Group Plan

BENEFIT SUMMARY

Bonneville County

Vision

Effective Date: November 1, 2018

Benefit Period: January 1 through December 31

An Independent Licensee of the Blue Cross and Blue Shield Association

ASC VISION MASTER GROUP PLAN BENEFITS OUTLINE

This Benefits Outline describes the benefits of this Plan in general terms. It is important to read the Plan in full for specific and detailed information that includes additional exclusions and limitations on benefits. Your manager of employee benefits should be able to help if you have questions.

If Participants receive these documents and/or any other Plan notices electronically, Participants have the right to receive paper copies of the electronic documents, including summary plan descriptions and plan amendments, upon request at no additional charge.

Throughout this Plan, Blue Cross of Idaho may be referred to as BCI. For Covered Services under the terms of this Plan, Maximum Allowance is the amount established by the Vision Care Services Vendor as the highest level of compensation for a Covered Service. There is more detailed information on how Maximum Allowance is determined and how it affects out-of-state coverage in the Definitions Section.

To locate a Participating Provider in your area, please visit our Web site at www.bcidaho.com. You may also call our Customer Service Department at 208-331-7347 or 800-627-1188 for assistance in locating a Provider.

NONDISCRIMINATION STATEMENT: DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

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

If you need these services, contact Blue Cross of Idaho's Customer Service Department. Call 1-800-627-1188 (TTY: 1-800-377-1363), or call the customer service phone number on the back of your card.

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

Manager, Grievances and Appeals
3000 East Pine Avenue, Meridian, Idaho 83642
Telephone: (800) 274-4018 ext.3838, Fax: (208) 331-7493
Email: grievances&appeals@bcidaho.com
TTY: 1-800-377-1363

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY).

Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html. Reference: https://federalregister.gov/a/2016-11458***

Language Assistance

ATTENTION: If you speak Arabic, Chinese, French, German, Korean, Japanese, Persian (Farsi), Romanian, Russian, Serbo-Croatian, Spanish, Sudanic Fulfulde, Tagalog, Ukrainian, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 1-800-377-1363).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-627-1188 (رقم هاتف الصم والبكم:1-800-377-1363).

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY：1-800-377-1363)。

French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 1-800-377-1363).

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 1-800-377-1363).

Japanese 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188 (TTY: 1-800-377-1363）まで、お電話にてご連絡ください。

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 1-800-377-1363)번으로 전화해 주십시오.

Persian-Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت اریگان برای شما فرا مهم می باشد. با (TTY: 1-800-377-1363) 1-800-627-1188 تماس بگیرید.

Romanian ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 1-800-377-1363).

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 1-800-377-1363).

Serbo-Croation OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-377-1363).

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 1-800-377-1363).

Sudanic Fulfulde MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-627-1188 (TTY: 1-800-377-1363).

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 1-800-377-1363).

Ukrainian УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-627-1188 (телетайп: 1-800-377-1363).

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 1-800-377-1363).

ELIGIBILITY AND ENROLLMENT
To qualify as an Eligible Employee under this Plan, a person must be and remain a full-time employee, sole proprietor, or partner of the Group who regularly works at least 30 hours per week and is paid on a regular, periodic basis through the Group's payroll system. *(see the Plan for additional Eligibility and Enrollment provisions)*

PROBATIONARY PERIOD
The Group will determine if there are certain probationary periods that must be satisfied before a new Eligible Employee can qualify for coverage under this Plan. Please contact your manager of employee benefits for the probationary period applicable to you.

VISION CARE BENEFITS (VSP) VI2/11/09	
For Covered Providers and Services	Plan II
Copayment	Participant pays $10 per eye exam and/or $25 per Frame and Lenses or Medically Necessary Contact Lenses.
Service Frequency Limitations	Participant may receive one (1) eye exam and/or one (1) pair of Lenses or one (1) pair of Medically Necessary Contact Lenses (in lieu of eyeglasses) and/or one (1) Frame every twelve (12) months.
Payment for Services Rendered:	
Participating VSP Doctor*	**Exam**—Plan pays 100% after Copayment **Prescription Glasses**[1]—Basic Lenses and Medically Necessary Contact Lenses are covered in full. Frame allowance of $130**,** and 20% off any Out-of-Pocket expenses. **Elective Contacts**[1]—includes an allowance of $130 for contact lens exam and materials in place of benefits for Prescribed Lenses and Frames.

Nonparticipating VSP Doctor	
***Professional Fees**	
Eye Exam	$45
***Materials—lenses per pair**	
Single Vision	$45
Bifocals, up to	$65
Trifocals, up to	$85
Frame, up to	$47
***Contact Lenses— per pair**	
***Medically Necessary, up to**	$210
***Elective**	
Includes basic eye exam and an allowance of $130 in place of benefits for Prescribed Lenses and Frames	$130

[1] If a Participant chooses lenses and/or frames or contacts valued at more than the allowance, a 20% discount for materials and a 15% discount on the contact lens exam will be applied to the Participant's Out-of-Pocket costs from a Participating Provider.

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

VISION

GROUP PLAN

AND

BENEFIT SUMMARY

Bonneville County

Group #10021478

Effective Date: November 1, 2018

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HOW TO SUBMIT CLAIMS

A Participant must submit a claim to BCI's designated Vision Care Services Vendor (VCSV), Vision Service Plan (VSP) in order to receive benefits for Covered Services. There are two (2) ways for a Participant to submit a claim:

1. The vision service Provider can file the claim for the Participant. Most Providers will submit a claim on a Participant's behalf if the Participant shows them a BCI identification card and tells them they have coverage through VSP.

