits paid for occupational therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.

Total benefits paid for Respiratory Therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.

Total benefits paid for cardiac rehabilitation therapy shall be limited to a maximum of \$1,000 per Beneficiary each calendar year.

Exclusions - Outpatient rehabilitation benefits do not cover the following:

- 1) Inpatient care and services;
- 2) Diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, whether or not that service is provided by a licensed or registered Provider;
- 3) Treatment primarily for Mental or Neuropsychiatric Conditions or Chemical Dependency;
- 4) Services, supplies, medications, or care of any kind, other than those directly related to rehabilitation care;
- 5) Biofeedback, unless rendered as neuromuscular electrical stimulation.

83. WORLD-WIDE COVERAGE

Benefits of this Plan shall be available on a world-wide basis.

84. OUT-OF-POCKET EXPENSE

In the event the total Coinsurance share of Covered Services for one (1) Beneficiary exceeds \$2,000 in one (1) calendar year (plus Deductible) for In-Network and Out-of-Network services combined, the Coinsurance amount payable by Regence BSI on behalf of that Beneficiary shall be increased to one hundred percent (100%) of the Allowable Charge for the remainder of the calendar year in which the excess charges were incurred. Each Beneficiary must meet the out-of-pocket expense amount, however, no Family shall be obligated to meet more than \$4,000 in the aggregate in any calendar year (plus Deductible).

The following expenses do not apply toward the out-of-pocket expense and are the financial responsibility of the Beneficiary:

- 1) Deductible amounts.
- 2) Copayments.
- 3) Chiropractic Services.
- 4) Expenses in excess of specific benefit limitations.
- 5) Services of a Nonparticipating Physician/Provider in excess of the Allowable Charge.
- 6) Noncovered services.

85. MAXIMUM BENEFITS

Total benefits paid under this Plan, In-Network and Out-of-Network combined, shall not exceed \$1,000,000 during a Beneficiary's lifetime for all Illnesses and Injuries, with automatic reinstatement up to \$5,000 each calendar year.

NOTICE TO BENEFICIARIES

WOMEN'S HEALTH AND CANCER RIGHTS

A Beneficiary who is receiving medical and surgical benefits under this Plan in connection with a covered mastectomy and who elects breast reconstruction in connection with such mastectomy and in a manner determined in consultation with the attending physician shall be entitled to receive benefits for:

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

Coverage provided shall be consistent with the benefits of this Plan and may be subject to the applicable Deductible and/or Coinsurance provisions of this Plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Regence BSI may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

COBRA CONTINUATION

This COBRA CONTINUATION OF COVERAGE Section applies only when the Group is subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA. Under certain circumstances, called qualifying events, Beneficiaries may have the right to continue coverage beyond the time coverage would ordinarily have ended. The following rights and obligations regarding continuation of coverage are governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. In the event of any conflict between this continuation of coverage provision and COBRA, the minimum requirements of COBRA will govern. This provision will automatically cease to be effective when federal law requiring continuation of eligibility for coverage no longer applies to the Group. This section does not provide a full description of COBRA and more complete information is available from the Group.

WHO IS ELIGIBLE FOR COBRA CONTINUATION AND HOW LONG IT LASTS

If the Enrolled Employee's health coverage terminates due to either of the following qualifying events, the Enrolled Employee may elect COBRA continuation coverage for a maximum of 18 months following the date that the Enrolled Employee's coverage normally would have been lost:

- termination of employment for reasons other than gross misconduct;
- loss of coverage due to position elimination and eligibility for the Trade Adjustment Act; or
- reduction in hours of employment.

The Enrolled Employee's Dependents whose health coverage terminates due to either of these qualifying events may also elect this COBRA Continuation Coverage for a maximum of 18 months.

If health coverage for any of the Enrolled Employee's Dependents terminates due to any of the following qualifying events, that Dependent may elect COBRA Continuation Coverage for a maximum of 36 months following the date his or her coverage would have normally been lost:

- the Enrolled Employee's death;
- the Enrolled Employee and Enrolled Employee's spouse dissolve their marriage (divorce) or legally separate;
- the Enrolled Employee becomes entitled to Medicare benefits; or
- the Dependent is a child and loses eligibility as a dependent under this Plan.

