



Health & Welfare Benefits

Summary of Plan

Sponsored by University of Idaho

For benefits effective January 1, 2023, to December 31, 2023

This book contains detailed information on all of your benefits, including:

- Medical and Prescription Drug (Self-Funded)
- Employee Assistance Plan
- Dental (Self-Funded)
- Vision (Self-Funded)
- Death Benefit
- Disability
- Flexible Spending Accounts and Health Spending Accounts

This is not insurance and not covered under the guaranty fund MEDHW-21

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Your Health & Welfare Benefits

At the University, we believe one size doesn't fit all. That's why we've created a benefits program that allows you to create a package that works for you. Your benefits represent a significant part of the total compensation you receive from the University. In addition to the actual dollars spent providing these benefits, this Summary Plan Description is part of our continuing efforts to provide you with the information you need regarding these benefits so that you can realize their full value.

About this Summary of Plan

This Summary of Plan describes benefits available to eligible employees as of January 1, 2023. Please review this booklet carefully to familiarize yourself with your eligible benefits coverage and your rights. If you provide coverage for any dependents, you should share this booklet with them.

The chapters in this booklet are a summary of each of the benefit plans. Because they are only summaries, they may not contain every plan detail. Each plan is governed by the terms of a legal document called a plan document. Plan documents are available from Benefit Services. If the provisions of the summary of plan document differs from the plan documents, the terms of the plan documents will govern.

Introduction

This section provides an overview of your University of Idaho benefits and contains basic eligibility and coverage information.

Eligibility

Eligible Employees

You are eligible to enroll for benefits if you are:

- Classified as a regular full-time, part-time, or temporary Board of Regents-appointed employee, and
- Assigned to work a minimum of 20 hours per week, and
- Working on an appointment lasting a minimum of five consecutive months.

You become eligible for benefits on the first day of the month following your date of hire (or on your date of hire if it is the first of the month). See *When Coverage Begins* for additional information.

Non-Board Appointed Employees

If you work, at least 30 hours a week in a non-Board of Regents appointed position or you teach at least 11 credit hours per semester as a temporary faculty member or lecturer, you may participate in the University's unsubsidized benefits plan. Participants in this plan are eligible for **medical and prescriptions benefits (including EAP) only** and are responsible for paying the full cost of the benefit. Enrollment in this plan is optional and all eligible participants will be automatically waived out of the benefit unless they actively elect to participate.

You are eligible to enroll for benefits if you are:

- Working, or reasonably expected to work, an average of 30 or more hours per week, or
- Teaching 11 credit hours or more per semester in a temporary faculty or instructor capacity

Non-Board Appointed Coverage Levels

- Employee Only
- Employee + Child
- Employee + Children

Affordable Care Act Eligibility

The Affordable Care Act has special rules for medical plan eligibility. If you are not reasonably expected to be in one of the above groups at the time you are hired, your hours of service will be measured during a 12-month initial measurement period (ACA initial measurement period) that begins on your date of hire. If you are credited with an average of 30 hours of service per week during your ACA initial measurement period (as determined by the University), you will be eligible for coverage the first of the month following the end of your initial ACA measurement period and an administrative period. You will continue to be eligible for a 12-consecutive month "stability period".

Hours of employees who are not new hires are measured during a measurement period (ACA standard measurement period) that begins of October 15th each year and ends on the next October 14th. An employee who is credited with an average of 30 hours of service per week during an ACA standard measurement period (as determined by the University) will be eligible for coverage beginning the next January 1st and will remain eligible for the entire plan year ("stability period").

For more information on this plan, please contact Benefit Services directly at benefits@uidaho.edu.

Eligible Dependents

To qualify as an eligible dependent, a person must be one of the following:

- Your spouse under a legally recognized marriage. You must be able to present proof of the legally recognized marriage to add a spouse.
- Other Eligible Adult. For the purposes of the Plan, a “qualified other eligible adult” is defined as someone who is:
 - Age 18 or older and mentally competent to consent, and
 - Not legally married to anyone, and
 - Residing in the employee’s household for the previous six continuous months, and
 - Financially interdependent with the employee (for example, have joint checking account or joint utility bills), which can be demonstrated upon request by providing proof of existence of at least two of the following:
 - A joint mortgage or lease or other evidence of common residence such as joint utility bills
 - Durable property or health care power of attorney
 - Joint checking account/credit account
 - Designation of each other as the primary beneficiary in a will, death benefit policy, or retirement plan
 - Other Eligible Adult may not be an employee’s parent, parents’ other descendants (siblings, nieces, nephews), grandparents and their descendants (aunts, uncles, cousins), renters, boarders, tenants, employees, children, or their descendants (children, grandchildren)
 - To add an Other Eligible Adult to your medical plan, a Qualification Affidavit must be completed, notarized, and uploaded to the myBenefits portal in VandalWeb.
- A child under the age of 26. For purposes of the plan, a “child” means your:
 - Biological child,
 - Legally adopted child or a child placed with you for adoption,
 - Stepchild,
 - Child for whom you are the legal guardian, and/or
 - Child who is required to be covered by a Qualified Medical Child Support Order (QMCSO). See *Qualified Medical Child Support Order* for more information.

A child as described in the first sentence of subparagraph three (3) who has attained age twenty-six (26) provided:

- a) The child is medically certified as incapable of self-sustaining employment due to an intellectual disability or physical handicap that began prior to age twenty-six (26);
- b) The child is chiefly dependent upon the Enrollee or the Enrollee’s spouse for support and maintenance; and
- c) The Enrollee submits proof of such child’s incapacity and dependency as described in this subparagraph three (3) within thirty-one (31) days of such child's attainment of age twenty-six (26) and as subsequently required by BCI and/or the Employer at reasonable intervals.

Coverage will terminate for you the last day of the month for which the child turns age 26, unless he or she is incapable of self-support because of a physical or mental disability that began prior to age 26. A child is dependent for purposes of section 4980H for the entire calendar month during which he or she attains age 26. You must apply for this continuation within 31 days after the child reaches the maximum age. Documentation will be provided by Blue Cross of Idaho which will need to be submitted to Benefit Services.

To enroll eligible dependents applying for coverage under a QMCSO, contact Benefit Services and speak with a Benefits Specialist.

Are your eligible dependents University employees?

A participant cannot be covered as both an employee and as a dependent. If your spouse or other eligible adult is employed in a benefit-eligible University position, one employee can waive coverage and be covered as a dependent on the other. Alternatively, each employee can enroll in employee only coverage. However, keep in mind, if you both enroll in employee only coverage, you each must meet your own deductible and cost-share maximum. If you and your spouse or other eligible adult have dependent children, all of your dependent children may be covered as dependents under only one employee's plan.

Coverage Levels

For medical, dental and vision coverage, you can enroll in any of the following coverage tiers:

- Employee Only,
- Employee + Spouse or Other Eligible Adult,
- Employee + Child,
- Employee + Children, and
- Employee + Family (Spouse or Other Eligible Adult and Child(ren)).

Qualified Medical Child Support Order (QMCSO)

You may be required to provide medical plan coverage for your child(ren) pursuant to a Qualified Medical Child Support Order (QMCSO). If you receive a court order to provide coverage, please contact the University's Benefits Specialist. In some cases, the orders will be directed to the University from a court or child welfare agency. The Benefits Specialist will determine whether the order is a QMCSO.

To be considered qualified, the order must:

- Specify the name and last known mailing address of the covered employee and the employee's child(ren) who are subject to the order,
- Indicate the type of coverage to be provided (or the manner in which such coverage will be determined),
- Identify the period covered by the order, and
- Specify each plan to which the order applies.

If the medical child support order is qualified, you must enroll yourself, if you are not already enrolled, and the specified child(ren) for medical coverage. To learn more, contact Benefit Services and speak with a Benefits Specialist.

How You Pay for Coverage

You create a benefits package that works best for you from the choices available. If you want more coverage, you will generally pay more. If your needs are not as great, you will most likely pay less. Benefit contributions are never pro-rated. Employees must be actively enrolled in the University's medical plan in order to enroll in the dental and/or vision plans.

You and the University share in the cost of benefits. As shown below, you pay for some benefits with pre-tax dollars and others with after-tax dollars.

Pre-tax Dollars	After-tax
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<ul style="list-style-type: none"> • Medical • Health Savings Account (HSA) • Dental* • Vision** • Health Care Spending Account • Dependent Care Spending Account 	<ul style="list-style-type: none"> • Short-Term Disability • Long-Term Disability • Optional Death Benefit • Optional AD&D • Spouse Death Benefit • Dependent Death Benefit • Other Eligible Adult • Dependent of Other Eligible Adult
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* For full-time employees, the Delta Dental Standard plan coverage is provided at no cost to the employee.

** For all-time employees and dependents, vision coverage is provided at no cost to the employee.

Employee contributions for each benefit are listed in the enrollment materials on the benefits website.

If You Have Other Benefits Coverage: Waiving Coverage

If you have medical and prescription drug coverage elsewhere — for example, through the plan of your spouse's employer — you may elect to waive coverage.

Your election to waive medical and prescription drug coverage is not automatic. You must submit evidence of your other coverage each year. In addition, non-Board appointed employees and employees who become eligible for medical and prescription drug coverage through an ACA initial or standard measurement period may waive coverage without proof of other coverage. If you are a part-time Board Appointed employee and wish to enroll in coverage, you must make an active election every year to avoid defaulting into waived coverage status. Proof of other coverage is not required for part-time employees waiving coverage.

To submit evidence of your other coverage, please upload a copy of your ID card or a letter from your spouse's employer or insurance carrier to the myBenefits portal (in VandalWeb) within 30 days of hire or by January 31 if waiving coverage during annual enrollment. Providing proof of other coverage is required each year.

Paying for Benefits with Pre-Tax Dollars

When you pay for benefits with pre-tax dollars, the cost of your contributions is taken from your pay before federal and state income taxes are deducted. This lowers your pay, which means you may owe less in taxes.

There are some important facts you should be aware of regarding this tax break:

- In exchange for the tax break, the IRS generally requires that your annual benefit elections be "locked in" for the entire calendar year. There are exceptions to this rule if you have a qualified life event during the year, as described in the *Making Changes to Your Benefits During the Year* section.
- Benefits that are based on the amount of your base pay, such as your Death Benefit and disability benefits, are generally not affected by your pre-tax deductions. These benefits are based on your total, unreduced base pay.
- By federal law, you do not pay Social Security (FICA) taxes on any pre-tax money you contribute toward your benefits. You should be aware that this could mean reduced Social Security benefits. This reduction is generally very small, however, and may be outweighed by your current tax savings.

Other Eligible Adult

Current tax law requires you pay federal income and Social Security taxes on the full value of the coverage for other eligible adults and their children, unless they qualify as your tax dependent for purposes of tax-free health coverage. The value of the coverage will be included in your gross income and reported as imputed income on your W-2 form.

When Coverage Begins

You become eligible for benefits as described previously in the *Eligibility* section. To participate in many of these benefits, you must actively enroll within 30 days of your date of hire.

If you enroll within 30 days of hire, your coverage will begin on the date you first become eligible for benefits (the first of the month following your date of hire or your date of hire if you were hired on the first of the month).

If you become eligible under an Affordable Care Act (ACA) initial measurement period as described in the *Affordable Care Act Eligibility* section, and you enroll within the timeframe specified by the University, your medical and prescription drug coverage will become effective on the first day of the month following the end of your initial ACA measurement period and an administrative period.

Coverage for your eligible dependents begins on the same day as your coverage, provided you have enrolled them for coverage.

How to Enroll for Coverage

If you are a new employee, you must make your benefit elections within 30 days of hire. Plan information is available at www.uidaho.edu/benefits. If you become eligible under an ACA initial measurement period, you must make your benefit election within the time period specified by the University.

If you do not enroll for benefits within 30 days of hire, you will be automatically enrolled in default coverage as described below in *If You Don't Enroll: Default Coverage*. You will not be able to change your elections until the next annual enrollment period unless you qualify for a mid-year election change as described in *Making Changes to Your Benefits During the Year*.

If you have other insurance available to you and choose to waive your health benefits through the University, you must go through the enrollment process to make that election within 30 days of hire. You must also provide proof of the other insurance coverage. If you do not waive your health benefits, you will be automatically enrolled in default coverage as described below in *If You Don't Enroll: Default coverage*. You will not be able to change your elections until the next annual enrollment period unless you qualify for a mid-year election change as described in *Making Changes to Your Benefits During the Year*.

Annual Enrollment: Your Once-a-Year Opportunity to Make Benefit Changes

Each fall we hold an annual enrollment period. This is your opportunity to enroll in or change coverage elections for you and your eligible dependents. We will provide you with information to make your coverage elections each year.

The choices you make during the annual enrollment period take effect on the next January 1 through December 31. You may not change coverage until the next annual enrollment period unless you qualify for a mid-year election change as described in *Making Changes to Your Benefits During the Year*.

If You Don't Enroll: Default Coverage

If you are a benefit eligible full-time employee and you do not enroll within 30 days of hire, you will automatically be enrolled in the default coverage. If you don't provide required documentation triggered by your event, you will be defaulted into coverage for that benefit as noted below. Default coverage is employee-only coverage and consists of the following:

- High Deductible Health Plan (HDHP),
- Standard Dental Plan,
- VSP Vision Care,
- Death Benefit coverage equal to one times your pay,
- Short-term Disability equal to 50% of your pay, up to \$500 per week, and
- Long-term Disability equal to 50% of your pay, up to \$2,000 per month.

If you are a benefit eligible three-quarter time or half-time employee and you do not enroll within 30 days of hire, your coverage will automatically be waived and consist of the following:

- Medical Plan – Waived, No Coverage,
- Dental Plan – Waived, No Coverage,
- VSP Vision Plan – Waived, No Coverage,
- Death Benefit coverage equal to one times your pay,
- Short-term Disability equal to 50% of your pay, up to \$500 per week, and
- Long-term Disability equal to 50% of your pay, up to \$2,000 per month

You will not be able to change your elections until the next annual enrollment period unless you qualify for a mid-year election change as described in *Making Changes to Your Benefits During the Year*.

Note: Non-Board appointed employees and employees who become eligible for medical and prescription drug coverage through an ACA initial or standard measurement period will not be automatically enrolled in the default medical coverage option. If you do not enroll for coverage in a timely manner, you will not have medical and prescription drug coverage for the plan year. You will not be able to change your elections until the next annual enrollment period unless you qualify for a mid-year election change as described in *Making Changes to Your Benefits During the Year*.

Making Changes to Your Benefits During the Year

The benefit elections you make either when you initially enroll or during the annual enrollment period will remain in effect throughout the plan year. You may be permitted to change your elections if you have a qualified life event or qualify for special enrollment rights. See *How to Make Qualified Life Event Changes or Exercise Your Special Enrollment Rights* for information on making your benefit changes.

Qualified Life Event Changes

A qualified life event includes:

- Your marriage, divorce (including annulment) or legal separation.
- A child's birth, adoption, or placement for adoption.
- Receipt of a Qualified Medical Child Support Order (QMCSO) requiring you to provide coverage for a child.
- Death of your spouse or child.
- Your child reaching the maximum age for coverage (age 26).
- You, your spouse, other eligible adult, or child becomes entitled to or loses eligibility for Medicare or, Medicaid or exhaust COBRA coverage.
- Any change in the employment status of you, your spouse, other eligible adult, or child that results in a change in eligibility, such as:
 - Start or end of employment,

- A change from full-time to part-time employment (or vice versa), or
- Start or end of an unpaid leave of absence.
- You, your spouse, other eligible adult, or child becomes eligible for, or loses, other healthcare coverage. (For information about your rights in the event of a loss of coverage, see *Special Enrollment Rights*.)
- Your spouse, other eligible adult or child changes his or her benefit elections during another company's annual enrollment held at a different time than the University's annual enrollment period.
- A change in residence or worksite, either by you, your spouse, other eligible adult, or child that affects the benefit plans that are available to you.
- A significant change in coverage or the cost of coverage under a benefit program provided through your spouse's employer.
- A change in your dependent care situation. For example, you change day care providers, the amount your provider charges changes (and the provider is not your relative) or the amount of care that you require changes. In this case, you may only change your contribution to the Dependent Care Flexible Spending Account.

If you have a qualified life event and want to make a change to your elections, you must make the allowed change(s) within 30 days of the event. If you've had a baby, adopted a child, or had a child placed for adoption with you, you must make your election changes within 60 days of the birth, adoption, or placement for adoption. Any benefit change you make must be directly related to and consistent with the qualified life event. For example, if your child no longer qualifies as an eligible dependent, you may drop coverage for that child. However, you may not drop coverage for your spouse.

Please be aware that the Internal Revenue Service (IRS) has issued specific rules and restrictions for making changes as a result of a qualified life event. When making changes, it is your responsibility to review these rules carefully and to ensure the changes you make comply with these rules.

Failure to follow the IRS's rules can result in adverse tax consequences to you and the Plan. The University reserves the right to request appropriate documentation before allowing an election change.

Affordable Care Act Election Changes

You may drop your medical and prescription drug coverage during the plan year to:

- Enroll in Marketplace coverage.
- Enroll in other medical coverage, such as a spouse's employer's plan, if you are in a stability period but have had a change in employment status so you are working less than 30 hours a week.

Special Enrollment Rights

To ensure individuals have access to healthcare coverage, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). Under the special enrollment provisions of HIPAA, you may be eligible to enroll in benefits during the plan year, even if you previously declined coverage. This right extends to you and all eligible dependents.

There are three circumstances under which you will qualify for HIPAA special enrollment rights; these rights only apply to medical and prescription drug benefits.

1. **You acquire a new dependent.** If you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your new dependent (and your spouse, in the case of birth or adoption of a child) in any medical plan. If you are already enrolled in the plan when you acquire a new dependent, you

may enroll your dependent in your current option or you may change your election and enroll yourself and your dependent in a different option.

- If you acquire a dependent through marriage, you have 30 days to submit your election change. The new election will be effective on the date of the marriage as long as you have notified our administrator within 30 days after the date you acquire the dependent upon providing required documentation.
- If you acquire a new dependent through birth, adoption, or placement for adoption, you have 60 days to submit your election change. Coverage for newborns and adopted newborns placed within 60 days of birth is effective from and after the moment of birth. Coverage for adopted children placed after 60 days of birth (up to age 26) is effective from and after the moment of placement upon providing required documentation.
 - “Placed” or “Placement” means physical placement in the care of the adopting covered family. If physical placement is prevented due to the medical needs of the child, “placed” means the date the adopting covered family signs an agreement for adoption of the child and assumes financial responsibility for the child.
 - If you don’t enroll a new dependent within the above time frames, you generally will not be permitted to enroll the dependent until the next annual enrollment period. The due date for payment of any additional contribution, if required, is thirty-one (31) days from receipt by the member of a contribution billing statement.

2. You or a dependent loses eligibility for other coverage. If you opted out or waived enrollment for yourself or for an eligible dependent because other medical coverage (including COBRA coverage) was in effect, and you previously provided appropriate proof of other coverage, you may enroll yourself and your dependents in the plan if you or your dependents lose eligibility for that other coverage or if employer contributions for that coverage are terminated. For this purpose, “loss of eligibility” includes, but is not limited to:

- A loss of coverage that results from termination of employment, reduction in hours of employment, legal separation or divorce, death, or cessation of dependent status (e.g., reaching the maximum age to be eligible as a dependent under a plan),
- The exhaustion of COBRA coverage,
- Loss of individual coverage in the Marketplace,
- In the case of (Health Maintenance Organization) HMO coverage, a loss of coverage that results when an individual no longer resides, lives, or works in an HMO service area and there is no other benefit package available to the individual,
- A situation in which a plan no longer offers any benefits to the class of individuals of which that individual is a part.
- Loss of eligibility for other coverage does not include a loss due to the failure to pay contributions on a timely basis or termination of coverage for cause, such as fraud.

If you were not enrolled in the plan, you may enroll yourself and your eligible dependents in any medical plan option. If you already are enrolled and one of your dependents loses other coverage (or employer contributions for the other coverage terminate), you may enroll your dependent in your current option or you may change your election and enroll yourself and your dependent in a different option upon providing required documentation.

To exercise your special enrollment rights, you must enroll yourself and/or your dependents no more than 30 days after the date the other coverage ends (or employer contributions terminate). The new election will be effective on the date of eligibility under the qualified life event.

3. You or a dependent loses eligibility for Medicaid or CHIP or becomes eligible for contribution assistance.

- If you or an eligible dependent are enrolled for coverage under Medicaid or a state children's health insurance program (CHIP), and that coverage is terminated as a result of loss of eligibility, you may enroll yourself and your eligible dependent for medical coverage under the plan, provided you do so no more than 60 days after the Medicaid or CHIP coverage terminates.
- If you or an eligible dependent becomes eligible to have Medicaid or CHIP assist in the payment of your coverage under the plan, you may enroll yourself and your eligible dependent for medical coverage under the plan, provided you do so no more than 60 days after you or your dependent is determined to be eligible for such assistance.
- If you were not enrolled in the plan, you may enroll yourself and your eligible dependents in any benefit option. If you are already enrolled in the plan and your dependent loses eligibility for coverage under or becomes eligible for contribution assistance from Medicaid or CHIP, you may enroll your dependent in your current option or you may change your election and enroll yourself and your dependent in a different option.

The due date for payment of any additional contribution, if required, is thirty-one (31) days from receipt by the member of a contribution billing statement.

How to Make Qualified Life Event Changes or Exercise Your Special Enrollment Rights

If you have a qualified life event or qualify for a special enrollment, report your change through the myBenefits portal in VandalWeb or contact the University of Idaho Benefits Center (see the *Plan Administration and Contact Information* chart).

Failure to Enroll During for Qualified Life Event or Special Enrollment (Very Important Information):

If you fail to request enrollment for yourself and/or any of your Eligible Dependents within 30 days, or, as applicable, 60 days after the date on which you and/or they first become eligible for Qualified Life Events or Special Enrollment, you will not be able to enroll yourself or them until the next Open Enrollment period.

When Coverage Ends

Your coverage ends on the earlier of the following dates:

- The date you no longer meet the eligibility requirements defined in the *Eligibility* section, for example, you terminate employment or
- The last day of the period for which you paid your contributions toward coverage, for example, you fail to pay your contributions while on an unpaid leave.
- Your dependents' coverage will end on the earliest of the following dates:
 - The date your coverage ends and/or the date you no longer meet the eligibility requirements, as defined in the *Eligibility* section.
 - The last day of the period for which you paid your contributions toward dependent coverage, or
 - The date your dependent no longer qualifies as your dependent as defined in the *Eligible Dependents* section, provided however, that the coverage of an otherwise eligible child will not end until the last day of the month in which he or she reaches age 26.

You are responsible for notifying the University when a spouse, other eligible adult, or child is no

longer eligible for coverage. This includes (but is not limited to) notifying the University of a divorce, death or a child reaching age 26.

You may be eligible to continue certain coverages after your coverage as an employee ends. See the *COBRA Continuation of Coverage* section for more details.

ID Cards

You and your covered dependents will receive identification cards for medical and prescription drug, and dental benefits when your coverage begins. You may request additional cards; all cards will list the employee's name only.

Remember to carry your ID cards with you at all times. If a provider wants to verify your or your dependent's coverage, have him or her call the number listed on the ID card. In addition, you and/or your provider should use your Prescription ID card to contact CVS Caremark to determine if you need preauthorization.

Your Medical and Prescription Drug Coverage

At the University of Idaho, we are committed to providing flexible, high-quality benefits. The medical and prescription drug plan that we offer helps you and your family with the costs of maintaining good health and treating illness and injury.

You can choose from one of two medical plan options that provide the best fit for you and your family. Your options include:

- **Standard Preferred Provider Organization (PPO) Plan**
- **High Deductible Health Plan (HDHP)**

Both medical plan options cover the same services. The amount you pay for services, however, differs by option.

Blue Cross of Idaho administers all medical plan options and provides access to its PPO network of providers. CVS Caremark administers prescription drug benefits and provides mail-order services.

Preferred Provider Organizations (PPOs)

Both plans are Preferred Provider Organizations (PPOs). A preferred provider organization (PPO) is a national network of doctors and hospitals that agree to provide their services at a negotiated fee.

As a PPO participant, you can choose to go to any doctor or healthcare provider, and you will receive benefits. However, if you receive your healthcare services from a provider who belongs to the PPO network, your cost is based on a negotiated rate and is generally less than what you would pay if you used a provider who does not belong to the network.

When you use in-network providers:

- Your provider will file all claims for you and your covered dependents.
- You typically pay less for services because the provider accepts a negotiated rate; and
- You cannot be billed for any covered charges above the negotiated rate the provider has agreed to charge.

How to Locate Providers

To locate an in-network provider in your area, please visit the Blue Cross of Idaho website at www.members.bcidaho.com. Click on “Find a doctor” and you will be taken to the searchable directory. You may also contact the Customer Service Department listed on your ID card to locate providers in or out of your area.

If you obtain and rely upon incorrect information about whether a provider is an In-network provider from the Plan or its administrators, the Plan will apply In-network cost-sharing to your claim, even if the provider was an Out-of-network provider at the time the service was rendered.

How the Standard PPO Plan Works

Through this PPO plan, you may choose care from any provider you wish. When you seek care at an in-network physician’s office, you pay a copayment for each office visit. These copayments are not subject to the deductible, nor do they work to satisfy the deductible, however they do work to satisfy the cost-share maximum. Other covered services, such as laboratory, radiology, and inpatient hospital admissions, are subject to the deductible and cost-sharing.

You will receive greater benefits when you seek care from an in-network provider. When you visit an out-of-network provider, you will first need to meet the out-of-network deductible. You will also pay a higher out-of-network cost-sharing rate and have a separate out-of-network, cost-share maximum.

How the High Deductible Health Plan (HDHP) Works

This plan is a high deductible health plan (HDHP) with a Health Savings Account (HSA). (You must be enrolled in the university HDHP account to participate in the University HSA.

In the HDHP, you pay 100% of your covered healthcare expenses until you satisfy the annual deductible (eligible, in-network preventive care services are covered at 100% before the deductible is satisfied). Once you reach your deductible, you pay cost-sharing for covered services until you reach the cost-share maximum. After you reach the cost-share maximum, the plan pays 100% of your covered expenses for the remainder of the plan year.

The HDHP is considered an “Open Access PPO” plan. This means that except for preventive/wellness services (which must be received in-network to be covered), you may see any provider you choose, either in-network or out-of-network, without a reduction of benefit. However, you receive discounted rates, and you pay less out of your pocket, when you visit an in-network provider. If you visit an out-of-network provider, you will be charged the provider’s full rate without any discounts, and you may be responsible for any charges that exceed the maximum allowance. The maximum allowance is explained further in the *Important Terms* section of this summary plan description.

How an HSA Works

An HSA combines some of the best features of a flexible spending account with those of a 401(k) or Individual Retirement Account (IRA) savings plan. An HSA is an individual account you own that allows you and the University to contribute pre-tax dollars to pay for qualified, out-of-pocket medical expenses now, later, and on into retirement. HSA dollars may only be used to pay for medical expenses for qualified tax dependents.

Your unused HSA contributions roll over from year to year. Additionally, money in your HSA can be invested, tax-free, to pay for future medical expenses. You receive a debit card linked to your HSA account to pay for eligible healthcare expenses at the time of service. You can choose to pay for services out of your pocket and leave the money in your HSA to accumulate for another time or another year. What’s more, you own the money in your HSA and can take it with you if you

leave the University or retire.

More information on HSAs is included in the *Tax-Free Spending and Savings Accounts* section.

Medical Plan Coverage At-a-Glance Chart

This section provides you with detailed information on your medical and prescription drug coverage.

The following table summarizes the coverage available under your two medical plan choices. Please note that while the chart provides a list of covered services, it is important to contact Blue Cross of Idaho before a service is provided to be sure it is covered and to determine if any special requirements need to be met, such as preauthorization. Contact Blue Cross of Idaho by calling the number listed on your ID card. Additionally, please review the *What the Medical Plans Cover* section for more detailed information.

WEIGHT MANAGEMENT PROGRAM	
<p>This program is available at no cost to Participants who qualify. Wondr Health is an evidence-based, digital counseling program that helps Participants lose weight and improve their quality of life and reverse clinical risk. The program is built to prevent diabetes, reduce the risk of heart disease, reverse metabolic syndrome, and combat other obesity-related diseases. To find out if you qualify, send an email to support@wondrhealth.com or call 855-999-7549.</p> <p>The program includes three different phases to help Participants learn new skills and apply them to their real life:</p> <ul style="list-style-type: none">• WondrSkills: Initial skill-building• WondrUp: Personalized skill reinforcement• WondrLast: Long-term skill maintenance	

Benefits	Standard PPO		High Deductible Health Plan (HDHP)
	In-Network	Out-of-Network	In-Network, and Out-of-Network
Annual deductible for medical services and supplies (you pay)			
Individual or Self-Only	\$800	\$1,300 per individual	\$1,900
Family	\$1,600		\$3,800
Preventive care/wellness services – for specifically listed services (plan pays) For services not listed, you pay your	You pay nothing; plan pays 100%	Not covered	You pay nothing; plan pays 100% of the maximum allowance for in-network services.

deductible and cost-sharing amount.			
<p>Preventive Care/Wellness services as required under ACA include, but not limited to:</p> <p>Adult Examinations and services – Annual physical examinations including Pap tests, fecal occult blood test, PSA tests, cholesterol panel, chemistry panel, diabetes screening, urinalysis, complete blood count, bone density, tuberculosis skin or tine test, thyroid stimulating test, uric acid, GGT (liver function test), screening EKG, preventive screening mammogram, colorectal cancer screening, one routine wellness hearing exam per year, thyroid stimulating hormone, transmittable disease screening (Chlamydia, Gonorrhea, HIV, Syphilis, Tuberculosis), abdominal aortic aneurysm screening and ultrasound, alcohol and drug use assessment, genetic counseling for high-risk family history of breast or ovarian cancer, health risk assessment for depression, lipid disorder screening, nicotine, smoking and tobacco-use cessation counseling visit, dietary counseling, urinary incontinence screening, lung cancer screening (age 50 and older), healthy diet and physical activity behavioral counseling (cardiovascular disease risk factors).</p> <ul style="list-style-type: none"> • Women’s Preventive Care Services – Coverage for additional preventive services including breast-feeding support, supplies and counseling, contraception methods and counseling, domestic violence screening, gestational diabetes screening, HIV screening and counseling, Human Papillomavirus testing, sexually transmitted infections counseling, and well-women visits. <p>Well-Baby Care and Well-Child Care – Routine or scheduled well-baby and well-child examinations, including rubella, thyroxine, sickle cell and PKU tests, newborn hearing test and screening examinations for sports physicals.</p> <p>Maternity Benefits – Urine culture, hepatitis B virus screening, iron deficiency screening, Rh (D) incompatibility screening, perinatal depression counseling and intervention, behavioral counseling to promote healthy weight gain and prevent excess weight during pregnancy.</p> <p>Immunizations and Travel Vaccines – Acellular pertussis, cholera, diphtheria, hemophilus, influenza B, hepatitis A, hepatitis B, human papilloma virus (HPV), influenza, H1N1, Japanese encephalitis, measles, meningococcal, mumps, plague, pneumococcal (pneumonia), poliomyelitis (polio), rotavirus, rubella, tetanus, typhoid, typhim VI, typhus, varicella (chicken pox), yellow fever, zoster, and Dengue.</p>			

Benefits	Standard PPO		High Deductible Health Plan (HDHP)
	In-Network	Out-of-Network	In-Network, and Out-of-Network
Office visit copayment and/or cost sharing (you pay)			
Primary Care Specialist	\$35 copayment per visit, not subject to deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Non-physician services, such as lab work, imaging, etc. (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Annual Cost-Share Maximum (includes cost sharing and copayment) * Once you satisfy the applicable deductible, you pay cost-sharing (and copayments if you are in the Standard PPO) until you satisfy the applicable medical expenses cost-share maximum. After that, the plan pays for 100% of covered medical services. Please see “Cost-Share Maximum” in the General Benefit Information section for more information.)			
Individual	\$3,650	\$5,300 per individual	\$3,100
Family	\$7,300		\$6,200*
*When your family has satisfied the \$3,800 deductible, you will pay cost-sharing (you pay 30%; plan pays 70%) for covered services for all family members. If one family member’s covered services satisfy the \$3,100 individual embedded cost-share maximum, the plan will pay 100% for all covered services for that family member. When any combination of family members covered serves satisfies the overall \$6,200 family cost-share et maximum, the plan will pay 100% of all covered services for all family members for the remainder of the benefit period.			
Total Annual Out-of-Pocket Maximum for Medical Expenses (deductible plus medical cost-share maximum plus copayments if you are in the Standard PPO)			
Individual or Self-only	\$4,450 including all applicable medical deductible, cost sharing and copayments*	\$6,600 per individual PLUS all applicable medical deductible and cost sharing	\$5000
Family	\$8,900 including all applicable medical deductible, cost sharing and copayments*		\$6,900/Person \$10,000/Family
*Does not include prescription drug expenses which are subject to a separate out –of-pocket maximum			

Lifetime benefit Maximum	Unlimited, except for TMJ services, and for hearing aid appliances and fitting exam for Eligible Dependents, as outlined below		
Benefits	Standard PPO		High Deductible Health Plan (HDHP)
	In-Network	Out-of-Network	In-Network, and Out-of-Network
Ambulance transportation services (Ground) (you pay)	\$50 copayment per trip, not subject to deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after the deductible
Air Ambulance (you pay) <i>Payment for Out-of-Network Air Ambulance Services is based on the Qualifying Payment Amount. Out-of-Network Air Ambulance Services accumulate towards the In-Network Out-of-Pocket Limit.</i>	35% of the maximum allowance, after deductible	35% of the maximum allowance, after In-Network deductible	30% of the maximum allowance, after the deductible
Breastfeeding Support and Supply Services <i>(Includes rental and/or purchase of manual or electric breast pumps. Limited to one (1) breast pump purchase per Benefit Period, per Participant.)</i>	You pay nothing; plan pays 100% of the maximum allowance	35% of the maximum allowance, after deductible	30% of the maximum allowance, after deductible
Mental Health and Substance Use Disorder Services			
Inpatient mental health and substance use disorder services (you pay)	20% of the maximum allowance after deductible, and \$100 per day copayment up to 3 days per year per person	35% of the maximum allowance after deductible, and \$100 per day copayment up to 3 days per year per person	30% of the maximum allowance, after deductible

Outpatient psychotherapy services (you pay)	\$35 copayment per visit, not subject to deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after deductible
Benefits	Standard PPO		High Deductible Health Plan (HDHP)
	In-Network	Out-of-Network	In-Network, and Out-of-Network
Outpatient Applied Behavioral Analysis (ABA) (you pay)	\$35 copayment per visit, not subject to deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after deductible
Outpatient Nutritional/Dietary Counseling (As part of an approved treatment plan and up to 20 visits combined in-network and out-of-network)	\$35 copayment per visit, not subject to deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after deductible
Blood service (you pay)	20% of the maximum allowance, after deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after the deductible
Colonoscopy & Sigmoidoscopy Preventive screening (plan pays)	You pay nothing; plan pays 100% of the maximum allowance	Not covered	Plan pays 100% of the maximum allowance for in-network services (not subject to the deductible or cost-sharing)
Bariatric Surgery	Separate \$1,500 Deductible, then 20% of	Not Covered	Separate \$1,500

(requires pre-authorization) (you pay)	the maximum allowance after the separate Bariatric deductible (Covered at a Blue Cross Center of Excellence Provider Only)		Deductible, then 30% of the maximum allowance after the annual deductible (Covered at a Blue Cross Center of Excellence Provider Only)
Benefits	Standard PPO		High Deductible Health Plan (HDHP)
	In-Network	Out-of-Network	In-Network, and Out-of-Network
Diagnostic services related to Bariatric Surgery (you pay)	20% of the maximum allowance after the separate Bariatric deductible (Covered at a Blue Cross Center of Excellence Provider Only)	Not Covered	30% of the maximum allowance after the separate Bariatric deductible (Covered at a Blue Cross Center of Excellence Provider Only)
Contraceptive services (you pay)			
Birth control pills	See <i>Prescription Drug Benefits</i> for more information		
Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections, tubal ligation, and male condoms.)	Plan pays 100% of the maximum allowance	35% of the maximum allowance, after deductible	Plan pays 100% of the maximum allowance
Breast Reduction Surgery (you pay)	20% of the maximum allowance after deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after the deductible
Chiropractic Care Services	Plan pays 100% of the maximum allowance, after \$35 copayment (not subject to deductible)	You pay 35% of the maximum allowance, after deductible	You pay 30% of the maximum allowance, after deductible
Dental services related to accidental injury (you pay)	20% of the maximum allowance, after deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after the deductible
Diabetes self-management education (you pay)	\$35 copayment per provider, not subject to deductible	Not Covered	30% of the maximum allowance, after the deductible
Diagnostic services (you pay) <i>excluding eligible wellness and</i>	20% of the maximum allowance, after deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after the deductible

<i>preventive care services</i>			
Benefits	Standard PPO		High Deductible Health Plan (HDHP)
	In-Network	Out-of-Network	In-Network, and Out-of-Network
Emergency room co-pay (you pay) <i>Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount.</i>	\$100 copayment per visit plus deductible and cost sharing	\$100 copayment per visit plus In-Network deductible and In-Network cost sharing	30% of the maximum allowance, after the deductible
All Other Emergency services (you pay) <i>Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount.</i>	20% of the maximum allowance, after deductible	20% of the maximum allowance, after In-Network deductible	30% of the maximum allowance, after the deductible
Hearing examination <i>Limited to one routine exam per participant per benefit period</i>	You pay nothing, plan pays 100%	You pay 35% of the maximum allowance, after deductible	Plan pays 100% of the maximum allowance, after deductible
Hearing Aid Appliances and fitting exams (Limited to \$800 per participant per lifetime; lifetime limit does not apply to Eligible Dependent Children)	20% of the maximum allowance, after deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after deductible
Home health skilled nursing services	Plan pays 100% of the maximum allowance, after deductible	You pay 35% of the maximum allowance, after deductible	You pay 30% of the maximum allowance

Hospice services	Plan pays 100% of the maximum allowance, after deductible	You pay 35% of the maximum allowance, after deductible	You pay 30% of the maximum allowance, after deductible
Hospital services - Inpatient (you pay)	20% of the maximum allowance, after deductible AND \$100 per day copayment up to 3 days per year per person for inpatient services	35% of the maximum allowance, after deductible AND \$100 per day copayment up to 3 days per year per person for inpatient services	30% of the maximum allowance, after deductible
Hospital services – Out-patient (you pay)	20% of the maximum allowance, after deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after deductible
Urgent care facility (you pay) Additional services, such as laboratory, x-ray, and other Diagnostic Services are not included in the office visit	\$35 copayment, not subject to or applied to deductible	You pay 35% of the maximum allowance, after deductible	You pay 30% of the maximum allowance, after deductible

Benefits	Standard PPO		High Deductible Health Plan (HDHP)
	In-Network	Out-of-Network	In-Network, and Out-of-Network
Injections (you pay)	\$35 copayment per visit if this is the only service provided during the visit	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after deductible
Injections – Allergy (you pay)	\$5 copayment per visit if this is the only service provided during the visit	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after deductible
Inpatient Rehabilitation or Habilitation Services (you pay)	20% of the maximum allowance, after deductible AND \$100 per day copayment up to 3 days per year per person for inpatient services	35% of the maximum allowance, after deductible AND \$100 per day copayment up to 3 days per year per person for inpatient services	30% of the maximum allowance, after deductible
Mammography services			

Preventive screening – Mammography (plan pays)	You pay nothing; plan pays 100% of the maximum allowance	Not covered	You pay nothing; plan pays 100% of the maximum allowance
Diagnostic service – Mammography (you pay)	20% of the maximum allowance, after deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after deductible
Maternity Services			
Maternity – Physician services (you pay) <i>see Bright Beginnings Early Prenatal Management Program section for more information</i>	\$250 copayment, then plan pays 100% (Not subject to deductible or cost-sharing)	35% of the maximum allowance after deductible, and \$100 per day copayment up to 3 days per year per person	30% of the maximum allowance, after deductible
Maternity – Hospital services (you pay) <i>see Bright Beginnings Early Prenatal Management Program section for more information</i>	20% of the maximum allowance, after the deductible and \$100 per day copayment up to 3 days per year per person	35% of the maximum allowance after deductible, and \$100 per day copayment up to 3 days per year per person	30% of the maximum allowance, after deductible
Benefits	Standard PPO		High Deductible Health Plan (HDHP)
	In-Network	Out-of-Network	In-Network, and Out-of-Network
Medical services (you pay) <ul style="list-style-type: none"> • Inpatient and • Out-Patient 	20% of the maximum allowance, after deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after deductible
Outpatient cardiac rehabilitation services (Up to a combined total of 36 visits, per participant, per benefit period)	Plan pays 100% of the maximum allowance, after \$35 copayment (not subject to the deductible)	You pay 35% of the maximum allowance, after deductible	You pay 30% of the maximum allowance, after deductible
Out-patient habilitation therapy services <ul style="list-style-type: none"> • Out-patient occupational therapy 	Plan pays 100% of the maximum allowance, after \$35 copayment (not subject to the deductible)	You pay 35% of the maximum allowance, after deductible	You pay 30% of the maximum allowance, after deductible

<ul style="list-style-type: none"> Out-patient physical therapy Out-patient respiratory therapy Out-patient speech therapy 			
Out-patient rehabilitation therapy services <ul style="list-style-type: none"> Out-patient occupational therapy Out-patient physical therapy Out-patient respiratory therapy Out-patient speech therapy 	Plan pays 100% of the maximum allowance, after \$35 copayment (not subject to the deductible)	You pay 35% of the maximum allowance, after deductible	You pay 30% of the maximum allowance, after deductible
Palliative Care Services	Plan Pays 100% of the Maximum Allowance (Deductible does not apply)	Plan pays 35% of Maximum Allowance after Deductible	Plan Pays 100% of the maximum allowance, after deductible
Benefits	Standard PPO		High Deductible Health Plan (HDHP)
	In-Network	Out-of-Network	In-Network, and Out-of-Network
Prescription drug services	CVS/Caremark manages prescription drug benefits; please see <i>Prescription Drug Benefits</i> for more information		
Selected therapy (you pay)	20% of the maximum allowance, after deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after deductible
Skilled nursing facility (you pay) <i>Limited to 30 combined inpatient days per benefit period</i>	20% of the maximum allowance, after the deductible and \$100 per day copayment up to 3 days per year per person	35% of the maximum allowance after deductible, and \$100 per day copayment up to 3 days per year per person	30% of the maximum allowance, after deductible
Tobacco Cessation Services			
Counseling-Tobacco Cessation	Approved counseling services are covered at 100%		

Medications- Tobacco Cessation	Most generic prescription medications are covered at 100% under prescription drug benefit managed by CVS/Caremark; Please see <i>Prescription Drug Benefits</i> for more information		
Temporomandibular Joint (TMJ) Syndrome Services (you pay) (Up to a combined \$2,000 lifetime limit, per Participant)	50% of the maximum allowance, after deductible	50% of the maximum allowance, after deductible	30% of the maximum allowance, after deductible
Transplant services (you pay)	20% of the maximum allowance, after deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after deductible

General Benefit Information

This section provides you with additional information on how your benefits operate.