2. The Participant can send the claim to VSP.

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

1. The Participant can visit VSP's Web site at www.vsp.com and sign on under the "Members & Consumers" section. Click on the "Out of Network Reimbursement" link under "My Forms." Once completed, mail the form to VSP at the address listed below.

2. Make a copy of the itemized billing statement, provide the following information, and mail to the address listed below.
   a. Participant & Patient Name (first and last)
   b. Patient Date of Birth
   c. Date of Service
   d. Address & Phone Number

   VSP
   P. O. Box 385018
   Birmingham, AL 35238-5018

For assistance with claims the Participant can call VSP Customer Service at 1-800-877-7195 Monday through Friday 6 a.m. – 8 p.m. MT.

How the Participant is Notified
If the Participant receives services from an In-Network Provider (Participating), the Provider will provide a statement explaining the cost of the services.

BLUE CROSS OF IDAHO CONTACT INFORMATION

For general information, please contact your local Blue Cross of Idaho office:

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

Mailing Address
P.O. Box 7408
Boise, ID 83707
(208) 387-6683 (Boise Area)
1-800-365-2345

Lewiston
(208) 746-0531

Mailing Address
P.O. Box 7408
Boise, ID 83707

Coeur d'Alene
1450 Northwest Blvd., Suite 106
Coeur d'Alene, ID 83814
(208) 666-1495

Pocatello
275 S. 5th Ave., Suite 150
Pocatello, ID 83201
(208) 232-6206

Idaho Falls
1910 Channing Way
Idaho Falls, ID 83404
(208) 522-8813

Twin Falls
1503 Blue Lakes Blvd N
Twin Falls, ID 83301
(208) 733-7258

IDAHO DEPARTMENT OF INSURANCE CONTACT INFORMATION

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise ID 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

VISION CARE BENEFITS SECTION

(VSP)

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

I. Copayment And Limitations On Frequency Of Services

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

II. Covered Providers

The following are Covered Providers under this section:

- Optometrist (OD)
- Ophthalmologist (MD)

III. Procedures For Obtaining Covered Services

A. A Participant will need to select a VSP Participating Provider by visiting the VSP Web site at www.vsp.com, or by calling VSP Customer Service at 1-800-877-7195. No preauthorization, referral, or special benefit form is required. The doctor is responsible for verifying eligibility and obtaining the necessary authorization from VSP prior to the delivery of service. Each authorization is valid for fifteen (15) days. A Participant must provide the VCSV Participating Provider sufficient information to verify eligibility. Failure of the Participant to provide sufficient information may delay services and may affect benefit payment under this Plan.

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

IV. Covered Services

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

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

A. Eye Examination

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

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

1. **Intermediate Examination**—brief or limited routine check-up or vision survey.
2. **Vision Analysis**—various tests for prescription Lenses.
3. **Tonometry**—measurement of eye tension for glaucoma.
4. **Biomicroscopy**—examination of the living eye tissue.
5. **Central And/Or Peripheral Field Study**—measurement of visual acuity in the central and/or peripheral field of vision.
6. **Dilation—**allows for a better view inside the eye, i.e., optic nerve blood vessels, etc.

B. Prescribed Lenses And Frames

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

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

VSP reserves the right to limit the cost of Frames provided by VSP Participating Doctors. The allowance is published periodically by VSP to its Participating Doctors and is set at a level to cover

the majority of Frames in common use. If a Participant wishes to select a more expensive Frame than allowed in this section, the difference in cost is not the responsibility of VSP, Blue Cross of Idaho (BCI) or the Plan Administrator.

C. Contact Lenses

1. **Medically Necessary Contact Lenses**—Contact Lenses are furnished when the VSP Participating Doctor receives prior approval from VSP for any of the following:
   a) Following cataract Surgery.
   b) To correct extreme visual acuity problems that cannot be corrected with eyeglass Lenses.
   c) Certain conditions of Anisometropia.
   d) Keratoconus.

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

   Contact Lenses once furnished as described above can be replaced only upon prior authorization by VSP.

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

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

V. Additional Amount Of Payment Provisions

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

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

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

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

2. The nonparticipating Doctor is not obligated to accept VSP's payment as payment in full. Neither VSP, Blue Cross of Idaho (BCI) or the Plan Administrator are responsible for the difference, if any, between VSP's payment and the actual charge, any such difference is the Participant's responsibility.

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

C. The amounts shown in the Benefits Outline under Payment for services rendered by a nonparticipating VSP Doctor are maximums. The actual amount paid in reimbursement to the Participant is either the amount indicated in the Benefits Outline, the amount actually charged, or the amount usually charged by the Provider of such services to his or her private patients, whichever is less.

VI. Exclusions And Limitations

In addition to any other exclusions and limitations of this Plan, the following exclusions and limitations apply to this particular section and throughout the entire Plan, unless otherwise specified:

A. Enrollee's Options

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

1. Blended Lenses.
2. Contact Lenses, except as provided in this section.
3. Oversize Lenses.
4. Photochromic Lenses.
5. Tinted Lenses except Pink #1 and Pink #2.
6. Progressive multi-focal Lenses.
7. Coating of the lens or Lenses.
8. Laminating of the lens or Lenses.
9. A Frame that costs more than the VSP allowance.
10. Cosmetic Lenses.
11. Optional cosmetic processes.
12. UV (ultraviolet) protected Lenses.
13. Polycarbonate Lenses (except for Eligible Dependent Children).