By electing COBRA continuation coverage, unless the Enrolled Employee specifies to the contrary, The Enrolled Employee will automatically be maintaining benefits for the Enrolled Employee and Dependents. If COBRA continuation coverage is not desired for the Enrolled Employee or any of the Enrolled Employee's Dependents, each Beneficiary may independently elect such coverage on behalf of him or herself. Any election by the Enrolled Employee's spouse will automatically continue coverage of the Enrolled Employee's Dependent children, unless specified to the contrary.

COBRA coverage following a termination of employment/reduction in hours qualifying event can be extended to a maximum of up to 29 total months if the Enrolled Employee and the Enrolled Employee's Dependent is determined to have been disabled for purposes of Title II or Title XVI of the Social Security Act at the time of the initial qualifying event or within the first 60 days of COBRA continuation coverage. To be eligible for the extension, the Enrolled Employee and the Enrolled Employee's Dependent must provide the Group documentation of the Social Security disability determination within 60 days of the date it is made and while still within the 18-month continuation period. The disability extension extends to the Enrolled Employee and the Enrolled Employee's Dependents, even if only one of person is disabled.

An 18-month period of COBRA continuation coverage following a termination of employment/reduction in hours qualifying event (or a 29-month COBRA Continuation period involving such a termination/reduction followed by a disability extension) may be extended to a total period of up to 36 months for the Enrolled Employee's Dependent who would otherwise lose health coverage by virtue of any of the following "second" qualifying events occurring within the first 18-month (or, if there has been a disability extension, 29-month) period:

- the Enrolled Employee's death;
- the Enrolled Employee and the Enrolled Employee's spouse dissolve their marriage (divorce) or legally separate;
- the Enrolled Employee becomes entitled to Medicare benefits; or
- the Enrolled Employee's Dependent is a child and loses eligibility as a dependent under this Plan.

However (except with regard to employer Chapter 11 bankruptcy as described below), in no event will COBRA continuation coverage extend beyond 36 months from the date coverage was first lost due to the termination of employment/reduction in hours qualifying event. The Enrolled Employee and the Enrolled Employee's Dependent must provide the Group notice of the occurrence of one of these qualifying events.

IF THE ENROLLED EMPLOYEE IS RETIRED AND THE GROUP FILES CHAPTER 11 BANKRUPTCY

COBRA also allows continuation of coverage if the Enrolled Employee is retired, the Group files a Chapter 11 bankruptcy petition, and the Enrolled Employee and the Enrolled Employee's Dependent experiences a loss of plan coverage (or substantial reduction in coverage) within one year before or after the bankruptcy filing. Retired employees, and widows or widowers of retired employees who died before the bankruptcy, may continue coverage for the remainder of their lifetimes. If the Enrolled Employee is retired and die after the bankruptcy, and the Enrolled Employee's Dependents may continue coverage for up to 36 months after the Enrolled Employee death.

IF THE ENROLLED EMPLOYEE BECOMES ENTITLED TO MEDICARE BEFORE ELECTING COBRA

If the Enrolled Employee becomes entitled to Medicare before electing COBRA in connection with a termination of employment or reduction in hours qualifying event, the Enrolled Employee may maintain both Medicare and up to 18 months of COBRA coverage and the Enrolled Employee's Dependents will be allowed to continue their COBRA coverage until the later of:

- up to 18 months from the date coverage otherwise would be lost due to the termination of employment/reduction in hours, or
- up to 36 months from the date the Enrolled Employee became entitled to Medicare.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA continuation under this Plan will end for the Enrolled Employee and the Enrolled Employee's Dependents as of the last day of the monthly premium payment period in which any of the following occurs:

- failure to make premium payments necessary to bring premiums current within 45 days of electing COBRA;
- failure to make the monthly premium payment within 30 days of the premium due date;
- the date, after election of COBRA, that the Enrolled Employee and the Enrolled Employee's Dependents become covered under another group health plan (which does not limit or exclude any Preexisting Condition the person might have, either because of no applicable Preexisting Condition or sufficient creditable coverage to eliminate any Preexisting Condition limitation) or become entitled to Medicare benefits;
- the date the lifetime maximum benefit under this Plan is met for a Beneficiary;
- the date this Plan terminates; or
- the applicable period of COBRA continuation ends.