Annual Deductible

For each medical plan option there is an annual deductible that you must satisfy before certain services will be covered.

The deductible amount(s) you must satisfy depend on:

- **The plan option in which you enrolled:** Each option has its own deductible amount, as described in the *Medical Plan Coverage At-a-Glance Chart*.
- **Whether you are enrolled for individual or family coverage:**
 - In Standard PPO Plan, benefit payments for any covered participant will begin after he or she meets the plan's individual deductible, even if the family deductible has not been satisfied.
 - In the High Deductible Health Plan (HDHP), the family deductible must be satisfied before the plan begins to pay benefits for any covered participant. In other words, if you are enrolled in HDHP family coverage, you will have only one family deductible, there is no individual deductible – only a family deductible.
- **Whether you receive care from in-network or out-of-network providers (Standard PPO Plan only):** In Standard PPO Plan, there are separate deductibles for care you receive in-network and out-of-network. Keep in mind, covered services that are counted toward the in-network deductible do not count toward the out-of-network deductible and vice versa.

Amounts over the maximum allowance for in- and out-of-network care do not apply to the deductible or the cost-share maximum.

In general, amounts you pay for covered services count toward satisfying the deductible. In the Standard PPO Plan, amounts you pay in copayments for medical and prescription drug covered services do not count toward satisfying the deductible.

In the High Deductible Health Plan (HDHP), you generally will pay 100% of the cost for covered services until you meet the deductible before the plan begins to pay benefits. Eligible preventive care is covered at 100% with no deductible when you use network providers – you do not pay any amount out of pocket for eligible, in-network preventive care services.

Care Away from Home (BlueCard Program)

If you travel outside of your Blue Cross of Idaho coverage area or have dependents who live in other areas, coverage is available through the BlueCard Program through the Blue Cross or combined Blue Cross Blue Shield networks. Blue Cross of Idaho also has negotiated arrangements throughout countries outside the United States. If you are traveling abroad, call the number on your ID card to locate a provider near where you will be visiting or if you become ill while traveling. These negotiated arrangements will provide you with care at the best rates and will often include arrangements for direct billing and payment.

Tip

If you have to pay for care in a country outside of the United States, your rate of exchange is calculated based on the day of the credit card transaction. However, a currency exchange fee may be charged by your credit card company.

Cost-Sharing

Cost-sharing is the portion of the cost of covered services you are required to pay out of your own pocket. For covered services in Standard PPO Plan and the High Deductible Health Plan (HDHP), you pay a percentage of the maximum allowance toward a service's cost. Typically, you pay cost-sharing after you have satisfied any copayments or deductibles. Your cost-sharing amount depends on the plan in which you've enrolled and the covered service, as described in the *Medical Plan Coverage At-a-Glance Chart*. Information relating to the cost-sharing for services subject to the No Surprises Act is described in the *No Surprises Act* section.

Generally, you will continue paying cost-sharing for covered services until you satisfy the out-of-pocket maximum. Once you have satisfied the cost-share maximum, the plan pays 100% of covered services for the remainder of the plan year.

Copayments (Standard PPO Plan only)

For some services in the Standard PPO Plan, you pay a fixed dollar amount at the time the covered services are rendered. The fixed dollar amount you pay is called a copayment. Copayment amounts required for covered services are listed in the *Medical Plan Coverage At-A-Glance Chart*.

Generally, the plan pays covered services after you pay the applicable copayment. However, in some cases you must meet the annual deductible and then pay the designated copayment for a covered service. After you pay the deductible and any required copayment, the plan typically pays 100% of the maximum allowance for the covered service.

Lifetime Maximum

There is a \$2,000 lifetime limit for Temporomandibular Joint (TMJ) Services per participant. There is an \$800 lifetime limit for hearing aid appliances and fitting exam; the limit does not apply to Eligible Dependent children. and there is a \$2,000 lifetime adoption benefit for full-time employees (pro-rated for part-time employees).

The hearing aid appliances and fitting exam are also subject to a deductible and any required cost-sharing.

Maximum Allowance

The maximum allowance is the amount Blue Cross of Idaho will pay for a covered service.

The maximum allowance for covered services is the billed charge or the reasonable level of

compensation Blue Cross of Idaho considers for a covered service, whichever is less. Special rules apply for services subject to the No Surprises Act. See *Important Terms* for more information.

Cost-Share Maximum

The annual cost-share maximum provides additional protection for you by putting a “cap” on what you pay in cost-sharing for one year for covered services. Once your share of covered charges reaches the cost-share maximum, the plans pay 100% of most covered charges for the year. The cost-share maximum includes amounts you pay toward cost-sharing and any copayments.

The cost-share maximum you must meet depends on:

- **The plan in which you enrolled:** Each plan has its own cost-share maximum amount, as described in the *Medical Coverage Plan At-a-Glance Chart*.
- **If you have individual or family coverage:** There is an individual and a family cost-share maximum. The individual cost-share maximum applies to each participant every calendar year. Once a participant satisfies the individual cost-share maximum, the plan will begin paying 100% of covered charges for that participant. Combined expenses for all covered family members can be used to satisfy the family cost-share maximum, even if each covered participant does not satisfy the individual cost-share maximum. However, no one participant may contribute more than the individual cost-share maximum toward satisfying the family cost-share maximum.
- **If you receive care from in-network and out-of-network providers (Standard PPO Plan only):** The Standard PPO Plan has separate cost-share maximums for in-network and out-of-network care, as described in the *Medical Plan Coverage At-a-Glance Chart*. Keep in mind, covered services that are counted toward the in-network cost-share maximum do not count toward the out-of-network cost-share maximum and vice versa.

Additionally, out-of-pocket expenses associated with the following will not count toward satisfying the cost-share maximum:

- The annual deductible,
- Prescription drug expenses (these are subject to separate cost-share maximum. See the Prescription Drug section),
- Non-covered services or supplies received in- and out-of-network,
- Amounts that exceed the maximum allowance from in- and out-of-network care,
- Amounts or services that exceed any lifetime benefit limits,
- Amounts or services that exceed the benefit period limits,
- Morbid obesity surgical services deductible,
- Vision care covered services,
- Tobacco cessation program,
- Amounts paid toward hearing aid appliances and fitting exam.

Information relating to the cost-sharing for services subject to the No Surprises Act is described in the *No Surprises Act* section.

Nondiscrimination in Health Care

The Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. In this context, discrimination means treating a provider differently based solely on the type of the provider's license or certification. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established

by the Plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

In-Network Providers

If you enroll for medical benefits, you are *not* required to elect a primary care physician. However, you will receive the greatest benefits, and pay less out of pocket, when you seek services from a Blue Cross of Idaho PPO provider.

In-network providers have agreed to terms that reduce costs to you and the University. All Providers and Facilities 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 to be payable by the Plan. Additional information on providers can be found in the Important Terms section. Network providers include, but not limited to:

- Ambulance transportation service,
- Ambulatory surgical facility (surgery center),
- Audiologist,
- Certified nurse-midwife,
- Certified registered nurse anesthetist,
- Chiropractic physician,
- Clinical nurse specialist,
- Alcoholism or substance use disorder treatment facility,
- Speech therapist,
- Clinical psychologist,
- Electroencephalogram (EEG) provider,
- Home intravenous therapy company,
- Hospice,
- Licensed Clinical Professional Counselor (LCPC),
- Licensed Clinical Social Worker (LCSW),
- Licensed Associate Marriage and Family Therapists (LAMFT),
- Licensed Marriage and Family Therapist (LMFT),
- Licensed Master Social Worker (LMSW),
- Licensed occupational therapist,
- Licensed physical therapist,
- Licensed Psychologist Associate (LPA),
- Licensed Professional Counselor (LPC),
- Licensed rehabilitation hospital,
- Lithotripsy provider,
- Psychiatric hospital,
- Dentist/denturist,
- Diagnostic imaging provider,
- Durable medical equipment supplier,
- Freestanding diabetes facility,
- Freestanding dialysis facility,
- Home health agency,
- Independent laboratory,
- Licensed general hospital,
- Nurse practitioner, Optometrist/optician,
- Physician,
- Physician assistant,
- Podiatrist,
- Prosthetic and orthotic supplier,
- Radiation therapy center, and

- Skilled nursing facility.

How to Locate a Network Provider

To locate a provider in your area, please visit the Blue Cross of Idaho web site at www.members.bcidaho.com. Click on "Find a doctor" and you will be taken to the searchable directory. You may also call the Customer Service number listed on your ID card for assistance in locating a provider. If you obtain and rely upon incorrect information about whether a provider is an In-network provider from the Plan or its administrators, the Plan will apply In-network cost-sharing to your claim, even if the provider was an Out-of-network provider at the time the service was rendered.

In-network providers will work with Blue Cross of Idaho to complete any preauthorization requirements. You are responsible for obtaining preauthorization when seeking treatment from an out-of-network provider. You are financially responsible for services performed by an out-of-network provider when those services are determined to be not Medically Necessary. You are responsible for notifying BCI if the proposed treatment will be provided by an out-of-network provider.

Out-of-Network Providers

You may choose to use a healthcare provider who is not a Blue Cross of Idaho PPO network provider, but you should know that this will increase your out-of-pocket costs. The plan does not pay as large of a share of the charges for an out-of-network provider. All Providers and Facilities 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 their licensure to be payable by the Plan. Additional information on providers can be found in the Important Terms section.

Additionally, in the Standard PPO Plan, you will have to satisfy a separate out-of-network deductible and cost-share maximum. Information relating to the services subject to the No Surprises Act is described in the *No Surprises Act* section.

Claims for Benefits

You do not have to file a claim for benefits if you use a Blue Cross of Idaho in-network facility or in-network provider. However, if you receive services from an out-of-network facility or out-of-network provider and the provider requires you to pay for services up front, claims should be submitted to:

Blue Cross of Idaho
P.O. Box 7408
Boise, ID 83707

Claims for services paid by a participant to an out-of-network provider must be submitted for reimbursement within 12 months of the date the services were rendered to be eligible for coverage.

As soon as Blue Cross of Idaho processes your claim, you will receive an Explanation of Benefits, or EOB. Your EOB will show payments Blue Cross of Idaho has made and to whom payments have been made. It will also provide any information on why a claim was denied or not paid in full.

Please contact the Customer Service number on your ID card with questions about your claims and EOBs. See the *Claims Procedures for Medical Claims* section for more information on claims.

Women's Health and Cancer Rights Act

Federal law requires group health plans to provide coverage for the following services to a participant receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The medical benefits plan determines the manner of coverage in consultation with you and your attending physician. Coverage for breast reconstruction and related services will be subject to deductibles and cost-sharing amounts that are consistent with those that apply to other benefits under the medical benefits plan.

Newborn and Mother Health Protection Act

Under federal law, group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain preauthorization, see "Preauthorization" in the **Medical Management Program** section for more information.

The No Surprises Act

The No Surprises Act offers many protections to Participants, including protections to Participants in an emergency situation or when an unanticipated Out-of-network provider treats a Participant at an In-network facility or when a Participant uses an Out-of-network Air Ambulance provider.

The No Surprises Act requires plans to cover Emergency Services provided at an Out-of-network facility or by an Out-of-network provider in the same manner as In-network Emergency Services and without pre-authorization. The Plan currently covers both In-network and Out-of-network Emergency Services on the same basis and does not require pre-authorization for Emergency Services. However, the No Surprises Act offers other protections and expands the requirements applicable to Emergency Services.

You are still encouraged to use In-network facilities and In-network providers whenever possible.

Emergency Services from Out-of-network Emergency Facilities and Providers

- You will pay the same cost-sharing whether you receive covered Emergency Services from an Out-of-network Emergency facility or provider or an In-network facility or provider.
- In general, you cannot be balance billed for costs beyond plan-allowed cost sharing for covered Emergency Services. Your cost-sharing will be based on the Recognized Amount payable for these services. The Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.
- Any cost-sharing payments you make with respect to Out-of-network Emergency Services (and other services subject to No Surprises Act protections), will count toward your In-network deductible and In-network out-of-pocket maximum in the same manner as those received from an In-network provider.
- The Plan will not impose prior authorization requirements for Emergency Services and will not impose more restrictive administrative requirements on Out-of-network Emergency Services than requirements for Emergency Services received at an In-network facility or provider.

Post-stabilization Services

Emergency Services received at an In-network or Out-of-network facility or from an In-network or Out-of-network provider include post-stabilization services (services after the patient is stabilized) and include services received in any part of the In-network or Out-of-network Emergency facility. Emergency Services may also include outpatient observation or an inpatient or outpatient stay that is related to the Emergency Medical Condition until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is an Out-of-network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any In-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-network providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the Out-of-network provider, acknowledging that the participant or beneficiary understands that continued treatment by the Out-of-network provider may result in greater cost to the participant or beneficiary.

Out-of-network Non-Emergency Services from In-network Facilities and Out-of-network Providers

If you receive Out-of-network items or services that are otherwise covered by the Plan from an Out-of-network provider who is working at an In-network facility, those non-emergency items or services will be covered by the Plan as follows:

- The non-emergency items or services received from an Out-of-network provider working at an In-network facility will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an In-network provider.
- In general, you cannot be balance billed for these non-emergency items or services. Your cost-sharing will be based on the Recognized Amount payable for these services. The Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

Any cost-sharing payments you make with respect to covered non-emergency services will count toward your In-network deductible and In-network out-of-pocket maximum in the same manner as those received from an In-network provider.

Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plan from an Out-of-network provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from an Out-of-network provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an In-network provider.
- In general, you cannot be balance billed for these services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by an In-network provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your In-network deductible and In-network out-of-pocket maximum in the same manner as those received from an In-network provider.

Payments to Out-of-network Providers and Facilities

The Plan will make an initial payment or notice of denial of payment for Emergency Services from In-network Facilities and Out-of-network Providers and Non-Emergency Services from In-network Facilities, Out-of-network Providers, and Air Ambulance Services within 30 calendar days of receiving the clean claim from the Out-of-network provider. The 30-day calendar period begins on the date the Plan receives the information necessary to decide a claim for the payment for the services.

If a claim is subject to the No Surprises Act, you cannot be required to pay more than the in-network cost-sharing under the Plan, and the provider or facility is prohibited from billing you in

excess of the required cost-sharing. The Plan's payment or denial or payment to the Out-of-network provider does not affect your cost-sharing amount.

When You May Be Billed For Out-of-network Providers Who Work at In-network Facilities

In certain circumstances, you can be billed by an Out-of-network provider who works at an In-network facility. This can occur if you are notified by the Out-of-network provider that the provider does not participate with the Plan, and you provide informed notice and consent.

The Out-of-network provider must give you Notice that:

- is in writing.
- is provided to you at least 72 hours before the day of the appointment or at least 3 hours in advance of services rendered for a same day appointment.
- states the provider is an Out-of-network provider.
- includes the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment.
- includes the names of any In-network providers at the facility who are able to treat you.
- provides you may elect to be referred to an In-network provider; and
- your costs will be greater if you consent to service or treatment

If you give informed consent to be treated by the In-network provider, then the Plan will pay for these services at the Out-of-network rate, and the provider can bill you for the balance directly.

You may revoke your consent prior to the receipt of services.

This rule does not apply to services provided by hospital-based providers, such as anesthesiologists and radiologists, also referred to as Ancillary Services. For Ancillary Services, your cost-sharing will be based on the Recognized Amount and any cost-sharing payments you make count toward your In-network deductible and In-network out-of-pocket maximum in the same manner as those received from an In-network provider.

Continuing Coverage with an In-Network Provider who leaves the Plan's Network

If you are a Continuing Care Patient and the Plan terminates its contract with your In-network provider or facility, or you can no longer access qualifying covered services by a specific provider because of a change in terms of the providers' and/or facilities' participation in the Plan, the Plan will do the following:

- Notify you in a timely manner of the Plan's termination of its contracts with the In-Network provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and
- Allow you up to ninety (90) days of continued coverage at In-network cost sharing to allow for a transition of care to an In-network provider.
- You are a Continuing Care Patient with respect to a provider or facility if you are:
 - undergoing a course of treatment for a serious and complex condition from the provider or facility.
 - undergoing a course of institutional or inpatient care from the provider or facility.
 - scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery.
 - pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
 - determined to be terminally ill and receiving treatment for such illness from such provider or facility.

Medical Management Program

Blue Cross of Idaho's Medical Management Program helps ensure that you receive the right care in the right place at the right time.

Medical management helps you better manage your health, your healthcare, and your costs. There are many benefits of medical management, including less work or school missed due to illness, enjoying a better quality of life, staying healthy and living longer. Additionally, you may save money by paying less out of your pocket for healthcare expenses.

The Medical Management Program consists of a number of programs and provisions discussed in this section, including:

- Care management,
- Preauthorization,
- Non-emergency preadmission notifications,
- Emergency notifications,
- Continued stay review,
- Discharge planning,
- Disease management, and
- Bright Beginnings Early Prenatal Management Program.

Care Management

The care management program helps you coordinate care before, during and after treatment to ensure continuity of care for participants. It is a collaborative process among Blue Cross of Idaho, participants, and providers. The program will help ensure you and your providers know what the plan will cover.

Preauthorization

The preauthorization program is designed to ensure you get the most appropriate, cost-effective care for your condition(s). Under the program, Blue Cross of Idaho determines whether certain services and supplies are medically necessary or otherwise meet the requirements for plan coverage. Services that are authorized by Blue Cross of Idaho will be covered subject to all the other terms and conditions of the plan. Services that are not authorized by Blue Cross of Idaho will not be covered, and you will be financially responsible if you choose to receive those services.

Generally, the provider will obtain the preauthorization, particularly if you use an in-network provider. However, if you use an out-of-network provider, it is your responsibility to make sure that the preauthorization is obtained. If your in-network provider fails to obtain the appropriate preauthorization, you will not be held responsible for the charges if the services are not authorized.

In-network providers will work with Blue Cross of Idaho to complete any preauthorization requirements. You are responsible for obtaining preauthorization when seeking treatment from an out-of-network provider. However, it is always a good idea to check and ensure preauthorization has been completed. You are financially responsible for services performed by an out-of-network provider when those services are determined to be not Medically Necessary. You are responsible for notifying Blue Cross of Idaho if the proposed treatment will be provided by an out-of-network provider.

Services Requiring Preauthorization

The following services require preauthorization:

Procedures:

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

Services:

- Acute inpatient hospitalization
- Long-term acute care hospital (LTACH) admissions
- Rehabilitation and long-term care facility admissions
- Skilled nursing facility admissions
- Sub-acute and transitional care admissions
- Diagnostic infertility services
-
- Non-emergency ambulance transport

- Behavioral Health Services
 - Psychological testing/neuropsychological evaluation testing
 - Electroconvulsive therapy (ECT)
 - Intensive outpatient program (IOP)
 - Partial hospitalization program (PHP)
 - Residential treatment center (RTC)
 - Transcranial Magnetic Stimulation (TMS)

Durable Medical Equipment:

- Equipment with costs of more than \$1,000 (including rent-to-purchase items)
-
- Covered orthotics and prosthetics with costs of more than \$1,000

Advanced Imaging Specialty Health Services:

- Sleep therapy including studies, appliances and treatment
- Magnetic Resonance Imaging (MRI)
-
- Computed Tomography (CT)
-
- Positron Emission Tomography (PET) scan
- Pain Management
- Musculoskeletal procedures for spine and joints

Pharmacy:

- Certain prescription drugs (find a list at CVS Caremark at www.cvs.com)
- Growth hormone therapy (find a list at CVS Caremark at www.cvs.com)
- Outpatient IV therapy for infusion drugs (find a list at CVS Caremark at www.cvs.com)

How to Preauthorize Medical Services

To obtain medical preauthorization, call the number on the Blue Cross of Idaho ID card.

Blue Cross of Idaho will respond to a request for Prior Authorization received from either the provider or the participant within seventy-two (72) hours for an expedited request or fourteen (14) days for a standard request of the receipt of the medical information necessary to make a determination. Blue Cross of Idaho may review medical records, test results and other sources of information to ensure a covered service is medically necessary and/or to suggest alternate treatments.

- ***If the service is authorized***, Blue Cross of Idaho will notify your healthcare provider within one working day. Written/electronic confirmation will be provided to you and your healthcare provider within one working day of the telephone notice.
- ***If the service is not authorized***, Blue Cross of Idaho will notify your healthcare provider within 24 hours. Written/electronic confirmation to you and your healthcare provider will be provided within one working day of the telephone notice. Services will be continued without additional liability to you, except the applicable copayment or any deductible, until you have been notified that the service is no longer certified. If you choose to continue to receive care from a provider after notification that the services will not be covered, you will be responsible for the full cost of such services and such amount will not apply to any deductible or cost-share maximum. If you wish to appeal a decision by Blue Cross of Idaho, please review the information in the *Claims Procedures for Medical Claims* section.

Non-Emergency Preadmission Notification Requirement

You are required to notify Blue Cross of Idaho by calling the Customer Service number on your ID card of all inpatient admissions (except for emergencies and maternity care). Please notify Blue Cross of Idaho as soon as you know you will be admitted.

Emergency Notification Requirement

When an emergency occurs and you cannot notify Blue Cross of Idaho before you are admitted to the hospital, you or a representative must contact Blue Cross of Idaho within 72 hours of the admission. If the admission is on a weekend or legal holiday, Blue Cross of Idaho should be notified by the end of the next working day after the admission.

Continued Stay Review

Blue Cross of Idaho will contact the hospital utilization review department and/or the attending physician the day before the proposed discharge date. If the patient will not be discharged as originally proposed, Blue Cross of Idaho will evaluate the medical necessity of the continued stay and approve or disapprove benefits for the proposed course of inpatient treatment.

Discharge Planning

When you are being discharged from the hospital, Blue Cross of Idaho will provide you with additional information and benefits for various post-discharge courses of treatment.

Condition Support Programs (Get Help with Managing Chronic Conditions)

The condition support feature of the medical benefits plan is available to help you and your covered dependents manage chronic health conditions. Condition Support is based on the concept that many disease complications can be prevented if:

- Patients become active participants in controlling and managing their diseases through appropriate lifestyle changes and compliance with prescribed treatment, and
- People are given assistance in managing the risk factors before health conditions become chronic.

Condition support helps participants with chronic illnesses, such as asthma, diabetes, congestive heart disease or low back pain, avoid or minimize costly complications by focusing on compliance with well-accepted treatment protocols. Through your participation in the program, you will also receive education and supportive resources.

Participants with certain chronic conditions or a risk for developing these conditions will be contacted by a Blue Cross of Idaho medical professional and invited to voluntarily participate at no cost. All information is confidential and, by law, cannot be shared with the University, staff members or family members without your permission.

Learn more about the condition support program or enroll by calling the customer service number on your ID card and asking for Disease Management Services or logging on to www.bcidaho.com/members.

Bright Beginnings Early Prenatal Management Program

Bright Beginnings is a no-cost prenatal program designed to promote healthy prenatal care to expectant mothers through education and support.

When a Participant enrolls, she receives a free copy of the *Mayo Clinic Guide to a Healthy Pregnancy*, which provides information on maintaining a healthy pregnancy and delivering a

healthy baby. Upon completion of the initial registration, the pregnant woman receives a call from a Blue Cross of Idaho case manager who conducts a clinical assessment to determine risk status and offer services through the Blue Cross of Idaho high-risk pregnancy case management program if warranted. For each subsequent trimester, the case manager reaches out to evaluate the risk status again and provide support as needed. After delivery, the case manager contacts the mother again to offer a post-delivery assessment for postpartum depression and to ensure that mother and baby are engaged in appropriate follow up care.

Eligible participants will receive an incentive for participation in the program and for attending all of her scheduled visits with her prenatal caregiver that must begin during the first trimester. During the third trimester, the enrolled member will receive a reminder to obtain the appropriate attestation that she has completed all of her visits and to submit it after delivery. Upon submission, the incentive (gift card) will be sent to the eligible participant.

Bright Beginnings is available to all eligible Participants. To enroll, the expectant member should call Blue Cross of Idaho at **1-800-741-1871** and leave her name, address, contact information, member ID number and current week of pregnancy.

What the Medical Plans Cover

The following are covered services when obtained in accordance with the terms and conditions of this plan. Benefits are subject to the copayments, deductibles, cost-sharing, visit limits, exclusions, limitations, and other provisions as specified.

Note: To receive benefits, some covered services require preauthorization. Please review the *Preauthorization* section for more specific details.

Ambulance Transportation Services

For the purpose of this section, “Ambulance” means a specially designed and equipped vehicle used only for transporting the sick and injured. Coverage will be provided for medically necessary ambulance transportation of a participant within the local community:

- From a participant’s home or scene of injury or emergency medical condition to a licensed general hospital,
- Between licensed general hospitals,
- Between a licensed general hospital and a skilled nursing facility,
- From a licensed general hospital to the participant’s home, or
- From a skilled nursing facility to the participant’s home.

If there is no facility in the local community that can provide covered services appropriate to the participant’s condition, then ambulance transportation services mean transportation to the closest facility outside the local community that can provide the necessary service. Blue Cross of Idaho will also cover air ambulance transportation services for emergency services when it is medically necessary to use air transportation instead of ground transportation.

Benefits are available under this *Ambulance Transportation Services* section for medical services provided to a participant only if the participant is transported to a medical facility.

Approved Clinical Trials

Participation in either a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, provided the charges are those that are:

- Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Plan if the individual were not participating in the Approved Clinical Trial; and

- Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

Benefits related to participation in an Approved Clinical Trial if participant:

- Satisfies the protocol prescribed by the Approved Clinical Trial provider; and
- Either:
 - The participant's in-network participating provider determines that the participant's participation in the Approved Clinical Trial would be medically appropriate; or
 - The participant provides the Plan with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

No benefits are provided for:

- the investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial.
- items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or
- items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
- expenses incurred at an out-of-network provider if an in-network participating provider will accept the patient in an Approved Clinical Trial.

Behavioral Health Services (Mental Health and Substance Use Disorder Services)

Behavioral health benefits provide coverage for inpatient and outpatient psychiatric, mental health and substance use disorder services for you and your covered dependents. Your benefits are counted toward your medical plan deductible and are paid by cost-sharing in the same manner as any other major medical expense, see the *Medical Plan Coverage At-a-Glance Chart* for more information on how services are covered.

Covered psychiatric care services include intensive outpatient programs (IOP), partial hospitalization programs (PHP), residential treatment center, psychological testing/neuropsychological evaluation testing and electroconvulsive therapy (ECT).

All Providers and Facilities 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 to be payable by the Plan. Additional information on providers can be found in the Important Terms section.

Inpatient Mental Health and Substance Use Disorder Care

The benefits provided for inpatient hospital services and inpatient medical services in this section are also provided for the care of mental or nervous conditions, alcoholism, substance use disorder or addiction, or any combination of these.

Outpatient Mental Health and Substance Use Disorder Care

The benefits provided for outpatient hospital services and outpatient medical services in this section are also provided for mental or nervous conditions, alcoholism, substance use disorder or addiction, or any combination of these. The use of hypnosis to treat a participant's mental or nervous condition is a covered service.

Outpatient Psychotherapy Services

Covered services include professional office visit services, and family, individual and/or group therapy.

Don't forget about your EAP benefits!

Our Employee Assistance Plan (EAP) provides up to eight counseling sessions per household member per issue at no cost to you. You may want to exhaust these sessions before seeking care through the behavioral health program, however, you are not required to do so. See the *Employee Assistance Plan* section for more information.

Obtaining Mental Health and Substance Use Disorder Services

The behavioral health program covers a wide array of mental health and chemical dependency problems. To obtain behavioral health services, call **1-800-743-1871**. When you call, you will be connected to a customer service representative who will work with you to match you with a provider in your area. Although you can select any provider, you will receive maximum benefits if you use a provider who is part of the network.

Protecting Your Confidentiality

All program staff and providers are bound by strict confidentiality requirements. Blue Cross of Idaho follows all state and federal laws and regulations regarding the release of patient information. A patient must always provide written consent for such release, unless there is an emergency or legal exception. The release of records related to drug or alcohol use disorder must not only follow written authorization by the patient but also appropriate federal regulations.

Applied Behavioral Analysis (ABA) - Outpatient

Emergency Admissions

If you are admitted on an emergency basis, you and your provider should call **1-800-743-1871** within 72 hours to obtain authorization. If you seek emergency medical care under a masked behavioral health diagnosis (a condition that presents itself as a medical emergency but is instead diagnosed as a behavioral health matter) from an out-of-network facility or provider, benefits will be considered without reduction if the rules for in-network medical care were followed based on the participant's medical plan choice and if Blue Cross of Idaho was promptly notified following diagnosis.

Emergency Medical Condition

Emergency Medical Condition means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Emergency Care.

Emergency Services

Emergency Services means the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and

treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by an Out-of-Network provider or an Out-of-network emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is an Out-of-network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any In-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-network providers listed; and The participant or beneficiary gives informed consent to continued treatment by the Out-of-network provider, acknowledging that the participant or beneficiary understands that continued treatment by the Out-of-network provider may result in greater cost to the participant or beneficiary.

Chiropractic Care Services

Benefits are limited to Chiropractic Care Services related to a significant medical condition necessitating appropriate Medically Necessary evaluation and Neuromusculoskeletal Treatment services.

Chiropractic Care Services are covered when:

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

No benefits are provided for:

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

Dental Services Related to Accidental Injury

Dental services rendered by a physician or dentist that are required as a result of an accidental injury to the jaw, sound natural tooth, mouth or face. Such dental services shall be covered only for the 12-month period immediately following the date of injury.

No benefits are available for services, diagnostic testing or appliances relating to orthodontics or dentofacial orthopedics; services that are required as a result of damage caused by chewing or biting; or services associated with the treatment of Temporomandibular Joint (TMJ) Syndrome.

Benefits for covered dental services are secondary to dental benefits available to a participant under a dental policy of insurance, contract or underwriting plan that is separate from this plan.

In addition to any other exclusions and limitations of this plan, the following exclusions and limitations apply to this particular *Dental Services Related to Accidental Injury* section and throughout the entire plan, unless otherwise specified.

Before providing benefits for covered services, Blue Cross of Idaho has the right to refer the participant to a dentist of its choice and at its expense to verify the need, quantity and quality of dental work claimed as a benefit under this section.

If a participant transfers from the care of one dentist to another dentist during a dental treatment plan, or if more than one dentist renders services for one dental procedure, Blue Cross of Idaho will pay no more than the amount that it would have paid if only one dentist had rendered the service.

Diabetes Self-Management Education Services — Outpatient

Diabetes self-management education includes instruction in the basic skills of diabetes management through books/educational material as well as an individual or group consultation with a certified diabetes educator, nurse or dietitian in an American Diabetes Association (ADA) certified program.

Diagnostic Services

Diagnostic services are covered, provided such services are not related to chiropractic care. Diagnostic services include, but are not limited to, mammograms, routine lab tests, X-rays, MRIs, CAT scans, pregnancy tests and Pap tests. Tests to determine pregnancy and Pap tests are covered regardless of results. Benefits for medically necessary genetic testing are only available when preauthorization has been completed and approved by Blue Cross of Idaho.

Durable Medical Equipment (DME)

The plan pays the lesser of the maximum allowance or billed charge for rental (but not to exceed the lesser of the maximum allowance or billed charge for the total purchase price) or, at the option of Blue Cross of Idaho, the purchase of medically necessary durable medical equipment required for therapeutic use. The durable medical equipment must be prescribed by an attending physician or other professional provider within the scope of license. Benefits shall not exceed the cost of the standard, most economical durable medical equipment that is consistent, according to generally accepted medical treatment practices, with the participant's condition. If the participant and his or her provider have chosen a more expensive treatment than is determined to be the standard and most economical by Blue Cross of Idaho, the excess charge is solely the responsibility of the participant. Equipment items considered to be common household items are not covered.

Hearing Aid Appliances and Fitting Exam

Hearing aid appliances and a fitting exam are subject to your plan's deductible and cost-sharing and the \$800 per participant lifetime limit. Any amount due to the provider above the \$800 lifetime benefit limit will be the participant's responsibility. Amounts paid toward hearing aid appliances and the fitting exam do not count toward your cost-share maximum. The \$800 lifetime maximum benefit does not apply to Eligible Dependent Children. Eligible Dependent Children are eligible for one device every three years with no dollar limit.

Hearing Examination

For in-network covered services, Blue Cross of Idaho will pay or otherwise satisfy a percentage of the maximum allowance up to the benefit limit as shown in the *Medical Plan Coverage At-a-Glance Chart*. Covered services include one routine wellness hearing examination per participant, per benefit period.

Home Health Skilled Nursing Care Services

The plan covers the delivery of Skilled Nursing Care services under the direction of a Physician to a homebound participant, provided this provider does not ordinarily reside in the participant's household or is not related to the participant by blood or marriage. The services must not constitute custodial care. Services must be provided by a Medicare-certified home health agency and limited to intermittent skilled nursing care. The patient's physician must review the care at least every 30 days. No benefits are provided during any period of time in which the participant is receiving hospice covered services.

Hospice Services

A participant must request hospice benefits specifically and must meet the following conditions to be eligible for hospice benefits:

- The attending or primary physician must certify that the participant is a terminally ill patient with a life expectancy of six months or less.
- The participant must live within the contracting hospice's local geographical area.
- The participant must be formally accepted by the contracting hospice.
- The participant must have a designated volunteer primary caregiver at all times.

Exclusions and limitations. No benefits are provided for:

- Hospice services not included in a hospice plan of treatment and not provided or arranged and billed for through a contracting hospice.
- Continuous skilled nursing care services except as provided specifically as part of respite care or continuous crisis care.
- No hospice benefits will be provided during any period of time in which a participant is also receiving skilled nursing care services.