B. Not Covered

No benefits are available for professional services or materials connected with:

1. Orthoptics or other vision training and any associated supplemental testing; Plano Lenses; or two (2) pair of eyeglasses in place of bifocals.
2. Replacement of Lenses, Frames, or Contact Lenses furnished hereunder that are lost or broken (Lenses, Frames, or Contact Lenses are only replaced at the normal intervals when Covered Services are otherwise available).
3. Medical or surgical treatment of the eye(s).
4. Any eye examination or any corrective eyewear required by an employer as a condition of employment.
5. Low vision aids.

ELIGIBILITY AND ENROLLMENT SECTION

I. Eligibility and Enrollment

All Eligible Employees will have the opportunity to apply for coverage under this Plan.

A. Eligible Employee

Qualifications for eligibility are shown in the Benefits Outline.

B. Eligible Dependent

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

1. The Enrollee's spouse under a legally valid marriage.

2. The Enrollee's natural child, stepchild, legally adopted child, child placed with the Enrollee for adoption or child for whom the Enrollee, the Enrollee's spouse has court-appointed guardianship or custody. The child must be:
   a) Under the age of twenty-six (26); or
   b) Medically certified as disabled due to intellectual disability or physical handicap *and* financially dependent upon the Enrollee for support, regardless of age.

3. An Enrollee must notify Bonneville County within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate the last day of the month in which the change in eligibility status took place.

II. Leave of Absence

During an employer-approved, temporary leave of absence, and subject to the payment by the Group of the amount paid in benefits plus the administrative fee provided in the Administrative Services Agreement and payment of the monthly Excess Loss Premium, if any, submitted with the regular Group billing, coverage under this Plan shall continue for no more than three calendar months.

On its regular billing, the Group shall notify Blue Cross of Idaho of the Enrollee's date of departure for the leave of absence, and shall continue its regular contribution for the Enrollee's coverage during the leave of absence.

III. Group Contribution

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

IV. Miscellaneous Eligibility and Enrollment Provisions

A. All eligible Persons will have the opportunity to apply for coverage. All applications submitted to BCI now or in the future, are for Eligible Persons or Eligible Dependents only.

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

B. Before the Effective Date of the change, the Group must submit all eligibility changes for Enrollees and Eligible Dependents on BCI's usual forms. It is the Group's responsibility to verify that all Participants are eligible for coverage as specified in this Plan. BCI will have the right to audit the Group's employment, payroll, and eligibility records to verify that all Participants are eligible and properly enrolled and to ensure that the Group meets enrollment requirements.

C. This Plan is issued to the Group upon the express condition that a pre-established required percentage of the Eligible Employees specified in the Application for Group Coverage who meet the underwriting criteria of BCI are and continue to be Enrollees. This Plan is issued under the express

condition that the Group continues to make the employer contribution specified in the Application for Group Coverage and this Plan. BCI may terminate this Plan if the percentage of Eligible Employees as Enrollees or the percentage of the employer contribution drops below the required level.

D. 1. For an Eligible Employee to enroll himself or herself and any Eligible Dependents for coverage (or for an Enrollee to enroll Eligible Dependents for coverage) the Eligible Employee or Enrollee must complete a BCI application and submit it and any required contributions to BCI in a manner approved by both BCI and the Trust.

2. Except as provided otherwise in this section, the Effective Date of coverage for an Eligible Employee or an Eligible Dependent is the first day of the month following the month of enrollment.

3. The Effective Date of coverage for an Eligible Employee and Eligible Dependents listed on the Eligible Employee's application is the Group's Plan Date, if the application is submitted to BCI by the Group on or before the Plan Date.

E. 1. Except as stated otherwise in subparagraphs E.2. and 3. below, the initial enrollment period is thirty (30) days for Eligible Employees and Eligible Dependents. The initial enrollment period begins on the date the Eligible Employees or Eligible Dependent first becomes eligible for coverage.

2. An Enrollee's newborn Dependent, including adopted newborn children who are placed with the adoptive Enrollee within sixty (60) days of the adopted child's date of birth, are covered under this Plan from and after the date of birth for 60 days.

In order to continue coverage beyond the sixty (60) days outlined above, the Enrollee must complete an enrollment application within sixty (60) days of date of birth and submit the required contribution, for the first sixty (60) days, within thirty-one (31) days of the date monthly billing is received and a notice of contribution is provided to the Enrollee from the Group.

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

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

3. The initial enrollment period is thirty (30) days for an Eligible Dependent who becomes eligible because of marriage. The initial enrollment period begins on the date of such marriage. The Effective Date of coverage is the first day of the month following the month of enrollment.

F. Late Enrollee

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

G. Special Enrollment Periods

An Eligible Employee or Eligible Dependent will not be considered a Late Enrollee if:

1. Individuals Losing Other Coverage — An Eligible Enrollee or Eligible Dependent losing other coverage may enroll for coverage under this Plan if each of the following conditions is met:
    a) The Eligible Enrollee or Eligible Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the Eligible Person or Eligible Dependent.
    b) The Eligible Enrollee's or Eligible Dependent's coverage described in subparagraph a):
        (1) was under a COBRA continuation provision and the coverage under such provision was exhausted; or
        (2) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.
    c) Under the terms of this Plan, the Eligible Enrollee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph b)(1) or termination of coverage or employer contribution described in subparagraph b)(2).