COBRA Continuation under this Plan will end for the Enrolled Employee and the Enrolled Employee's Dependents:

- when there is final determination that the Enrolled Employee and the Enrolled Employee's Dependent are no longer disabled for the purposes of Title II or Title XVI of the Social Security Act, as of the later of:
 - the last day of 18 months of continuation coverage; or
 - the first day of the month that is more than 30 days following the date of the final determination of the nondisability.

This event will terminate the continuation of all Beneficiaries who had qualified to extend by virtue of the Beneficiary's disability and it is the Enrolled Employee and the Enrolled Employee's Dependent's responsibility to notify the Group of such a final determination within 30 days of the day it is made.

WHEN THE ENROLLED EMPLOYEE ACQUIRES A NEW DEPENDENT CHILD WHILE THE ENROLLED EMPLOYEE IS ON COBRA

Children born to the Enrolled Employee or placed with the Enrolled Employee for adoption while the Enrolled Employee is on COBRA may be added to COBRA coverage and have all the rights extended to the Enrolled Employee and the Enrolled Employee's Dependents who have elected COBRA. Addition of such children must occur in accordance with the terms of the Enrollment Qualifications of this Booklet.

NOTIFICATION RESPONSIBILITIES

In order to preserve rights under COBRA, Beneficiaries and the Group must meet certain notification, election and payment deadline requirements.

Under COBRA, the Enrolled Employee and the Enrolled Employee's Dependents must inform the Group in writing within 60 days of the Enrolled Employee's divorce or legal separation, or a loss of dependent status. The Group is responsible for notifying the Enrolled Employee and the Enrolled Employee's Dependents of the right to elect COBRA continuation due to any of the other qualifying events (for example, employee's death, termination of employment or reduction in hours, or Medicare entitlement).

Once the Group is notified or aware of a qualifying event, it will send the Enrolled Employee and the Enrolled Employee's Dependents information concerning continuation options, including the necessary COBRA continuation election forms. The Enrolled Employee and the Enrolled Employee's Dependents will have 60 days from the later of the date of the qualifying event or the date of the Group notice to the Enrolled Employee and the Enrolled Employee's Dependent in which to make an election.

As mentioned above, to be eligible for disability extension, the Enrolled Employee and the Enrolled Employee's Dependent must provide the Group documentation of a Social Security disability determination within 60 days of the date it is made and while still within the 18-month COBRA Continuation period following a termination or reduction of hours qualifying event. The determination must reflect that the Enrolled Employee and the Enrolled Employee's Dependent was disabled for Social Security purposes at the time of the initial qualifying event or within the first 60 days of COBRA continuation. If a final determination is subsequently made that the Enrolled Employee and the Enrolled Employee's Dependent is no longer disabled for Social Security purposes, the Enrolled Employee and the Enrolled Employee's Dependent must provide the Group notice of that determination within 30 days of the date it is made.

To be eligible for an extension of the 18-month continuation following a termination of employment/reduction in hours qualifying event (or a 29 month COBRA Continuation period involving such a termination/reduction followed by a disability extension), the Enrolled Employee and the Enrolled Employee's Dependent must notify the Group within 30 days of the occurrence of any of the following "second" qualifying events causing a loss of coverage within that 18-month (or 29-month) period:

- the Enrolled Employee's death;
- the Enrolled Employee and the Enrolled Employee's spouse dissolve their marriage (divorce) or legally separate;

- the Enrolled Employee becomes entitled to Medicare benefits; or
- the Enrolled Employee's Dependent is a child and loses eligibility as a dependent under this Plan.

However (except with regard to employer Chapter 11 bankruptcy as described above), in no event will COBRA continuation coverage extend beyond 36 months from the date coverage was first lost due to the termination of employment/reduction in hours qualifying event. The Enrolled Employee and the Enrolled Employee's Dependent must provide the Group notice of the occurrence of one of these "second" qualifying events.