Hospital Services – Inpatient

The following are covered services:

- Room, board, and general nursing services. Room and board, special diets, the services of a dietitian, and general nursing service when a participant is an inpatient in a licensed general hospital are covered as follows:
 - A room with two or more beds is covered. If a private room is used, the benefit provided in this section for a room with two or more beds will be applied toward the charge for the private room. Any difference between the charges is a non-covered expense under this plan and is the sole responsibility of the participant.
 - If isolation of the participant is: (a) required by the law of a political jurisdiction, or (b) required to prevent contamination of either the participant or another patient by the participant, then payment for approved private room isolation charges shall be in place of the benefits for the daily room charge stated in paragraph one.
- Benefits for a bed in a special care unit shall be in place of the benefits for the daily room charge stated in paragraph one.
- A bed in a nursery unit is covered.
- Ancillary services.
- Licensed general hospital services and supplies, including:
 - Use of operating, delivery, cast and treatment rooms and equipment.
- Prescription drugs administered while the participant is an inpatient.
- Administration and processing of whole blood and blood products when the whole blood or blood products are actually used in a transfusion for a participant; whole blood or blood plasma that is not donated on behalf of the participant or replaced through contributions on behalf of the participant.
- Anesthesia, anesthesia supplies and services rendered by the licensed general hospital as a regular hospital service and billed by the licensed general hospital in conjunction with a procedure that is a covered service.

- Medical and surgical dressings, supplies, casts, and splints that have been ordered by a physician and furnished by a licensed general hospital; specially constructed braces and supports are not a covered service under this section.
- Oxygen and administration of oxygen.
- Patient convenience items essential for the maintenance of hygiene provided by a licensed general hospital as a regular hospital service in connection with a covered hospital stay. Patient convenience items include, but are not limited to, an admission kit, disposable washbasin, bedpan or urinal, shampoo, toothpaste, toothbrush, and deodorant.
- Diagnostic services and therapy services as specified in their respective sections in this plan. If diagnostic services or therapy services furnished through a licensed general hospital are provided in part or in full by a physician under contract with the licensed general hospital to perform such services, and the physician bills separately for such services, the physician's services shall be a covered service.

Hospital Services – Outpatient

The following are covered services:

- Emergency care: licensed general hospital services and supplies for the treatment of an accidental injury or an emergency medical condition.
- Surgery: licensed general hospital or ambulatory surgical facility services and supplies including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the licensed general hospital or ambulatory surgical facility who is not the surgeon or surgical assistant, in conjunction with a procedure that is a covered service.

Therapy services as specified in the *Selected Therapy Services* paragraph.

Hospital Services – Preadmission Testing

Tests and studies required with the participant's admission and accepted or rendered by a licensed general hospital on an outpatient basis prior to a scheduled admission as an inpatient, if the services would have been available to an inpatient of a licensed general hospital. Preadmission testing does not include tests or studies performed to establish a diagnosis.

- Preadmission testing benefits are limited to inpatient admissions for surgery. Preadmission testing must be conducted within seven days prior to a participant's inpatient admission.
- Preadmission testing is a covered service only if the services are not repeated when the participant is admitted to the licensed general hospital as an inpatient, and only if the tests and charges are included in the inpatient medical records.
- No benefits for preadmission testing are provided if the participant cancels or postpones the admission to the licensed general hospital as an inpatient. If the licensed general hospital or physician cancels or postpones the admission, then benefits are provided.
- Hospital benefits may be provided for dental extractions, or other dental procedures if certified by a physician that a non-dental medical condition requires hospitalization to safeguard the health of the participant. Non-dental conditions that may receive hospital benefits are:
 - Brittle diabetes,
 - History of a life-endangering heart condition,
 - History of uncontrollable bleeding,
 - Severe bronchial asthma,
 - Children under 10 years of age who require general anesthesia, and
 - Other non-dental, life-endangering conditions that require hospitalization, subject to approval by Blue Cross of Idaho.

Inpatient Rehabilitation or Habilitation

For covered services rendered by a licensed general hospital or a licensed rehabilitation hospital, Blue Cross of Idaho will pay or otherwise satisfy a percentage of the maximum

allowance up to the benefit limit as shown in the *Medical Plan Coverage At-a-Glance Chart*.

Benefits are provided for inpatient rehabilitation or Habilitation subject to the following:

- Admission for inpatient physical rehabilitation must occur within 120 days of discharge from an acute care licensed general hospital.
- Continuation of benefits is contingent upon approval by Blue Cross of Idaho of a physical rehabilitation or habilitation plan of treatment and documented evidence of patient progress submitted to Blue Cross of Idaho at least twice each month.

Mammography

Mammogram screening means the X-ray examination of the breast using equipment dedicated specifically for mammography, as well as the provider's interpretation of such examination.

Maternity Services

You have 60 days from the birth of a child to enroll him or her in benefits coverage. For more information about enrolling your newborn in benefits coverage, see *Making Changes to Your Benefits During the Year*.

The benefits provided for licensed general hospital services and surgical/medical services in this plan are also provided for the maternity services listed below when rendered by a licensed general hospital or physician.

If you have a birth, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child will include 48 hours following a vaginal delivery and 96 hours following a cesarean section delivery. Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable. For stays in excess of 48 hours or 96 hours, additional benefits may be available; however, you must preauthorize those services. See the *Medical Management Program* section for more information.

Please note that nursery care of a newborn infant is not a maternity service.

Benefits are also provided for a normal pregnancy or involuntary complications of pregnancy as defined below.

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

Involuntary complications of pregnancy. Involuntary complications of pregnancy include, but are not limited to:

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

Medical Foods

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

Medical Services – Inpatient

Inpatient medical services rendered by a physician or other professional provider to a participant who is receiving covered services in a licensed general hospital or covered skilled nursing facility.

Inpatient medical services also include consultation services when rendered to a participant as an inpatient of a licensed general hospital by another physician at the request of the attending physician. Consultation services do not include staff consultations that are required by licensed general hospital rules and regulations.

Medical Services – Outpatient

The following outpatient medical services rendered by a physician or other professional provider to a participant who is an outpatient, provided such services are not related to pregnancy, chiropractic care, mental or nervous conditions, alcoholism, substance use disorder or addiction, except as specified elsewhere in this section:

- **Emergency care:** medical care for the treatment of an accidental injury or emergency medical condition.
- **Special therapy services:** deep radiation therapy or chemotherapy for a malignancy when such therapy is performed in the physician's office.
- **Home and other outpatient services:** medical care for the diagnosis or treatment of an accidental injury, disease, condition or illness.
- **Wellness/preventive care services:** see *Preventive Care Services/Wellness* paragraph).

Outpatient Nutritional/Dietary Counseling

Outpatient Nutritional/Dietary Counseling is a covered service if provided by a registered dietician for patients who are diagnosed with an eating disorder by a mental health professional and if the counseling is part of a treatment plan. Covered services include but are not limited to: an initial nutrition and lifestyle assessment, individual and/or group nutritional/dietary counseling, assistance managing lifestyle factors that may affect the participant's condition and follow-up visits to monitor the participant's progress in managing their nutritional/dietary needs. Subject to maximum visit limit up to 20 visits combined in-network and out-of-network.

Outpatient Cardiac Rehabilitation Services

Cardiac rehabilitation is a covered service for participants who have a clear medical need and who are referred by their attending physician and (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months; (2) have had coronary bypass surgery; or (3) have stable angina pectoris.

Outpatient Pulmonary Rehabilitation Services

Benefits will be provided for but not limited to the following diagnoses: COPD, chronic bronchitis, asthma, emphysema, bronchiectasis, and restrictive lung disease. Services must adhere to Medicare guidelines.

Orthotic Devices

Orthotic devices include, but are not limited to, medically necessary braces, back or special surgical corsets, splints for extremities and trusses, when prescribed by a physician, chiropractic physician, podiatrist, licensed physical therapist or licensed occupational therapist. Arch supports,

other foot support devices, orthopedic shoes and garter belts are not considered orthotic devices. Benefits shall not exceed the cost of the standard, most economical orthotic device that is consistent, according to generally accepted medical treatment practices, with the participant's condition.

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

Palliative Care Services

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

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

Post-Mastectomy/Lumpectomy Reconstructive Surgery

Reconstructive surgery in connection with a disease-related mastectomy/lumpectomy, including:

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

Coverage is provided in a manner determined in consultation with the attending physician and the participant. The deductible and copayment requirements that apply to other covered services also apply to these post-mastectomy reconstructive and treatment services.

Prescription Drugs

Please see the *Prescription Drug Benefits* section for additional information

Preventive Care Services/Wellness

This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010. Coverage is provided on an in-network basis only, with no cost-sharing (for example, no deductibles or copayments), for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and
- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics *Bright Futures* guidelines and HRSA guidelines relating to services for women.
- In-network preventive
- services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the participant or dependent. This means that the service will be

covered at 100% of the Plan's allowable charge, with no copayment or deductible.

Covered services are only available from PPO in-network providers and include, but are not limited to, the following:

- **Adult examinations and services**— Annual physical examinations including Pap tests, fecal occult blood test, PSA tests, cholesterol panel, chemistry panel, diabetes screening, urinalysis, complete blood count, bone density, tuberculosis skin or tine test, thyroid stimulating test, uric acid, GGT (liver function test), screening EKG, preventive screening mammogram, colorectal cancer screening, one routine wellness hearing exam per year, thyroid stimulating hormone, transmittable disease screening (Chlamydia, Gonorrhea, HIV, Syphilis, Tuberculosis), aortic aneurysm ultrasound, alcohol misuse assessment, genetic counseling for high-risk family history of breast or ovarian cancer, health risk assessment for depression, lipid disorder screening, smoking and tobacco use tobacco cessation counseling visit, dietary counseling, urinary incontinence screening, lung cancer screening (age 50 and older), healthy diet and physical activity behavioral counseling (cardiovascular disease risk factors).
- **Women's Preventive Care Services** – Coverage for additional preventive services including breast-feeding support, supplies and counseling, contraception methods and counseling, domestic violence screening, gestational diabetes screening, HIV screening and counseling, Human Papillomavirus testing (, sexually transmitted infections counseling, and well-women visits.
- **Well-baby care and well-child care** – Routine or scheduled well-baby and well-child examinations, including PKU, thyroxine and sickle cell tests, newborn hearing test, and screening examinations for sports physicals.
- **Maternity benefits** – Urine culture, Hepatitis B virus screening, iron deficiency screening, Rh(D) incompatibility screening, behavioral counseling to promote healthy weight gain and prevent excess weight during pregnancy.
- **Immunizations and travel vaccines** – Acellular Pertussis, Cholera, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Human Papilloma Virus (HPV), Influenza, H1N1, Japanese Encephalitis, Measles, Meningococcal, Mumps, Plague, Pneumococcal (pneumonia), Poliomyelitis (polio), Rotavirus, Rubella, Tetanus, Typhoid, Typhim VI, Typhus, Varicella (Chicken Pox), Yellow Fever, Zoster, and Dengue.

Coverage of Preventive Services and Vaccines for COVID-19

Effective January 1, 2021, the Plan will cover a preventive service within 15 business days of the date it becomes a **Qualifying Coronavirus Preventive Service** on an in-network basis, without participant cost sharing (such as a copayment or a deductible), prior authorization, or other medical management requirements.

Effective January 1, 2021, through the end of the **COVID-19 Public Health Emergency**, the Plan will cover a preventive service within 15 business days of the date it becomes a **Qualifying Coronavirus Preventive Service** on an out-of-network basis, without participant cost sharing (such as a copayment or a deductible), prior authorization, or other medical management requirements. The plan will reimburse an out-of-network provider for the item or service in an amount that the Plan determines is reasonable, as determined in comparison to prevailing market rates for such services. A reasonable amount shall include the amount that the provider would be paid under Medicare for the item or service.

Prosthetic Appliances

The plan covers the purchase, fitting, necessary adjustment, repair and replacement of prosthetic appliances including post-mastectomy prostheses. Benefits for prosthetic appliances are subject to the following limitations:

- Benefits shall not exceed the cost of the standard, most economical prosthetic appliance that is consistent, according to generally accepted medical treatment practices, with the

participant's condition. If the participant and his or her provider have chosen a more expensive treatment than is determined to be the standard and most economical by Blue Cross of Idaho, the excess charge is solely the responsibility of the participant.

- No benefits are provided for dental appliances or major artificial organs, including but not limited to, artificial hearts and pancreases.
- Following cataract surgery, benefits for a required contact lens or a pair of eyeglasses are limited to the first contact lens or pair of eyeglasses, which must be purchased within 90 days of the surgery.
- No benefits are provided for the rental or purchase of any synthesized, artificial speech or communications output device or system or any similar device, appliance or computer system designed to provide speech output or to aid an inoperative or unintelligible voice, except for voice boxes to replace all or part of a surgically removed larynx.

Selected Therapy Services

Benefits for therapy services include:

- Chemotherapy,
- Enterostomal therapy,
- Home intravenous therapy (home infusion therapy), and
- Renal dialysis.

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

Benefits are available only as preauthorized and approved by Blue Cross of Idaho when medically necessary.

Skilled Nursing Services

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

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

1. Room and board, routine nursing care, training, supervisory, Custodial Care, or support.
2. Care for senile deterioration, mental deficiency, or intellectual disability.
3. Care for Mental or Nervous Conditions, Alcoholism or Substance use disorder or Addiction.
4. Maintenance Physical Therapy, Hydrotherapy, Speech Therapy, or Occupational Therapy.

Tobacco Cessation Services

Approved counseling services and most prescription medications associated with tobacco cessation are provided free of charge. To obtain a medication, simply have your doctor complete a prescription and have it filled at an in-network pharmacy. Prescription benefits are through the pharmacy benefit provider

Surgical Services

The plan covers the following:

- **Surgical services:**
 - Surgery performed by a physician or other professional provider.
 - Benefits for multiple surgical procedures performed during the same operative session by one or more physicians or other professional providers shall be calculated based upon Blue Cross of Idaho's maximum allowance and payment guidelines.
- **Surgical supplies:**
 - When a physician or other professional provider performs covered surgery in the office, benefits are available for a sterile suture or surgery tray normally required for minor surgical procedures.
- **Surgical assistant:**
 - Medically necessary services rendered by a physician or other appropriately qualified surgical assistant who actively assists the operating surgeon in the performance of covered surgery where an assistant is required. The percentage of the maximum allowance that is used as the actual maximum allowance to calculate the amount of payment under this section for covered services rendered by a surgical assistant is 20% for a physician assistant and 10% for other appropriately qualified surgical assistants.
- **Anesthesia:**
 - In conjunction with a covered procedure, the administration of anesthesia ordered by the attending physician and rendered by a physician or other professional provider. The use of hypnosis as anesthesia is not a covered service. General anesthesia administered by the surgeon or assistant surgeon is not a covered service.
- **Second and third surgical opinion:**
 - Services consist of a physician's consultative opinion to verify the need for elective surgery as first recommended by another physician.
- **Specifications:**
 - Elective surgery is covered surgery that may be deferred and is not an emergency.
 - Use of a second consultant is at the participant's option.
 - If the first recommendation for elective surgery conflicts with the second consultant's opinion, then a third consultant's opinion is a covered service.
 - The third consultant must be a physician other than the physician who first recommended elective surgery or the physician who was the second consultant.

Temporomandibular Joint (TMJ) Syndrome

Benefits are provided as specified in the *Medical Plan Coverage At-a-Glance Chart* for services, including surgery and supplies related to the misalignment or discomfort of the temporomandibular joint, including splinting services and supplies.

Therapy Services

Occupational Therapy

Payment is limited to occupational therapy services related to Habilitative and Rehabilitative care, with a reasonable expectation that the services will produce measurable improvement in the participant's condition in a reasonable period of time. Occupational therapy services are covered when performed by:

- A physician.
- A licensed occupational therapist provided the covered services are related directly to a written treatment regimen prepared by a licensed occupational therapist and approved by a physician.

Benefits are not provided for:

- Facility-related charges for outpatient occupational therapy services, health club dues or charges, or occupational therapy services provided in a health club, fitness facility or similar setting.
- General exercise programs, even when recommended by a physician or a chiropractic physician, and even when provided by a licensed occupational therapist.
- Maintenance palliative or supportive care.
- Behavioral modification services.

Physical Therapy

Payment is limited to physical therapy services related to habilitative and rehabilitative care with reasonable expectation that the services will produce measurable improvement in the participant's condition in a reasonable period of time. Physical therapy services are covered when performed by:

- A physician,
- A licensed physical therapist, provided the covered services are related directly to a written treatment regimen prepared by the physical therapist, or
- A podiatrist.
- No benefits are provided for the following physical therapy services when the specialized skills of a licensed physical therapist are not required:
 - Range of motion and passive exercises that are not related to the restoration of a specific loss of function but are useful in maintaining range of motion in paralyzed extremities,
 - Assistance in walking, such as that provided in support for feeble or unstable patients,
 - Facility-related charges for outpatient physical therapy services, health club dues or charges, or physical therapy services provided in a health club, fitness facility or similar setting, or
 - General exercise programs, even when recommended by a physician or a chiropractic physician, and even when provided by a licensed physical therapist.
- Maintenance, palliative, or supportive care.
- Behavioral modification services.

Speech Therapy

Benefits are limited to speech therapy services related to habilitative and rehabilitative care with reasonable expectation that the services will produce measurable improvement in the participant's condition in a reasonable period of time. Speech therapy services are covered when performed by:

- A physician, or
- A speech therapist provided the services are related directly to a written treatment regimen designed by the speech therapist.

No benefits are provided for:

- Maintenance or supportive care.
- Behavioral modification services

Transplant Services

Transplants or auto-transplants of arteries, veins, blood, ear bones, cartilage, muscles, skin, hematopoietic, CAR T-Cell, and tendons; heart valves regardless of their source; implantation of artificial or mechanical pacemakers; and auto-transplants of teeth or tooth buds, and other auto-transplants as Medically Necessary.

The applicable benefits provided for hospital services and surgical services in this plan are provided only for a recipient of medically necessary transplant services.

No benefits are available for services, expenses, or other obligations of or for a deceased donor, even if the donor is a plan participant.

Transplants of corneas, kidneys, bone marrow, livers, hearts, lungs, pancreas, islet tissue, hematopoietic, heart-lung and pancreas- kidney combinations, and other solid organ or tissue transplants or combinations, and other Transplants as Medically Necessary. The applicable benefits provided for hospital services and surgical services in this plan are also provided for a recipient of medically necessary transplant services.

Benefits for transplant are subject to the following conditions:

- The participant must have the transplant performed at an appropriate recognized transplant center. If the recipient is eligible for Medicare, the recipient must have the transplant performed at a recognized transplant center that is approved by the Medicare program for the requested transplant covered service.

If the recipient is eligible to receive benefits for these transplant services, organ procurement charges shall be paid for the donor, even if the donor is not a plan participant. Benefits for the donor shall be charged to the recipient's coverage.

If the recipient is eligible to receive benefits for these transplant services, benefits for transportation and living expenses of the participant recipient and/or the participant recipient's immediate family shall be provided up to the lifetime benefit maximum of \$10,000, as shown in the *Medical Plan Coverage At-a-Glance Chart*. The benefit will be paid upon the following terms and conditions.

- The benefits will be paid only for the listed expenses incurred by the recipient or the recipient's immediate family members.
- The benefits will be reimbursed upon the submission to Blue Cross of Idaho of dated receipts showing the service provided, the cost of the service and the name, address and phone number of the service provider.
- The listed expenses will not be reimbursed unless such expenses are incurred between the time period of five days prior to the transplant to 120 days after the transplant.
- Blue Cross of Idaho reserves the exclusive right to deny payment of any such expenses it deems inappropriate, excessive, or not in keeping with the intent of this provision.

In addition to any other exclusions and limitations of this plan, the following exclusions and limitations apply to transplant services:

- Transplants of brain tissue or brain membrane, intestine, pituitary and adrenal glands, hair transplants or any other transplant not named specifically as a covered service in this plan; or for artificial organs, including, but not limited to, artificial hearts or pancreases.
- Any eligible expenses of a donor related to donating or transplanting an organ or tissue unless the recipient is a participant who is eligible to receive benefits for transplant services.
- The cost of a human organ or tissue that is sold rather than donated to the recipient.
- Transportation costs, including, but not limited to, ambulance service or air service for the donor or to transport a donated organ or tissue.
- Living expenses for the donor or the donor's family members.
- Costs covered or funded by governmental, foundation or charitable grants or programs, or physician fees or other charges if no charge is generally made in the absence of insurance coverage.
- Any complication to the donor arising from a donor's transplants. Surgery is not a covered benefit under the participant transplant recipient's plan. If the donor is a Blue Cross of Idaho participant, eligible to receive benefits for covered services, benefits for medical complications to the donor arising from transplant surgery will be allowed under the donor's policy.

Treatment for Autism Spectrum Disorder

Payment is limited to Applied Behavioral Analysis (ABA) for autism spectrum disorder and treatment for autism spectrum disorder.

Breastfeeding Support and Supply Services

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

What the Medical Plans Do Not Cover

The medical plans provide coverage for medically necessary services. They do not provide coverage for the following services, supplies, drugs, or other charges, except as required by law or otherwise specified as covered under this plan:

- Not specifically listed as a covered service.
- Not medically necessary.
- In excess of the maximum allowance.
- For hospital inpatient or outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an accidental injury or unless an attending physician certifies in writing that the patient has a non-dental, life-endangering condition that makes hospitalization necessary to safeguard the patient's health and life.
- Not prescribed by or upon the direction of a physician or other professional provider; or that are furnished by any individuals or facilities other than licensed general hospitals, physicians, and other providers.
- Investigational in nature.
- Provided for any condition, disease, illness or accidental injury covered, 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 you claim such benefits or compensation or recover losses from a third party.
- Provided or paid for by any federal governmental entity except when payment under this plan is expressly required by federal law or provided or paid for by any state or local governmental entity where its charges therefore would vary or would be affected by the existing of coverage under this plan.
- Provided for any condition, accidental injury, disease, or illness suffered as a result of any act of war or any war, declared or undeclared.
- Received from a dental, vision or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- For surgery intended mainly to improve appearance or for complications arising from surgery intended mainly to improve appearance, except for:
 - Reconstructive surgery necessary to treat an accidental injury, infection or other disease of the involved part, or
 - Reconstructive surgery to correct congenital anomalies in a dependent child.
 - Benefits for reconstructive surgery to correct an accidental injury are available even though the accident occurred while the participant was covered under a prior insurer's coverage if there is no lapse of more than (63) days between the prior coverage and coverage under this plan
- Rendered prior to the participant's effective date, or during an inpatient admission commencing prior to the participant's effective date except as specified as a covered service.
- For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance) even if prescribed by a physician

- For exercise or relaxation items or services even if prescribed by a Physician, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs, spas, hot tubs, whirlpool baths, waterbeds or swimming pools.
- For convenience items including but not limited to Durable Medical Equipment such as bath equipment, cold therapy units, duplicate items, home traction devices, or safety equipment.
- For relaxation or exercise therapies, including but not limited to, educational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, homeopathic, or naturopathic, massage, or music even if prescribed by a Physician.
- Recreational therapy or therapeutic recreation programs, which can include, but are not limited to, diabetes camps, adventure therapy, and/or wilderness therapy (which can include, but are not limited to, programs for outdoor behavioral health, childhood diabetes, and childhood cancer).
- For telephone consultations and all computer or Internet communications, except as provided in connection with Telehealth Virtual Care Services during the health care pandemic or as specified as a covered service in this plan
- For failure to keep a scheduled visit or appointment, completion of a claim form, personal mileage, transportation, food or lodging expenses or mileage, transportation, food or lodging expenses billed by a physician or other professional provider.
- For inpatient admissions that are primarily for diagnostic services or therapy services; or for inpatient admissions when the patient is ambulatory and/or confined primarily for bed rest, special diet, behavioral problems, environmental change, or treatment that does not require continuous bed care.
- For inpatient or outpatient custodial care or for inpatient or outpatient services consisting mainly of educational therapy, behavioral modification, self-care, or self-help training, except as specified as a covered service.
- For any cosmetic foot care including, but not limited to treatment of corns, calluses and toenails (except for surgical care of ingrown or diseased toenails).
- Related to dentistry or dental treatment, even if related to a medical condition or orthoptics, eyeglasses or contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses, unless specified as a covered service.
- For hearing aids or examinations for the prescription or fitting of hearing aids, except as specified as a covered service under this plan.
- For any treatment of sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence, even if related to a medical condition, except as specified as a covered service under this plan. (Covered services include treatments for the self-determined gender identity of the Participant. Covered services also include hormone therapy and treatment for the organs possessed by the Participant (e.g. prostate or ovary) regardless of gender identity.)
- Made by a licensed general hospital for failure to vacate a room on or before the established discharge hour.
- Not directly related to the care and treatment of an actual condition, illness, disease or accidental injury.
- Furnished by a facility that is primarily a place for treatment of the aged or that is primarily a nursing home, convalescent home, or rest home.
- For acute care, rehabilitative care, or diagnostic testing except as specified as a covered service in the plan; for mental or nervous conditions and substance use disorder services not recognized by the American Psychiatric and American Psychological Associations.
- For any of the following, even if the service or supply is to treat a result of a congenital anomaly or a developmental problem and even if it is medically necessary — appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a covered service;; for implants in the jaw; for pain,

treatment or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies.

- For alveolectomy or alveoloplasty when related to tooth extraction.
- For weight control or treatment of obesity or morbid obesity, even if medically necessary, including but not limited to surgery for obesity unless specified as a covered service under this plan or as specifically provided by the Weight Management Program listed as a Covered Service in the Plan. For reversals or revisions of surgery for obesity, except when required to correct an immediately life-endangering condition.
- For use of operating, cast, examination, or treatment rooms or for equipment located in a provider's office or facility, except for emergency room facility charges in a licensed general hospital, unless specified as a covered service.
- For the reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties.
- Treatment for reproductive procedures, including but not limited to, ovulation induction procedures and pharmaceuticals, artificial insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance reproductive ability, including but not limited to laboratory services, radiology services or similar services related to treatment for fertility or fertilization reproduction procedures.
- For transplant services and artificial organs, except as specified as a covered service.
- For acupuncture.
- For surgical procedures that alter the refractive character of the eye including, but not limited to, radial keratotomy, myopic keratomileusis, Laser-In-Situ Keratomileusis (LASIK) and other surgical procedures of the refractive-keratoplasty type, to cure or reduce myopia or astigmatism, even if medically necessary, unless specified as a covered service. Additionally, reversals, revisions and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.
- For hospice home care, except as specified as a covered service.
- For pastoral, spiritual, bereavement counseling or marriage counseling.
- For homemaker and housekeeping services or home-delivered meals.
- Payment for items or services not permitted under applicable state law or for the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.
- For treatment or other healthcare in connection with an illness, disease, accidental injury or other condition that would otherwise be covered under any medical payments provision, no-fault provision, motorist provision or other first party or no-fault provision of any automobile, homeowner's or other similar policy of coverage, contract or underwriting plan.
- For which you would have no legal obligation to pay in the absence of coverage under this policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of coverage, or for which reimbursement or payment is contemplated under an agreement with a third party.
- For a routine or periodic mental or physical examination that is not connected with the care and treatment of an actual illness, disease, or accidental injury or for an examination required on account of employment; or related to an occupational injury; for a marriage license; or for coverage, school or camp application; or a screening examination including routine hearing examinations, unless specified as a covered service.
- For immunizations except as provided as a covered service.
- For surgery for gynecomastia
- For nutritional supplements.
- For replacements, nutritional formulas except, when administered enterally due to impairment in digestion and absorption of an oral diet and is the sole source of caloric

- need or nutrition in a participant, or except as specified as a covered service in this plan.
 - For vitamins and minerals, unless required through a written prescription and cannot be purchased over the counter.
 - For an elective abortion, except to preserve the life of the participant upon whom the abortion is performed.
 - For alterations or modifications to a home or vehicle.
 - For special clothing, including shoes (unless permanently attached to a brace).
 - Provided to a person enrolled as an eligible dependent, but who no longer qualifies due to a change in eligibility status that occurred after enrollment.
 - Provided outside the United States, if it would not be a covered service if it had been provided in the United States.
 - For outpatient pulmonary and/or cardiac rehabilitation except as provided as a covered service.
 - For complications arising from the acceptance or utilization of non-covered services.
 - For the use of hypnosis, as anesthesia or other treatment, except as specified as a covered service.
 - For dental implants, appliances, and/or prosthetics and/or treatment related to orthodontia, even when medically necessary, unless specified as a covered service.
 - For arch supports, orthopedic shoes, and other foot devices, except as specified as a covered service in this plan
 - For wigs and cranial molding helmets, unless used to protect post cranial vault surgery, except as specified as a covered service in this plan. Wigs are covered for \$300 for alopecia and cancer (subject to deductible and co.)
 - For surgical removal of excess skin that is the result of weight loss or gain, including but not limited to association with prior weight reduction (obesity) surgery.
 - For the purchase of therapy or service dogs/animals and the cost of training/maintaining said animals.
 - For the treatment of injuries sustained while operating a motor vehicle under the influence of alcohol and/or narcotics unless the injuries arose as result of a physical or mental health condition. For purposes of this Plan exclusion, "Under the influence" means a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred, or no breathalyzer exam was performed, or the person refused to submit to a requested breathalyzer or blood test or was under the influence of illegal drugs.
- Rendered after exhaustion of an established benefit limit, unless authorized at the discretion of the Plan Sponsor and in accordance with specific Blue Cross of Idaho medical criteria.

Prescription Drug Benefits

When you enroll in a medical plan, you automatically receive prescription drug coverage. Our prescription drug coverage provides you with retail and mail-order pharmacy prescription drug benefits — offering you cost savings and convenience.

Prescription drug benefits are managed by CVS Caremark.

Prescription Discount Cards, Manufacturer's Coupons & Rebates

Using a discount card, manufacturer's coupon or rebate may cause you to receive improper benefits and potentially even commit fraud if you accumulate expenses towards your pharmacy deductible or cost-share maximum that you did not actually pay out of pocket when using the University of Idaho Medical Program.

If you are on the High Deductible Health Plan (HDHP) it is YOUR responsibility to advise Blue Cross of Idaho so an adjustment can be made to your deductible and out-of-pocket accumulators appropriately. All applicable claims will be re-adjudicated, and you will be

responsible for amounts that were incorrectly applied toward your deductible and/or cost-share maximum. **You can do this by calling the Customer Service number listed on the back of your member medical ID card.**

The Prescription Drug Formulary

The CVS Caremark formulary is a list of drugs approved for coverage under your pharmacy benefit. The formulary includes brand name and generic drugs that have undergone rigorous testing and are approved by the Food and Drug Administration (FDA).

How the Formulary Works

In most cases you will be responsible for a portion of the cost of each prescription you have filled. The portion you pay is your copayment or cost-sharing, and depending on the drug prescribed, your cost can vary. The CVS Caremark formulary has three tiers, with the first tier (i.e., generic drugs) costing you the least and the third tier (i.e., non-formulary brand name drugs) costing you the most. Asking your doctor to prescribe drugs listed in the first (i.e., generic drugs) or second tier (i.e., formulary brand name drugs) of the formulary can save you money.

Information on Drug Tiers

In the Standard PPO Plan, there are three tiers of prescription drugs subject to different payment levels. The list of covered drugs and their tier level is available at www.caremark.com. **Drugs that include a zero co-pay are also included on the list of prescription drugs and tier level found on www.caremark.com. The zero-copay list includes the full-range of the U.S. Food and Drug Administration (FDA) approved preventive contraceptive drugs for compliance with the affordable care act.** For prescription drugs that must be covered at 100% under the ACA, the plan will provide an exception for brand drugs, and will accommodate any individual for whom the generic would be medically inappropriate.

Covered formulary generic drugs.

- Generic drugs are the most affordable. A generic drug is labeled with the medication's basic chemical name and usually has a brand name equivalent. The (FDA) requires generic drugs to have the same active chemical composition, same potency and be offered in the same form as their brand name equivalents. Generic drugs must meet the same FDA standards as brand name drugs and are tested and certified by the FDA to be as effective as their brand name counterparts.

You will pay the least when your doctor prescribes generic drugs.

- *Covered formulary brand name drugs.* These are the preferred brand name drugs that have no generic equivalent. You're covered for these medications at a slightly higher cost than generic drugs.

You will pay more for a brand name drug on CVS Caremark's formulary than for generics.

- *Covered non-formulary brand name drugs.* These are brand name drugs that either have equally effective and less costly generic equivalents or one or more brand name formulary options. You or your doctor may decide that a brand name non-formulary medication is best for you.

You pay the highest copayment when your doctor prescribes a drug that is not on the CVS Caremark formulary. If you purchase a brand name drug when an equivalent generic is available, you will pay the appropriate brand copayment, plus 100% of the cost difference between the brand and generic. This is almost always 100% of the cost of the brand name drug.

Preauthorization

Your physician or pharmacist will tell you if your medication requires preauthorization. If

preauthorization is required, your physician must provide documentation showing that the prescription is medically necessary. A determination will be made within 15 days of the request for preauthorization, or a request for additional information will be made to your physician.

If preauthorization is not obtained, you may be held responsible for the entire cost of the drug. Please refer to “*Preauthorization*” section below.

Quantity Limits

Certain drugs found on the formulary can only be dispensed in limited quantities. Your pharmacist can only dispense these drugs up to the predetermined limit. These drugs have been found to be less effective or even dangerous when taken at higher-than-normal doses. The quantity limit restrictions on these drugs are consistent with usage recommendations from the manufacturers.

For More Information

For the most current, up-to-date information, please refer to the prescription drug formulary found at the CVS Caremark Website at **www.caremark.com**.

If you have questions about any of your medications, please discuss them with your doctor or pharmacist.

Finding a Network Pharmacy

It’s easy to find a CVS Caremark Network Pharmacy in Idaho. Call the number on your ID card or log on to **www.caremark.com**.

Using the Mail Order Pharmacy

Participants enrolled in the Standard PPO and the High Deductible Health Plan (HDHP) can purchase a 90-day supply of prescription drugs from the mail order pharmacy. The mail order pharmacy can be used on a continued basis for maintenance medication and may save you money.

To order a new prescription through the mail order pharmacy:

Mail your prescription and a completed order form to CVS Caremark or ask your doctor to call in your prescription toll-free at 1-800-378-5697.

You should receive your prescription drug in 10-14 business days. There is no charge for regular U.S. Postal Service.

You can download prescription refill forms at **www.caremark.com**. Make sure your physician writes your prescription for a 90-day supply of medicine with three refills (if possible).

Flexibility in Filling 90-day Prescriptions

You can receive a 90-day supply of prescription drugs either at a participating retail pharmacy or through the mail order pharmacy. You will pay three retail copayments for 90-day prescriptions filled at the retail pharmacy. Find a participating pharmacy by calling the number listed on your ID card. Keep in mind, you will continue to pay less for 90-day prescriptions when you use the mail order pharmacy.

Preauthorization

Certain prescription drugs may require preauthorization. If your physician prescribes a drug that requires preauthorization, you will be informed by the pharmacist. To obtain preauthorization, your physician must provide CVS Caremark with information describing the medical necessity for the prescription.

Utilization Review

CVS Caremark may review prescription drug use. If there are patterns of over-utilization or misuse of drugs, a participant's physician or pharmacist may be notified. CVS Caremark reserves the right to limit quantities to prevent over-utilization or misuse of prescription drugs.

Prescription drug benefits work differently in the Standard PPO Plan and the High Deductible Health Plan (HDHP).

Standard PPO Prescription Drug Benefits

In the Standard PPO Plan, you pay for the full cost of prescription drugs until you meet the \$125 per-individual deductible (or two individual deductibles per family). Once you meet the deductible, you will pay 25% cost-sharing for your prescription drugs from the retail pharmacy until you reach your prescription drug Cost-Share Maximum. However, your cost-sharing amount will be subject to a minimum and maximum copayment. If you order from the mail order pharmacy, you will pay a flat dollar copayment. This table shows your costs **after you've met the prescription drug deductible**.

* **IMPORTANT!** If you purchase a brand name drug when an equivalent generic is available, you will pay the appropriate brand copayment, plus 100% of the cost difference between the brand and the generic. This is almost always 100% of the cost of the brand name drug.

Prescription Discount Cards, Manufacturer's Coupons & Rebates

- Using a discount card, manufacturer's coupon or rebate may cause you to receive improper benefits and potentially even commit fraud if you accumulate expenses towards your deductible or cost-share maximum that you did not actually pay out of pocket when using the University of Idaho Medical Program.
- **It is YOUR responsibility** to advise Blue Cross of Idaho so an adjustment can be made to your deductible and out-of-pocket accumulators appropriately. All applicable claims will be re-adjudicated, and you will be responsible for amounts that were incorrectly applied toward your deductible and/or cost-share maximum. **You can do this by calling the customer service number listed on the back of your member ID card.**

Generic Drug Requirement

Standard PPO Prescription Drug Benefit		
Prescription Drug Deductible		
Individual	\$125	
Family (max of 2x individual)	\$250	
Prescription Drug Tier	Retail Pharmacy 30-day or less supply through CVS Caremark pharmacies	Mail-Order 90-day supply through CVS Caremark
Generic	25% \$12 minimum / \$25 maximum	\$36
Formulary Brand Name*	25% \$25 minimum / \$75 maximum	\$75
Non-formulary Brand* Name	25% \$40 minimum / \$100 maximum	\$120

Annual Prescription Drug Cost-Share maximum

(Once you satisfy the applicable deductible, you pay cost-sharing/copayments until you satisfy the prescription drug cost-share maximum, then the plan pays for 100% of expenses for covered prescription drugs. Please see “Cost-Share Maximum” in the *General Benefit Information* section for more information.)

Individual	\$ 4,525
Family	\$ 9,050
Total Annual Cost Exposure Prescription Drug Expenses	
Individual	\$ 4,650
Family	\$9,300

You receive the highest level of benefit when you purchase generic drugs. Using generic drugs maximizes the value to both you and the University of Idaho by providing the same therapeutic effect as the more expensive equivalent name brand but at a fraction of the cost.

You can keep your copayments and contributions as low as possible without sacrificing quality by utilizing generic drugs whenever they are available.

If you purchase a brand name drug when an equivalent generic is available, you will pay the appropriate brand copayment, plus 100% of the cost difference between the brand and generic. This is almost always 100% of the cost of the brand name drug.

IMPORTANT!

In the Standard PPO Plan, prescription drug cost-sharing and copayments do not count toward satisfying the annual medical deductible or medical cost-share maximum.

High Deductible Health Plan (HDHP) Prescription Drug Benefits

The HDHP offers a Preventive Therapy Drug formulary covered at 100%. The list of covered prescriptions is available at www.caremark.com. For all prescriptions not covered under the Preventive Therapy Drug formulary, you pay 100% of prescription drug costs until your eligible, combined medical and prescription drug expenses satisfy the deductible. Once you satisfy the deductible, you pay 30% of your prescription drug's cost until you reach the out-of-pocket maximum, then the plan pays 100% of covered services.