2. For Dependent Beneficiaries —
    a) If a person becomes an Eligible Dependent of an Enrollee (or of an Eligible Employee who failed to enroll during a previous enrollment period) through marriage, birth, adoption before age 18 or placement for adoption before age 18, the Eligible Dependent (or, if not otherwise enrolled, the Eligible Person) may enroll, and in the case of the birth or adoption of a child, the spouse of the Enrollee or Eligible Employee may enroll as an Eligible Dependent if such spouse is otherwise eligible for coverage.
    b) The dependent special enrollment period under this subparagraph 2 shall be a period of sixty (60) days and shall begin on the date of the marriage, birth, adoption or placement for adoption (as the case may be).
    c) If an Enrollee enrolls an Eligible Dependent during the dependent special enrollment period described in this subparagraph 2, the Effective Date of coverage shall be:
        (1) in the case of marriage, the first day of the month beginning after the date a completed application and any required contribution is received by Blue Cross of Idaho;
        (2) in the case of an Eligible Dependent's birth, as of the date of such birth; or
        (3) in the case of an Eligible Dependent's adoption or placement for adoption, the date of birth for an Eligible Dependent adopted or placed for adoption within 60 days of the Eligible Dependent's date of birth; and the date of such adoption or placement for adoption for an Eligible Dependent adopted or placed for adoption more than 60 days after the Eligible Dependent's date of birth.

3. The Eligible Employee and/or Eligible Dependent become eligible for a premium assistance subsidy under Medicaid or the Children's Health Insurance Program (CHIP) and coverage under this Plan is requested no later than 60 days after the date the Eligible Employee and/or Eligible Dependent is determined to be eligible for such assistance.

4. Coverage under Medicaid or CHIP for an Eligible Employee and/or Eligible Dependent is terminated as a result of loss of eligibility for such coverage, and coverage is requested under this Plan no later than 60 days after the date of termination of such coverage.

V. Qualified Medical Child Support Order

A. If this Plan provides for Family Coverage, BCI, on behalf of the Plan Administrator, will comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of Section 609 of ERISA and any other applicable federal or state laws. A medical child support order is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:

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

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

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

C.

1. Within fifteen (15) days of receipt of a medical child support order, BCI will notify the party who sent the order and each affected child of the receipt and of the criteria by which BCI determines if the medical child support order is a QMCSO. In addition, BCI will send an application to each affected child. The application must be completed by or on behalf of the affected child and promptly returned to BCI. With respect to a medical child support order, affected children may designate a representative for receipt of copies of notices sent to each of them.
2. Within thirty (30) days after receipt of a medical child support order and a completed application, BCI will determine if the medical child support order is a QMCSO and will notify the Enrollee, the party who sent the order, and each affected child of such determination.

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

DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout this Plan. Other terms may be defined where they appear in this Plan. All Providers listed in this Plan and in the following section must be licensed and/or registered by the state where the services are rendered, unless exempt by Federal law, and must be performing within the scope of license in order for the VCSV to provide benefits. Definitions in this Plan shall control over any other definition or interpretation unless the context clearly indicates otherwise.

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

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

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

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

Anisometropia—a condition of unequal refractive state for the two (2) eyes, one (1) eye requiring a different lens correction than the other.

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

Benefits After Termination—the benefits, if any, remaining under this Plan after a person ceases to be a Participant.

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

Blue Cross of Idaho Health Service, Inc. (Blue Cross of Idaho or BCI)—a nonprofit mutual insurance company, hired by Bonneville County, to act as the third party Contract Administrator to perform claims processing and other specific administrative services as outlined in the Plan and/or Administrative Services Agreement.

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

Coinsurance—the percentage of the Maximum Allowance or the actual charge, whichever is less, a Participant is responsible to pay Out-of-Pocket for Covered Services after satisfaction of any applicable Copayments.

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

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

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

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

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

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

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

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

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

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

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

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

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

Frame—a standard eyeglass Frame adequate to hold Lenses.

Group—Bonneville County, also referred to as the Trust.

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

In-Network Services—Covered Services provided by a Participating Provider.

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

- <u>The technology must have final approval from the appropriate government regulatory body.</u> This applies to drugs, biological products, devices, and other products/procedures that must have approval from the U.S. Food and Drug Administration (FDA) or another federal authority before they can be marketed. Interim approval is not sufficient. The condition for which the technology is approved must be the same as that BCI is evaluating.
- <u>The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.</u> The evidence should consist of current published medical literature and investigations published in peer-reviewed journals. The quality of the studies and consistency of results will be considered. The evidence should demonstrate that the technology can measure or alter physiological changes related to a Disease, injury, Illness, or condition. In addition, there should be evidence that such measurement or alteration affects health outcomes.

- <u>The technology must improve the net health outcome.</u> The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- <u>The technology must be as beneficial as any established alternatives.</u>
- <u>The technology must show improvement that is attainable outside the investigational setting.</u> Improvements must be demonstrated when used under the usual conditions of medical practice.

If a technology is determined to be investigational, all services specifically associated with the technology, including but not limited to associated procedures, treatments, supplies, devices, equipment, facilities or drugs will also be considered investigational.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Photochromic Lenses—lenses that change color with intensity of sunlight.

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

Plan(s)—a self-insured program(s) maintained by the Plan Sponsor for the purpose of providing health care benefits to the Plan Participants.

Plan Administrator—the Plan Administrator, Bonneville County, who is the sole fiduciary of the Plan, has all discretionary authority to interpret the provisions and control the operation and administration of the Plan within the limits of the law. All decisions made by the Plan Administrator, including final determination of Medical Necessity, shall be final and binding on all parties. Bonneville County also reserves the right to modify eligibility clauses for new Plan participants who join the Plan as a result of a merger, acquisition or for any employee who was covered under a labor agreement plan during a previous period of employment to which Bonneville County, contributes, provided that coverage under this Plan begins within 31 days of the date coverage under the previous Plan terminates. Bonneville County may choose to hire a consultant and/or Contract Administrator to perform specified duties in relation to the Plan. The Plan Administrator also has the right to amend, modify or terminate the Plan at any time or in any manner as outlined in the Administrative Services Agreement.