PAYING CONTINUATION PREMIUM

If Beneficiaries wish to continue coverage, they must pay for it. The premium will reflect the total cost of the group health care coverage and up to a 2% administration fee. For those Beneficiaries who receive COBRA Continuation Coverage due to a Social Security disability determination, the premium and administration fees will be up to 150% of the total cost for coverage for the period of the disability extension (provided the disabled individual is among those continuing coverage). Coverage will cease if timely premium payments are not made. Beneficiaries have a maximum of 45 days from the date that the election form is mailed to the Group to submit the first payment. This first payment must retroactively cover any period of time after the date coverage was terminated. All subsequent payments are due on the first day of the month for which coverage is to be provided or within a 30-day grace period thereafter.

IF BENEFICIARIES DO NOT ELECT COBRA CONTINUATION

If Beneficiaries do not elect COBRA continuation coverage, coverage under this Plan will end according to the terms of this Plan and Regence BSI will not pay claims for services provided on and after the date coverage ends. If Beneficiaries elect and exhaust COBRA continuation coverage, they may be eligible for an individual conversion-type plan.

IMPORTANCE OF KEEPING INFORMATION CURRENT

It is very important that the Enrolled Employee keep the Group informed of the current address of all Beneficiaries who are or may become qualified beneficiaries.

ERISA RIGHTS

If this Plan is part of an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA), the Group's and Regence BSI's responsibilities include the following:

Kootenai County intends that this Plan be maintained for the exclusive benefit of the employees.

Kootenai County intends to continue this Plan indefinitely, but it also reserves the right to discontinue or change this Plan at any time. If Kootenai County terminates this Plan for any reason and does not replace the coverage with comparable benefits, employees will receive ample notice. Employees will also receive instructions for converting their coverage to individual policies.

Employees are entitled to certain rights and protection under ERISA. ERISA provides that all employees shall be entitled to:

- Examine without charge, at the plan administrator's office, all policy documents, including insurance policies and copies of certain documents filed by the plan administrator with the U.S. Department of Labor, such as detailed annual reports and policy descriptions.
- Obtain copies of all documents governing the operation of the plan and other information upon written request to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary financial report.
- Continue generally at their own expense, health care coverage for themselves, their spouses and children if plan coverage ends due to certain qualifying events. Review the summary plan description and governing documents of the plan for rules and other details about such COBRA continuation rights.
- Reduce or eliminate periods that coverage for Preexisting Conditions is excluded under the plan, if they have creditable coverage from another plan. Group plans and health insurance issuers should provide a certificate of creditable coverage, free of charge, when an employee loses that other coverage, when he or she becomes entitled to elect COBRA continuation under it, when COBRA continuation is exhausted, and if an employee requests one within 24 months after losing that other coverage. Without evidence of creditable coverage, an employee may not have coverage for preexisting conditions for up to 12 months (18 months for late enrollees) after the Beneficiary's enrollment date in this coverage.

In addition to creating rights for employees, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of employees and their dependents. No one, including the employer, or any other person, may fire an employee or otherwise discriminate against one in any way to prevent an employee from obtaining a welfare benefit or exercising his or her rights under ERISA. If an employee's claim for a welfare benefit is denied (or ignored) in whole or in part, he or she must receive a written explanation of the reason for the denial. Employees have the rights to obtain copies of related documents without charge and to appeal any denial within certain time frames. Under ERISA, there are steps they can take to enforce the above rights. For instance, if an employee requests certain materials from the Plan in writing and does not receive them within 30 days, the employee may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay an employee up to \$110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the plan administrator.

If an employee has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or federal court. An employee may also do so if he or she disagrees with a Plan decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order. If it should happen that plan fiduciaries misuse money, or if employees are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal

fees. If an employee is successful, the court may order the person an employee has sued to pay these costs and fees. If an employee loses, the court may order the employee who sued to pay these costs and fees, for example, if it finds the claim frivolous. If an employee has any questions about the Plan, he or she should contact the plan administration. If an employee has any questions about this statement or his or her rights under ERISA, or if he or she needs assistance obtaining documents from the plan administrator, the employee should contact the nearest Field Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor (listed in the telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Employees can also obtain publications about their ERISA rights and responsibilities by calling the publications hotline of the Employee Benefits Security Administration.