In the HDHP, amounts you pay for prescription drugs count toward the deductible. Amounts you pay in cost-sharing after you satisfy the deductible, count toward the annual combined pharmacy and medical out-of-pocket maximum.

What the Prescription Drug Plan Covers

The following are covered under the prescription drug plan:

- Prescription drugs approved by CVS Caremark Appeals Committee.
- Compounded medication of which at least one ingredient is a prescription drug.
- Insulin and insulin syringes/needles, so long as you have a valid prescription on file with the pharmacy.
- Oral contraceptives and other prescription hormonal contraceptives, such as the Ortho Evra patch and NuvaRing. Generally, only generic contraceptives will be zero-cost, but brand names may be covered if the patient's physician verifies it is due to medical necessity. (Coverage is in compliance with ACA with specific information located on www.caremark.com)
- Medications prescribed for the treatment of erectile dysfunction or impotency.

- Bariatric medications with a valid pre-authorization (Blue Cross of Idaho Center of Excellence Provider Only)

Please note: Prescription drugs received while in the hospital are covered under the medical plan.

Prescription Discount Cards, Manufacturer's Coupons & Rebates

- Using a discount card, manufacturer's coupon or rebate may cause you to receive improper benefits and potentially even commit fraud if you accumulate expenses towards your deductible or cost-share maximum that you did not actually pay out of pocket when using the University of Idaho Medical Program.
- **It is YOUR responsibility** to advise Blue Cross of Idaho so an adjustment can be made to your deductible and cost-share accumulators appropriately. All applicable claims will be re-adjudicated, and you will be responsible for amounts that were incorrectly applied toward your deductible and/or Cost-share maximum. **You can do this by calling the Customer Service number listed on the back of your member ID card.**

What's Not Covered under the Prescription Drug Plan

In addition to other plan limitations and exclusions, the prescription drug benefit does not cover the following:

- Drugs used for the termination of early pregnancy and/or resulting complications, except when required to correct an immediately life-endangering condition.
- Over-the-counter drugs (other than insulin and smoking and tobacco use cessation drugs), even if prescribed by a physician.
- Special handling fees associated with any covered prescription drug.
- Drugs labeled "Caution — Limited by Federal Law to Investigational Use" or experimental drugs, even though a charge is made to the participant.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.
- Any newly FDA-approved prescription drug, biological agent or other agent, until it has been reviewed and approved by CVS Caremark's Pharmacy and Therapeutics Committee.
- Prescription drugs, biological or other agents that are:
 - An anorectic, amphetamine, or stimulant, unless authorized by CVS Caremark.
 - Prescribed primarily to slow the rate of hair loss or to aid in the replacement of lost hair.
 - Prescribed primarily to increase fertility including, but not limited to, drugs that induce or enhance ovulation.
 - Prescribed primarily for personal hygiene, comfort, beautification, or the purpose of improving appearance.

Wellness and Health Improvement Resources

Here is a summary of the various tools and incentives that can support you on your journey to good health.

Resource	Description	How to Access
WellConnected Web site (For medical plan participants)	<p>Access to health and well-being programs, information, and online tools through Blue Cross of Idaho.</p> <p>Complete the online health assessment for a snapshot of your current health status, recommendations for how to stay healthy and comparisons with prior results if you've completed a personal health assessment in the past.</p>	<p>Log on to Error! Hyperlink reference not valid.(Register for site access if you haven't already.)</p> <p>Click on Members, enter your username and password, select Go, then select Get Connected.</p> <p>Complete any additional registration requested, and then you will be able to take the personal health assessment.</p>
Wondr Health (for medical plan participants)		
Tobacco cessation support	Most tobacco cessation medications as prescribed by your doctor.	Simply obtain a prescription from your doctor and take it to any in-network pharmacy to have it filled.
Chronic condition management (For medical plan participants)	<i>Information, counseling and other support provided through trained healthcare providers for conditions such as asthma, diabetes, heart disease and low back pain.</i>	Call 1-800-627-6655 . Or, log on to www.members.bcidaho.com/Health_Wellness/ , and click on Learn More under Disease Management Programs.
Nurse Help Line (for medical plan)	Around-the-clock access to medical service representatives as well as hundreds of recordings	Call the Nurse Help Line at 1-888-993-7120 .
Health advocate (HDHP participants only)	Provides HDHP participants with a range of benefits and services, such as help finding the best doctors and hospitals and assistance resolving insurance claims.	Call a Health advocate at 1-866-695-8622 .

Adoption Assistance

Employees enrolled in university medical benefits are eligible for financial assistance toward an adoption. Full-time employees are eligible for up to a \$2,000 lifetime benefit. Three-quarter-time and half-time employees are eligible for a prorated benefit. Learn more at <https://www.uidaho.edu/benefits/otherbenefits/adoptionassistance>.

Claims Procedures for Medical Claims

This section provides you with important information about how to file a claim for medical benefits.

There are several types of health claims:

- **Pre-service claim:** This is a claim for a benefit for which the plan conditions receipt of the benefit (in whole or in part) on approval of the benefit before medical care is received.
- **Urgent care claim:** This is a type of pre-service claim for medical care or treatment in which the application of the time periods for making pre-service claim determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- **Concurrent care claim:** This is a type of pre-service claim involving approval of ongoing treatment over a period of time or the number of treatments; some concurrent claims are also urgent care claims.
- **Post-service claim:** Any claim for a benefit that is not a pre-service or urgent care claim; a post-service claim involves reimbursing you or a provider for care you have already received; claims for reimbursement under the Healthcare FSA are considered post-service claims.

Failure to Follow Claims Procedures

Pre-Service Claim

If you fail to follow the claim procedures for filing a pre-service claim, you will be notified of the failure no later than five days after the failure — and the notice will describe the proper procedures for filing a claim. The five-day time frame only applies in the case of a failure:

- That involves communication made to an individual or department that customarily handles benefits matters, and
- That names a specific claimant; specific medical condition or symptom; and the specific treatment, service or product being requested.

Urgent Care Claim

If you fail to follow the claim procedures for filing an urgent care claim, you will be notified of the failure no later than 24 hours after the failure — and the notice will describe the proper procedures for filing a claim. The 24-hour time frame only applies in the case of a failure:

- That involves communication made to an individual or department that customarily handles benefits matters, and
- That names a specific claimant; specific medical condition or symptom; and the specific treatment, service or product being requested.

Failure to Provide Sufficient Information

Urgent Care or Urgent Concurrent (Ongoing) Care Claims

If you fail to provide sufficient information necessary to decide the claim, you will be notified no

later than 24 hours after receipt of your claim about the specific, additional information that you need to submit. You will have at least 48 hours to provide the requested information.

Then, you will be notified of the claim decision no later than 48 hours after the earlier of:

- The date of receipt of the specific, additional information, or
- The end of the period during which you may provide this additional information.

Pre-Service Claim

If you fail to provide sufficient information necessary to decide the claim, and an extension is necessary because you failed to submit the necessary information, you will be notified within 15 days. The notice will specify what information is necessary to complete the claim and you will have at least 45 days to provide the requested information.

Post-Service Claim

If you fail to provide sufficient information necessary to decide the claim, and an extension is necessary because you failed to submit the necessary information, you will be notified within 30 days. The notice will specify what information is necessary to complete the claim and you will have at least 45 days to provide the requested information.

If you do not provide the requested information within the specified time frame, your claim will be decided without that information.

Timing of Notification of Claim Decision

You will receive written notification of the decision regarding your claim within the time frames noted below (based on the type of claim).

Type of Claim	Timing of Notification	Extension
Urgent care	As soon as possible, taking into account the medical demands, but not later than 72 hours after receipt of the claim	Not applicable
Concurrent care – Urgent claim for ongoing care: Extension of the course of treatment or number of treatments	As soon as possible, taking into account the medical demands, but not later than 24 hours after receipt of the claim (provided that you submitted a claim at least 24 hours before the expiration of the course of treatment or number of treatments); if you did not submit a claim at least 24 hours before the expiration of the course of treatment or number of treatments, the notice of claim decision will be provided no later than 72 hours after receipt	Not applicable

Concurrent care – non-urgent claim for ongoing care: Reduction or elimination of a course of treatment before the end of the course of treatment or number of treatments	Sufficiently in advance of the reduction or termination of a course of treatment to allow time for you to appeal and get a review before the benefit is reduced or eliminated	Not applicable
Pre-service	Within a reasonable period of time appropriate to the medical circumstances but not later than 15 days after receipt of the claim	Initial notification may be extended up to 15 days if an extension is necessary due to matters beyond the control of the plan; you will be notified before the end of the first 15-day period why the extension is necessary and when a decision is expected to be made
Post-service	Within a reasonable period of time appropriate to the medical circumstances but not later than 30 days after receipt of the claim	Initial notification may be extended up to 15 days if an extension is necessary due to matters beyond the control of the plan; you will be notified before the end of the first 30-day period why the extension is necessary and when a decision is expected to be made

If Your Claim Is Denied

If your claim is denied, in whole or in part, you will receive a written notice within the timeframes specified above (In the case of an urgent care claim, you may be notified orally and within three days of this oral notification, you will receive a written notice that contains the information described below.)

For purposes of this claim and appeal procedure, a benefit determination includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

- A determination of an individual's eligibility to participate in coverage,
- A determination that a benefit is not a covered benefit,
- The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits, or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

In addition, if your coverage is rescinded (terminated retroactively), that decision also will be considered a benefit determination which can be appealed as provided in this section.

The notice of initial denial will contain the following information:

- Identify the claim involved (e.g., the date of service, health care provider, claim amount if applicable).
- State that, upon free of charge, the diagnosis code and/or treatment code, and their

corresponding meanings will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review.

- The specific reason(s) for the denial including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim
- The specific plan provisions on which the denial is based.
- Contain a statement that you are entitled, upon request, free access to and copies of documents relevant to your claim.
- Provide an explanation of the Plan's internal appeal along with time limits information regarding how to initiate an appeal.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon to determine a claim, you will either receive a copy of the actual rule, guideline, protocol or other criterion or a statement that the rule, guideline, protocol, or other criterion was used and that you can request a copy free of charge.
- If the denial is based on a provision such as medical necessity, experimental treatment or a similar exclusion or limit, you will either receive an explanation of the scientific or clinical judgment for the determination based on the plan terms and your medical circumstances, or a statement that you can receive the explanation free of charge upon request.
- A description of any additional material or information needed to perfect the claim and an explanation of why it is necessary.
- An explanation of the expedited claim review procedure, for an urgent care claim.
- Disclose the availability of and contact information for any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is relevant).
- If applicable, include an offer of assistance in the appropriate non-English language to satisfy the ACA's culturally and linguistically appropriate requirements.
- Such other information as required by applicable law.

If new or additional evidence is considered, relied upon, or generated in connection with the claim, or if any new or additional rationale is used for a denial at the internal appeals stage, such evidence or rationale will be provided to you free of charge. You will be given a reasonable opportunity to respond to such new evidence or rationale.

As an employee in the State of Idaho, you have access to an independent external review process; please see the *Independent External Review* section for more information.

Filing an Appeal

You or your authorized representative may appeal a claim decision by submitting a written appeal to the appropriate Claims Administrator. If you want someone else to represent you, you must include a signed Blue Cross of Idaho's "Appointment of an Authorized Representative" form with the request before Blue Cross of Idaho, on behalf of the University, determines that an individual has been authorized to act on your behalf. The form can be found on Blue Cross of Idaho's Web site www.members.bcidaho.com. You must make this request in writing within 180 calendar days from the date you receive written notice of the denied claim. For a second level appeal you must make the request in writing within 60 calendar days of receipt of written notification of 1st level appeal decision.

You or your authorized representative will be given reasonable access to all documents, records, and information relevant to the claim for benefits, and you may request copies free of charge. You can also submit written comments, documents, records, and other information relating to the claim. Review of your claim will take into account all comments, documents, records, and other

information, without regard to whether such information was submitted or considered in the initial benefit determination.

If the Claims Administrator relies on or generates any new evidence during the appeal process or bases its appeal decision on a new rationale, it will provide you with the new evidence or rationale to you free of charge, as soon as possible and sufficiently in advance of the appeal decision deadline to give you the opportunity to respond.

In case of an urgent care claim that is denied, you can submit a request for an expedited appeal to the Claims Administrator either orally or in writing. All necessary information, including the decision on review, may be transmitted by phone, fax or other similarly expeditious method.

Decision on Appeal

The appeal will be considered by someone who did not make the initial decision and who is not a subordinate of the party who made that decision. In either case, this level fiduciary (or “appeals fiduciary”) will not defer to the initial benefit determination and will consider all comments, documents, records, and other information you submit for the claim, even if the information was not submitted or considered in the initial benefit determination. If the initial denial was based on a medical judgment, the appeals fiduciary will consult with a healthcare professional who has appropriate training and experience in the medical field. This healthcare professional will not be an individual who was consulted in connection with the initial benefit determination or the subordinate of any such individual. The appeals fiduciary will identify any medical or vocational experts whose advice was sought in making the earlier determination.

Timing of Notification of Appeal Decision

In most cases, you will receive written notification of the appeal decision within the following time frames after the Claims Administrator receives your request for review:

Type of Appeal	Timing of Notification
Urgent care	As soon as possible, taking into account the medical demands, but not later than 72 hours after receipt of the appeal request
Concurrent care – Urgent	As soon as possible, taking into account the medical demands, but not later than 72 hours after receipt of the appeal request
Concurrent care – non-urgent	Before a reduction or termination of benefits would occur
Pre-service	A reasonable period of time appropriate to the medical circumstances; if there are two levels of appeal, notification on the first level will be made no more than 15 days after receipt of the first-level appeal request and notification on the second level will be made no more than 15 days after receipt of the second-level appeal request

Post-service	A reasonable period of time appropriate to the medical circumstances; if there are two levels of appeal, notification on the first level will be made no more than 30 days after receipt of the first-level appeal request and notification on the second level will be made no more than 30 days after receipt of the second-level appeal request
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If your appeal is denied, in whole or in part, you will receive a written notice (a final adverse benefit determination) that contains:

- The specific reason(s) for the denial,
- The specific plan provisions on which the denial is based,
- A statement that you are entitled to receive, upon request and free of charge, access to and copies of all documents, records, and other information relevant to the claim,
- If an internal rule, guideline, protocol, or other similar criterion was relied upon to deny your claim, you will either receive a copy of the actual rule, guideline, protocol or other criterion or a statement that the rule, guideline, protocol or other criterion was used and that you can request a copy free of charge, and
- If the denial is based on a provision such as medical necessity, experimental treatment or a similar exclusion or limit, you will either receive an explanation of the scientific or clinical judgment for the determination based on the plan terms and your medical circumstances, or a statement that you can receive the explanation free of charge upon request.
- Such other information as required by 45 CFR 147.136(b)(2)(E).

If the Claim Administrator fails to adhere to the timeframes set out above or other fails to meet the requirements of this section, a claimant will be deemed to have exhausted the internal appeals process and may initiate the External Review process described below or pursue any applicable remedies under state law.

Legal Action

You cannot bring legal action to recover any benefit under a University benefit plan if you do not file a claim for a benefit and seek timely review of an adverse benefit determination. In addition, no legal action may be brought more than one year after an appeal has been denied.

Your Right to an Independent External Review

Please read this carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with the Claims Administrator. If you or your authorized representative requests an independent external review of a claim, the decision made by the independent reviewer will be binding and final on the Trust and you. Except in limited circumstances, you or your authorized representative will have no further right to have the claim reviewed by a court, arbitrator, mediator, or other dispute resolution entity.

If the Claims Administrator on behalf of the University, issues a final adverse benefit determination of your request to provide or pay for a health care service or supply, you may have the right to have the Claims Administrator's decision reviewed by health care professionals who have no association with the Claims Administrator. You have this right only if the Claims Administrator's denial decision involved:

- The medical necessity of your health care service or supply,
- The Claims Administrator's determination that your health care service or supply was investigational, or
- A request for benefits that are covered by the federal No Surprises Act..

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

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

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

For more information and for an external review request form:

- See the department's web site, **www.doi.idaho.gov**, or
- Call the department's telephone number, **(208) 334-4250**, or toll-free in Idaho, **1-800-721-3272**.

You may act as your own representative in a request, or you may name another person, including your treating health care provider, to act as an authorized representative for a request. If you want someone else to represent you, you must include a signed Blue Cross of Idaho "Appointment of an Authorized Representative" form with the request before Blue Cross of Idaho, on behalf of the Claims Administrator, determines that an individual has been authorized to act on your behalf. The form can be found on Blue Cross of Idaho's website at www.members.bcidaho.com. Your written external review request to the Department of Insurance must include a completed form authorizing the release of any medical records the independent review organization may require reaching a decision on the external review, including any judicial review. The department will not act on an external review request without your completed authorization form. If the request qualifies for external review, the Claims Administrator's final adverse benefit determination will be reviewed by an independent review organization selected by the Department of Insurance. The University will pay the costs of the review.

Standard External Review Request: You must file a written external review request with the Department of Insurance within four months after the date the Claims Administrator issues a final notice of denial.

1. Within seven days after the Department of Insurance receives the request, the Department of Insurance will send a copy to the Claims Administrator.
2. Within 14 days after the Claims Administrator receives the request from the Department of Insurance, it will review the request for eligibility. Within five business days after the Claims Administrator completes that review, it will notify you and the Department of Insurance in writing if the request is eligible or what additional information is needed. If the Claims Administrator denies the eligibility for review, you may appeal that determination to the Department.
3. If the request is eligible for review, the Department of Insurance will assign an independent review organization to your review within seven days of receipt of the Claims Administrator's notice. The Department of Insurance will also notify you in writing.

4. Within seven days of the date you receive the Department of Insurance's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, the Claims Administrator, and the Department of Insurance within 42 days after receipt of an external review request.

Expedited External Review Request: A Participant may file a written "urgent care request" with the Department of Insurance for an expedited external review of a pre-service or concurrent service denial. The Participant may file for an internal urgent appeal with the claims administrator and for an expedited external review with the Idaho Department of Insurance at the same time.

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

- Could seriously jeopardize you or your dependent's life or health or the ability of the to regain maximum function.
- In the opinion of the covered provider with knowledge of the covered person's medical condition, would subject you or your dependent to severe pain that cannot be adequately managed without the disputed care or treatment; or the treatment would be significantly less effective if not promptly initiated.

The Department of Insurance will send your request to the Claims Administrator. The Claims Administrator will determine, no later than the second full business day, if the request is eligible for review. The Claims Administrator will notify you and the Department of Insurance no later than one business day after the Claims Administrator's decision if the request is eligible. If the Claims Administrator denies the eligibility for review, you may appeal that determination to the Department of Insurance. If the request is eligible for review, the Department of Insurance will assign an independent review organization to the review upon receipt of the Claims Administrator's notice. The Department of Insurance will also notify you. The independent review organization must provide notice of its decision to you, the Claims Administrator, and the Department of Insurance within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses the Claims Administrator's denial, the Claims Administrator will notify you and the Department of Insurance of the approval of coverage as soon as reasonably practicable, but not later than one business day after making the determination.

Binding Nature of the External Review Decision: The external review decision by the independent review organization will be final and binding on the Claims Administrator, Trust and you. **This means that if you elect to request external review, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of the Claims Administrator's denial after the independent review organization issues its final decision.** If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

Your Health Information

This section summarizes how medical information about you may be used and disclosed. It also describes how you can access this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This section is intended to satisfy HIPAA's requirement to provide you with notice that the University complies with the HIPAA privacy rules with respect to safeguarding your health information that is created, received, or maintained by the University's healthcare plans.

The University's healthcare plans need to create, receive, and maintain records that contain health information about you to administer the plans and provide you with healthcare benefits. Under the HIPAA privacy rules, the University's healthcare plans may use and disclose health information about you.

The University's Pledge Regarding Health Information Privacy

The privacy policy and practices of the University's healthcare plans protect the confidential health information that identifies you or could be used to identify you and relate to a physical or mental health condition or the payment of your healthcare expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as otherwise permitted or required by federal and state health information privacy laws.

HIPAA Privacy and Security

Certain authorized individuals of the University's workforce perform services in connection with administration of the Plan. To perform these services, it is necessary for certain employees to have access to PHI.

Under the standards for privacy of individually identifiable health information, these individuals are permitted to have such access to the following:

General. The Plan will not disclose PHI to any authorized individual of the University's workforce unless the requirements of this section are met. PHI will generally mean individually identifiable health information about the past, present and future physical or mental health condition of an individual, including information about treatment or payment for treatment.

Permitted Uses and Disclosures for Plan Administration. PHI disclosed to Authorized Individuals of the University's workforce will be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions will include all payment and health care operations. Generally, payment is defined as any activity undertaken by the Plan to collect money due to it or to determine or fulfill its responsibility for payment of benefits due under the Plan. Health care operations include activities related to payment and plan administration. Plan administration functions do not include employment-related functions or functions in connection with other benefit plans.

Prohibition on Use or Disclosure of Genetic Information for Underwriting Purposes. The Plan will not use or disclose PHI that is genetic information for underwriting information.

Underwriting purposes means, with respect to the Plan:

- rules for, or determination of, eligibility (included enrollment and continued eligibility) under the Plan.
- the computation of contribution amounts under the Plan.
- the application of any preexisting condition exclusion under the Plan, coverage or policy, and
- other activities related to the creation, renewal, or replacement of a contract of health benefits.

Authorized employees/individuals. The Plan will disclose PHI only to authorized individuals of the University's workforce who are authorized to receive PHI and only to the extent and in the minimum amount necessary for these individuals to perform Plan functions. These individuals include:

- the Director of Human Resources.
- employees working in the benefits department.
- employees working in the Information Technology Department who support those working in the benefits department.

Use and Disclosure Restricted. An Authorized Individual of the University's workforce who receives PHI will use or disclose the PHI only to the extent necessary to perform his or her duties with respect to the Plan's administrative functions.

Resolution of Issues of Noncompliance. In the event that any Authorized Individual of the University's workforce uses or discloses PHI other than as permitted by the privacy standards, the incident will be reported to the Privacy Official. The Privacy Official will take appropriate action, including:

- Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
- Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
- Mitigating any harm caused by the breach, to extent practicable; and
- Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

Certification of Employer. The University must provide certification to the Plan that it agrees to:

- Not use or further disclose the PHI other than as permitted or required by the plan documents or as required by law.
- Ensure that any agent or subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to the University with respect to such information.
- Not use or disclose PHI for employment-related actions and decisions and in connection with any other benefit or employee benefit plan of the University.
- Report to the Plan any use or disclosure of PHI of which it becomes aware that it is inconsistent with the uses or disclosures permitted or required by law.
- Make available PHI to individual Plan covered individuals in accordance with Article 164.524 of the Privacy Standards.

- Make available PHI by for amendment by individual Plan covered individuals and incorporate any amendments to PHI in accordance with Article 164.526 of the Privacy standards.
- If feasible, return or destroy all PHI received from the Plan that the University maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and ensure the adequate separation between the Plan (including Authorized Individuals of the Employer's workforce) and the Employer, as required by Article 164.504(f)(2)(iii) of the privacy standards.

Compliance with HIPAA Security Standards. If the University creates, receives, maintains, or transmits Electronic PHI of behalf of the Plan (other than enrollment/disenrollment information, summary health information, and information disclosed pursuant to a HIPAA-compliant authorization, which are not subject to these restrictions, the University will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
- Ensure that the adequate separation between the Plan and University (i.e., the firewall is supported by reasonable and appropriate security measures.
- Ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which it becomes aware as follows: University will report to the Plan, with such frequency and as such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, University will report to the Plan as soon as feasible any successful unauthorized access, use disclosure, modification, or destruction of Electronic PHI or interference with systems operation in an information system containing Electronic PHI.

Electronic Protected Health Information or Electronic PHI means Protected Health Information that is transmitted by or maintained in electronic media.

Subrogation and Right of Reimbursement

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 Participant shall furnish the name and contact information of the liability insurer and its

adjuster of the third party, including the policy number, of any liability insurance that covers, or may cover, such injury, harm, or loss.

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.

Out-of-Area Services Overview

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

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

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

BlueCard® Program

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

1. Liability Calculation Method Per Claim – In General

a. Participant Liability Calculation

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

b. The Plan Sponsor Liability Calculation

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

2. Claims Pricing

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

- (i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or
- (ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced, or increased by a percentage to take into account certain payments negotiated with the Provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or
- (iii) An average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its Providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

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

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

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

3. BlueCard Program Fees and Compensation

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

B. Special Cases: Value-Based Programs

Value-Based Programs Overview

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

Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

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

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

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

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

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

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

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

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

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

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

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

Note: Participants will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

Care Coordinator Fees

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

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

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

Value-Based Programs under Negotiated Arrangements

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

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

C. Prepayment Review and Return of Overpayments

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

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

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

its participating healthcare Providers, notwithstanding to the contrary any other provision of this Plan.

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

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

E. Nonparticipating Providers Outside BCI Service Area Other Than Services Covered Under the No Surprises

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

F. Blue Cross Blue Shield Global Core

1. General Information

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

- **Inpatient Services**

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

- **Outpatient Services**

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

- **Submitting a BCBS Global Core Claim**

When Participants pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Participants should complete a BCBS Global Core claim form and send the claim form with the Provider's itemized bill(s) to the BCBS Global Core service center address on the form to initiate claims processing. The claim form is available from Blue Cross of Idaho, the BCBS Global Core service center, or online at www.bcbsglobalcore.com. If Participants need assistance with their claim submissions, they should call the BCBS Global Core service center at 1 .800. 810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

2. BCBS Global Core-Related Fees

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

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

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

When You Have Other Coverage (Coordination of Benefits)

If you or your eligible dependents are covered by more than one medical plan, reimbursements are coordinated between plans, so benefits are not duplicated.

How the Plans Coordinate Coverage

Your medical benefits plan has a maintenance of benefits (MOB) provision. This provision coordinates benefit payments from all medical plans that cover you and your eligible dependents, so that plan benefits are maintained at the level set by this plan after payments from all sources of coverage have been considered.

When you have a claim for expenses covered by two or more plans, one plan pays benefits first. This is known as the primary plan. The other plan(s), called the secondary plan(s), then determines how much of the covered services, if any, are to be paid from the secondary plan(s). The Order of Benefit Determination rules on the next page govern which plan will be considered primary and pay first, and which plan(s) will be considered secondary.

A "plan" is any of the following that provides benefits or services for medical or dental care or treatment:

- 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.
- If separate plans are used to provide coordinated coverage for a group member, the separate plans are considered parts of the same plan, and there is no MOB among those separate plans.
- A plan 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,
- Benefits for non-medical components of long-term care policies,
- Medicare supplement policies, or
- Medicare or any other federal governmental plan, unless permitted by law.

When this medical benefits plan is primary, it pays or provides its benefits according to this plan's terms of coverage and without regard to the benefits of any other plan.

When this medical benefits plan is secondary, it pays the amount necessary to ensure that the total combined amount you receive from this medical benefits plan and the primary plan is no greater than the amount you would have received under this medical benefits plan alone.

Example of Secondary Plan Payment

Under the Order of Benefit Determination Rules, if your enrolled spouse also has medical coverage through his or her employer, your spouse's employer's plan will be the primary payer. The University's benefit plan will be the secondary payer. This means the University's benefit plan will pay up to the amount allowed under this plan's coverage *less* the amount the primary plan already has paid.

For example, let's say that the University's benefit plan provides 80 percent coverage, your spouse's plan covers 50 percent, and your spouse has a covered, payable expense of \$100. Your spouse's primary plan will pay 50 percent of the charge (\$50), and the University's benefit plan will then pay 80 percent of the charge *less* \$50 (in this case, \$30) toward the remaining eligible expense.

But if your spouse's plan pays 80 percent and the University's benefit plan also allows 80 percent, no payment will be made by the University's benefit plan; this is because the maximum benefit of 80 percent has already been paid for the service.

Coordination of this Plan's Benefits with Other Benefits

The following Order of Benefit Determination Rules governs the order in which each plan will pay a claim for benefits.

- A plan that covers a patient as an active employee or a primary beneficiary is primary over a plan that covers the patient as a dependent.
- When both parents have medical coverage for their child(ren), the plan of the parent whose birthday comes earlier in the year is the primary plan. If the parents are divorced or legally separated, special rules apply:
 - The plan of the natural parent with custody of a dependent child is primary. If the parent with custody remarries, the plan of the stepparent with custody pays second, the plan of the parent without custody pays third and the plan of the stepparent without custody pays last.
 - However, if a court decree places financial responsibility for the dependent child's medical care on one parent, that parent's plan always pays first, regardless of who has custody of the child. The plan of the parent with custody pays second, the plan of the stepparent with custody pays third and the plan of the stepparent without

custody pays last.

- A plan that covers the person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. A plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
- If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of such a person is the primary plan and the plan covering that same person pursuant to COBRA or other continuation law is the secondary plan.
- Medicare will pay before the Plan to the extent allowed under federal law. When Medicare is to be primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether the person was enrolled under these parts. The Plan reserves the right to coordinate benefits with Part D.
- If an individual covered under the Plan is under a disability extension from a previous benefit plan, that plan will pay first and the Plan will pay second. The Plan will pay primary to TRICARE and a state child health plan to the extent required by law.
- If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan, and the plan that covered the person for the shorter period of time is the secondary plan.

You may be asked, on an annual basis, to provide or confirm information about other plans under which you or your dependents are covered.

Important Terms

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, that requires medical attention at the time of the accident. The force may be the result of the injured party's actions but must not be intentionally self-inflicted unless caused by a medical condition or domestic violence. Contact with an external object must be unexpected and unintentional, or the results of force must be unexpected and sudden.

Acute care: Medically necessary inpatient treatment in a licensed general hospital or other facility provider for sustained medical intervention by a physician and skilled nursing care to safeguard a participant's life and health. The immediate medical goal of acute care is to stabilize the participant's condition, rather than upgrade or restore a participant's abilities.

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

Admission: Begins the first day a participant becomes a registered hospital bed patient or a Skilled Nursing Facility patient and continues until the participant is discharged.

Adverse benefit determination: Any denial, reduction, or termination of, or the failure to provide payment for, a benefit for services or ongoing treatment. Adverse benefit determination also includes a rescission of coverage.

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

Alcoholism or substance use disorder treatment facility: A facility provider that is engaged primarily in providing detoxification and rehabilitative care for alcoholism or substance use disorder or addiction. To be payable by this Plan, a facility must be licensed as an alcoholism or substance use disorder treatment facility (licensure requirements may vary by state) or must be accredited by The Joint Commission.

Ambulance: A vehicle or other mode of ground transportation, licensed by the state, designed, and operated to provide medical services and transport to medical facilities.

Air Ambulance: Medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Ambulatory surgical facility (surgery center): A facility provider, with an organized staff of physicians, that:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis.
- Provides treatment by or under the supervision of physicians and provides skilled nursing care services when the participant is in the facility.
- Does not provide inpatient accommodations appropriate for a stay of longer than 12 hours.
- Is not primarily a facility used as an office or clinic for the private practice of a physician or other professional provider.

Ancillary services: With respect to an In-network facility,

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists,
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary, and
- Items and services provided by an Out-of-network provider if there is no In-network provider who can furnish such item or service at such facility.

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

Artificial organs: Permanently attached or implanted man-made devices that replace all or part of a diseased or nonfunctioning body organ, including, but not limited to, artificial hearts and pancreases.

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

Auto transplant (or autograft): The surgical transfer of an organ or tissue from one location to another within the same individual.

Approved Clinical Trial: a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to prevention, detection, or treatment of cancer or other life-threatening condition. The Approved Clinical Trial's study or investigation must be:

- approved or funded by one or more of:
 - the National Institutes of Health (NIH),
 - the Centers for Disease Control and Prevention (CDC),

- the Agency for Health Care Research and Quality (AHCQRQ), (d) the Centers for Medicare and Medicaid Services (CMS),
 - a cooperative group or center of the NIH, CDC, AHCQRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA);
 - a qualified non-governmental research entity identified by NIH guidelines for grants; or
 - the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
 - a drug trial that is exempt from investigational new drug application requirements.

Benefit period: The specified period of time in which a participant's benefits for incurred covered services accumulate toward annual benefit limits, deductible amounts, and cost-share maximum limits.

Benefits: The amount the University will pay for covered services after deductible requirements are met.

Blue Cross of Idaho Health Service, Inc. (Blue Cross of Idaho): A non-profit mutual insurance company, hired by University of Idaho 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.

BlueCard: A program to process claims for most covered services received by participants outside of Blue Cross of Idaho's service area.

Certified nurse-midwife: An individual licensed to practice as a certified nurse-midwife. A Midwife may **not** independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. Expenses associated with a pre-planned home birth are [are not] payable by this Plan.

Certified registered nurse anesthetist: A licensed individual registered as a certified registered nurse anesthetist by the state in which services are rendered. Services rendered must be within the scope of the registration.

Chemotherapy: The treatment of malignant disease by chemical or biological antineoplastic agents.

Chiropractic care: Services rendered, referred, or prescribed by a chiropractic physician, when those services are within the scope of the license held by the chiropractic physician.

Chiropractic physician: An individual licensed to provide chiropractic care in the state in which services are rendered.

Claims administrator: Third party contractor also referred to as third party contract administrator or contract administrator with fiduciary responsibility. Performs claims processing, medical necessity determinations, medical reviews and preauthorization approvals in accordance with the Plan Administrator and the law. (See also Plan Administrator for final fiduciary responsibilities).

Clinical nurse specialist: An individual licensed to practice as a clinical nurse specialist.

Clinical psychologist: An individual licensed to practice clinical psychology in the state in which services are rendered.

Congenital anomaly: A condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or a developmental defect or disease. In this plan, the term significant deviation is defined to be a deviation that impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

Continuing Care Patient means an individual who, with respect to a provider or facility-

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility.
2. is undergoing a course of institutional or inpatient care from the provider or facility.
3. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery.
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Continuous crisis care: Hospice nursing care provided during periods of crisis to maintain a terminally ill participant at home. A period of crisis is one in which the participant's symptom management demands predominantly skilled nursing care services.

Contribution: The amount paid or payable to the Trust by Employer or Participant in accordance with the terms of the Plan and the Trust.

Copayment: The amount a participant must pay directly to a provider for covered services. A copayment is typically a flat dollar amount that is due to the provider at the time certain covered services are provided.

- Standard PPO office visit copayments are pre-deductible.
- There are no copayments in the High-Deductible Health Plan HDHP).
- Amounts paid in copayments do not work to satisfy the deductible.

Cost-sharing: Except for items and services that would invoke No Surprises Act protections (see Cost Sharing Amount below), 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 deductibles or copayments, or both.

The **Cost Sharing Amount** for In-network and Out-of-network Emergency Services at In-network Facilities performed by Out-of-network Providers will be based on the Recognized Amount, and air ambulance services from Out-of-network providers will be based on the Qualifying Payment Amount.

Cost-Share maximum: The maximum amount of out-of-pocket expenses incurred during a plan year that a participant is responsible for paying. Eligible out-of-pocket expenses include the participant's cost-sharing and copayments for covered services.

Covered provider: A provider specified in this plan from whom a participant must receive covered services 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.

COVID-19 Public Health Emergency: COVID-19 Public Health Emergency means the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)), as determined by the Secretary of Health and Human Services pursuant to authority under Section 319 of the Public Health Service Act (42 U.S.C. 247(d)). The Public Health Emergency was initially declared as of January 27, 2020 and has been extended thereafter.

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

Deductible: The amount a participant is responsible to pay out of pocket per benefit period before the plan begins to pay benefits for covered services. The amount credited to the deductible is based on the maximum allowance or the actual charge, whichever is less.

Dentist: An individual licensed to practice dentistry in the state in which services are rendered.

Dentistry or dental treatment: The treatment of teeth and supporting structures, including, but not limited to, replacement of teeth.

Diagnostic imaging provider: A Medicare-certified person or entity that is licensed, where required, to render covered services.

Diagnostic service: A test or procedure performed on the order of a physician or other provider because of specific symptoms, in order to identify a particular condition, disease, illness or injury. Diagnostic services include, but are not limited to:

- Radiology services,
- Laboratory and pathology services, and/or
- Cardiographic, encephalographic and radioisotope tests.

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

Durable medical equipment: Items that can withstand repeated use, are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of injury, disease, or illness, and are appropriate for use in the participant's home.

Durable medical equipment supplier: A business that is Medicare-certified and licensed, where required, to sell or rent durable medical equipment.

Effective date: The date when coverage for a participant begins under this plan.

Electroencephalogram (EEG) provider: A facility provider that participates with Medicare and has technologists certified by the American Board of Registration of Electroencephalographic and Evoked Potential Technologies to render covered services.

Eligible dependent: A person eligible for enrollment under an employee's coverage as specified in the *Eligibility* section.

Eligible employee: An employee who is eligible to enroll for benefits as discussed in the *Eligibility* section.

Emergency inpatient admission: Medically necessary inpatient admission to a licensed general hospital or other inpatient facility due to the sudden, acute onset of a medical condition or mental health or substance use disorder or an accidental injury that requires immediate medical treatment to preserve life or prevent severe, irreparable harm to a participant.

Emergency medical condition: A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy. Emergency medical conditions include, but are not limited to, heart attacks, cerebrovascular accidents, poisoning, loss of consciousness or respiration, and convulsions.

Emergency or maternity admission notification: Notification by the participant to Blue Cross of Idaho of an emergency inpatient admission resulting in an evaluation conducted by Blue Cross of Idaho to determine the medical necessity of a participant's emergency inpatient admission or unscheduled maternity admission, and the accompanying course of treatment.

Emergency Services: Emergency Services means the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by an Out-of-Network provider or an Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is an Out-of-Network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any In-Network providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network providers listed.

The participant or beneficiary gives informed consent to continued treatment by the Out-of-Network provider, acknowledging that the participant or beneficiary understands that continued treatment by the Out-of-Network provider may result in greater cost to the participant or beneficiary.

Employer: University of Idaho, which also is the Plan Administrator.

Enterostomal therapy: Counseling and assistance provided by a specifically trained enterostomal therapist to participants who have undergone a surgical procedure to create an artificial opening into a hollow organ (e.g., colostomy).

Formulary: A drug formulary is a list of prescription drugs, both generic and brand name, that are preferred by the health plan.

Freestanding diabetes facility: A person or entity that is recognized by the American Diabetes Association to render covered services.

Freestanding dialysis facility: A facility provider that is primarily engaged in providing dialysis treatment, maintenance, or training to patients on an outpatient or home care basis.