The administration of the Plan document is under the supervision of the Plan Administrator, Bonneville County**.** The Employee Benefits Department of Bonneville County acts on behalf of the Plan Administrator. Bonneville County has agreed to indemnify each employee in the Employee Benefits Department for any liability he/she incurs as a result of acting on behalf of the Plan Administrator, except if such liability is due to his/her gross negligence or misconduct.

Plan Date—the date specified in this Plan when coverage commences for the Group.

Plan Sponsor—Bonneville County.

Plano Lenses—lenses that have no refractive power.

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

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

Provider—a person or entity that is licensed, where required, to render Covered Services. For the purposes of this Plan, Providers include only Ophthalmologist/Physicians and Optometrists

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

1. Generally accepted operative and cutting procedures.
2. Invasive procedures using specialized instruments.

3. Customary preoperative and postoperative care.

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

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

VSP Participating Doctor—an Optometrist or Physician who is a member panelist of Vision Service Plan (VSP).

EXCLUSIONS AND LIMITATIONS SECTION

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

I. General Exclusions and Limitations

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

A. Not Medically Necessary.

B. In excess of the Maximum Allowance.

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

D. Investigational in nature.

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

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

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

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

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

J. Rendered prior to the Participant's Effective Date

K. For telephone consultations, and all computer or Internet communications; for failure to keep a scheduled visit or appointment; for completion of a claim form; for interpretation services; or for personal mileage, transportation, food or lodging expenses or for mileage, transportation, food or lodging expenses billed by a Physician or other Professional Provider.

L. For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.

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

In the event Blue Cross of Idaho (BCI) for any reason makes payment for or otherwise provides benefits excluded by the above provisions, it shall succeed to the rights of payment or reimbursement

of the compensated Provider, the Participant, and the Participant's heirs and personal representative against all insurers, underwriters, self-insurers or other such obligors contractually liable or obliged to the Participant, or his or her estate for such services, supplies, drugs or other charges so provided by BCI in connection with such Illness, Disease, Accidental Injury or other condition.

N. Any services or supplies for which a Participant would have no legal obligation to pay in the absence of coverage under this Plan or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage.

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

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

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

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

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

T. Plano Lenses.

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

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

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

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

Y. Low vision aids.

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

II. Preexisting Condition Waiting Period

There are no waiting periods for treatment of preexisting conditions under this Plan.

GENERAL PROVISIONS SECTION

I. Termination Or Modification Of A Participant's Coverage Under This Plan

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

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

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

D. Except as otherwise provided in this Plan, no benefits are available to a Participant for Covered Services rendered after the date of termination of a Participant's coverage.

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

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

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

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

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

II. Benefits After Termination Of Coverage

A. Continuation of Coverage Under Federal Law

As mandated by federal law, the Plan offers optional continuation of coverage to the enrollee and their covered dependents if coverage ends due to one of the following qualifying events:

1. Termination of the enrollee's employment for any reason, except gross misconduct as defined in the Bonneville County personnel policies. Coverage may continue for the enrollee and/or their Eligible Dependents.

2. A reduction in hours worked by the enrollee that results in loss of Plan eligibility. Coverage may continue for the enrollee and/or their Eligible Dependents.

3. The enrollee's death. Coverage may continue for their Eligible Dependents.

4. Divorce or legal separation from the enrollee's spouse. Coverage may continue for that spouse and the Eligible Dependents.

5. The enrollee becomes entitled to Medicare. Coverage may continue for Eligible Dependents that are not entitled to Medicare.

6. Loss of eligibility of covered dependent children due to Plan eligibility requirements. Coverage may continue for that dependent.

To choose this continuation of coverage, an individual must be an Enrollee or an enrolled Eligible Dependent under the Plan on the day before the qualifying event.

B. Notification Requirement

The Enrollee or the Eligible Dependent has the responsibility to inform the Plan Sponsor of a divorce, legal separation or a child losing dependent status under the Bonneville County Employee Benefit Plan within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of continuation coverage rights.

The Group has the responsibility of notifying BCI of your death, termination of employment, reduction in hours, or entitlement to Medicare within 30 days of the qualifying event.

Blue Cross of Idaho, on behalf of the Plan Administrator, will notify you or the qualifying individual of continuation coverage rights within 14 days of notification from Bonneville County. The qualifying individual then has 60 days to elect continuation coverage. Failure to elect continuation coverage within 60 days after being notified by Blue Cross of Idaho, on behalf of the Plan Administrator, will result in loss of continuation of coverage rights.

C. Cost of Continuation Coverage

The cost of continuation coverage is determined by the Plan Administrator and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable contribution cannot exceed 102% of the Plan Administrator's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150% of the Plan Administrator's cost of coverage.

The qualified individual must make the first payment within 45 days of notifying the Contract Administrator (Blue Cross of Idaho) of selection of continuation coverage. Future payments can be made in monthly installments within 30 days of the due date. Rates and payment schedules are established by Bonneville County and may change when necessary due to Plan modifications.

The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

D. Maximum Period of Continuation Coverage

The maximum period of continuation coverage for individuals who qualify due to termination of employment or reduction in hours worked is 18 months from the date of the qualifying event.

If a qualifying individual is disabled (as determined by the Social Security Administration) at the enrollee's time of termination or reduction in hours or is declared disabled within the first sixty (60) days of continuation coverage, continuation coverage for the qualifying individual may be extended to twenty-nine (29) months provided the qualifying individual notifies the Contract Administrator (Blue Cross of Idaho) within the eighteen (18) month continuation coverage period and within sixty (60) days after they receive notification of disability from the Social Security Administration (SSA).

The maximum period of continuation coverage for individuals who qualify due to any other described qualifying event, except bankruptcy, is 36 months from the date of the qualifying event.

E. Multiple Qualifying Events

Should the Eligible Dependent(s) experience more than one qualifying event, they may be eligible for an additional period of continued coverage not to exceed a total of thirty-six (36) months from the date of the first qualifying event. For example, if the Enrollee terminates employment, the Enrollee and any enrolled Eligible Dependents may be eligible for eighteen (18) months of continued coverage. If during this eighteen (18) month period a second qualifying event (divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent) takes place, then the original eighteen (18) months of continuation coverage can be extended to thirty-six (36) months from the date of the original qualifying event date for the enrolled Eligible Dependent qualified beneficiaries. If a second event occurs, it is the qualified beneficiary's responsibility to notify BCI.

F. When Continuation Coverage Ends

Continuation Coverage ends on the earliest of:

1. The date the maximum continuation period expires.
2. The date the qualifying individual becomes entitled to coverage under Medicare.
3. The last period for which payment was made when coverage is cancelled due to nonpayment of the required cost.
4. The date the Trust no longer offers a group health plan to any of its employees.
5. The date the qualifying individual becomes covered under another group health plan that does not exclude or limit coverage for a pre-existing condition the qualifying individual may have.

III. Contract Between BCI and the Group—Description of Coverage

This Plan is a contract between BCI and the Group. BCI will provide the Group with copies of the Plan to give to each Enrollee as a description of coverage or provide electronic access to the Plan, but this Plan shall not be construed as a contract between BCI and any Enrollee. BCI's mailing or any other delivery of this Plan to the Group constitutes complete and conclusive issuance and delivery thereof to each Enrollee.

IV. Applicable Law

This Plan shall be governed by and interpreted according to the laws of the state of Idaho.

V. Benefits to Which Participants are Entitled

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

B. Benefits will be provided only if Covered Services are prescribed by, or performed by, or under the direction of a Physician or other Professional Provider and are regularly and customarily included in such Covered Providers' charges.

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

D. Bonneville County intends the Plan to be permanent, but because future conditions affecting Bonneville County cannot be anticipated or foreseen, Bonneville County reserves the right to amend,

modify, or terminate the Plan at any time, which may result in the termination or modification of the Participants' Coverage. Expenses incurred prior to the Plan modification or termination will be paid as provided under the terms of the Plan prior to its modification or termination. Any material change made to this Plan will be provided in writing within sixty (60) days of the Effective Date of change.

VI. Notice of Claim

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

VII. Release and Disclosure of Medical Records and Other Information

A. In order to effectively apply the provisions of this Plan, BCI may obtain information from Providers and other entities pertaining to any health related services that the Participant may receive or may have received in the past. BCI may also disclose to Providers and other entities, information obtained from the Participant's transactions such as Plan coverage, contributions, payment history and claims data necessary to allow the processing of a claim and for other health care operations. To protect the Participant's privacy, BCI treats all information in a confidential manner. For further information regarding BCI's privacy policies and procedures, the Participant may request a copy of BCI's Notice of Privacy Practices by contacting Customer Service at the number provided in this Plan.

B. As a condition of coverage under this Plan, each Participant authorizes Providers to testify at BCI's request as to any information regarding the Participant's medical history, services rendered, and treatment received. Any and all provisions of law or professional ethics forbidding such disclosures or testimony are waived by and in behalf of each Participant.

VIII. Exclusion of General Damages

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

IX. Payment of Benefits

Blue Cross of Idaho provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

B. Blue Cross of Idaho prohibits direct or indirect payment by third parties unless it meets the standards set below.

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

Each of the following criteria must be met for BCI to accept a third party payment:

1. the assistance is provided on the basis of the Participant's financial need;

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

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

Contributions submitted in violation of this provision will not be accepted and the Enrollee's Plan may be terminated for non-payment. Cost-sharing contributions made from non-permitted third parties will not be applied to the Participants applicable Deductible and/or Out-of-Pocket Limit. BCI will inform the Participant in writing of the reason for rejecting or otherwise refusing to treat a third party payment as a payment from the Participant and of the Participant's right to file a complaint with the Department of Insurance.

C. Once Covered Services are rendered by a Provider, BCI, on behalf of the Plan Administrator, shall not be obliged to honor Participant requests not to pay claims submitted by such Provider, and BCI, on behalf of the Plan Administrator, shall have no liability to any person because of its rejection of such request; however, in its sole discretion, for good cause, BCI, on behalf of the Plan Administrator, may nonetheless deny all or any part of any Provider claim.

X. Participant/Provider Relationship

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

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

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

XI. Participating Plan

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

XII. Coordination Of This Plan's Benefits With Other Benefits

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

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

A. Definitions

1. A Contract is any of the following that provides benefits or services for medical or dental care or treatment. If separate Contracts are used to provide coordinated coverage for members of a group, the separate Contracts are considered parts of the same Contract and there is no COB among those separate contracts.
   a) Contract includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group

type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

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

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

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

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

4. Allowable Expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Contract covering the Participant. When a Contract provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Contract covering the Participant is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

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

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

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

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

d) If a Participant is covered by one (1) Contract that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Contract

that provides its benefits or services on the basis of negotiated fees, the Primary Contract's payment arrangement shall be the Allowable Expense for all Contracts. However, if the provider has contracted with the Secondary Contract to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Contract's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Contract to determine its benefits.