Health Care Facility: For non-emergency services is each of the following:

1. A hospital (as defined in section 1861(e) of the Social Security Act).
2. A hospital outpatient department.
3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Human growth hormone therapy: Treatment administered by intramuscular injection to treat children with growth failure due to pituitary disorder or dysfunction. (Prescription Benefit)

Homebound: Confined primarily to the home as a result of a medical condition. The term connotes that it is “a considerable and taxing effort” to leave the home due to a medical condition and not because of inconvenience.

Home health agency: Any agency or organization that provides skilled nursing care services and other therapeutic services and meets one of the following three tests:

1. It is approved by Medicare and/or accredited by The Joint Commission; or
2. It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
3. If licensing is not required, it meets all of the following requirements:
 - has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home.
 - has a full-time administrator,
 - is run according to rules established by a group of professional health care providers including Physicians and Registered Nurses (RNs),
 - maintains written clinical records of services provided to all patients,
 - its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available,
 - its employees are bonded,
 - maintains malpractice insurance coverage.

Home health aide: An individual employed by a hospice, under the direct supervision of a licensed registered nurse (R.N.), who performs, and trains others to perform, intermittent custodial care services that include, but are not limited to, assistance in bathing, checking vital signs and changing dressings.

Home Health Skilled Nursing Care Services:

Home intravenous therapy (home infusion therapy): Treatment provided in the home of the participant or other locations outside of a licensed general hospital, that is administered via an intravenous, intra-spinal, intra-arterial, intrathecal, subcutaneous, enteral, or intramuscular injection or access device inserted into the body, at or under the direction of a home health agency or other provider approved by Blue Cross of Idaho.

Home intravenous therapy company: A Medicare-certified and licensed, where required, pharmacy that is principally engaged in providing services, medical supplies and equipment for certain home infusion therapy covered services, to participants in their homes or other locations outside of a licensed general hospital.

Hospice: A Medicare-certified public agency or private organization designed specifically to provide services for care and management of terminally ill patients, primarily in the home. The hospice agency must meet one of the following tests:

1. It is approved by Medicare; or is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. If licensing is not required, it meets all of the following requirements:
 - provides 24 hour-a-day, 7 day-a-week service,
 - is under the direct supervision of a duly qualified Physician,
 - has a full-time administrator,
 - has a nurse coordinator who is a Registered Nurse (RN) with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
 - the main purpose of the agency is to provide Hospice services,
 - maintains written records of services provided to the patient,
 - maintains malpractice insurance coverage.

Hospice nursing care: Skilled nursing care services and home health aide services provided as a part of the hospice plan of treatment.

Hospice plan of treatment: A written plan of care that describes the services and supplies for the medically necessary treatment to be provided to a participant by a hospice. The written plan of care must be established and periodically reviewed by the attending physician.

Hospice therapy services: Hospice therapy services include only the following:

- Hospice physical therapy — the treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain, enable a participant to maintain basic functional skills and manage symptoms.
- Respiratory therapy.
- Speech therapy.

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

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

Independent Freestanding Emergency Department is a health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

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

In-network provider: A provider that has entered into a written agreement with Blue Cross of Idaho to accept the participant's and Blue Cross of Idaho payments as payments in full for covered services.

In-network services: Covered services provided by an in-network provider.

Inpatient: A participant who is admitted as a bed patient in a licensed general hospital or other facility provider and for whom a room and board charge is made.

Investigational: Any technology (service, supply, procedure, treatment, drug, device, facility, equipment, or biological product) that 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 Blue Cross of Idaho, it fails to meet any one of the following criteria:

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

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

In determining whether a technology is investigational, Blue Cross of Idaho considers the following source documents: Blue Cross Blue Shield Association Center for Clinical Effectiveness (CCE) assessments, the Blue Cross and Blue Shield Association Medical Policy Reference Manual as adopted by Blue Cross of Idaho, and Blue Cross of Idaho Medical Policies. Blue Cross of Idaho also considers, at its discretion, current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

Blue Cross of Idaho reserves the right to interpret the meaning of the terms used in this definition and any policies or procedures, which support this definition.

Licensed clinical professional counselor (LCPC): An individual providing diagnosis and treatment of mental or nervous conditions.

Licensed clinical social worker (LCSW): An individual providing diagnosis and treatment of mental or nervous conditions.

Licensed general hospital: A short-term, acute care, general hospital that:

- Is an institution duly licensed in and by the state in which it is located, and thereby is lawfully entitled to operate as a general, acute care hospital. The facility may also be accredited as a hospital by The Joint Commission.
- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians for compensation from and on behalf of its patients.
- Has functioning departments of medicine and surgery.
- Provides 24-hour nursing service by or under the supervision of licensed registered nurses.
- Is not predominantly a:
 - Skilled nursing facility,
 - Nursing home,
 - Custodial care home,
 - Health resort,
 - Spa or sanatorium,
 - Place for rest,
 - Place for the treatment or rehabilitative care of alcoholism or substance use disorder or addiction,
 - Place for the treatment or rehabilitative care of mental or nervous conditions,
 - Place for hospice care,
 - Residential treatment center, and/or
 - Transitional living center.

Licensed marriage and family therapist (LMFT): A licensed individual providing diagnosis and treatment of mental or nervous conditions.

Licensed pharmacist: An individual licensed to practice pharmacology in the state in which services are rendered.

Licensed rehabilitation hospital: A facility provider principally engaged in providing diagnostic, therapeutic and physical rehabilitation services to participants on an inpatient basis.

Maximum allowance: For covered services under the terms of this plan unless subject to the No Surprises Act effective for claims incurred on or after January 1, 2022, the maximum allowance is:

- the lesser of the billed charge or the amount established as the highest level of

compensation for a covered service. If the covered services are rendered outside the state of Idaho by an in-network or out-of-network provider with a Blue Cross and/or Blue Shield affiliate in the location of the covered services, the maximum allowance is the lesser of the billed charge or the amount established by the affiliate as compensation.

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

In addition, maximum allowance for covered services provided by contracting or non-contracting dentists is determined using many factors, including pre-negotiated payment amounts, a calculation of charges submitted by contracting Idaho dentists, and/or a calculation of the average charges submitted by all Idaho dentists.

For claims subject to the No Surprises Act, the Maximum Allowance is defined as:

- the Recognized Amount for Emergency Services.
- the Recognized Amount for Out-of-network Providers Who Work at In-network Facilities; and
- the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA) for Out-of-network Air Ambulance Services.

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

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 services or supplies required to identify or treat a participant's condition, disease, illness, or accidental injury and which, as recommended by the treating physician or other covered provider and as determined by Blue Cross of Idaho, are:

- The most appropriate supply or level of service, considering potential benefits and harms to the participant,
- Proven to be effective in improving health outcomes,
 - For new treatments, effectiveness is determined by scientific evidence,
 - For existing treatments, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion,
- Not primarily for the convenience of the participant or covered provider, and/or
- Cost-effective for this condition, compared to alternative treatments, including no treatment.
- Cost-effectiveness does not necessarily mean lowest price.

When applied to the care of an inpatient, it further means that the participant's medical symptoms or condition are such that the services cannot be safely and effectively provided to the participant as an outpatient.

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.

In determining whether a service is Medically Necessary, BCI considers the medical records and, the following source documents: Blue Cross Blue Shield Association Center for Clinical Effectiveness (CCE) Technology Evaluation Center (TEC) assessments, the Blue Cross and Blue Shield Association Medical Policy Reference Manual as adopted by BCI, and Blue Cross of Idaho Medical Policies. BCI also considers current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

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

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

These standards are the minimum health and safety requirements that providers and suppliers must meet to be Medicare- and Medicaid-Certified. As a condition of their contract with Blue Cross of Idaho, certain in-network providers must be certified by Medicare.

Mental or nervous condition: Means and includes mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions (whether organic or inorganic, whether of biological, non-biological, chemical, or non-chemical origin and irrespective of cause, basis or inducement). Mental and nervous conditions include but are not limited to psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

No Surprises Act means the federal No Surprises Act (Public Law 116-260, Division BB).

Nurse practitioner: An individual licensed to practice as a nurse practitioner (NP), Family Nurse Practitioner (FNP) or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate health care practitioners and bills and is able to be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered.

Occupational therapist: An individual licensed to practice occupational therapy.

Occupational therapy: The treatment of a physically disabled participant by means of constructive activities designed and adapted to promote the restoration of the participant's ability to accomplish the ordinary tasks of daily living and those tasks required by the participant's particular occupational role.

Office visit: Any direct, one-on-one examination and/or exchange, conducted in the covered provider's office, between a participant and a provider, or members of his or her staff for the purposes of seeking care and rendering covered services. For purposes of this definition, a medically necessary visit by a physician to a homebound participant's place of residence may be considered an office visit.

Optometrist: An individual licensed to practice optometry.

Organ procurement: Diagnostic services and medical services to evaluate or identify an acceptable donor for a recipient and a donor's surgical and hospital services related directly to the removal of an organ or tissue. Transportation for a donor or for a donated organ or tissue is not an organ procurement service.

Orthotic devices: Any rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part.

Out-of-Network emergency facility: An emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively.

Out-of-network provider: A professional provider or facility provider that has not entered into a written agreement with Blue Cross of Idaho.

Out-of-Network Rate: With respect to items and services furnished by an Out-of-Network provider, emergency facility or Non-PPO provider of ambulance services, means one of the following:

- the amount the parties negotiate.
- the amount approved under the independent dispute resolution (IDR) process; or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system.

Out-of-network services: Any covered services rendered by an out-of-network provider.

Outpatient: A participant who receives services or supplies while not an inpatient.

Outpatient psychiatric facility: A facility provider that, for compensation from or on behalf of its patients, is engaged primarily in providing outpatient diagnostic and therapeutic services for treatment of mental or nervous conditions and/or substance use disorder or addiction. To be payable by this Plan, a facility must be licensed as a psychiatric facility (licensure requirements may vary by state) or must be accredited by The Joint Commission.

Pain rehabilitation: An intensive inpatient program administered by qualified healthcare professionals, under the orders of an attending physician, to a participant who is suffering from chronic, intractable pain, regardless of its origin, that has failed to respond to medical or surgical treatment. Pain rehabilitation is intended to teach the participant how to control and cope with pain and regain normal function.

Palliative Care: is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of

suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical and psychosocial.

Participant: An eligible employee or his or her enrolled eligible dependent.

Physical rehabilitation: Medically necessary, non-acute therapy rendered by qualified healthcare professionals, intended to restore a participant's physical health and well-being as closely as reasonably possible to the level that existed immediately prior to the occurrence of a condition, disease, illness, or injury.

Physical rehabilitation plan of treatment: A written plan established and reviewed periodically by an attending physician that describes the services and supplies for the physical rehabilitation care and treatment to be provided to a participant.

Physical therapist: An individual licensed to practice physical therapy.

Physical therapy: The treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, or devices to relieve pain, restore maximum function or prevent disability following a condition, disease, illness, injury or loss of a body part. Physical therapy does not include educational training or services designed to develop a physical function.

Physician: A Doctor of Medicine (M.D.) or doctor of osteopathy (D.O.) licensed to practice medicine to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

Physician assistant: An individual licensed to practice as a physician assistant who acts within the scope of his or her license and acts under the supervision of a Physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising Physician; and bill and be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered.

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, University of Idaho, is the fiduciary of the plan, and has all final 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 including the Trust. (See claims administrator for additional fiduciary responsibilities)

Plan Sponsor: The University of Idaho.

Post-service claim: Any claim for a benefit under this plan that does not require preauthorization before services are rendered.

Preadmission testing: Tests and studies required in connection with a participant's inpatient admission to a licensed general hospital that are rendered or accepted by the licensed general hospital on an outpatient basis. Preadmission tests and studies must be done prior to a scheduled inpatient admission to the licensed general hospital, provided the services would have been available to an inpatient of that hospital. Preadmission testing does not include tests or studies performed to establish a diagnosis.

Preferred Provider Organization (PPO): A health benefit plan in which the highest level of benefits is received when the participant obtains covered services from an in-network provider.

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

Pre-service claim: Any claim for a benefit under this plan that requires preauthorization before services are rendered.

Primary caregiver: A person designated to give direct care and emotional support to a participant as part of a hospice plan of treatment. A primary caregiver may be a spouse, relative or other individual who has personal significance to the participant, such as a neighbor or friend. A primary caregiver must be a volunteer who does not charge a fee or expect or claim any other compensation for services provided to the participant.

Preauthorization: The provider's request to Blue Cross of Idaho, or delegated entity, for authorization of a participant's proposed treatment. Blue Cross of Idaho, on behalf of the Plan Administrator, may review medical records, test results and other sources of information to ensure that it is a covered service and make a determination as to medical necessity or alternative treatments.

Prosthetic and orthotic supplier: A person or entity that is Medicare-certified and licensed, where required, to render covered services.

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

Provider: A person or entity that is licensed, certified, or accredited by the Joint Commission, where required, to render covered services. For the purposes of this plan, providers include the following:

- Facility providers:
 - Ambulatory surgical facility (surgery center),
 - Alcoholism or substance abuse treatment facility,
 - Electroencephalogram (EEG) provider,
 - Home intravenous therapy company,
 - Hospice,
 - Licensed rehabilitation hospital,
 - Lithotripsy provider,
 - Psychiatric hospital,
 - Diagnostic imaging provider,
 - Freestanding diabetes facility,
 - Freestanding dialysis facility,
 - Home health agency, or
 - Independent laboratory,
 - Licensed general hospital,
 - Prosthetic and orthotic supplier,
 - Radiation therapy center,
 - Skilled nursing facility.

- Professional providers:
 - Ambulance transportation service,
 - Certified nurse-midwife,
 - Certified registered nurse anesthetist,
 - Certified speech therapist,
 - Chiropractic physician,
 - Clinical nurse specialist,
 - Clinical psychologist,
 - Licensed clinical professional counselor (LCPC),
 - Licensed clinical social worker (LCSW),
 - Licensed marriage and family therapist (LMFT),
 - Dentist/denturist,
 - Durable medical equipment supplier,
 - Licensed occupational therapist,
 - Licensed pharmacist,
 - Licensed physical therapist,
 - Nurse practitioner,
 - Optometrist/optician,
 - Physician,
 - Physician assistant, and/or
 - Podiatrist.

Psychiatric hospital: A facility provider principally engaged in providing diagnostic and therapeutic services and rehabilitation services for the inpatient treatment of mental or nervous conditions, alcoholism or substance abuse or addiction, licensed under state law or accredited by the Joint Commission. These services are provided by or under the supervision of a staff of physicians, and continuous nursing services are provided under the supervision of a licensed registered nurse. A psychiatric hospital provides these services for compensation from and on behalf of its patients.

Qualifying Coronavirus Preventive Service: Qualifying Coronavirus Preventive Service means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease (COVID-19) and that is, with respect to the individual involved:

- An evidence-based item or service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force, or
- An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), which has been adopted by the Director of the CDC. This provision is in effect regardless of whether the immunization is recommended for routine use.

Qualifying Payment Amount (QPA): The amount calculated using the methodology described in 29 CFR 716-6(c).

Radiation therapy: The treatment of disease by X-ray, radium or radioactive isotopes.

Radiation therapy center: A facility provider that is primarily engaged in providing radiation therapy services to patients on an outpatient basis and is licensed under state law or accredited by The Joint Commission.

Recognized Amount: In order of priority, one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.
2. An amount determined by a specified state law; or

3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Recognized transplant center: A licensed general hospital that:

- Is approved by the Medicare program for the requested transplant covered services,
- Is included in the Blue Cross and Blue Shield System's National Transplant Network,
- Has arrangements with another Blue Cross and/or Blue Shield Plan for the delivery of the requested transplant covered services, based on appropriate approval criteria established by that plan, and
- Is approved by Blue Cross of Idaho based on the recommendation of Blue Cross of Idaho's medical director.

Renal dialysis: The treatment of an acute or chronic kidney condition, which may include the supportive use of an artificial kidney machine.

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

Respiratory therapy: Introduction of dry or moist gasses into the lungs for treatment purposes.

Respite care: Care provided to a homebound participant as part of a hospice plan of treatment for the purpose of providing the primary caregiver a temporary period of rest from the stress and physical exhaustion involved in caring for the participant at home.

Serious and Complex Condition: With respect to a participant, beneficiary, or enrollee under the Plan one of the following:

1. in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent.
2. in the case of a chronic illness or condition, a condition that is—
 - a. is life-threatening, degenerative, potentially disabling, or congenital; and
 - b. requires specialized medical care over a prolonged period of time.

Skilled nursing care: Nursing service that must be rendered by or under the direct supervision of a licensed registered nurse to maximize the safety of a participant and to achieve the medically desired result according to the orders and direction of an attending physician. The following components of skilled nursing care distinguish it from custodial care that does not require professional health training:

- The observation and assessment of the total medical needs of the participant,
- The planning, organization, and management of a treatment plan involving multiple services, where specialized healthcare knowledge must be applied to attain the desired result, and
- Rendering to the participant of direct nursing services that require specialized training.

Skilled nursing facility: A licensed facility provider primarily engaged in providing inpatient skilled nursing care to patients requiring convalescent care rendered by or under the supervision of a physician and meets all the following requirements:

- It is accredited by The Joint Commission as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
- It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
- It provides services under the supervision of Physicians; and
- It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with at least one licensed Registered Nurse on duty at all times; and
- It maintains a daily medical record of each patient who is under the care of a licensed Physician; and
- It is not (other than incidentally) a home for maternity care, rest, domiciliary care (non-skilled/custodial care, or care of individuals who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or mentally ill; and
- It is not a hotel or motel.

Other than incidentally, a skilled nursing facility is not a place or facility that provides minimal care, custodial care, ambulatory care or part-time care services, or care or treatment of mental or nervous conditions, alcoholism or substance abuse or addiction.

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

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

Special care unit: A designated unit within a licensed general hospital that has concentrated facilities, equipment, and support services for the provision of an intensive level of care for critically ill patients.

Speech therapy: The corrective treatment of a speech impairment resulting from a condition, illness, disease, surgery, injury, congenital anomaly, or previous therapeutic process.

Substance use or addiction: A behavioral or physical disorder manifested by repeated excessive use of a drug or alcohol to the extent that it interferes with a participant's health, or the participant's social or economic functioning.

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

Surgery: The performance, within the scope of a provider's license, of:

- Generally accepted operative and cutting procedures,
- Endoscopic examinations and other invasive procedures utilizing specialized instruments,
- The correction of fractures and dislocations, and

- Customary preoperative and postoperative care.

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

Termination: In the context of Continuity of Care, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Therapy services: Therapy services include only the following:

- Chemotherapy,
- Enterostomal therapy,
- Growth hormone therapy,
- Home intravenous therapy,
- Occupational therapy,
- Physical therapy,
- Radiation therapy,
- Renal dialysis
- Respiratory therapy, and/or
- Speech therapy

Third party contract administrator: See claims administrator.

Transplant: Surgical removal of a donated organ or tissue and the transfer of that organ or tissue to a recipient.

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

Trust: The University of Idaho Health Benefits Trust, the trust fund established in conjunction with the Plan for receipt of Contributions and payment of Benefits in accordance with the terms of the Plan.

Trustee: The person(s) designated as trustee(s) of the Trust in accordance with the Trust agreement.

Employee Assistance Plan (EAP)

The Employee Assistance Program (EAP) is a free, confidential service that provides eligible employees and their families with the opportunity to discuss personal problems with a professional counselor, receive unlimited telephone and Internet access to resource and referral information, and obtain other self-help information.

You do not have to enroll in a medical plan to participate in the EAP. However, if you are enrolled in a medical plan, you may be able to maximize your benefits by accessing the free services of the EAP before using behavioral health benefits, which require you to pay a share of the cost.

Services Provided

The EAP's Master's-level, licensed professional counselors are available to you and your family 24 hours a day, 365 days a year. Counselors can help with any situation that creates stress including:

- Family problems,
- Stress/anxiety,
- Personal relationships,
- Depression,
- Grief,
- Anger management,
- Substance use disorder,
- Legal concerns,
- Finances,
- Workplace,
- Aging,
- Abuse, and
- Workplace Training

How the Program Works

You can call the EAP at **1-800-999-1077**, 24 hours a day, 365 days a year. For online services go to **Error! Hyperlink reference not valid.**(University code: UI1), and for networked providers and company information go to www.qualitycareforme.com.

When you call the EAP, you should identify yourself as a University of Idaho employee. If you have a straightforward issue or just need information, such as the name and location of a support group, your issue may be resolved during the phone call. However, if you have a more complex issue, the counselor will help you determine the “next steps” to find a solution. You’ll receive an authorization number and the name of an EAP counselor. Call the counselor to schedule your appointment — be sure to provide your authorization number to ensure cost-free service.

Next steps may include:

- **Assessment:** Employees or immediate family members who contact the EAP can meet with a counselor for an assessment to accurately identify their problem. Upon completion of the Assessment, the counselor will make specific recommendations.
- **Short-term Counseling:** Employees or immediate family members may be offered short-term counseling (up to eight sessions per situation) with a counselor.
- **Referral Services:** Sometimes it may be necessary to refer you or your family member to services or treatment beyond what is offered by the EAP.
- **Legal Care:** You will be able to consult with an attorney at no cost for any non-work-related legal concern. Consultation services are available during business hours, Monday through Friday, and also during “off hours” for emergencies. Common legal concerns may include divorce, wills, child custody, estate planning, civil disputes, criminal issues, taxes, consumer rights, etc. To meet with a lawyer, you will receive a referral to a law firm in your area. Referral lawyers have agreed to provide the initial half-hour consultation at no cost to you. If you decide to retain the lawyer for further services, the lawyer will charge a special 25% reduced rate because you were referred through the EAP.
- **Financial Care:** You can also access a financial consultant who will discuss your concerns and provide suggestions regarding a course of action. The telephone consultation is provided free of charge to you and your dependent family members. When appropriate, the EAP can provide a local community referral for a specific concern, such as: taxes, housing, mortgage,

retirement planning, wage garnishment/liens, bankruptcy, credit problems, budgeting and cash flow and credit restoration.

Internet Self-Help

This service provides self-help resources and referral for a variety of community-based services such as elder and child care, assisted transportation and home meal delivery services. Information to help prepare for life events and other resources that may help as you face life challenges are available. Many of these same services are also offered through the 24-hour helpline. These services are unlimited.

Contacting the EAP

You can contact the EAP at **1-800-999-1077**, 24 hours a day, 365 days a year. For online services, go to **Error! Hyperlink reference not valid.**(University code: UI1) and for network providers and company information, go to www.qualitycareforme.com.

Dental Coverage

Dental coverage encourages you and your family to take good care of your teeth and gums.

Please note that:

- Three coverage options are offered; you may choose to waive dental benefits.
- You must be actively enrolled in the University's medical plan in order to enroll in one of the three dental plans.
- If you cover eligible dependents under the University's medical plan, you can elect a different coverage tier for the dental plan (for example, family coverage for medical and single coverage for dental).
- You can choose the dental plan option that provides the best fit for you and your family. Your options include:
 - **Standard Dental Plan: *basic dental coverage***. In addition to covering diagnostic and preventive services, this plan covers treatment for problems with your teeth and gums. This option is provided *free* to all full-time employees.
 - **Plus Dental Plan: *"plus" dental coverage with orthodontic coverage***. This plan provides comprehensive dental coverage, plus orthodontia coverage for both children and adults.
 - **Willamette Dental: *comprehensive dental coverage with orthodontic coverage***. This plan practices evidence-based dentistry with no annual maximum limit, plus orthodontia coverage for both children and adults. ***You must receive services at a Willamette Dental clinic. No reimbursement is provided outside of Willamette's network of clinics.***

Covered dental services, the portion of covered charges paid by the plan and the amount you pay for coverage vary between plans.

Delta Dental of Idaho administers the Standard Dental and Dental Plus plan options and provides access to its Premier and PPO networks of dental providers. (The PPO network provides the best discount.) Willamette Dental provides coverage through their dental clinics in the Idaho, Washington, and Oregon area.

How the Plans Works

Willamette Dental plan provides fixed copays for dental services received at one of their

participating clinics. A list of copays may be found on the University of Idaho Benefits website and as further described in the below chart.

Delta Dental's Standard plan and Plus plan pays a percentage of eligible dental charges. As a plan participant, you may visit any dentist you choose — a Delta Dental network provider, or a non-network dentist. Delta Dental has two participating provider networks: Delta Dental Premier and Delta Dental PPO. Some dentists participate in both networks.

However, it's usually to your benefit to visit a participating dentist in the Delta Dental Premier or Delta Dental PPO network. When you use a Delta Dental participating provider:

- You don't have to file claim forms.
- You typically pay less for services because the provider charges a negotiated rate; and
- You cannot be billed for any charges above the negotiated fee the provider has agreed to charge.

If you use a **non-participating dentist, under the Delta Dental plans** you may need to pay additional out-of-pocket expenses. If the dentist is a non-participating dentist, Delta Dental will base the benefit on the lesser of the submitted amount or Delta Dental's non-participating dentist fee. It is your responsibility to make full payment to the non-participating dentist for charges above Delta Dental's non-participating dentist fee.

How to Locate Participating Dentists

You can find names of Delta Dental participating providers by logging on to **www.deltadentalid.com**.

Willamette Dental Group providers may be found on <https://www.willamettedental.com/locations.htm> or by calling 1-855-433-6825.

Dental Plan Coverage At-a-Glance Chart

The following table summarizes the coverage available under your three dental plan choices. You will see that dental benefits fall into four "classes" of covered services. Additionally, please review the *What the University of Idaho Dental Plan Covers* section for more detailed information.

DELTA DENTAL	DELTA DENTAL STANDARD	DELTA DENTAL PLUS	WILLAMETTE DENTAL	
ANNUAL DEDUCTIBLE/ANNUAL MAXIMUM			ANNUAL DEDUCTIBLE/ANNUAL MAXIMUM	
Individual	\$25	\$50	Annual Deductible	\$0
Family	\$75	\$150	General and Orthodontic Office Visit	\$20 copay
Annual maximum	\$1,000	\$1,500	Annual Maximum	None
CLASS I BENEFITS			DIAGNOSITC AND PREVENTIVE SERVICES	
<ul style="list-style-type: none">• Preventive care• Diagnostic care• X-rays	Plan pays 100%		<ul style="list-style-type: none">• Routine and emergency exams• Head and neck cancer screening	Covered with office visit copay
CLASS II BENEFITS				

<ul style="list-style-type: none">• Oral surgery• Endodontic care• Periodontic care, including perio cleaning• Minor restorative services	25% of maximum allowance after deductible	20% of maximum allowance after deductible	<ul style="list-style-type: none">• X-rays• Teeth Cleaning• Fluoride treatment• Sealants (per tooth)• Oral Hygiene Instruction• Periodontal charting• Periodontal evaluation	
CLASS III BENEFITS			RESTORATIVE DENTISTRY	
<ul style="list-style-type: none">• Major restorative services• Prosthodontics	55% of maximum allowance after deductible	45% of maximum allowance after deductible	Fillings	Covered with office visit copay
			Porcelain-Metal Crown	\$200 copay
CLASS IV BENEFITS			PROSTHODONTICS	
Adult, child orthodontia (Covered services only include those started when coverage under the plan begins)	N/A	50% up to lifetime maximum benefit of \$1,500 per person	Root Canal Therapy	\$75 - \$150 copay
			Osseous Surgery (Per Quadrant)	\$150 copay
			Root Planing (Per Quadrant)	\$60 copay
			ORAL SURGERY	
			Routine Extraction (Single Tooth)	Covered with Office Visit copay
			Surgical Extraction	\$75 copay
			ORTHODONTIA TREATMENT	
			Pre-orthodontia Treatment	\$150 copay; copay credited toward comprehensive orthodontia treatment
			Comprehensive Orthodontia Treatment	\$1,500 copay
			RESTORATIVE DENTISTRY	
			Fillings	Covered with office visit
			Porcelain-Metal Crown	\$200
			MISCELLANEOUS	
			Local Anesthesia	Covered with office visit copay
			Dental Lab Fees	Covered with office visit copay
			Nitrous Oxide	\$40 copay
			Specialty Office Visit	\$30 copay
			Out of Area Emergency Care Reimbursement	You pay charges in excess of \$100

General Dental Benefit Information

This section provides you with additional information on your benefits.

Annual Deductible

Both of the Delta Dental plans have an annual deductible you must satisfy before the plan will pay benefits for certain services during that calendar year. There is *no deductible* for Class I services with Delta Dental's Standard and Plus plans.

Willamette Dental does not have an annual deductible. You will pay a \$20 copay for Class I services with a Willamette Dental provider.

The deductible amount you must satisfy depends on:

- **The plan in which you enrolled:** Each Delta Dental plan has its own deductible amount, as described in the *Dental Plan Coverage At-a-Glance Chart*.
- Willamette Dental does not have an annual deductible, you will be responsible for office and procedure copays.
- **Whether you have individual or family coverage:** There is an individual and a family deductible for the Delta Dental Standard and Plus plans. The deductible applies to each participant every calendar year. Combined expenses for all family members can be used to satisfy the family deductible, even if each participant does not satisfy the individual deductible amount. Benefit payments for any covered person in the Standard or Plus Delta Dental Plans will begin after he or she meets the plan's individual deductible, even if the family deductible has not been satisfied.

Annual Maximum Benefit

For both Delta Dental Standard and Plus plans, there is a maximum total benefit that the plan will pay annually for each covered person for covered services.

Willamette Dental does not have an annual maximum.

Lifetime Maximum Orthodontia Benefit for Delta Dental Plus

The lifetime maximum benefit payable by the Delta Dental Plus plan for all covered orthodontia services is \$1,500 per covered participant.

Willamette Dental does not have a lifetime maximum.

Predetermination Review for Delta Dental Plans

To help you and your dentist know in advance how much the plan will pay for a specific treatment, ask your dentist to submit a predetermination review form outlining the proposed services and expected costs. Although not required, predetermination reviews are strongly encouraged when expenses are expected to exceed \$200. During a predetermination review, the claims administrator reviews proposed dental treatments and expected charges before treatment begins. A predetermination confirms how much Delta Dental will pay for proposed treatment and the patient's payment portion of the treatment. Delta Dental's statement of estimated benefits is valid if treatment is performed within 90 days of when the predetermination is processed.

Willamette Dental Plan Costs of Services

Is a predetermined copay for services. Summary of Benefits and copay amounts are available on the University of Idaho Benefits website.

What the University of Idaho Dental Plans Covers

The following are covered services when obtained in accordance with the terms and conditions of this plan. Benefits are subject to the deductibles, cost-sharing, exclusions, limitations, and other provisions as specified.

Benefits under the plans are divided into four classes. The following list shows the specific services under each class. Note that not all dental plan options cover all classes of benefits.

Class I Benefits: Diagnostic and Preventive Services, X-rays (Covered by all plans)

- **Diagnostic and Preventive Services:** Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease including:
 - **Periodic oral examination** is a benefit limited to twice per calendar year under the Delta Dental plans, based on individual need under the Willamette Dental plan.
 - **Comprehensive oral examination** is a benefit once every three calendar years and is applied toward the examination benefit under the Delta Dental, based on individual need under the Willamette Dental plan.
 - **Cleaning of teeth and gums** is a benefit up to twice per calendar year under the Delta Dental plans. A periodontal cleaning (covered as a Class II benefit) may be used toward the “twice per calendar year” cleaning benefit. Cleanings are based on individual’s needs under the Willamette Dental plan.
 - **Preventive fluoride treatment** is a benefit for children under age 19 — once in any 12- month period under the Delta Dental plans. There are no age restrictions for covered fluoride treatment under Willamette Dental.
 - **Radiographs:** X-rays as required for routine care or as necessary for the diagnosis of a specific condition.
 - **Bitewing X-rays:** are a benefit once in any period of 12 consecutive months.
 - **Full mouth X-rays (*which include bitewing X-rays*):** are a benefit once in any five-year period. **Note:** A panoramic X-ray that includes bitewing X-rays on the same date of service counts as fulfilling both the full-mouth X-ray benefit paid once in five years and the bitewing X- ray benefit paid once in 12 months.
 - **Occlusal X-rays:** are a benefit twice in a 12-consecutive-month period.
 - **Space maintainers:** Delta Dental plans provide this benefit prior to age 19. Re- cementation of a space maintainer is a benefit once in a 12-month period. Replacement of a space maintainer is a benefit only if additional extractions are performed or to accommodate growth. Willamette Dental provides this benefit under the office copay without age limitations.

Class II Benefits: Basic Services (Covered by all plans)

Oral Surgery Services: Extractions and dental surgery, including pre- and post-operative care. Delta Dental provides a once-per-lifetime benefit that is payable for: extractions (per tooth); removal of cysts, tumors, lesions and foreign bodies; alveoloplasty; incision and drainage of abscess; frenulectomy; and excision of hyperplastic tissue. Excision of pericoronal gingiva is a benefit once in a 60-month period under the Delta Dental plans. Willamette Dental provides oral surgery services for set copays; some procedures are covered under the office copay. Services are based upon patient’s individual oral health need with no lifetime restrictions.

Endodontic Services: Treatment of teeth with diseased or damaged nerves, including:

Root canals, including root canal retreatment 24 months after the initial root canal.

Apical surgery, once in a 24-month period.

Pulpotomy, limited to primary teeth. For benefit purposes, a pulpectomy and/or root canal on a primary tooth is covered as a pulpotomy.

Periodontal Services: Treatment of diseases of the gums and supporting structures of the teeth. This includes periodontal maintenance following active therapy (periodontal cleaning). Benefits include:

- **Root Planing** — once in any two-year period under Delta Dental plans. For a copayment under Willamette Dental
- **Periodontal surgery** — once in any three-year period.

Sealants are a benefit for molar and bicuspid teeth, on the occlusal surface, once every three years up to age 16 under Delta Dental plans. Covered under office visit copay under Willamette Dental without age restriction.

Minor Restorative Services: Services to rebuild and repair natural tooth structure when damaged by disease or injury. Benefits include:

- **Delta Dental**
 - Amalgam (silver) and resin (white) fillings, payable once per surface per tooth within a 24-month period paid at resin fee.
 - Prefabricated crowns (stainless steel, resin) on primary teeth, payable once in a 24-month period.
 - Inlays are benefited as the corresponding filling material with the patient responsible up to the submitted charge for the cost of a regular filling, depending on type of material used, as covered under Class I.
 - Crown/denture/bridge recementation, repair and adjustment are a benefits six months after the initial placement and once in a 24-month period.
- **Willamette Dental**
 - Amalgam (silver) and resin (white) fillings are covered under the office co-pay.
 - Prefabricated crowns (stainless steel, resin) on primary teeth are covered with an additional copay.
 - Inlays are benefited with an additional copay.
 - Crown/denture/bridge recementation, repair and adjustment are including in the office visit copay.

Emergency Palliative Treatment: Emergency treatment to temporarily relieve pain.

General anesthesia and IV conscious sedation are benefits under Delta Dental plans only when administered for oral surgical and periodontal surgical procedures.

Class III Benefits: Major Services (Covered by all plans)

Major Restorative Services: Services to rebuild and repair natural tooth structure when damaged by disease or injury, including crowns when teeth cannot be restored with another filling. Benefits include:

- **Delta Dental**
 - Cast (indirect) restorations (including veneers, crowns and onlays) on the same tooth are payable once in any seven-year period.
 - Porcelain, porcelain substrate and cast (indirect) restorations are not payable for children under age 16. If these types of restorations are placed on permanent teeth of dependent children under age 16, the benefit is limited to a plastic or stainless-steel crown, with the participant responsible for the balance of the submitted fee. In this case the benefit is allowed once in a two-year period.
 - For benefit purposes, onlays, and porcelain veneers are covered the same as porcelain- fused-to-metal crowns, with the participant responsible for the balance of the submitted fee.
 - Dentures rebase and relines are a benefit six months after the initial placement and once in a 24-month period.
 - Crown build-ups (including pins), prefabricated post and core build-ups, and cast post and core buildups are a benefit once in a two-year period.

- **Willamette Dental**

- Cast (indirect) restorations (including veneers, crowns and onlays) on the same tooth are covered if dentally necessary and recommended by a participating dentist.
- Porcelain, porcelain substrate and cast (indirect) restorations are covered under an additional copay.
- For benefit purposes, onlays, and porcelain veneers are covered under an additional copay.
- Dentures rebase and relines are covered under the office visit copay.
- Crown build-ups (including pins) are covered under the crown copay.

Prosthodontic Services: Services and appliances that replace missing natural teeth (such as bridges, partial dentures, and complete dentures). Benefits include:

Delta Dental Plans

- One complete upper and one complete lower denture — once in any seven-year period.
- Partial denture or fixed bridge — once in any seven-year period.
- Reline or complete replacement of denture base material — once in any two-year period per appliance.
- Fixed bridges and removable cast partials are not payable for children under age 16.

Implant benefit: An implant body, implant abutment and the prosthesis placed on the implant are a covered benefit, with a lifetime benefit of \$900 per implant per tooth. All implants placed in an edentulous to partially edentulous arch have a lifetime benefit of \$900 per arch.

- Removal of an implant or repair to an implant abutment is not covered. All procedures directly related to the implant will be paid at 50%, up to a lifetime maximum benefit of \$900 per implant per tooth. The \$900 allowance counts toward the dental plan's annual maximum.

Occlusal guard is a benefit once in a 24-month period. Occlusal guard relines/repair is a benefit within 12 months of insertion.

Willamette Dental Plan

- One complete upper and one complete lower denture — once every 5-year period if a tooth within the denture is extracted, the appliance cannot be made serviceable or was an immediate denture being replaced by a permanent denture.
- Partial denture or fixed bridge is covered under the office visit copay.
- Realignment of dentures is covered under the office visit copay and complete replacement of denture base material is covered with an additional copay per appliance.

Implant benefit: An implant body, implant abutment and the prosthesis placed on the implant are not a covered benefit. Removal of an implant or repair to an implant abutment is not covered.

Occlusal guard is not a covered benefit.

Class IV Benefits: Orthodontic Services

(Covered by the Plus Dental Plan and Willamette Dental Plan Only)

Services, treatment, and procedures to correct malpositioned teeth.