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

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

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

B. Order Of Benefit Determination Rules

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

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

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

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

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

4. Each Contract determines its order of benefits using the first of the following rules that apply:

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

b) Dependent Child Covered Under More Than One Contract. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Contract the order of benefits is determined as follows:

(1) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Contract of the parent whose birthday falls earlier in the calendar year is the Primary Contract; or If both parents have the same birthday, the Contract that has covered the parent the longest is the Primary Contract.

(2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Contract of that parent has actual knowledge of those terms, that Contract is primary. This rule applies to Contract year commencing after the Contract is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) shall determine the order of benefits;

iii. If a court decree states both parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;

iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The Contract covering the Custodial Parent;
2. The Contract covering the spouse of the Custodial Parent;
3. The Contract covering the non-Custodial Parent; and then
4. The Contract covering the spouse of the non-Custodial Parent.

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

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

d) COBRA or State Continuation Coverage. If a Participant whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Contract, the Contract covering the Participant as an employee, member, subscriber or retiree or covering the Participant as a dependent of an employee, member, subscriber or retiree is the Primary Contract and the COBRA or state or other federal continuation coverage is the Secondary Contract. If the other Contract does not have this rule, and as a

result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

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

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

C. Effect On The Benefits Of This Contract

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

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

D. Facility Of Payment

A payment made under another Contract may include an amount that should have been paid under This Contract. If it does, BCI may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Contract. BCI will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

E. Right Of Recovery

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

XIII. Benefits For Medicare Eligibles Who are Covered Under This Plan

A. If the Group has twenty (20) or more employees, any Eligible Employee or spouse of an Eligible Employee who becomes or remains a Participant of the Group covered by this Plan after becoming eligible for Medicare (due to reaching age sixty-five (65)) is entitled to receive the benefits of this Plan as primary.

B. If the Group has one hundred (100) or more employees or the Group is an organization which includes an employer with one hundred (100) or more employees, any Eligible Employee, spouse of an Eligible Employee or dependent child of an Eligible Employee who becomes or remains a Participant of the Group covered by this Plan after becoming eligible for Medicare due to disability is entitled to receive the benefits of this Plan as primary.

C. A Participant eligible for Medicare based solely on end stage renal disease is entitled to receive the benefits of this Plan as primary for eighteen (18) months only, beginning with the month of Medicare entitlement, if Medicare entitlement is effective before March 1, 1996. If Medicare entitlement is effective on or after March 1, 1996, the Participant is entitled to receive benefits of this Plan as primary for thirty (30) months only, beginning with the month of Medicare entitlement.

D. The Group's retirees, if covered under this Plan, and Eligible Employees or spouses of Eligible Employees (if a Participant) who are not subject to paragraphs A., B. or C. of this provision and who are Medicare eligible, will receive the benefits of this Plan reduced by any benefits available under Medicare. This applies even if the Participant fails to enroll in Medicare or does not claim the benefits available under Medicare.

XIV. Incorporated by Reference

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

XV. Inquiry and Appeals Procedures

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

A. Informal Inquiry

For any initial questions concerning a claim, a Participant should call the VCSV phone number listed on the back of the Participant's Blue Cross of Idaho ID card.

B. Formal Appeal

A Participant who wishes to formally appeal a Pre-Service Claim decision by BCI may do so through the following process:

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

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

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

4. If the original, non-urgent claim decision is upheld upon reconsideration, the Participant may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within thirty (30) days of BCI's or its VCSV designee's mailing of the initial reconsideration decision. A BCI Medical Director or its VCSV designee who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt.

C. A Participant who wishes to formally appeal a Post-Service Claims decision by BCI may do so through the following process:

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

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

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

4. If the original decision is upheld upon reconsideration, the Participant may send an additional written appeal to the Appeals and Grievance Coordinator requesting *further review*. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within sixty (60) days of BCI's (or a VCSV designee's) mailing of the initial reconsideration decision. A BCI Medical Director who is not the subordinate to the Medical Director, physician designee, or a VCSV designee who decided the initial appeal, will issue a final decision after consideration of all relevant information, if the appeal requires medical judgment. A final decision on the appeal will be made within thirty (30) days of its receipt. If the appeal does not require medical judgment, a BCI Vice President who did not decide the initial appeal will issue the decision.

D. External Review

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

Submission of an appeal for External Review is voluntary and does not affect a Participant's right to file a civil action under section 502(a) of the Employee Retirement Income Security Act (ERISA) following the exhaustion of the formal appeals process, except that the time to file such action shall be tolled while the External Review is pending.

XVI. Reimbursement of Benefits Paid by Mistake

If BCI mistakenly makes payment for benefits on behalf of an Enrollee or his or her Eligible Dependent(s) that the Enrollee or his or her Eligible Dependent(s) is not entitled to under this Plan, the Enrollee must reimburse the erroneous payment to BCI, on behalf of the Plan Administrator. .

The reimbursement is due and payable as soon as BCI notifies the Enrollee and requests reimbursement. BCI, on behalf of the Plan Administrator, may also recover such erroneous payment from any other person or Provider to whom the payments were made. If reimbursement is not made in a timely manner, BCI, on behalf

of the Plan Administrator, may reduce benefits or reduce an allowance for benefits as a set-off toward reimbursement.