What's Not Covered by Delta Dental's Plans

Covered expenses do not include, and no payment will be made for, the following charges if incurred:

- Services for injuries or conditions payable under Workers' Compensation or Employer's
- Liability laws.
- Benefits or services that are available from any government agency, political subdivision, community agency, foundation, or similar entity. This provision does not apply to any programs provided under Title XIX Social Security Act, i.e., Medicaid.
- Services, as determined by Delta Dental, for correction of congenital or developmental malformations.
- Services for cosmetic surgery or dentistry for cosmetic (aesthetic) reasons.
- Veneers placed for cosmetic purposes only.
- Services or appliances started before an individual became eligible under the plan.
- Prescription drugs, pre-medications and/or relative analgesia. General anesthesia and/or intravenous sedation other than for covered oral surgery. Charges for hospitalization, laboratory tests and examinations, and any additional fees charged by the dentist for hospital treatment.
- Preventive control programs, including home care items.
- Charges for failure to keep a scheduled visit with the dentist.
- Repairs, relines or adjustments of occlusal guards.
- Occlusal (complete) equilibration.
- Charges for completion of forms. A participating dentist may not make these charges to an eligible participant.
- Lost, missing or stolen appliances of any type, and replacement or repair of orthodontic appliances.
- Services for which no valid dental need can be demonstrated, that are specialized techniques, or that are experimental in nature as determined by the standards of generally accepted dental practice.
- Experimental procedures not yet approved by Delta Dental.
- Appliances, surgical procedures, and restorations for increasing vertical dimension; for restoring occlusion; or for replacing tooth structure loss resulting from attrition, abrasion or erosion.
- Treatment by someone other than a dentist, except for services performed by a licensed dental hygienist or denturist within the scope of his or her license.
- Those benefits excluded by the policies and procedures of Delta Dental, including the processing policies.
- Services or supplies for which no charge is made, for which the patient is not legally obligated to pay or for which no charge would be made in the absence of Delta Dental coverage.
- Services or supplies received as a result of defect or injury due to an act of war, declared or undeclared.
- Services that are covered under a hospital, surgical/medical or prescription drug program.
- Appliances, restorations or services for the diagnosis or treatment of disturbances of the temporomandibular joint dysfunction (TMD). Refer to the Medical Benefits Plan summary plan description.
- Myofunctional therapy.
- Oral hygiene instruction and dietary instruction.
- Plaque control programs.
- Duplicate dentures.
- Periodontal splinting, including crowns or bridgework.
- The dental Plan Administrator is not obligated to pay claims received more than 12 months after the date of service.

What's Not Covered by Willamette Dental's Plan

Exclusions. Willamette Dental does not provide benefits for any or the following conditions, treatments, services or for any direct complications or consequences thereof. Willamette does not provide benefits for excluded services even if approved, prescribed, or recommended by a Participating Provider.

- Bridges, crowns, dentures, or prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.
- The completion or delivery of treatments or services initiated prior to the effective date of coverage under this contract, including the following:
 - An appliance or modification of one, if an impression for it was made prior to the effective date of coverage under this contract or.
 - A crown, bridge, cast or processed restoration if the tooth was prepared prior to the effective date of coverage under this contract. Such services are the liability of the Enrollee, prior dental insurance plan and/or provider.
- Dental implants, including attachment devices and maintenance.
- Endodontic services, prosthetic services and implants that were provided prior to the effective date of coverage. Such services are the liability of the Enrollee, prior dental plan and/or provider.
- Exams or consultations needed solely in connection with a service that is not covered.
- Experimental or Investigational services and related exams or consultations.
- Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation including crowns, bridges or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions, or correcting attrition, abrasion or erosion.
- General anesthesia, moderate sedation, and deep sedation.
- Hospital care or other care outside of a dental office for dental procedures, physician services or facility fees.
- Maxillofacial prosthetic services.
- Nightguards.
- Orthognathic surgery.
- Personalized restorations.
- Plastic, reconstructive, or cosmetic surgery and other services, which are primarily intended to improve, alter or enhance appearance.
- Prescription and over the counter drugs and pre-medication.
- Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.
- Replacement of lost, missing, or stolen appliances.
- Replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
- Replacement of sound restorations.
- Services and related exams or consultations that are not within the prescribed treatment plan or are not recommended and approved by a Participating Provider.
- Services and related exams or consultations to the extent they are not necessary for the diagnosis, care or treatment of the condition involved.
- Services by any person other than a Dentist, Denturist, hygienist, or dental assistant within the scope of his or her license.
- Services for diagnosis or treatment of temporomandibular joint disorders.
- Services for treatment of an occupational injury or disease, including an injury or disease arising out of self-employment or for which benefits are available under workers' compensation or similar law.
- Services for the treatment of injuries sustained while practicing for or competing in a professional athletic contest of any kind.

- Services for the treatment of intentionally self-inflicted injuries.
- Services for which coverage is available under any federal, state or other governmental program, unless required by law.
- Services not included in the Schedule of Covered Services and Cost-Sharing or appendices.
- Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Limitations

Alternate Services. If alternative services can be used to treat a condition, the service recommended by a Participating Provider is covered. In the event the Enrollee elects a service that is more costly than the service a participating Provider has approved, the Enrollee is responsible for the Copayment for the recommended Covered Service plus the cost differential between the Reasonable Cash Value of the recommended service and the Reasonable Cash Value of the more costly requested service.

Congenital Anomalies. Services listed in Appendix A which are provided to correct congenital anomalies will be covered for Dependent children if dental necessity has been established. Dental necessity means that treatment is primarily for the purpose of controlling or eliminating infection, controlling, or eliminating pain or restoring function. "Congenital anomaly" means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term "significant deviation" is defined as a deviation that impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate and other conditions that are medically diagnosed to be congenital anomalies.

Hospital Setting, the services provided by a Dentist in a hospital setting are covered if the following criteria is met:

- A hospital or similar setting is medically necessary.
- The services are authorized in writing by a participating Provider.
- The services provided are the same services that would be provided in a dental office; and
- The applicable Copayments are paid.

Replacements. The replacement of an existing denture, crown, inlay, onlay or other prosthetic appliance is covered if the appliance is more than 5 years old and replacement is dentally necessary due to one of the following conditions:

- A tooth within an existing denture or bridge is extracted.
- The existing denture, crown, inlay, onlay or other prosthetic appliance or restoration cannot be made serviceable; or
- The existing denture was an immediate denture to replace one or more natural teeth extracted while covered under this Contract and replacement by a permanent denture is necessary.

Claims for Dental Benefits

This section provides you with important information about how to file a claim for dental benefits.

Willamette Dental clinics file enrollee's claim when services are provided by a participating clinic. Out-of-network services are limited to Out of Area Emergency Treatment and limited to \$100 per visit for covered services. The Enrollee is responsible for all other charges and fees charged by the Non-Participating Provider to the extent such amount exceeds \$100.

You do not have to file a claim for benefits if you use a Delta Dental of Idaho participating provider (a provider who belongs to the Delta Dental Premier or Delta Dental PPO network). However, if you receive services from a non-participating provider the provider may require payment in full at the time of service. All dental claims should be submitted to:

Delta Dental of Idaho
P.O. Box 2870
Boise, ID 83701

Claims for services paid by a participant to an out-of-network provider must be submitted for reimbursement within 12 months of the date the services were rendered in order to be eligible for coverage.

After Delta Dental of Idaho processes your claim, you will receive an Explanation of Benefits, or EOB. Your EOB will show payments Delta Dental of Idaho has made and to whom payments have been made. It will also provide any information on why a claim was denied or not paid in full. Please contact the number on your ID card with questions about your claims and EOBs. See the *If Your Claim Is Denied* section for more information on claims.

If Your Claim Is Denied

If your claim is denied, in whole or in part, you will receive a written notice that contains the information described below.

- The specific reason(s) for the denial.
- The specific plan provisions on which the denial is based.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon to determine a claim, upon request you can receive either a copy of the actual rule, guideline, protocol or other criterion, or a statement that the rule, guideline, protocol or other criterion was used.
- If the denial is based on a provision such as medical necessity, experimental treatment or a similar exclusion or limit, you will either receive an explanation of the scientific or clinical judgment for the determination based on the plan terms and your medical circumstances, or a statement that you can receive the explanation free of charge upon request.
- A description of any additional material or information needed to process the claim and an explanation of why it is necessary.

Appealing a Denied Claim

You or your authorized representative may appeal a claim decision by submitting a written appeal to your Dental Carrier. You must make this request within 12 months following receipt of the denied claim. You must submit your request for appeal in writing and state why it is believed the claims decision was incorrect.

Upon request, you or your authorized representative will be given reasonable access to all documents, records, and information relevant to the claim for benefits, and you may request copies free of charge. You can also submit written comments, documents, records, and other information relating to the claim. Review of your claim will take into account all comments, documents, records, and other information, without regard to whether such information was submitted or considered in the initial benefit determination.

Third Party Committee's Review

The appeal will be considered by someone who did not make the initial decision and who is not a subordinate of the party who made that decision. If the initial denial was related to dental necessity, experimental treatment, or a clinical judgment in applying contract terms, the appeal will be reviewed by a third-party committee. This committee will consist of three dentists who have the appropriate training and experience in dentistry and who are neither the dental

consultant who made the initial decision nor the subordinate of the consultant.

Coordination of Benefits

If you have dental coverage under another dental plan, such as through your spouse's employer, benefits will be coordinated.

Through coordination of benefits, payments for dental services for you and your eligible dependents will be coordinated between your Dental plan benefits and the other employer's dental plan. This means that benefits are adjusted so that benefits equal to more than 100% of covered charges are not paid on your behalf.

Coordination of benefit rules determine which plan pays first. The plan that pays first is called the primary plan. Other plans are secondary and pay benefits after the primary plan.

The end result of Coordination of Benefits is that for covered services, the secondary plan picks up a portion of the payment, up to the allowed amount, for the service.

The order of payment (which plan pays as primary and which plan pays as secondary) is determined using the following rules.

The plan that covers a patient as an employee pays as primary. If there is another plan covering the patient as a spouse or dependent, this plan would pay secondary.

This plan determines benefits using the first of the following rules that applies:

- If children are covered under both parents' dental plan coverage, the "birthday rule" applies.
- The plan of the parent whose birthday (month and day) comes first in the calendar year pays first. If both parents have the same birthday, the plan that has covered the parent for the longest period will pay first.
- When parents are separated or divorced:
 - If a court has given financial responsibility for the child's healthcare expenses to one parent, that parent's dental plan pays first.
 - If a court order has not given financial responsibility for a child's healthcare expenses,
 - the order of benefits will be determined in the following order, the plan of the:
 - Parent with primary legal custody of the children,
 - Spouse of the parent with primary legal custody,
 - Parent without legal custody, and
 - Spouse of the parent without legal custody.
- A plan that covers a patient as an active employee or as the dependent of an active employee pays before a plan covering him or her as a retired or laid-off employee. (If the other plan does not include this provision, it does not apply.)
- A plan that covers a patient as an active employee or as the dependent of an active employee pays before a plan covering him or her through COBRA coverage. (If the other plan does not include this provision, it does not apply.)
- For oral surgical procedures that qualify under the medical plan, the medical plan always pays as primary and dental plan pays secondary.
- If none of the above situations applies, the plan that has covered the person for the longest period of time pays first.

The primary plan pays benefits as if no other plan were in effect. If there is a balance of charges after the primary plan has paid, the secondary plan pays benefits. When the Delta Dental plan is

the secondary plan, payment is reduced so that total benefits paid by all plans are not more than the total allowed amount for services rendered.

Vision Care Coverage

Vision care coverage by the Vision Focus Network Plan (**VSP**) encourages eye health by providing benefits for routine exams, frames, lenses and contacts. **You must be actively enrolled in the University's medical plan in order to enroll in the vision plan.** You can visit any provider you choose. However, you typically receive greater benefits for services and supplies you receive from VSP providers. When you use a non-VSP provider, you pay the full cost at the time of service and then submit a claim for reimbursement.

VSP Plan Coverage-at-a-Glance Chart

The following table summarizes benefits available through the VSP plan.

Vision Focus Network (VSP) Plan		
Service	VSP Provider	Non-VSP Provider
Eye exam – annual	\$10 deductible – plan pays 100%	\$10 deductible – plan reimburses up to \$52
Eyeglass lenses (once every 12 months)		\$25 deductible ¹ – plan reimburses up to:
– Single vision	\$25 deductible ¹ – plan pays 100%	\$55
– Bifocal		\$75
– Trifocal		\$95
– Lenticular		\$125
– Progressive	\$60 - \$119 deductible – plan pays 100%	Not Covered
Eyeglass frames (once every 24 months)	\$25 deductible ¹ – plan pays up to \$150	\$25 deductible ¹ – plan reimburses up to \$45
Contact lenses (once every 12 months)	Plan pays up to \$120 for contact and fitting exam	Plan reimburses up to \$105 for contacts and fitting exam

¹ Deductible applies to complete pair of glasses or to frames, whichever is selected.

Services are covered as listed above based on last service date (example: last vision exam was June 15, 2018, next vision exam permitted on or after June 15, 2019).

Additional Benefits

The following table summarizes additional benefits available through the VSP Plan.

Service	Benefits
Contact Lenses Elective	<p>Allowance includes fitting, exam and lenses. The cost of the fitting and evaluation is deducted from the allowance and any amount left is applied toward the contact lens material. Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6-month supply).</p> <p>New and current soft contact lens wearers may be eligible for a special program that includes an initial contact lens evaluation and initial supply of lenses. Contact VSP or your VSP provider for additional details.</p>
Lens Options (Member Cost) *	<p>\$14 - High Luster Edge Polish \$13 - Solid Plastic Dye (Except Pink I & II) \$15 - Plastic Gradient Dye \$27 - \$76 - Photochromic Lenses (Glass & Plastic)</p> <p>Lens Option member cost vary by prescription and option chosen.</p>
Additional Glasses	20% discount off the retail price on additional pairs of prescription glasses (complete pair).
Frame Discount	VSP offers a 20% discount off the remaining balance in excess of the frame allowance.
Laser Vision Care	VSP offers an average discount of 15% on LASIK and PRK. The maximum out-of-pocket per eye for members is \$1,800 for LASIK and \$2,300 for custom LASIK using Wavefront technology, and \$1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With preauthorization, 75% of approved amount (up to \$1,000 is covered every two years).

Annual Vision Examinations

With the VSP plan, you receive coverage for an annual vision examination, which includes an examination of visual functions and, if necessary, prescription of corrective eyewear.

Vision Care Materials

With the VSP plan, you receive coverage for lenses and frames, including all necessary professional services such as:

- Prescribing and ordering proper lenses,
- Assisting in the selection of frames,
- Verifying the accuracy of the finished lenses,
- Proper fitting and adjustment of frames,
- Subsequent adjustments to frames to maintain comfort and efficiency, and
- Progress or follow-up work as necessary.

Contact Lenses

Through the VSP plan, you may receive benefits for your purchase of contact lenses, *in place of* all other lenses and frames, once every calendar year.

For contact lenses to be covered in full under the VSP Plan, they must be considered visually necessary by your in-network provider.

See the *VSP Plan Coverage-at-a-Glance Chart* to learn how coverage works for both visually necessary and elective (not visually necessary) contact lenses.

After purchasing contact lenses, you will not be covered for a purchase of eyeglasses (lenses and frames) for another 12 months.

What Costs Extra

The VSP plan is designed to cover visual needs, not cosmetic materials. If you purchase any of the following enhancements, the plan will pay up to the basic cost of the allowed lenses or frames and you will pay the additional cost (however, you can save money through the discount program described in the *Value-Added Discounts from VSP Providers* section):

- Anti-reflective coating,
- Scratch resistant coating,
- Progressive multifocal lenses,
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2,
- UV (ultraviolet) protected lenses, and
- A frame that costs more than the plan allowance.

In addition, you will pay any costs that exceed certain limitations on low vision care.

Low Vision Benefit

The VSP Plan provides additional benefits to eligible participants who have severe vision problems that cannot be corrected with regular lenses. To receive coverage for services preauthorization is required. Coverage is limited to 75% of the approved amount up to \$1,000 every two years.

Value-Added Discounts from VSP Providers

When you participate in the VSP Plan and use a VSP provider, you are eligible for a 20% discount toward a complete pair of glasses. Also, you are eligible to receive a discount of 15% off contact lens examination services from any VSP provider.

Discounts are applied to the VSP provider's usual and customary fees for such services and are unlimited for 12 months on or following the date of your last eye exam.

For example, if you choose contact lenses but also wear prescription glasses, you will benefit from valuable savings of 20% off the cost of prescription glasses (lenses and a frame), which wouldn't be eligible for normal plan coverage because you order them within 12 months of purchasing contacts. The same applies if you obtain glasses but also wish to purchase an additional pair not covered by the plan, including sunglasses. Obtain service within 12 months of your last covered eye exam to receive the discount.

Please note the following rules that apply to this discount plan:

- Discounts are only available through VSP providers.
- The 20% discount applies to complete pairs of glasses only.
- The 20% discount applies to services received within 12 months of the last eye exam.
- Discounts do not apply if they are prohibited by the manufacturer.
- Discounts do not apply to sundry items, such as contact lens solution, cases, cleaning products or repairs of lenses or frames.

What's Not Covered

The VSP plan does not cover the following services or products:

- Vision examinations more than the frequency as indicated in the "VSP Plan Coverage-at-a-Glance Chart"
- Lenses more than the frequency as indicated in the "VSP Plan Coverage-at-a-Glance Chart".

- Frames more than the frequency as indicated in the “VSP Plan Coverage-at-a-Glance Chart”.
- Contact lenses more than once in any twelve-month period. When chosen, contact lenses shall be in lieu of any other lens or frame benefit during the twelve-month period. When lenses and frames are chosen, expenses for contact lenses are not covered expenses during the twelve-month period.
- Examinations performed or frames or lenses ordered before the member was covered under the eye care expense benefits.
- Subject to extension of benefits, any examination performed, or frame or lens ordered after the member's coverage under the eye care expense benefits ceases.
- Sub-normal eye care aids; orthoptic or eye care training or any associated testing.
- Non-prescription lenses.
- Replacement or repair of lost or broken lenses or frames except at normal intervals.
- Any eye examination or corrective eyewear required by an employer as a condition of employment.
- Medical or surgical treatment of the eyes.
- Any service or supply not shown on the Schedule of Eye Care Procedures.
- Coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.

How to Obtain Vision Care and Filing Claims

To locate a VSP provider near you, visit the VSP Web site at **www.vsp.com**, or call VSP Customer Service at **1-800-877-7195**, Monday – Friday, from 5:00 a.m. to 7:00 p.m. PT, and Saturday, from 6:00 a.m. to 2:30 p.m. PT. Please remember to use your Vandal number as your identification number, replacing the “V” with a “9,” both on the Web site and at your eye care provider.

Network Providers

To schedule an in-network appointment, contact your VSP provider. Be sure to identify yourself as a VSP patient. The provider will contact VSP to obtain authorization for you to receive services and supplies.

You do not have to file a claim for benefits if you use a VSP participating provider (a provider who belongs to the VSP network). However, if you receive services or supplies from an out-of-network provider, you must pay for these services or supplies at the time of service.

Out-of-Network Providers

If you receive vision care from an out-of-network provider under the VSP plan, pay the provider at the time of service. Then submit your itemized receipt directly to VSP with a VSP out-of-network reimbursement form, available by contacting VSP or printing from the **www.vsp.com** Web site. You will need to include:

- The name of the patient,
- His or her ID number (your Vandal number, replacing the “V” with a “9”),
- Date of birth,
- Relationship to the insured (employee or dependent),
- Plan number: 010-301274, and
- Employer's name.

All claims for reimbursement of fees paid to out-of-network providers should be submitted to:
VSP

ATTN: Out of Network Provider Claims
P.O. Box 997100
Sacramento, CA 95899-7100

Claims for services paid by a participant to an out-of-network provider must be submitted for reimbursement within 180 days of the date the services were rendered in order to be eligible for coverage.

Appealing Denied Claims

Please know that if you disagree with how your claim was processed, you have the right to appeal. There are specific steps the Claims Administrator must follow in handling your appeal. A general summary of your claims appeal rights is provided in the *If Your Claims is Denied* section of the Dental Coverage description.

Disability Coverage

When you are unable to work because of a non-work-related illness (including pregnancy) or injury, you may be eligible for disability benefits. Disability benefits can provide a source of continuing income while you are unable to work. The University offers two types of disability benefits:

- **Short-term disability (STD) benefits** provide short-term income protection if you become disabled from a covered illness or injury.
- **Long-term disability (LTD) benefits** provide continuing income when you are unable to work for a longer period of time due to an illness or injury.

All eligible employees must enroll in STD and LTD benefits.

You are eligible to enroll for disability benefits if you meet the criteria outlined in the *Eligibility* section. Please see the *How to Enroll for Coverage* section for information on how to enroll.

The Standard is the insurance carrier and administrator of the University's disability plan benefits.

Short-term Disability (STD) Benefits

All eligible employees automatically receive a core Short-Term Disability benefit at 50% of pre-disability earnings, up to \$500 per week.

You may enroll for "buy-up" coverage and increase your benefits to:

- 60% of your pre-disability earnings, up to \$700 a week, or
- 66.67% of your pre-disability earnings, up to \$1,250 a week.

Your "pre-disability earnings" are equal to your annual rate of pay divided by the number of pay periods. Your STD plan benefit will be reduced by the amount of any other disability income benefits you receive (see *Other Income Benefits*).

Your Cost for Coverage

If you enroll for buy-up disability coverage, your cost for STD benefits is based on the option you choose and your pay. Your costs under all options are listed in your myBenefits enrollment portal.

If you become eligible to receive disability benefits, and you have elected only the core Short-Term Disability option at 50% of your earnings, you will pay taxes on the 50% University-paid benefits. However, if you enroll for buy-up coverage you will pay taxes on only a percentage of your disability benefit. This percentage is based off a calculation performed each plan year and depends on which plan you have chosen.

Coverage during a Leave of Absence or Sabbatical

If you are absent under the terms of the Family Medical Leave Act of 1993 (FMLA), your STD plan coverage may be continued for up to 12 weeks (and up to 26 weeks if you qualify for Family Military Leave, or longer if required by other applicable law). See the *Continuation of Coverage under the Family and Medical Leave Act (FMLA)* section for more information on FMLA leave.

If you are on a documented paid sabbatical, your medical coverage may be continued for six months at full pay or 12 months at half pay.

If your leave or sabbatical terminates prior to the agreed-upon date and you do not return to work, your STD coverage will immediately end. If you return to work from your leave or sabbatical earlier than the agreed-upon date, your benefit coverage will be reinstated as an active employee – unless you have a break in service of one day or more. In that case, it may be necessary for you to re-enroll in benefit coverage.

Evaluating Your STD Plan Options

When deciding which STD plan option to elect, consider:

- ☐ *Sick leave time accumulated:* After your disability begins, you must exhaust all your sick leave time or wait at least 30 days, whichever time period is longer, before payment of STD benefits begins.
- ☐ *Annual salary:* Keep in mind your salary and the maximum weekly benefit that would be payable under each STD option.

When STD Benefits Begin

If you are approved for STD benefits, you will receive a weekly check from The Standard. Your benefits will begin after the waiting period, which is the later of:

- The 30th consecutive day of your being “totally disabled or
- When you have exhausted all of your sick leave time.

You can receive STD benefits for up to 22 weeks of disability.

“Total Disability”

You will be considered *totally disabled* if you are prevented from performing the essential duties of your occupation because of an injury, sickness, pregnancy, mental illness, or substance use disorder and as a result, you are earning less than 20% of your pre-disability earnings.

If you are in an occupation that requires you to maintain a license and you fail to pass a physical examination required to maintain a license to perform the duties of your occupation, that failure, on its own, does not mean that you are disabled from your occupation.

Short-Term Disability Waiting Period

Short-term disability begins paying on the 31st day you miss work and lasts up to six months from your last day worked. Your basic coverage pays 50 percent of your salary up to \$500 a week. You may increase your coverage during annual enrollment to 60 or 66.67 percent of your salary. If you increase your coverage, then apply for STD within 12 months, the waiting period for the increased amount could be up to 60 days; however, the basic coverage amount will start on the 31st day. This is called a late enrollment penalty.

How to Apply for STD Benefits

Contact The Standard as soon as you know you will be going on disability or within 30 days after your disability occurs (or as soon as reasonably possible, if it is not possible to give notice within that time frame).

To file an STD benefit claim:

- Call **1-855-758-4773**, Monday through Friday, 6:00 a.m. to 6:00 p.m. PT, or
- Log on to **www. standard.com**.
- Have the following information ready:
 - Your department and last day of active, full-time or regularly scheduled work,
 - Manager's name and phone number,
 - Nature of the claim and whether it's work-related, and
 - Treating physician's name, address, and phone number.

Terms to Know

Pre-Disability Earnings — Your pre-disability earnings are equal to your annual rate of pay divided by the number of pay periods.

STD Plan Benefit Amounts

If You Are Totally Disabled

The amount of your STD plan benefit will be determined by your pre-disability earnings, the option in which you are enrolled (core or buy-up options) and the maximum benefit for that option.

An Example

For example, if you are enrolled in the core benefit and your weekly pre-disability earnings are \$1,000 per week, you are entitled to STD plan benefits of \$500 per week (50% x \$1,000) during a qualifying period of disability.

Other Income Benefits

Your STD plan benefit payments will be reduced by any income earned from university employment, as well as by any of the following other income benefits for which you are eligible (even if you do not apply for payment):

- Temporary disability, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law, or substitutes or exchanges for such benefits.
- Benefits under a governmental law or program that provides disability or unemployment benefits as a result of your job with the University.
- Plan or arrangement of coverage, whether insured or not, that is received from the University as a result of your employment by or association with the University or that is the result of membership in or association with any group, association, union or other organization.
- Portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates you for your loss of earnings.
- Individual insurance policy whose contribution is wholly or partially paid by the University.
- Mandatory "no-fault" automobile insurance plan.
- United States Social Security disability benefits or those provided by an alternative plan offered by a state or municipal government; the Railroad Retirement Act; the Canada Pension Plan, Canada Old Age Security Act, Quebec Pension Plan or any provincial pension or disability plan; or a similar plan or act that you are eligible to receive as a result of your disability.

- Retirement benefits from any of the above organizations unless you were receiving them prior to becoming disabled.
- Disability benefits from the Department of Veterans Affairs or any other foreign or domestic governmental agency that begin after you become disabled or (only as far as the amount of any increase in the benefit attributed to your disability) that you were receiving before becoming disabled.
- Disability benefits from a university retirement plan.

An Example

For example, if you are enrolled in the core benefit and your weekly pre-disability earnings are \$1,000 per week, you are entitled to STD plan benefits of \$500 per week (50% x \$1,000) during a qualifying period of disability. If you also receive Social Security disability income benefits of \$200 per week during this period, your STD plan weekly benefits will be reduced to \$300 (\$500 - \$200).

Cost of Living Increase

The amount of any increase to your other income benefits will not be subtracted from your STD plan benefit, as long as the increase takes effect after benefits become payable to you under this STD plan, and as long as it is a general increase that applies to all persons entitled to such benefits.

Minimum Benefit

Even if your disability benefits are subject to reduction, or if you are not eligible for disability benefits because of your accrued sick time, you will receive a minimum weekly benefit of \$15.

If You Are Disabled and Working

If you are able to work while you are disabled, your STD plan benefits will be calculated as if you were totally disabled, then *reduced* by the amount of your current weekly employment earnings from both University and other employment.

To determine your disabled and working benefits, your weekly STD benefits will be determined by the following calculation:

$$\begin{array}{rcccl} \text{Weekly benefit} & & \text{Weekly pre-disability} & - & \text{Current weekly} \\ \text{payable if totally} & \times & \text{earnings} & & \text{earnings from} \\ \text{disabled} & & & & \text{employer} \\ & & & & \text{Weekly pre-disability earnings} \\ & & & & = \text{Weekly STD} \\ & & & & \text{Plan Benefit} \end{array}$$

An Example

Let's look at an example. Full-time University employee, Joe, becomes disabled and eligible for STD benefits, but he is able to work 20 hours a week.

- Since Joe enrolled for STD plan benefits under the buy-up option of 66.67%, he is eligible for 22 weeks of disability benefits equal to 66.67% of his annual salary.
- Joe's annual salary is \$55,000, so his weekly pre-disability earnings = \$1,057.69 (\$55,000 divided by 52 weeks).
- If totally disabled, Joe could receive \$705.13 from the STD plan each week (\$1,057.69 x 66.67).
- Joe's current weekly earnings from employment during his period of disability = \$528.80 (\$26.44 per hour x 20 hours).

Based on this information, Joe would receive a weekly STD plan benefit of \$352.59, as calculated below:

\$705.13 Weekly benefit as if totally disabled	X	\$1,057.69 Weekly pre-disability earnings	-	\$528.80 Current weekly earnings from employer	=	\$352.59 Weekly disabled and working STD plan benefit
		\$1,057.69				

When this weekly STD benefit is combined with Joe's weekly employment earnings of \$528.80, his total weekly income while disabled and working will be \$881.39 (\$528.80 + \$352.59).

Rehabilitative Employment

"Rehabilitative employment" means employment or service that prepares a disabled person to resume gainful work and is approved, in writing, by The Standard. If you accept rehabilitative employment while you are totally disabled or disabled and working, you will continue to receive an STD weekly benefit that is equal to your total disability weekly benefit *reduced by 50%* of any income you receive from your rehabilitative employment. The total of your STD weekly benefit plus your income from rehabilitative employment cannot exceed 100% of your pre-disability earnings. No other "disabled and working" reduction is made to your benefit. If you remain disabled after a period of rehabilitative employment, you may continue to receive STD benefits for as long as you are eligible.

Returning to Work from STD Leave

You should keep in contact with Benefit Services and your manager throughout your disability leave. When you are released to return to work at the University, you must provide The Standard and Benefit Services with a doctor's release before you are allowed to return to work. If your doctor releases you to return to work on a temporary or part-time basis, your doctor must certify both the number of hours you may work each day and the total number of hours you may work in a week.

When STD Benefits End

Your STD weekly benefits will end on the earliest of the following dates:

- When you are no longer disabled,
- When you fail to furnish proof of disability,
- When you are no longer under the regular care of a physician,
- When you fail to comply with The Standard's request for an exam by a physician or other qualified medical professional,
- The date of your death,
- When you refuse to receive recommended treatment that is generally accepted,
- Twenty-two weeks after you have been receiving STD benefits (at which time, you may be eligible to receive LTD benefits),
- The date your current weekly earnings exceed 80% of your pre-disability earnings if you are receiving benefits for being disabled from your occupation, or
- The date no further benefits are payable under any plan provision that limits benefit duration.

Recurrent Disability

Special rules apply if you return to work after receiving STD benefits and again become disabled:

- If you become disabled **within** 30 consecutive calendar days of returning to work, your new disability will be considered a continuation of the first disability.
- If the same or related **disability** recurs **after** 30 consecutive calendar days of your return

to work, it will be considered a new disability and will be subject to the waiting period before STD benefits **begin** to be paid.

STD Plan Exclusions

The plan will cover disabilities only if you are under the regular care of a physician.

In addition, the plan does not cover and will not pay benefits for any disability:

- Caused or contributed to by war or act of war, whether declared or not,
- Caused by your commission of or attempt to commit a felony,
- Caused or contributed to by your engagement in an illegal occupation,
- Caused or contributed to by an intentionally self-inflicted injury,
- For which you are receiving Workers' Compensation benefits, including benefits you receive from work you were doing for another employer, or
- Sustained as a result of your doing work for pay or profit for another employer.

Overpayment Recovery and Subrogation

If you receive an overpayment of STD plan benefits, you must reimburse The Standard within 30 days. The Standard has the right to take measures to recover overpayments not reimbursed in a timely manner.

The Standard also has the right to request to be reimbursed for any benefit payments it has made for a disability for which you recover payment from a third party through a legal judgment, arbitration award, and settlement or otherwise. If you suffer a disability because of the act or omission of a third party and do not initiate legal action in a reasonable period of time to recover from the third party the benefits The Standard has paid, The Standard has the right to bring legal action to the third party to recover any payments The Standard has made in connection with your disability.

Long-Term Disability Benefits

Long-term Disability (LTD) coverage is designed to protect your income through monthly benefits in case a prolonged disability prevents you from working.

All eligible employees automatically receive a core benefit of Long-Term Disability benefits at 50% of your monthly salary, up to \$2,000 per month.

You may enroll for "buy-up" coverage and increase your benefits to either:

- 60% of your monthly salary, up to \$3,000, or
- 66.67% of your monthly salary, up to \$5,000.

Your LTD plan benefit will be reduced by the amount of any other income benefits you receive. In general, LTD benefits continue as long as you remain disabled or, if earlier, until you reach normal Social Security retirement age. (Your normal Social Security retirement age is determined by your birth year; please contact the Social Security Administration at www.ssa.gov for your normal retirement age.) See *When LTD Benefits End* for more information.

Your Cost for Coverage

If you enroll for buy-up disability coverage, your cost for LTD benefits is based on the option you choose and your pay. Your costs under all options are listed in your myBenefits enrollment portal.

If you become eligible to receive disability benefits, and you have elected only the core Long-Term Disability option at 50% of your earnings, you will pay taxes on the 50% University-paid benefits. However, if you enroll for buy-up coverage you will pay taxes on only a percentage of your disability benefit. This percentage is based off of a calculation conducted each plan year and depends on which plan you have chosen.

Benefit Enrollment

When you enroll for LTD coverage within 30 days of your date of hire, you are guaranteed coverage without having to provide Evidence of Insurability (EOI). You may change your plan election during annual enrollment or with a qualified life-style change. Pre-existing conditions are imposed upon long-term disability coverage for 12 months.

Pre-existing Condition Limitation

LTD benefits will not be paid for pre-existing conditions until you have been covered by the LTD plan for 365 consecutive days. A “pre-existing condition” is any sickness or injury for which, during the 90 days before coverage begins, you:

- Received medical advice or treatment,
- Consulted a physician or other health care providers, and/or
- Took prescription drugs.

This pre-existing condition limitation applies to both initial enrollments and requests to increase current coverage amounts. If you want to increase your coverage amount, the pre-existing condition limitation applies only to the amount of the coverage increase. For example, if you have participated in the core LTD plan with a 50% income replacement benefit for two years and then enroll in the buy up option that provides 60% coverage, the pre-existing condition limitation applies only to the 10% increase in coverage. You will still be eligible for a 50% income replacement benefit if you ever become disabled and eligible for LTD benefits.

Coverage During a Leave of Absence or Sabbatical

If you are absent under the terms of the Family Medical Leave Act of 1993 (FMLA) or other applicable state or local law, your LTD plan coverage may be continued for up to 12 weeks (and up to 26 weeks if you qualify for Family Military Leave, or longer if required by other applicable law). See *Continuation of Coverage under the Family and Medical Leave Act (FMLA)* for more information on FMLA leave.

If you are on a documented paid sabbatical, your coverage may be continued for six months during the sabbatical.

If your leave or sabbatical terminates prior to the agreed-upon date, and you do not return to work, your LTD coverage will immediately end. In the event that the employee returns to regular duty early from sabbatical or leave of absence, benefits are reinstated as an active employee.

When LTD Benefits Begin

Your benefits will begin after a waiting period of 180 days. (Keep in mind, you may be eligible to receive STD benefits for up to 22 weeks of your disability during this waiting period.) If you are approved for LTD benefits, you will receive a monthly check from The Standard.

What Is a “Disability”?

You are considered “disabled” if due to accidental bodily injury, sickness (including pregnancy), mental illness or substance use disorder, you are prevented from performing one or more of the essential duties of:

- Your occupation during the 180-day elimination period,
- Your occupation for 24 months following the elimination period, if you are unable to earn at least 80% of your indexed pre-disability earnings, or
- Any occupation after 24 months.

If at the end of the 180-day elimination period, you cannot perform one or more of the essential duties of your occupation, but your current weekly earnings are greater than 80% of your pre-disability earnings, your elimination period will be extended for the lesser of:

- 12 months from the original date of your disability, or
- Until your current monthly earnings are less than 80% of your pre-disability earnings.

For purposes of extending your elimination period, your current monthly earnings will not include the pay you could have received for another job or a modified job, if you refused such an offer.

Your occupation means your occupation as it is recognized in the general workplace. Your occupation does not mean the specific job you are performing for the University.

If you are in an occupation that requires you to maintain a license and you fail to pass a physical examination required to maintain a license to perform the duties of your occupation, the failure alone does not mean that you are disabled from your occupation.

Terms to Know

Pre-Disability Earnings — Your pre-disability earnings are equal to your annual rate of pay divided by the number of pay periods.

“Indexed Pre-Disability Earnings” — Your *indexed* pre-disability earnings are your pre-disability earnings adjusted annually by adding the lesser of 10% or the percentage change in the Consumer Price Index (which measures inflation) between the current year’s July 31 and the prior year’s July 31.

“Current Monthly Earnings” — Your current monthly earnings are monthly earnings you receive from your employer and any other employment while you are disabled.

However, if the other employment is a job you hold *in addition to* your university job, only the portion of your earnings that exceeds your average earnings from the other employer over the six-month period just before you became disabled will count as monthly earnings.

Current monthly earnings also include pay you received or could have received for another job or modified job from the University or another employer that is consistent with your education, training and experience, as well as your capabilities as substantiated by your physician.

How to Apply for LTD Benefits

If you are receiving STD benefits when you become eligible for LTD benefits, you do not need to make a separate LTD application. The Standard will roll over your STD claim to an LTD claim.

As a reminder, here is how to begin the disability claims process. You should:

- ☐ Call **1-855-758-4773**, Monday through Friday, 6:00 a.m. to 6:00 p.m. PT, or
- ☐ Log on to **www.standard.com**.

Have the following information ready:

- ☐ Your department and last day of active, full-time, or regularly scheduled work,
- ☐ Manager’s name and phone number,
- ☐ Nature of the claim and whether it’s work-related, and
- ☐ Treating physician’s name, address and phone number.

Please note: Even if you have more than six months of banked sick leave and thus will not receive benefits until you qualify for LTD, you still should apply for STD benefits as of your last day worked.

The Standard will follow up with telephone calls and/or documents mailed to your home address. Please respond with the required information within the deadlines communicated by The Standard to ensure no delay in claims processing.

LTD Benefit Amounts

The amount of your LTD plan benefit will be determined by your pre-disability earnings, the option in which you are enrolled (core or buy-up options) and the maximum benefit for that option.

Your LTD benefit payments will be reduced by any other income benefits for which you are eligible, and any income earned from employment. Exceptions apply to some employment income; see *Return to Work Incentive*.

Other Income Benefits

If you are eligible for any other income benefits, these benefits are subtracted from your LTD plan benefits. Other income benefits include, but are not limited to:

- Temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law, or substitutes or exchanges for such benefits.
- Governmental laws or programs that provide disability or unemployment benefits as a result of your job with the University.
- Any salary-continuance or wage continuance plan of your employer.
- Income from any "no-fault" automobile insurance policy.
- Disability benefits you receive from Social Security or other government plans, Railroad Retirement, Canadian Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan, any provincial pension or disability plan, or a similar plan or act.
- Disability benefits from the Department of Veterans Affairs or any other foreign or domestic governmental agency.
- Benefits that begin after you become disabled.
- Benefits that you were receiving before you became disabled, but only the amount of any increase in the benefit attributed to your disability.
- Amounts you receive from a third party (minus associated costs) by judgment, settlement or otherwise.
- Disability benefits you receive from PERSI that you earned while working for the University of Idaho.

Social Security Disability Benefits

You must apply for Social Security disability benefits before the end of the six-month period following the date you became disabled. If the Social Security Administration denies your eligibility for benefits, you will be required:

- To follow the process established by the Social Security Administration to apply for reconsideration of the denial, and
- If denied again, request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

The Standard may reduce your monthly benefit by estimating the Social Security disability benefits you or your family may be eligible to receive. Your monthly benefit will *not* be reduced by estimated Social Security disability benefits *if*:

- You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision,
- You sign a form authorizing the Social Security Administration to release information about awards directly to The Standard, and
- You sign and return The Standard's reimbursement agreement, which confirms that you agree to repay all overpayments.

Please coordinate your Social Security application with The Standard team designated to assist and support the Social Security application process.

Cost of Living Increase

The amount of your LTD plan benefits generally will not be affected by any cost-of-living increases made to other disability benefits you are receiving, as long as the cost-of-living increase applies to all persons entitled to receive those benefits.

Minimum Benefit

Even if your disability benefits are subject to reduction, or if you are not eligible for LTD benefits because of your accrued sick time or other sources of income, you will receive a minimum monthly benefit of \$100.

Return to Work Incentive

If you work while receiving monthly LTD benefits, your monthly LTD benefit generally will not be reduced by your current monthly earnings for up to 12 consecutive months. This 12-month period begins on the later of: the day you first start work, or the end of the elimination period before LTD benefit payments begin.

However, your LTD benefits will be reduced if the *total* of your current monthly earnings and your LTD benefits equals more than 100% of your pre-disability earnings. (Please note that your employment earnings include earnings from both the University and other employment.)

If you are still disabled after this 12-month period ends, you will receive only the regular disability payment.

A Return-to-Work Incentive Example

Let's look at an example. A full-time University employee, Sue, becomes eligible for LTD benefits but is able to work 20 hours a week.

- Sue enrolled for LTD benefits at the 60% buy-up option, so she is eligible for benefits equal to 60% of her monthly salary, up to a maximum benefit payable of \$3,000 a month.
- Sue's monthly pre-disability earnings = \$2,000 (\$24,000 annual salary, divided by 12). This means Sue is eligible for up to \$1,200 in monthly LTD payments (\$2,000 x 60%). We will assume she has no other disability income benefits that would reduce this LTD plan benefit.
- Sue's current monthly earnings from part-time employment = \$900.
- Sue's monthly LTD benefit of \$1,200 as calculated, plus her employment earnings of \$900, totals \$2,100. Since this amount exceeds her pre-disability earnings of \$2,000, her monthly LTD benefit will be reduced by \$100, to \$1,100. Under the Return-to-Work Incentive, Sue will continue to earn \$2,000 a month.

Returning to Work

You should keep in contact with Benefit Services and your manager throughout your disability leave. When you are released to return to work at the University, you must provide The Standard and Benefit Services with a doctor's release before you are allowed to return to work. If your doctor releases you to return to work on a temporary or part-time basis, your doctor must certify both the number of hours you may work each day and the total number of hours you may work in a week.

Additional Plan Benefits

As an LTD plan participant, you also may be eligible for one or more of the following benefits from the plan:

Rehabilitation Program

Our disability Plan Administrator, The Standard, will work with you to help you return to work. The Rehabilitation Program includes possible workplace modifications, vocational testing, vocational training, job placement, alternative treatment plans, family care credit benefits and other services. There is no cost to you to participate in such a program.

Workplace Modification Benefit

If you are disabled, the Plan Administrator, The Standard, may reimburse the University for expenses it incurs to make a reasonable accommodation to your workplace that allows you to return to work and perform the essential duties of your job. This payment is an incentive to help both you and the University. This Workplace Modification Benefit payment is made directly to the University; it is paid *in addition to* your LTD benefit and does not reduce your LTD benefit.

To evaluate and approve the proposed modification, The Standard may have you examined or evaluated, at its expense, by a physician, healthcare professional, vocational expert or rehabilitation specialist.

Family Care Credit Benefit

If while you are disabled, you work as part of a rehabilitation program designed to help you return to work, the plan will deduct from your work earnings, up to the limits described below, the expenses you incur to provide care for your eligible dependents while you work. As a result, you will be eligible for greater disability benefit payments.

Your eligible dependents include:

- Your children under age 13, and
- A member of your household who is mentally or physically handicapped and dependent on you for support and maintenance.
- You are eligible to receive a maximum monthly credit of up to \$350 for care of each qualifying child or family member for the first 12 months and up to \$175 a month thereafter, for up to another 12 months. When your benefits are calculated, your family care credit will be excluded from the amount of your current monthly payment.
- A few limitations apply to the family care credit:
 - Care may not be provided by a person related to the family member receiving the care.
 - Your family care credits cannot exceed \$2,500 per calendar year.
 - Family care credits will be paid for a maximum of 24 months.
 - Family care credits *will not* be made if your monthly earnings before the family care credit exceed your monthly earnings or 80% of your indexed pre-disability earnings.

You will be asked to provide proof that you have incurred eligible expenses by submitting to The Standard a receipt from the caregiver.

Survivor Income Benefit

If you die while receiving LTD benefits, a benefit will be paid to your surviving spouse. If you have no surviving spouse, the benefit will go to your children, in equal shares.

The survivor benefit is equal to three times the lesser of:

- Your pre-disability earnings minus your current monthly earnings multiplied by your LTD benefit percentage in effect on the date of your death, or
- Your maximum monthly benefit.

To be eligible for survivor benefits, your survivors must submit satisfactory proof of death within one year of your death.

If you have no surviving spouse or surviving children when you die, no benefit will be paid from this plan.

When LTD Benefits End

Your LTD benefits will generally continue, and no contribution payments will be required from you, for as long as you remain disabled, until you reach the age levels outlined in the table below.

If you become disabled at	Your LTD benefits will continue up to ...
Prior to age 63	The greater of 42 months or when you reach Social Security normal retirement age
Age 63	The greater of 36 months or when you reach Social Security normal retirement age
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

Your coverage under the LTD plan will also end on the earliest of the following dates if you:

- Are no longer disabled,
- Fail to furnish proof of disability,
- Are no longer under the regular care of a physician,
- Refuse The Standard's request for a physical examination,
- Die,
- Refuse recommended treatment by a physician,
- Earn current weekly earnings exceeding:
 - 80% of your pre-disability earnings if you are receiving benefits for being disabled from your occupation, or
 - Your indexed pre-disability earnings times the benefit percentage of your LTD plan option, if you are receiving benefits for being disabled from *any* occupation,
- Receive no further benefits payable under any plan provision that limits benefits duration, or
- Refuse to participate in a rehabilitative program or refuse to cooperate with or try:
 - Modifications to the work site or job process made to, or adaptive equipment or devices designed to, accommodate your medical limitations, and enable you to perform the essential duties of your occupation; or
 - Modifications to the work site or job process made to, or adaptive equipment or devices designed to, accommodate your identified medical limitations in order to enable you to perform the essential duties of any occupation, if you were receiving benefits for being disabled from any occupation.

Limits on LTD Benefits for Mental Illness and Substance use disorder

If you are eligible for LTD benefits because of mental illness or any condition resulting from mental illness, alcoholism that is being treated, or the non-medical use of narcotics, stimulants, hallucinogens or any other such substance, your LTD benefits will be limited. LTD benefits will be payable:

- For as long as you are confined to a hospital or other facility licensed to provide medical care for your disabling condition, or
- For up to a lifetime total of 24 months for all such disabilities, if you are not confined to a hospital or licensed facility or after you are discharged and still disabled.

Recurrent Disability

If you become disabled and then recover during the 180-day elimination period, the number of days you are working will count toward satisfaction of the elimination period as long as your total working days are 90 days or fewer.

If you return to active employment after receiving LTD benefits and you become disabled:

- *Within six months:* your disability will be considered a continuation of the first disability.
- *After six months:* it will be considered a new disability and will be subject to another 180-day elimination period.

LTD Plan Exclusions

The plan only covers disabilities if you are under the regular care of a physician. In addition, the plan does not cover and will not pay benefits for any disability that is:

- Caused or contributed to by war or act of war, whether declared or not,
- Caused by your commission of or attempt to commit a felony,
- Caused or contributed to by your being engaged in an illegal occupation,
- Caused or contributed to by an intentionally self-inflicted injury, or
- Caused or contributed to by a pre-existing condition (unless the pre-existing condition waiting period has been met).

In addition, limitations may apply to coverage of pre-existing conditions.

Overpayment Recovery and Subrogation

If you receive an overpayment of LTD plan benefits, you must reimburse The Standard within 30 days. The Standard has the right to take measures to recover overpayments not reimbursed in a timely manner, including reducing any further plan benefits until full reimbursement is made.

The Standard also has the right to request to be reimbursed for any benefit payments it has made for a disability for which you recover payment from a third party through a legal judgment, arbitration award, settlement or otherwise. If you suffer a disability because of the act or omission of a third party and do not initiate legal action in a reasonable period of time to recover from the third party the benefits The Standard has paid, The Standard has the right to bring legal action to the third party to recover any payments The Standard has made in connection with your disability.

Appealing Disability Benefit Claims

Applications for benefits and inquiries concerning eligibility to participate in present or future benefits under the short-term disability plan and/or the long-term disability plan must be submitted to The Standard, in writing on the prescribed forms, and must include the required information and substantiation as described in the sections above.

If Your Claim for Disability Benefits Is Denied

If any application for benefits is denied in whole or in part, The Standard will notify you in writing of such denial and of the right to a review of the denial. The written notice will provide:

- The specific reason(s) for the denial,
- Specific references to the plan provisions on which the denial is based,
- A description of any additional information necessary to process the claim and an explanation of why that material is necessary, and

- A description of the plan's review procedure.

If an adverse benefit determination was based on an internal rule, guideline, protocol or similar criterion, The Standard will advise you of the right to receive a free copy of that material. If the adverse determination was based on a scientific or clinical judgment, the notice provided to you will include an explanation of that scientific or clinical judgment. You may request that the plan identify the medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination, even if such advice was not relied upon in rendering that adverse determination.

The written notice will be given to you within 45 days after The Standard receives the application, unless special circumstances that are beyond the control of the plan require an extension of time of up to an additional 30 days for processing the application. If an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 45-day period. This notice of extension will indicate the special circumstances requiring the extension of time and the date by which The Standard expects to render its decision on the application for benefits. However, if The Standard determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that The Standard notifies you, prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date as of which the plan expects to render a decision.

The notice of any extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed. You will have 45 days within which to provide the additional specified information.

Appealing a Disability Claim Decision

If your application for benefits is denied, in whole or in part, you or your duly authorized representative may appeal the denial by submitting to the Plan Administrator a written request for a review of the application within 180 days after receiving written notice of such denial from The Standard. The Standard will give you or your representative (upon request) an opportunity to review pertinent documents (other than legally privileged documents) in preparing the request for a review.

You may submit written comments, documents, records, and other information relating to the claim. Upon request, you will be provided, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim. You may also request that the plan identify any medical or vocational expert from whom it received advice in connection with the benefit determination, regardless of whether the plan relied on such advice in making the initial benefit determination.

Time Frame for Disability Claim Appeals and Decisions

The table below outlines the maximum amount of time you have to file an appeal and the maximum amount of time the plan has to respond throughout the claim process.

For Denial of This Type of Claim...	You Must File an Appeal within...	The Standard Must Respond within ...
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STD	<ul style="list-style-type: none"> • 180 days after receiving written notice of such denial from the Insurance Company, if The Standard is required to make a determination of disability • 60 days after receiving written notice of such denial from The Standard, if a determination of disability <i>is not</i> required 	45 days of your appeal; may be extended another 45 days if needed
LTD	<ul style="list-style-type: none"> • 180 days after receiving written notice of such denial from the Insurance Company, if The Standard is required to make a determination of disability • 60 days after receiving written notice of such denial from The Standard, if a determination of disability <i>is not</i> required 	45 days of your appeal; may be extended another 45 days if needed

Notification of Disability Claim Appeal Decisions

The Standard will give you written notice of its decision. If The Standard confirms the denial of the application for benefits in whole or in part, you will receive written notification of an adverse benefit determination on appeal within the applicable time frames described above. The notice will contain the information listed in *“If Your Claim for Disability Benefits is Denied.”* The notice will also contain the following statement: *“You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”*

Death Benefit and Accident Insurance Coverage

The University of Idaho offers death benefit and accident insurance to provide you and your family with financial protection in the event of death or certain accidental injuries. The Standard Insurance Company is the insurance carrier and Plan Administrator for these plans.

Eligibility

You are eligible to enroll yourself and your dependents who meet the criteria outlined in the *Eligibility* section.

Electing Coverage

The University automatically provides Basic Death Benefit equal to one times your annual salary.

You may increase your coverage by electing Optional Death Benefit for yourself. You also may elect Spouse Death Benefit and/or Dependent Death Benefit. In addition, you may elect to purchase Accidental Death and Dismemberment (AD&D) Insurance for yourself or your family.

Note that the Death Benefit plan and the AD&D plan are two separate plans that are both administered by The Standard Insurance Company. If you enroll in *both* plans, your beneficiary designation/s will apply to both plans. (*Naming a Beneficiary* describes how to designate your beneficiary.)

Making Mid-Year Changes to Your Benefits

The benefit elections you make either when you initially enroll or during the annual enrollment period will remain in effect throughout the plan year. You may be permitted to change your

elections (or enroll for the first time) during the year if you experience a qualified life event. See *Making Mid-Year Changes to Your Benefits* for more information.

Cost for Coverage

The University pays the full cost of your Basic Death Benefit.

Optional and Spouse Death Benefit rates are determined by age of the insured, tobacco usage and the amount of insurance. Dependent Death Benefit rates are determined by the amount of insurance.

Your costs for all life and accident insurance options are listed in your profile in the myBenefits enrollment portal. You pay for Death Benefit on an after-tax basis.

Death Benefit and Tobacco Usage

Optional and Spouse Death Benefit rates are both based on tobacco usage. When you enroll for benefits you will be asked to confirm tobacco usage. If you are a tobacco user when you first enroll, but you later enroll in a tobacco cessation class, lower Death Benefit rates will be charged beginning the next plan year.

IMPORTANT!

If you have misstated your use of tobacco, The Standard Insurance Company has the right to rescind your insurance, subject to incontestability provisions (in which case, contributions paid on your behalf will be returned), or to make an equitable adjustment of your contributions, benefits or both.

What is annual salary?

For plan purposes, your “annual salary” is your annual rate of earnings, not including bonuses, commissions, overtime payments, shift differential payments, employer contributions to deferred compensation plans, and any other form of extra compensation. All benefit amounts are based on your annual salary as of your last date of active work, rounded up to the next \$1,000 if your annual salary does not equal a multiple of \$1,000.

Naming a Beneficiary

When you enroll for coverage, you will be asked to name a beneficiary — someone who will receive your benefits if you die. Your beneficiary designation applies to any Basic Life, Optional Life and Optional AD&D elections on file. To provide or update beneficiary information, please log in to the myBenefits portal and select the “update beneficiaries” link under myTools. You may name anyone as the beneficiary, except your employer. To provide your death benefit to the University as a gift, you may use a trust, gift, the foundation, or another vehicle.

You may name more than one beneficiary for your death benefit. If you list several beneficiaries, you must indicate how you want the benefit shared among them. If you do not indicate how the benefit should be shared, the claims administrator will make equal payments to each beneficiary. Because family situations change, you may want to review and update your beneficiary designation from time to time.

Please note: Generally, death benefit proceeds are not paid directly to minor beneficiaries. In Idaho, a minor is a single person under 18. If a minor beneficiary is named, then proceeds will be paid according to state law. In these cases, it may be necessary to have a conservator appointed for the estate of the minor. When preparing your beneficiary designation, review carefully any state

law that may impact the outcome of your designation. To understand the most recent determinations and statutes or for additional information, please contact an attorney.

If you also elect Spouse, Dependent Death Benefit and/or the Family level of AD&D, you automatically become the beneficiary for your covered eligible dependents in the event of their death. Any dismemberment benefit payable will be paid to the person incurring the loss.

Employee Death Benefit Options

Basic Death Benefit and Optional Death Benefit pay a benefit to your beneficiary(ies) if you die while covered. Your benefit amount is based on the option you elect and your annual salary.

Additionally, you may elect death benefits for your spouse and eligible dependent children. **Please note, your elections for your Spouse Death Benefit and Dependent Death Benefits cannot exceed the combined amount of your Basic and Optional Death Benefit election.** Please see the *How Much Spouse Death Benefit Can I Elect?*

Your options and benefits are described below.

Death Benefit Plan	
Employer-Paid Coverage	Automatically Provided by the University
Basic Death Benefit	One times your annual salary Maximum benefit: \$500,000
Voluntary Coverage (You pay the full cost)	Your Benefit Choices for Additional Coverage
Optional Death Benefit – available only if you elect one times annual salary in Basic Death Benefit	<div> 1 time your annual salary 2 times your annual salary 3 times your annual salary 4 times your annual salary </div> Maximum benefit: \$1 million
Please note: Depending on the amount you elect and whether you enroll when you are first eligible for coverage, you may need to provide health evidence. See <i>Evidence of Insurability</i> .	
Spouse Death Benefit	<div> <ul style="list-style-type: none"> \$10,000 \$25,000 \$50,000 \$75,000 <ul style="list-style-type: none"> \$100,000 \$150,000 \$200,000 \$250,000 </div>
Please note: The amount you select cannot exceed 100% of your combined Basic and Optional Life Insurance benefit. Depending on the amount you elect and whether you enroll when you are first eligible for coverage, you may need to provide health evidence. See <i>Evidence of Insurability</i> .	
Dependent Death Benefit	For each child: <ul style="list-style-type: none"> \$5,000 \$10,000 \$25,000
Please note: The amount you select cannot exceed 100% of your combined Basic and Optional Death benefit. Depending on the amount you elect and whether you enroll when you are first eligible for coverage, you may need to provide health evidence. See <i>Evidence of Insurability</i> .	

If You Have More Than \$50,000 of Basic Death Benefit Coverage

The cost of your Basic Death Benefit coverage in excess of \$50,000 is included in your

taxable income and is subject to federal income and Social Security taxes. This additional “imputed income” is reported on your paystubs and W-2 form.

How Much Spouse Death Benefit Can I Elect?

Your Spouse Life Insurance election is limited by your Basic coverage and Optional Death Benefit Election.

Your Spouse Death Benefit election cannot exceed the combined amount of your Basic coverage and Optional Death Benefit election, as shown below.

$$\begin{array}{rcl} \text{Your Basic} & & \\ \text{Death Benefit} & + & \text{Your Optional Death} \\ \text{Coverage} & & \text{Benefit Coverage} \end{array} = \begin{array}{l} \text{Your total Death Benefit for yourself and} \\ \text{the maximum Spouse Death Benefit for} \\ \text{which you are eligible to enroll} \end{array}$$

For example, let’s say you earn \$25,000 a year. And let’s say that in addition to your Basic Death Benefit equal to one times your annual salary, you elect one times your annual salary in Optional Death Benefit. As a result, you have two times your annual salary, or \$50,000, in total death benefit coverage for yourself. This means that your Spouse death benefit election must be \$50,000 or less.

How Much Dependent Death Benefit Can I Elect?

Your Dependent Death Benefit election is limited by your Basic coverage and Optional Death Benefit Election.

Your Dependent Death Benefit election cannot exceed the combined amount of your Basic coverage and Optional Death Benefit elections, as shown below.

$$\begin{array}{rcl} \text{Your Basic} & & \\ \text{Death Benefit} & + & \text{Your Optional Death} \\ \text{Coverage} & & \text{Benefit Coverage} \end{array} = \begin{array}{l} \text{Your total Death Benefit for yourself and} \\ \text{the maximum Dependent Death Benefit} \\ \text{for which you are eligible to enroll} \end{array}$$

For example, let’s say you earn \$10,000 a year. And let’s say that in addition to your Basic Death Benefit equal to one times your annual salary, you elect one times your annual salary in Optional Death Benefit. As a result, you have two times your annual salary, or \$20,000, in total death benefit coverage for yourself. This means that your Dependent Death Benefit election must be \$20,000 or less, so you may choose from the \$5,000 or \$10,000 level options.

Evidence of Insurability

In some cases, the insurance carrier requires evidence of insurability (EOI). Evidence of insurability procedures for each type of insurance are outlined below.

Optional Death Benefit

When you are first eligible for coverage, you may elect up to three times your annual salary in Optional Death Benefit coverage without providing EOI. However, if your initial Optional Death Benefit elections are more than \$500,000 or four times your annual salary, whichever is less, EOI will be required.

After your initial enrollment, you may be able to increase your election by one times your annual salary during annual enrollment without providing EOI as long as your Optional Death Benefit elections are less than \$500,000 or four times your annual salary — whichever is less.

If you do not enroll for coverage when you are first eligible and wish to enroll at a future date other than during annual enrollment, evidence of insurability will be required.

Spouse Death Benefit

You may elect up to \$25,000 of Spouse Death Benefit when you are first eligible without providing EOI.

You will be required to provide EOI if:

- You elect spouse coverage that exceeds \$25,000; and/or
- You increase Spouse Death Benefit from \$10,000 to \$25,000 at any time.

Dependent Death Benefit

When you are first eligible, you may elect Dependent Death Benefit without providing EOI.

After you initially enroll, you may increase coverage up to \$10,000 during annual enrollment or within 30 days following a qualified life-style change without providing EOI.

You will be required to provide EOI for dependent coverage if:

- Your dependent was eligible but not insured under the prior plan.
- You newly elect dependent coverage in excess of \$10,000 during annual enrollment or within 30 days following a qualified life-style change.

How to Submit Evidence of Insurability

To submit EOI, complete the Death Benefit health evidence questionnaire (also called a Medical History Statement) available on the Benefits web site or at

http://www.standard.com/mybenefits/mhs_ho.html. The form is also available immediately following the buy-up request in the myBenefits enrollment portal. The increased coverage and payroll deductions will begin after EOI is approved by Standard Insurance Company. While your evidence of insurability is under review, you will be enrolled in your prior coverage election.

Please note: EOI approval can take up to six months.

Age-based Reductions

Basic and Optional Death Benefit

Your Basic and Optional Death Benefit amounts are reduced as follows beginning at age 70:

Your Age	Reduced Life Insurance Benefit
70 - 74	75%
75 and older	50%

Spouse Death Benefit

If you purchase Spouse Death Benefit, that benefit is reduced as follows beginning when your spouse reaches 65:

Your Spouse's Age	Reduced Spouse Life Insurance Benefit
65 - 69	75%
70- 74	50%
75 and older	25%

How Death Benefit Benefits Are Paid

If you die while covered under the plan, your beneficiary will receive the death benefit. Your beneficiary's claim will be paid upon The Standard Insurance Company's receipt of written proof of loss.

If you name more than one beneficiary, each beneficiary will share equally unless you specify otherwise. If a beneficiary dies before you, his or her share will be paid equally to the surviving beneficiaries, unless you state otherwise.

If you did not name a beneficiary or your designated beneficiary dies before you, the benefit will be paid in one sum, in the following order, to your:

1. Spouse,
2. Child(ren),
3. Parents,
4. Sisters and brothers, or
5. Estate.

If your spouse or dependent child dies while covered under the plan, the benefit will be paid to you.

Additional Death Benefit Benefits

Repatriation Benefit

If you die more than 200 miles from your primary place of residence, the plan will pay expenses incurred to transport your body to a mortuary near that residence, up to the lesser of 10% of your death benefit or \$5,000.

Portability of Insurance

You can continue your Basic, Optional, Spouse and Dependent Death Benefit as long as you have been continuously covered under the group policy for at least 12 consecutive months (including time spent under the prior plan).

You must apply to the Home Office of The Standard Insurance Company for coverage and pay the first contribution within 31 days of leaving employment. Further notification will not be provided from the University. You may purchase from \$10,000 to \$300,000 of coverage for yourself; from \$5,000 to \$100,000 of coverage for your spouse; and from \$1,000 to \$5,000 of coverage for each dependent child. Each coverage amount must be in an increment of \$1,000. You will be responsible for all contribution payments. Your coverage will be effective on the day after you terminate employment.

If you or your covered spouse or dependent child dies within this 31-day period, benefits will be payable. Contact The Standard Life Insurance Company; see the Plan Administration and Contact Information chart for contact information.

If You Become Totally Disabled (Waiver of Contribution)

If you become totally disabled, while covered by this plan and under age 60, your Death Benefit can be continued with contribution payments waived. Waiver of contributions will begin after you meet the waiting period of 180 consecutive days of total disability and provide “proof of loss” as defined below. Additionally, you are eligible to receive a refund of up to 12 months of contributions you may have paid before waiver of contribution began.

You are considered to be “totally disabled” if, because of an illness or injury, you are unable to perform with reasonable continuity the material and substantial duties of any occupation for which you are qualified by education, training or experience.

You must apply for this benefit and give written proof of your total disability as soon as reasonably possible and within 12 months after the end of the waiting period. After that, proof of loss will be required at reasonable intervals, but not more than once a year after you have been continuously totally disabled for two years. Contribution payments are required during the 180-day waiting period of total disability. Contact Benefit Services to obtain the necessary forms. The insurance company may require that you be examined by a physician of its choice.

If it is not reasonably possible for you to apply for this benefit within the first 12 months of disability, your application will not be denied if proof of continuous disability is submitted as soon as reasonably possible and (unless you are legally found to be incapable of handling your own affairs) within one year after the date it would otherwise be required.

Your Death Benefit contribution waiver will end automatically when:

- You are no longer totally disabled.
- You fail to provide proof that you remain disabled within 90 days after a request from the insurance company.
- You fail to attend or cooperate with the examiner chosen by the insurance company.
- With respect to the amount of insurance which has been converted, the effective date of the individual policy; or
- You reach age 70.

Any AD&D coverage will not be continued under this provision.

Accelerated Benefit

If you qualify for Waiver of Contribution, you may be eligible for an accelerated plan benefit, paid during your lifetime. Receiving an accelerated benefit will reduce the Death Benefit payable to your beneficiary upon your death.

If eligible, you may request an accelerated benefit of up to 75% of your death benefit with a maximum of \$500,000. The minimum benefit is the greater of 10% of your death benefit or \$5,000. (If your death benefit is scheduled to be reduced within the next 24 months on account of your age, your accelerated benefit will be based on the reduced amount.)

To be eligible for the accelerated benefit:

- You must have plan Death Benefit of at least \$10,000; and
- You must be terminally ill and expected to die within 12 months, as stated in writing by your physician.

You must submit an application and satisfactory proof of loss to the insurance company. This statement must include your physician's statement that you have a terminal illness that is reasonably expected to result in death within 12 months. The insurance company may have you examined at its expense by its choice of physician, in connection with your claim.

For plan purposes, "totally disabled" means that as a result of sickness, accidental injury, or pregnancy, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably qualified by education, training or experience.

What's Not Covered

Any loss resulting from suicide or other intentionally self-inflicted injury while insured under Optional Life Insurance, unless on the date of your death the plan has been continuously in effect for at least two years. All contributions paid for the portion of insurance excluded from benefit coverage will be refunded.

Accidental Death & Dismemberment (AD&D) Insurance Benefits

Accidental Death & Dismemberment (AD&D) Insurance protects you and your family in the event of death, loss of a limb or eyesight, or certain other conditions that may result from an accident sustained while covered by the plan.

AD&D benefits are a voluntary benefit offered to you by the University. If you enroll for AD&D benefits, you pay the full cost of the coverage. In the event of your accidental death while covered by this plan, AD&D benefits would be payable *in addition to* benefits from the Death Benefit plan.

You may select one of several different coverage levels, each a multiple of your annual salary, rounded up to the next \$1,000 if your annual salary does not equal a multiple of \$1,000.

You may elect accident coverage for yourself only, or for you and your family. If you elect family coverage, each family member automatically will receive coverage equal to a percentage of your own AD&D benefit.

Your AD&D options and benefits are described below.

Accidental Death and Dismemberment (AD&D) Insurance Plan	
Voluntary Coverage (You pay the full cost)	Your Benefit Choices
Coverage for You	<div> <div> 1 times your annual salary 2 times your annual salary 3 times your annual salary 4 times your annual salary 5 times your annual salary </div> <div> } Maximum benefit: \$1 million </div> </div>
Coverage for You and Your Family	<ul style="list-style-type: none"> • For you: Same choices listed above. • For you and your spouse: Spouse coverage equals 50% of your benefit. • For you and your children: Each child's coverage equals 10% of your benefit, up to \$25,000 per child. • For you, your spouse and your children: Coverage for your spouse equals 40% of your benefit, and coverage for each child equals 5% of your benefit.

Reductions Beginning at Age 70

Beginning at age 70, your AD&D Insurance coverage amount is reduced according to the following schedule:

Your Age	Reduced AD&D Benefit
70 - 74	65%
75 - 79	45%
80 - 84	30%
85 - 89	20%
90 - 94	15%
95 and older	10%

How AD&D Insurance Benefits Are Paid

If, as the result of an accident, you or a covered family member suffers one or more of the losses described in the *Your AD&D Insurance Benefit* chart below, an AD&D benefit is payable. No more than 100% of the AD&D benefit in effect will be paid for all losses suffered by a covered person.

Death that Results from an Accident

In this case, the benefit is payable to the beneficiary. If you die while covered under the plan, your beneficiary will receive the AD&D benefit. If you name more than one beneficiary, each beneficiary will share equally unless you specify otherwise. If a beneficiary dies before you, his or her share will be paid equally to the surviving beneficiaries, unless you state otherwise.

If you did not name a beneficiary or your designated beneficiary dies before you, the benefit will be paid in one sum, in the following order, to your:

1. Spouse,
2. Child(ren),
3. Parents,
4. Sisters and brothers, or
5. Estate.

Other Covered Losses that Result from an Accident

In these cases, a percentage of the selected AD&D benefit is payable to the person suffering the loss, as described below.

Your AD&D Insurance Benefit	
If you suffer a loss within 365 days of an accident:	The plan will pay:
<ul style="list-style-type: none">• Loss of life	100% of your benefit
<ul style="list-style-type: none">• Loss of any two: one hand, one foot, sight in one eye, speech, hearing• Quadriplegia (total paralysis of both upper and lower limbs)	100% of your benefit
<ul style="list-style-type: none">• Loss of one hand or one foot• Loss of sight of one eye• Loss of speech or hearing• Paraplegia (total paralysis of both legs)• Hemiplegia (total paralysis of arm and leg on one side of the body)	50% of your benefit
<ul style="list-style-type: none">• Loss of thumb and index finger of the same hand	25% of your benefit

Here is how some of the above losses are defined:

- Loss of a hand means the hand is permanently severed from the body at or above the wrist.
- Loss of a foot means the foot is permanently severed from the body at or above the ankle.
- Paralysis is covered if it is certified by a licensed medical professional as permanent, complete, and irreversible, is continuous for 12 calendar months, and is caused by and occurs within 180 days of an accident.
- Loss of speech or hearing means entire and irrevocable loss of speech or hearing, as certified by a Diplomate of the American Board of Otolaryngology.
- Loss of thumb and index finger of the same hand means permanent severance from the body at or above the metacarpophalangeal joints (the third joint from the top of the index finger and the second joint from the top of the thumb).

If you elect family coverage, note that the plan benefit payable for accidental losses suffered by your spouse and/or children is a percentage of the benefit payable to you, as described in the *Your AD&D Insurance Benefit* chart above. If your spouse or dependent child dies while covered under the plan, the benefit will be paid to you. If you are not living, benefits will be paid in equal shares, in the following order, to your:

1. Spouse's or child's children,
2. Spouse's or child's parents, or
3. Estate.

Any dismemberment benefits payable will be payable to the person incurring the loss. You or your family member's claim will be paid upon the insurance company's receipt of written proof of loss.

Other AD&D Benefits

In addition to or instead of the benefits listed above, the plan may pay one or more of the benefits described below.

Seat Belt Benefit

If you, your covered spouse or your covered child dies as a result of an automobile accident, an additional benefit equal to 100% of the person's AD&D benefit (or if less, \$10,000) will be paid if a

police accident report shows that, at the time of the accident, the covered person was wearing a seat belt, lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration.

“Automobile” means a motor vehicle licensed for use on public highways. “Seat belt” means a properly installed seat belt, lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration.

Air Bag Benefit

If you die as a result of an automobile accident for which a seat belt benefit is payable from the plan (see above), an additional benefit equal to 100% of your AD&D benefit (or if less, \$5,000) will be paid if:

- The automobile is equipped with an air bag system that was installed as original equipment by the automobile manufacturer and received regular maintenance or scheduled replacement as recommended by the automobile or air bag manufacturer; and
- A police report shows that you were seated in the driver’s or a passenger’s seating position intended to be protected by the air bag system, and that the airbag deployed.

Public Transportation Benefit

A benefit equal to 200% of the AD&D benefit in effect will be paid if you or your covered spouse or child dies while traveling as a fare-paying passenger on public transportation. This benefit will be paid instead of any other AD&D benefit normally payable for this loss.

“Public transportation” means a vehicle operated by a common carrier to transport fare-paying members of the general public, and includes buses, trains, boats and planes operating on regular routes and selling tickets.

Higher Education Benefit

If you die, an additional benefit of five percent of your AD&D Insurance amount, up to \$5,000, will be paid annually for up to four years to *each* of your covered children who is, at the time of your death, a full-time, registered student at an accredited post-secondary school. A covered child who is in the 12th grade when you die can also receive this benefit if he or she enrolls in an accredited post-secondary school within one year of your death. If you have no covered children, this benefit is not payable.

Career Adjustment Benefit

If your spouse is covered by the plan and you die, an additional benefit of five percent of your AD&D Insurance amount, up to \$5,000, will be paid to your spouse. If you have no covered spouse, this benefit is not payable.

Benefit for Loss Due to Exposure

If you or a covered dependent suffers one of the losses listed in the *Your AD&D Insurance Benefit* chart as a result of exposure to the natural elements, the plan will pay the benefit amount that normally would be payable if this loss occurred as the result of an accident.

Benefit for Disappearance

If you or a covered dependent disappears as the result of an accident that could have caused loss of life, and you or your dependent is not found within one year from the date of the accident, the insurance company will presume that you or your dependent has died. The plan will pay the benefit amount that normally would be paid in the case of accidental death.

Common Disaster Benefit

If you and your covered spouse both die as the result of the same accident, a benefit equal to 200% of your AD&D benefit will be paid, in place of any other plan benefit payable for the same

accident, to your children. If you have no surviving children, or if your spouse is also covered as a university employee under this plan, the common disaster benefit will not be paid.

What's Not Covered

AD&D Insurance benefits are not payable if the accident or loss is caused or contributed to by any of the following:

- War or act of war. "War" means declared or undeclared war, whether civil or international, and
- any substantial armed conflict between organized forces of a military nature,
- Suicide or other intentionally self-inflicted injury, while sane or insane,
- Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties,
- The voluntary use or consumption of any poison, chemical compound, alcohol, or drug, unless used or consumed according to the directions of a physician,
- Sickness or pregnancy existing at the time of the accident,
- Heart attack or stroke,
- Medical or surgical treatment for any of the above.

Assignment of Your Life and AD&D Coverage

The rights and benefits under the Group Policy cannot be assigned.

When Life Coverage Ends

Death Benefit

Death Benefit ends automatically on the earliest of:

- The date the last period ends for which a contribution was paid for your Death Benefit.
- The date the Group Policy terminates.
- The date your employment terminates unless you are a retired member; and
- The date you cease to be a member. However, if you cease to be a member because you are working less than the required minimum number of hours, your Death Benefit will be continued with contribution payment during the following periods (unless it ends as described above in bullets one, two or three):
 - While you are being paid at least the same annual salary paid to you immediately before you ceased to be a member.
 - While your ability to work is limited because of sickness, injury or pregnancy.
 - Continuation during total disability: If you are totally disabled and you are not eligible for Waiver of Contribution, your Death Benefit will continue, while you remain totally disabled, for a period of six months, but not beyond the date the policy terminates. This applies even if your employment terminates.
 - During a leave of absence if continuation of your insurance under the policy is required by a state-mandated family or medical leave act or law.
 - During a sabbatical provided you are receiving 50% or more of your annual salary in effect on the day before your sabbatical.
 - During a school break or vacation.
 - During a leave of absence approved by the University of Idaho.

Dependent Death Benefit

Dependent Death Benefit ends automatically on the earliest of:

- Five months after you die (no contributions will be charged for your Dependent Death Benefit during this time);
- The date your Death Benefit ends.
- The date the policy terminates, or the date Dependent Death Benefit terminates under the policy.

- The date the last period ends for which you made a contribution.
- For your spouse, the date of your divorce.
- For any dependent, the date the dependent ceases to be an eligible dependent; and
- For a child who is disabled, 90 days after the insurance company mails you a request for proof of disability, if proof is not given.

When AD&D Coverage Ends

AD&D Insurance ends automatically on the earliest of:

- The date the policy terminates.
- The date the last period ends for which you made a contribution.
- The date you cease to be a member. However, if you cease to be a member because you are not working the required minimum number of hours, your insurance will be continued during a leave of absence if continuation of your insurance under the policy is required by the state mandated family or medical leave act or law, unless it ends under one or two above.
- For your spouse, the date of your divorce.
- For any dependent, the date the dependent ceases to be a dependent; and
- For a disabled child, 90 days after the date the insurance company mails a request for proof that the disabled child continues to qualify as a disabled child and proof is not given.

Continuing Life and AD&D Insurance Coverage

During a leave of absence that is approved according to the University's established leave policies, you may be eligible to continue your Death Benefit by paying the required contribution contributions. If you do not continue coverage while on leave, waiting periods or requirements for EOI may apply if you decide to re-enroll when you return to work. However, you may reinstate your coverage without restrictions when you return to work following a leave approved under the Family and Medical Leave Act of 1993.

Claims Procedures for Life and AD&D Insurance

Filing a Claim

To file a claim for benefits, you or your beneficiary should complete the appropriate forms that are available from Benefit Services or by calling the insurance carrier for a claim form (see the *Plan Administration and Contact Information* chart for more details).