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

XVII. Subrogation and Reimbursement Rights of Blue Cross of Idaho

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

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

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

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

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

The Participant shall pay Blue Cross of Idaho, on behalf of the Plan Administrator as the first priority, and Blue Cross of Idaho shall have a constructive trust and an equitable lien on, all amounts from any recovery by suit, settlement or otherwise from any third party or parties or from any third party's or parties' insurer(s), indemnitor(s) or underwriter(s), to the extent of benefits provided by Blue Cross of Idaho, on behalf of the Plan Administrator under this Plan, regardless of how the recovery is allocated *(i. e.,* pain and suffering) and whether the recovery makes the Participant whole. Thus, Blue Cross of Idaho will be reimbursed by the Participant, or his or her legal representative, from monies recovered as a result of the injury, harm or loss, for all benefits paid even if the Participant is not made whole or fully compensated by the recovery. Moreover,

Blue Cross of Idaho and the Plan Administrator are not responsible for any attorney's fees, other expenses or costs incurred by the Participant without the prior written consent of Blue Cross of Idaho and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by Blue Cross of Idaho, on behalf of the Plan Administrator.

To the extent that Blue Cross of Idaho, on behalf of the Plan Administrator provides or pays benefits for Covered Services, Blue Cross of Idaho's rights of subrogation and reimbursement extend to any right the Participant has to recover from the Participant's insurer, or under the Participant's "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions, and workers' compensation benefits.
Blue Cross of Idaho, on behalf of the Plan Administrator shall have the right, at its option, to seek reimbursement from, or enforce its right of subrogation against, the Participant, the Participant's personal representative, a special needs trust, or any trust, person or vehicle that holds any payment or recovery from or on behalf of the Participant including the Participant's attorney.

Blue Cross of Idaho's subrogation and reimbursement rights shall take priority over the Participant's rights both for benefits provided and payments made by Blue Cross of Idaho, and for benefits to be provided or payments to be made by Blue Cross of Idaho in the future on account of the injury, harm or loss giving rise to Blue Cross of Idaho's subrogation and reimbursement rights. Further, the-Plan's subrogation and reimbursement rights for such benefits and payments provided or to be provided are primary and take precedence over the rights of the Participant, even if there are deficiencies in any recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Participant and Blue Cross of Idaho.

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

XVIII. Statements

In the absence of fraud, all statements made by an applicant or the Planholder or by an enrolled person shall be deemed representations and not warranties, and no statement made for the purpose of acquiring insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the Planholder or the enrolled person.

XIX. Coverage and Benefits Determinations

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

RIGHTS OF PLAN PARTICIPANTS

As a participant in the Bonneville County Employee Benefit Plan, you are entitled to certain rights under federal law.

According to the law, you have the right to examine, without charge at the Plan Administrator's office or other specific locations, all documents and contracts of the Plan that are filed with the U.S. Department of Labor, such as detailed annual reports and Plan Contracts. You may obtain copies of all documents upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. You are also entitled to receive a summary of the Plan's annual financial report.

If your claim for benefits under this Plan is denied in whole or in part, you will receive a written explanation of the reason for the denial. If you do not agree with the denial, you have the right to ask the Plan Administrator to review the claim. If you are not satisfied with the result of such a review, you may file suit in a state or federal court.

Federal law imposes duties on the individuals responsible for the operation of the Plan to do so carefully and in the interest of all participants. No one, including your Trust, a union, or any other person, may fire you or discriminate against you to prevent you from obtaining any benefit under the Plan or exercising your rights under federal law.

Under federal law, there are steps you can take to enforce your rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. The court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the delay is beyond the control of the Plan Administrator. If the people who operate the Plan misuse the Plan's money, or if you are discriminated against for enforcing your rights you may seek assistance from the U.S. Department of Labor or file suit in a federal court. If you do file suit, the court will decide who should pay court costs and legal fees. If your case is upheld by the court, the court may order the person or organization you have sued to pay related expenses. If you lose or the court finds your case frivolous, you may be ordered to pay the court costs and legal fees.

If you have a question about this statement or about your rights under ERISA, HIPAA, or other applicable law, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, Seattle District Office, 1111 Third Avenue, Suite 815, MIDCOM Tower, Seattle, Washington 98101-3212, Phone: 206-553-7700 or as listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor 200 Constitution Avenue, NW, Washington, D.C. 20210.

GENERAL INFORMATION

Name and Address of the Plan Sponsor and Plan Administrator

Bonneville County
605 N. Capitol
Idaho Falls, ID 83402
(208) 529-1350

Name and Address of the Third Party Contract Administrator

Blue Cross of Idaho
3000 E. Pine Avenue
Meridian, ID 83642-5995
PO Box 7408
Boise, Id 83707
(208) 345-4550

Name and Address of the Reinsurance Carrier (if no reinsurance through BCI, delete)

Blue Cross of Idaho
3000 E. Pine Avenue
Meridian, ID 83642-5995
PO Box 7408
Boise, Id 83707
(208) 345-4550

Name and Address of the Designated Agent for Service of Legal Process

Bonneville County
Employee Benefit Plan Administrator
605 N. Capitol
Idaho Falls, ID 83402
(208) 529-1350

Internal Revenue Service and Plan Identification Number

The corporate tax identification number assigned by the Internal Revenue Service is (#82-6000286).

Plan Year

The Plan Year is the 12-month fiscal period for Bonneville County Employee Benefit Plan beginning November 1, which is used for the purpose of IRS tax filing.

Method of Funding Benefits

Health and vision benefits are self-funded from Trust and employee contributions.

Payments out of the Plan to health care providers on behalf of the covered person will be based on the provisions of the Plan.