If the claim is based on death, written notice and proof of claim must be submitted to the insurance company no later than 90 days after the date of death. If it is not possible to provide proof within this time frame, proof must be provided as soon as reasonably possible, but no later than one year after that 90-day period. The insurance company may request an autopsy if not prohibited by applicable law.

If claim is for Waiver of Contribution, proof of loss must be provided within 12 months after the end of the waiting period. The insurance company will require further proof of loss at reasonable intervals, but not more often than once a year after you have been continuously totally disabled for two years.

If your claim is for AD&D benefits, the insurance company must receive from you, or your beneficiary written notice of your claim within 90 days after the date your loss occurs. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.

It is your responsibility or the responsibility of your beneficiary to make certain that all required forms and proof of claim are submitted to the insurance company in a timely manner. If proof of loss is filed outside these time limits, the claim will be denied. These limits will not apply while the member or beneficiary lacks legal capacity.

Initial Claims Determinations

If Your Claim Is Based on Death or Dismemberment

The insurance company will make a determination on the claim within a reasonable period of time, but no longer than 90 days after the claim is received unless special circumstances require extra time for processing.

If such a time extension is necessary, you will receive written notice before the end of the initial 90 days. This notice will tell you why additional time is needed and the date you can expect a final decision. This decision must be made within 90 days after the end of the initial 90-day period.

If Your Claim Is Based on Disability (Waiver of Contribution)

If your claim involves a determination as to whether you are disabled, the insurance company will make a determination on your claim within a reasonable period of time, but not later than 45 days after a claim is received. This time period may be extended for an additional 60 days, in the form of two 30-day extensions, when necessary due to matters beyond the control of the insurance company. You will be advised in writing of the need for an extension during the initial 45-day period and you will be notified of the need for a second extension of time before the end of the first extension period. The notice will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and any additional information needed to resolve those issues.

If a Time Extension Is Necessary

If the extension is needed because you failed to submit information necessary to decide the claim, the notice will specifically describe the needed information and you will be allowed 45 days from receipt of the notice to provide the additional information. In this case, the extended time frame for deciding the claim will begin on the date on which you respond to the notice, rather than the date the notice was sent. If you do not provide the requested information within the specified time frame, your claim will be decided without that information.

If either type of claim is denied in whole or in part, you or your beneficiary will receive a written notice that includes:

- The specific reason(s) for the denial.
- A specific reference to the plan provisions on which the denial is based.
- A description of any additional material or information necessary for you to substantiate your claim and an explanation of why such material is needed.
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including:
 - Your right to submit written comments and have them considered.
 - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- If the claim is based on your disability, a statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request).

Review of Denied Claims

You must appeal any denial of your claim to the insurance company. If your claim involves death or dismemberment, this appeal must be made in writing within 60 days after you receive the written notice from the insurance company that your claim has been denied in whole or in part. If you do not file your appeal within this time period, you will lose the right to appeal the denial. If your claim involves a determination of disability (Waiver of Contribution), this appeal must be

made in writing no more than 180 days after you receive the written notice from the insurance company.

Your written appeal should include the reasons you believe that the claim should not have been denied and also should include any additional supporting information, documents, or comments that you consider appropriate. At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

If Your Claim Is Based on Death or Dismemberment

The insurance company will make a decision on your appeal within a reasonable period of time but no longer than 60 days after it is submitted. This time period may be extended for an additional 60 days if the insurance company determines that there are special circumstances that require an extension. You will be advised in writing of the need for an extension during the initial 60-day period, and a determination will be made no more than 60 days after the date the appeal was submitted.

If Your Claim Is Based on Disability (Waiver of Contribution)

The insurance company will make a decision on your appeal within a reasonable period of time but no longer than 45 days after it is submitted. This time period may be extended for an additional 45 days if the insurance company determines that there are special circumstances that require an extension. You will be advised in writing of the need for an extension during the initial 45-day period, and a determination will be made no more than 90 days after the date the appeal was submitted.

Tax-free Spending and Savings Accounts

You have the opportunity to save money and reduce your taxes by participating in tax-free flexible spending and savings accounts. Your options are:

Account	Features
Healthcare Flexible Spending Account (FSA)	<p>All benefits-eligible employees who are not enrolled in the HDHP may participate in the Healthcare Spending Account.</p> <p>The Healthcare Flexible Spending Account (FSA) is a tax-advantaged vehicle that is used to provide tax-free reimbursement for eligible healthcare expenses for you and your eligible dependents. You contribute pre-tax dollars, up to annual limits, which you can then use to pay for eligible healthcare expenses that year. Amounts not used by the end of the year are forfeited.</p> <p>Your FSA is administered by Health Equity</p>
Dependent Care Flexible Spending Account (DCSA)	<p>If you incur expenses to care for an eligible dependent, you may use the Dependent Care Spending Account (DCSA). You do not have to participate in the University's medical plan to participate in the DCSA.</p> <p>The DCSA is a tax-advantaged vehicle that is used to provide tax-free reimbursement for qualified dependent day care expenses. You contribute pre-tax dollars, up to annual limits, which you can then use to pay for qualifying dependent day care expenses that year. Amounts not used by the end of the year are forfeited.</p> <p>Your DCSA is administered by Health Equity</p>

Health Savings Account (HSA)	<p>High Deductible Health Plan (HDHP) participants can participate in this account that allows you to pay for today's qualified healthcare expenses – and to save for the future.</p> <p>A Health Savings Account (HSA) is a self-funded account permitted under federal tax law that allows you to save money for medical or pharmacy expenses on a tax-favored basis. An HSA is an individual account that belongs to you and is not part of the University's medical plan. It is portable, which means it is not tied to your university employment. Your HSA stays with you if you retire or leave the University. HSAs may earn interest or investment returns, based on the terms. Because the HSA has a special tax-favored status under law, it is governed by numerous mandatory tax rules and regulations.</p> <p>Your HSA is administered by HealthEquity.</p>
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Only High Deductible Health Plan (HDHP) participants are eligible for HSA contributions. In general, HDHP participants cannot save in an FSA, and Standard PPO Plan participants cannot save in an HSA.

Eligibility and Enrollment for Tax-Free Spending and Savings Account Benefits

You are eligible to enroll for tax-free spending and savings account benefits if you meet the criteria outlined in the *Eligibility* section. Please see the *How to Enroll for Coverage* section for information on how to enroll and when coverage begins.

You do not have to participate in the University's medical plan to participate in the FSA or DCSA.

Spending Accounts

A Spending Account is a tax-advantaged vehicle that is used to provide tax-free reimbursement for qualified expenses. You have two Spending Account options — one for healthcare and one for dependent day care expenses that enable you to work.

The Healthcare Flexible Spending Account (FSA)

The FSA allows you to pay for certain healthcare expenses not reimbursed under other coverage, such as amounts paid to meet your deductibles and copayments and cost-sharing, on a pre-tax basis. Additionally, expenses for eyeglasses, dental and some over-the-counter purchases may also qualify. However, the costs of over-the-counter drugs, other than insulin, are eligible for reimbursement only when prescribed by a health care provider.

If you choose to participate in this account, you will designate a dollar amount to save, up to the annual amount allowed by current Federal tax limitations. The amount you designate will be deducted from your paycheck during the year in equal installments on a pre-tax basis. Your contributions will be credited to your account.

When you have an eligible healthcare expense, you are reimbursed for it from your account with the pre-tax dollars. You can use your FSA to pay for eligible expenses for yourself, your spouse and anyone who is your eligible dependent for federal income tax purposes. This includes:

- Your children who are eligible for coverage under the medical and dental plan, even if they are not enrolled for coverage. Your children are eligible for coverage until the end of the calendar year in which they turn age 26.
- Your unmarried siblings and stepsiblings and/or their children who:
 - Have not reached age 19 (24 if a full-time student),
 - Live with you for more than one-half of the year,
 - Have not provided more than one-half of their own support for the year, and
 - Cannot be claimed as a dependent by another individual.

- Other relatives who receive more than one-half of their support from you for the year, including your unmarried children who are no longer eligible for health plan coverage, your parents, aunts, uncles, nieces, nephews and in-laws.
- Any other individuals (including your domestic partner and his or her children) who live with you, are members of your household and for whom you provide more than one-half of their support for the year.

You may be reimbursed for these expenses only if they are incurred (have a date of service) after the effective date of coverage in the FSA and while your FSA coverage is in effect.

Expenses for which you have been reimbursed by your FSA cannot be claimed as itemized deductions on your federal income tax return.

FSA Eligible Expenses

The following are some examples of expenses eligible for reimbursement under the FSA. These expenses have been approved specifically by the IRS or courts. The IRS may change these at any time with or without notice.

This list includes some expenses that already may be covered to some extent under your medical, dental or pharmacy plan:

- Acupuncture
- Ambulance service
- Artificial limbs
- Braces
- Braille books and magazines (to the extent the cost exceeds the regular editions)
- Chiropractors' fees
- Christian Science practitioners' fees
- Contact lenses, including solutions used for the care of lenses (excluding replacement insurance)
- Crutches
- Deductibles and copayments (the portion of expenses that you pay) under the medical, dental and pharmacy plans and vision plan (as long as you are not reimbursed for these expenses through coordination of benefits with another plan)
- Dental/orthodontic fees (except cosmetic procedures)
- Doctors' fees, including those of a medical doctor (M.D.), doctor of osteopathy (D.O.) and podiatrist (D.P.M.)
- Expenses in excess of coverage limits, such as hospital private room charges above the semiprivate rate, or charges in excess of the maximum allowance
- Fertility treatment
- Guide dogs
- Hearing care, aids and exams
- Hospital bills
- Immunizations
- Insulin
- Laetrile
- Lamaze classes
- Lasik eye surgery
- Nurses' fees (including nurses' board and Social Security tax when paid by the taxpayer)
- Nursing homes
- Obstetrical expenses
- Over the counter (OTC) items used to treat an illness or injury, such as bandages or blood- sugar test kits. (OTC medications other than insulin are not eligible for reimbursement unless prescribed by a healthcare provider.)

- Oxygen
- Parking and transportation expenses attributable solely to obtaining items and/or services eligible for reimbursement under FSA
- Prescription birth control pills and devices
- Prescription drugs and medical supplies
- Prostheses
- Psychoanalysis
- Psychologists' fees
- Radial keratotomy and other refractive surgery
- Routine physical exams
- Sales tax and shipping applied to items eligible for reimbursement under the FSA.
- Tobacco cessation programs and prescription and over-the-counter drugs to alleviate withdrawal symptoms, such as nicotine patches and nicotine gum to the extent such items are not covered under a health plan
- Special equipment or accommodations to help a disabled person perform the routine tasks of daily life (such as a hand control installed in a car for use by disabled persons)
- Sterilization fees
- Surgical fees (except cosmetic surgery)
- Therapy treatments (medical)
- Treatment for alcoholism or drug addiction
- Tuition at a special school for disabled persons
- Vitamins by prescription
- Weight reduction programs prescribed by a physician to treat a specific medical condition, including medically necessary nutritional counseling as described under the medical plan as a covered service and for which there is no coverage
- Wheelchairs
- In general, any other expenses allowed as medical deductions by the IRS on your federal tax return that are not paid for by any other plan. For a complete and up-to-date list, refer to IRS publication 502, available at www.irs.gov

FSA Ineligible Expenses

The following are some examples of expenses not eligible for reimbursement under the HCSA:

- Any illegal treatment
- Auto insurance providing medical coverage for persons injured in or by the taxpayer's
- Automobile
- Chauffeur services
- Contributions to other medical plans or care that is paid for by a medical plan
- Contributions to state disability funds
- Cosmetic surgery and other similar procedures
- Cost of non-prescription drugs and over-the-counter items used for general health and well-being, such as vitamins and nutritional supplements
- Cost of special foods taken as a substitute for regular diet, where the special diet is not medically necessary, and you cannot justify the cost in excess of cost of a normal diet
- Cost of toiletries, cosmetics, and similar items (such as soap and toothbrushes)
- Diaper service
- Distilled water purchased to avoid drinking a fluoridated city water supply
- Expenses of divorce when a doctor or psychiatrist recommends divorce
- Expenses that are eligible for reimbursement by any other plan or insurance
- Fees for an exercise, athletic or health spa or club membership
- Funeral, burial, or cremation expenses
- Illegal drugs

- Installation of power steering in an automobile
- Insurance contributions
- Marriage counseling provided by a clergyman
- Maternity clothes
- Mechanical exercise device not specifically prescribed by a doctor
- Mobile telephone used for personal calls, as well as calls to a doctor
- Non-medical expenses, such as electronic air filters, whirlpools, or exercise equipment, unless prescribed by a doctor for treatment of a specified medical condition
- Nursing services for a normal, healthy baby
- Over-the-counter medications (except insulin), if not prescribed by a physician
- Pajamas purchased to wear in hospital
- Payments for Church of Scientology auditing and processing
- Payments for domestic help, companion, baby-sitter, etc., who primarily renders services of a non-medical nature (may be allowed under the DCSA)
- Physical treatments unrelated to a specific health problem (such as massage for general well-being)
- Psychoanalysis undertaken to satisfy curriculum requirements of a student
- Reimbursement for calendar-year expenses incurred prior to effective date of coverage or expenses incurred after termination of coverage
- Religious cult deprogramming
- Tattoos and ear or body piercing or branding
- Union dues for sick benefits for members
- Vacuum cleaner purchased by an individual with a dust allergy
- Weight reduction programs to improve general health or appearance, even if prescribed by a physician
- Wigs (where not medically necessary for mental health)

The Dependent Care Spending Account (DCSA)

The cost of day care for young children has become a major expense for many families, and for some families the cost of day care for an elderly or disabled adult is another considerable expense. This is where the DCSA can help.

IMPORTANT!

The DCSA is *not* available for healthcare expenses for your dependents.

Healthcare expenses for your dependents are reimbursable under the FSA, as described in the preceding section.

You decide how much you want to deposit in your DCSA — up to \$5,000 per year (\$2,500 per year if you are married but file a separate income tax return). Your minimum annual contribution is \$260.

Keep in mind that your annual DCSA reimbursements cannot be greater than your annual earned income or your spouse's, whichever is lower. If your spouse is incapable of self-care or is a full-time student, he or she will be treated as having income of \$250 per month if you have one "qualifying individual" as described below, and \$500 per month if you have more than one qualifying individual. Once you designate an annual amount, it will be deducted in equal installments, on a pre-tax basis, from each paycheck during the year and credited to your account.

The rules for determining eligible expenses under the DCSA are the same as those that apply to the federal child care tax credit.

Qualifying Individuals

In order to be eligible for reimbursement, the dependent day care expenses must be incurred for the care of a “qualifying individual” as defined in the Internal Revenue Code. The term “qualifying individual” means a:

- Qualifying dependent child under age 13.
- Qualifying dependent child or relative who is mentally or physically incapable of self-care and who has the same principal place of residence as you for more than half of the year; or
- Your spouse who is mentally or physically incapable of self-care and who has the same principal place of residence as you for more than half of the year.

DCSA Eligible Expenses

In addition to being incurred to care for qualifying individuals, the dependent day care expense must also meet the following requirements:

- Care may be provided either inside or outside your home. If the care is provided by a facility that cares for more than six individuals who do not reside there, the facility must be licensed.
- Expenses for the care of a qualifying individual aged 13 or over outside your home (such as an adult day care facility) are eligible only if the dependent regularly spends at least eight hours each day in your household.
- Federal income tax law requires that you identify the provider of dependent care on your federal tax return.

When identifying the provider, you must include the provider's name, address and Social Security number or taxpayer identification number (TIN).

The following are some examples of expenses eligible for reimbursement under the DCSA:

- Expenses for after-school programs
- Expenses for a summer day camp or similar program to care for your child, even if the camp specializes in a particular activity, such as soccer or computers
- Amounts paid to a dependent day care center, baby-sitter, or nurse
- Amounts paid to a maid or cook if part of the services is provided to a person who qualifies for dependent care
- The full amount paid to a nursery school, even when the school provides lunch and educational services
- Amounts paid for services performed outside the home for the care of your dependent or spouse, including the cost of transporting the individual to or from the place where care is provided when transportation is furnished by a dependent care provider
- Application fees, agency fees and deposits that you have to pay in order to obtain related dependent care services, but only if the related care is subsequently provided

DCSA Ineligible Expenses

The following are some examples of expenses not eligible for reimbursement under the DCSA:

- Baby-sitting expenses when used for non-work activities
- Expenses for care in a convalescent nursing home
- Expenses for custodial care for a dependent who resides outside your home
- The cost of food, clothing, and education
- The cost of overnight camp
- Expenses for services provided by one dependent to care for another
- Expenses for which a dependent day care tax credit is taken or that are reimbursed under an HCSA
- The cost of transportation between your home and the place where dependent day care services are provided if transportation is provided by you or your spouse.

- Tuition for schooling for kindergarten or higher
- Expenses for dependent day care that allows you or your spouse to do volunteer work
- Care provided by your spouse, by anyone considered your dependent for federal income tax purposes, by your child who is under age 19 (even if not claimed as your dependent) or, in the case of your child who is under age 13, care provided by the parent of that child

Choosing the Best Tax Advantage for Dependent Care

If you are a working parent, you should compare the tax advantage of the DCSA and federal child care tax credit. Current tax laws generally make it impractical to use a combination of the two, since the maximum allowable expense under the tax credit must be reduced dollar for dollar by the amount you are reimbursed through the DCSA.

Keeping Track of Your Accounts

You may manage your FSA and DCSA by:

- Logging on to the plan's Web site, at **www.healthequity.com**. You can register for account access using your Social Security number and mailing address ZIP code. Online you can view account balances, verify claims submission, process claims, update personal information such as your address, and much more.
- Contacting the customer service center, at **1-866-346-5800**.

Special Spending Account Rules

In accordance with IRS regulations, the University managed accounts require you to forfeit any leftover money in a reimbursement account that you do not use for eligible expenses incurred during the calendar year. This means that you should put aside money only for those expenses that you feel certain you will incur during the calendar year. Expenses are "incurred" when the service is received, not when you pay for it.

The FSA and the DCSA are completely separate accounts. Account balances may not be transferred from one account to another.

Expenses incurred before you are a participant in the plan, or after your participation ends, are not eligible for reimbursement. In addition, expenses from a given calendar year must be paid with money credited to your reimbursement account for that same calendar year. New employees who elect FSA and/or the DCSA mid-year may only be reimbursed for eligible expenses incurred after the FSA and/or the DCSA is elected and before the end of that calendar year.

Enrollment in these accounts is not automatic from year to year. To enroll for each year, you must make an election during each annual enrollment period.

In general, an election you make at annual enrollment is binding throughout the plan year.

You cannot alter the amount you contribute to your FSA and/or the DCSA during the plan year unless you have a qualified life event that affects your benefit needs or your eligibility for benefits and you submit the paperwork to change your election within the appropriate time frame.

The changes that can be made under your FSA and/or DCSA are not identical to the changes that are explained in the *Making Changes to Your Benefits During the Year* section of this Plan. For example, if there is a significant cost increase in your spouse's plan, you cannot make an election change to your FSA.

If you increase your contribution amount during the plan year due to a qualified life event, the increased amount you put in can be used only for expenses you incur after the date the change is effective.

How to File for Reimbursement under the FSA and DCSA

You can choose how you want to be reimbursed for your qualified expenses by either:

- Submitting a claim form and asking for reimbursement to be sent to you in a check or deposited directly to your checking account if you established direct deposit; or
- Using your spending account debit card either when you receive eligible services or by asking the provider to bill the non-covered balance to your Visa Debit Card for this account. Substantiation of debit card transactions is required.

You have 90 days after the close of the plan year to submit a request for reimbursement of expenses incurred during the prior calendar year. For example, you have until March 31, 2023, to submit 2022 expenses for reimbursement. **If you terminate employment or otherwise cease to be an eligible employee during the plan year, you have 90 days after the date your employment ends in which to submit qualified expenses for reimbursement. These expenses must have been incurred prior to your last day of university employment. However, if you still have money remaining in your account, you can continue FSA participation through COBRA.**

Reimbursement by Check

Follow the steps below to receive your reimbursement by check:

- Complete a “Request for Reimbursement Form” available on the Benefits website or at www.healthequity.com.
- Obtain an itemized statement of your dependent day care or healthcare expense. The statement must include the name of the person receiving the service, the date of the service, the service provided, and the expense for the service.
- Dependent day care statements also require the provider’s Social Security number or tax payer identification number.
- Healthcare expenses also require an explanation of benefit statement showing how much of the charge was paid by your health plan coverage and how much is your remaining responsibility.

Reimbursement by Direct Deposit

If you wish to receive your reimbursement through a direct deposit to your checking account and did not sign up for this when you enrolled, log on to **Error! Hyperlink reference not valid.** to provide banking information.

Debit Card

When you enroll for the FSA and/or DCSA, you will automatically receive a free debit card. Additional Visa cards and replacement cards are provided for a \$5 fee per card. The card is not valid until you have activated it. You are not required to activate the debit card unless you want to use it. However, if you do not activate your card and you request your card at a later date, a \$5 re-issue fee will be charged to your account.

For Healthcare

You may use your debit card when you receive services, if the provider’s credit/debit card terminal has a vendor code that establishes it as an IRS-qualified healthcare provider. Your doctor’s office, dental office, hospital, or pharmacy counter are good examples of vendors that would be established as healthcare providers. Select grocery or superstores may also allow you to purchase eligible items if they have an approved system in place. Please note you cannot use your debit card to pay for eligible, prescribed over-the-counter medications.

The debit card will contain the full amount of your annual election, even if the funds have not yet been deposited in your account. However, the card will not reimburse amounts greater than your annual election. For example, if you elected \$1,500, had used \$1,400 throughout the year and then had an expense of \$106, the card would be declined. You can, however, submit just \$100 (the remaining balance of your annual election) of the expense to the card and pay the balance with some other form of payment.

For Dependent Day Care

You can also use your debit card to pay dependent day care providers if they accept Visa credit cards and you have submitted a completed DCSA Placeholder Claim form from Health Equity (forms are available at www.healthequity.com).

Additionally, you cannot request more than the amount that has already been deposited to your spending account for dependent day care.

Save and Submit Your Receipts

Even though you are able to access money from your spending accounts with a debit card, the IRS still requires that you prove that the expense was qualified. You must complete a request for reimbursement, indicating that you are substantiating debit card expenses, and send in your itemized receipts. You may do so online, via fax or through the mail.

If you fail to send in your receipts, a reminder letter will be sent. However, IRS regulations require that if you fail to provide acceptable receipts after the second reminder, access to your account through your debit card must be restricted. After a third reminder, the card must be terminated. If this happens, you may be required to repay the amount or have the amount added back to your earnings on your W-2 form at the end of the year.

Initial Claims Determinations

Health equity will process your claim within a reasonable period of time, but not later than 30 days after a claim is received. This time period may be extended for an additional 15 days when necessary due to matters beyond the control of Health Equity or if your claim is incomplete. You will be advised in writing of the need for an extension during the initial 30-day period, and a determination will be made no more than 45 days after the date the claim was submitted. If the extension is needed because your claim is incomplete, the notice will describe specifically the information necessary to complete the claim and you will be allowed 45 days from receipt of the notice to provide the information. The time frame for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you do not provide the requested information within the specified time frame, your claim will be determined without that information.

If Your Claim Is Denied

If take care by Health Equity denies your claim for a benefit in whole or in part, you will receive a notice that will provide:

- The specific reason or reasons for the denial.
- Reference to specific plan provisions on which the determination was based.
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary.
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including:
 - Your right to submit written comments and have them considered.
 - Your right to receive (upon request and free of charge) reasonable access to, and

- copies of, all documents, records, and other information relevant to your claim.
- If Health Equity relied on an internal rule, guideline, protocol, or other similar criterion in denying your claim:
 - A description of the specific rule, guideline, protocol, or criterion relied on, or
 - A statement that a copy of such a rule, guideline, protocol, or criterion will be provided free of charge upon request.

Review of Denied Claims

You have 180 calendar days after receiving notice that your claim has been denied in whole or in part in which to appeal the determination. The appeal must be in writing and must be submitted to take care by Health Equity. If you do not file an appeal within this time period, you will lose the right to appeal the determination.

Your written appeal should set out the reasons you believe that the claim should not have been denied and also should include any additional supporting information, documents, or comments that you consider appropriate.

At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim. A person not involved in the original claim denial will review and decide your appeal within a reasonable period of time, but not later than 30 days after it is submitted. If you are not satisfied with the decision, you must submit a second level appeal to the Plan Administrator, in care of Benefit Services. Your second level appeal request must be submitted within 60 days from receipt of the first level appeal decision and must be in writing. The address for submitting a second level appeal is:

Spending Accounts
Plan Administrator
University of Idaho
875 Perimeter Drive MS 4332
Moscow, ID 83844-4332

A determination will be made by the Plan Administrator no more than 30 days after your second level appeal is received.

The review will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial denial. In addition, the individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate.

You will be notified in writing of the decision on appeal. If the decision upholds the initial denial of your claim, the notification will provide, among other things, the specific reason, or reasons for the denial, including your right to pursue legal action.

The decision of the Plan Administrator is final and binding on all individuals dealing with or claiming benefits under the plan. No action shall be brought against the plan in any court unless the claims and review procedures prescribed above have been fully exhausted. No action may be brought more than one year after administrative remedies have been exhausted.

Designation of Authorized Representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. This authorization must be in writing and signed by you. Any reference in these claims procedures to "you" is intended to include your authorized representative.

The form that you sign at a healthcare provider's office or facility by which you assign your benefits to the provider does not make the provider your authorized representative under these claims procedures. If you want the provider to be your authorized representative, you must complete a separate authorization form for that purpose.

Plan Administration

For more information about plan administration such as plan funding, plan names and numbers, please refer to the *Plan Administration and Contact Information* section.

When Spending Account Coverage Ends

If your employment ends or you are no longer an eligible employee, your participation in the Spending Accounts will continue through the end of the last pay period for which contributions were made — that is, the last day of the pay period in which you worked.

You will not be able to claim healthcare expenses incurred after that date under the FSA unless you continue your account through COBRA. For more information about continuation of FSA coverage, see the *COBRA Continuation of Coverage* section.

If you have a balance remaining in your DCSA, you may only use it for reimbursement of eligible expenses incurred prior to the date you ceased to be an eligible employee.

If you go on a leave of absence:

- You may continue to make contributions to your FSA and DCSA while you are on an approved leave.
- If you choose to stop contributions to your FSA and DCSA during your leave, you will have the following options when you return to work:
 - You may choose not to participate for the remainder of the plan year. You may reinstate your salary reduction amount of your prior elections, in which case the amount of the salary reduction will remain the same, but the total amount of your election will be prorated.
 - You may reinstate the dollar amount of your prior elections; in which case the amount of your salary reduction will increase, and the total amount of your election will remain unchanged.
 - You may make new elections consistent with a qualified life-style change.
 - If you cancelled your FSA and DCSA elections while you were on leave, any expenses incurred during the period of the lapse in coverage will not be eligible for reimbursement.

Health Savings Account (HSA)

An HSA is an individual account you own that allows you to save pre-tax dollars to pay for eligible healthcare expenses — today and on into retirement.

Who Is Eligible to Contribute to the University Sponsored HSA

To contribute to the University HSA, you must meet certain criteria:

- Be enrolled in the University “high deductible health plan,” (HDHP).
- Not be covered by another healthcare plan (unless it qualifies as a high deductible health plan) or enrolled in Medicare Part A or B; and
- Not be claimed as a dependent on another person's tax return; and
- Not enrolled in a general-purpose FSA. Note that if your spouse participates in his/her employer's general-purpose FSA, unless reimbursements are limited only to your spouse, you cannot contribute to the University's HSA.

Medicare Part A

You are enrolled in Medicare Part A automatically when you apply for Social Security benefits. Medicare Part A enrollment is retroactive to the first day of the month in which you attain age 65 and you cannot contribute to an HSA during these months.

Opening an HSA with HealthEquity

When you elect to contribute to an HSA for the first time, your HSA will be automatically opened for you. Once your enrollment is complete and a deposit is made, your account will be established and available to use for eligible health care expenses. HealthEquity will mail a *Welcome Packet* to your home with more information and tools to use and manage your account.

Please note: Expenses incurred before the account is established are not eligible for reimbursement by your HSA.

Contributing to an HSA

HSA contributions to your account, including both your and the University's contributions, are exempt from federal and most states' income taxes.

You must contribute your portion before the University match is deposited. For example, if you have Employee-only coverage and contribute at least \$1,000, you will receive a \$500 total University match. However, if your total contribution is less than \$1,000.00, your total University match will be less than \$500. If you have Family coverage, you must contribute at least \$2,000 in order to receive the full \$1,000 University match.

You may change your contributions at any time during the year by logging on to the myBenefits portal.

This table shows the 2023 contributions amount.

If you enroll for ...	2023 HSA Contribution Amount	
	You may save up to ...	The University will contribute up to ...
Employee Only coverage	\$ 3,650	\$500
"Family" coverage in one of the following coverage tiers: – Employee + Spouse or Other Eligible Adult – Employee + Child – Employee + Children – Employee + Spouse (or Other Eligible Adult + Child(ren))	\$ 7,750	\$1,000
If you are age 55 or over in 2023, you can save an additional \$1,000 in catch-up contributions. "Family Coverage" includes employee + spouse or other eligible adult, or child or children or spouse or other eligible adult + child(ren).		

How to Contribute to Your HSA

You have two options for building your HSA balance:

- **Payroll deductions:** You may have your elected HSA contributions deducted directly from your paycheck, before Social Security, federal and most state income taxes are deducted. You may change your HSA contribution amount at any time and for any reason by opening your **myBenefits** employee portal and updating and submitting your new payroll deduction amount. Annual contribution limits are set by the IRS and may change each tax year.
- **After-tax contributions:** If you wish, you may make all or part of your annual contributions

to your HSA by personal check. Lump-sum contributions are made using after-tax money, but you may deduct the after-tax HSA contribution on your income tax return. Contact HealthEquity to learn more about making an after-tax contribution.

Spending Your HSA Dollars

You can use your HSA funds tax-free to pay qualified healthcare expenses only if you incurred the expenses *after* you established the HSA and only if the expenses are not reimbursed from another source (such as your spouse's health plan).

Only expenses incurred by you, your spouse or certain other individuals who qualify as your dependent for health care purposes under federal law* can be qualified healthcare expenses. Healthcare expenses incurred by someone who is not your dependent are not qualified expenses and HSA funds used to pay for them will be subject to regular income taxes plus a 20% penalty tax. Because you own your HSA, you are responsible for ensuring your tax-free withdrawals are spent on qualified healthcare expenses.

* For this purpose, the individual must meet the IRS definition of a "qualifying child" or "qualifying relative". Generally, a qualifying child is a child who is under age 19 (24 if a full-time student) who lives with you for more than half the year and provides less than half of his/her own support). A "qualifying relative" is a family member (or someone who lives with you in your household) who can't be claimed as another individual's qualifying child and who receives more than ½ of his or her support from you. You should consult with your tax adviser for more information.

Use or Save Your HSA Funds; It's Your Choice

Every time you have a qualified healthcare expense, you can choose to either use your HSA funds or pay the expense with after-tax dollars from your personal funds. When you pay for expenses with your after-tax dollars, you can allow your HSA funds to grow tax-free for future use.

Qualified Healthcare Expenses

Here is a general list of qualified healthcare expenses:

- Any medical expenses used to meet your deductible,
- Any portion of the cost of covered services (your cost-sharing) you pay after meeting the deductible,
- Any expenses the IRS considers qualified healthcare expenses for tax purposes. This category includes expenses such as dental treatment, vision care, hearing aids and over-the-counter supplies used to treat illness or injury (such as bandages, crutches, and blood-sugar test kits). Over-the-counter medications, other than insulin, are qualified health care expenses only when prescribed. Procedures not covered by traditional medical plans, such as laser eye surgery and alternative medicine treatments,
- The cost of your monthly contributions for coverage (such as COBRA coverage) while you are unemployed,
- Long-term care insurance contributions, and
- Once you reach age 65, Medicare contributions.

To learn more about eligible expenses, log on to
<http://www.healthequity.com/learn/qualified-medical-expenses>

What if ... I use my HSA money for an ineligible expense?

If you are under age 65 and you spend your HSA funds on an ineligible expense, the amount will be subject to regular income taxes, plus a 20% tax penalty. However, once you are age

65 and older, you may spend your HSA funds on any needs. You will pay regular income taxes on your distribution for ineligible expenses, but the 20% penalty tax will not apply.

What if ... I accidentally use my HSA money for an ineligible expense. How can I avoid tax penalties?

If you accidentally use your HSA funds for an ineligible expense, you can avoid paying taxes and penalties by redepositing the amount of money you used from your HSA by April 15 of the following year. Please note: You must be able to show by clear and convincing evidence that the HSA distribution resulted from a reasonable mistake (for example, you reasonably — but mistakenly — believed you had an eligible medical expense). To avoid paying tax penalties in addition to ordinary income tax, you will need to complete this deposit before April 15 of the following year (the annual tax filing deadline). And you must inform HealthEquity that the re-deposited funds are a reimbursement to the account.

Paying for Healthcare Services with Your HSA Funds

You may access HSA funds to pay for qualified healthcare expenses in a number of convenient ways:

- **Use your HealthEquity Visa check card** this card is linked to your HSA balance and works just like a conventional check card. Keep in mind, this is a signature-based card and not a PIN-based card. This means, when you use it, you should use it as a credit card and not a debit card. You may use your check card to pay for qualified healthcare expenses at many places where credit/debit cards are accepted, such as:
 - At the doctor's office, pharmacy, or healthcare facility, or
 - By writing your card number on a provider's invoice and returning it to your provider.
- **Use online bill pay to send a bank check directly to yourself or the provider.** Log into your account to use bill pay. Please note fees may apply to use bill pay services.

Managing Your HSA Account

You can manage your HSA through the HealthEquity:

- **Web site at www.HealthEquity.com.** When signing in to view your HealthEquity account, you will be asked to setup a user ID and password, along with security question. Once your account is setup online, you will have full access to your information.
- **Customer service number, 1-888-769-8696,** to speak with a customer service representative.

HSA Management Fees

As with many bank accounts, some fees apply. However, the University has an arrangement with HealthEquity to pay many fees on your behalf. However, insufficient funds fees are the account holder's responsibility. Please check your balance before writing checks.

For more information on fees, please log on to www.healthequity.com.

Investing Your HSA Dollars

Your unused HSA funds can be invested tax-free to help pay for future qualified healthcare expenses. Once your account balance is \$2,000 or greater, you may invest your funds in a variety of mutual funds offered by HealthEquity. (You will need to maintain \$1,000 in your HSA checking account.) Log on to www.healthequity.com for more information on investing.

Filing Your Taxes

In return for an HSA's tax-free privileges, the IRS requires documentation regarding how your HSA funds were used. Because you own your HSA, the IRS holds you accountable for monitoring the eligibility of your expenses and maintaining good records. As a result, it is recommended that you retain all covered healthcare receipts for three years.

To help you in filing your taxes, HealthEquity will send you the following IRS forms:

- In January, Form 1099-SA detailing your HSA withdrawals, and
- In May, Form 5498-SA detailing HSA contributions.

Additionally, the University's contributions and your payroll contributions will be shown in box 12 of Form W-2, Wage and Tax Statement, with code "W."

Use Form 1099-SA to complete IRS tax Form 8889 and file it with your federal tax return. Log on to **www.healthequity.com** for more information on completing your taxes.

You should learn the many tax rules that govern the use of HSAs and monitor your contributions and qualified expenses. For more information about HSAs and the tax rules that apply to them, review the material in Publication 969 at **www.irs.gov**.

When HSA Participation Ends

Because you own your HSA, your account is "portable." This means that you can take your HSA with you if you leave University employment. You may keep your HSA with HealthEquity or transfer it to another custodian.

If you stop participating in a qualified high deductible health plan, you may no longer contribute to your HSA. However, you may continue to access your HSA funds to pay for qualified healthcare expenses for you and your eligible dependents. However, you will become responsible for account fees that the University paid on your behalf.

COBRA Continuation of Coverage

You and your covered dependents may be offered COBRA continuation coverage when your coverage under the plan would otherwise end because of a life event known as a "qualifying event."

COBRA continuation coverage generally consists of the coverage under the plan that you and your family members had immediately before the qualifying event. This includes medical, prescription drug and dental and vision coverage as well as coverage under the Health Care Flexible Spending Account (FSA) that is in effect at the time of your qualifying event. You may elect to continue to participate in the FSA (on an after-tax basis) if the maximum benefit available to you under the FSA as of the date of the qualifying event exceeds the amount that is required for you to continue coverage for the remainder of the plan year on an after-tax basis. However, you may only continue your FSA through the end of the year in which your qualifying event occurs.

When COBRA Continuation of Coverage Is Available

The specific qualifying events that trigger the right to elect COBRA continuation coverage are listed below. After a qualifying event, COBRA continuation coverage will be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. COBRA coverage is **NOT** available for Other Eligible Adults and/or Other Eligible Adult's Child(ren).

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the plan because either one of the following qualifying events occurs:

- Your hours or terms of employment are reduced to a benefit-ineligible status, or
- Your benefit eligible employment ends.

If you are the **spouse** of an employee, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events occurs:

- Your spouse dies,
- Your spouse's hours or terms of employment are reduced to a benefit-ineligible status,
- Your spouse's benefit-eligible employment ends,
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both), or
- You become divorced or legally separated from your spouse.

An employee's **dependent children** will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events occurs:

- The parent-employee dies,
- The parent-employee's hours or terms of employment are reduced to a benefit-ineligible status,
- The parent-employee's benefit-eligible employment ends,
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both),
- The parent-employee becomes divorced or legally separated, or
- The child stops being eligible for coverage under the plan as a "dependent child."

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the COBRA Administrator in writing within 60 days of the latest of:

- The date of the qualifying event,
- The date coverage would be lost because of the qualifying event, or
- The date on which the qualifying beneficiary was informed of the responsibility to provide notice and the procedure for doing so.

This notice should be sent to the COBRA Administrator at the address specified in the section *How to Contact the COBRA Administrator*. A notice mailed to the COBRA Administrator will be considered provided on the date of mailing.

The notice must include the employee's name, the name of the spouse and/or dependent child, the nature of the qualifying event (e.g., divorce, legal separation, or a child's loss of dependent status) and the date the qualifying event occurred (date of divorce or legal separation or the date the dependent child reached the plan's limiting age or gets married).

If notice is not provided during this 60-day notice period, the spouse or dependent child who loses coverage will not be offered the opportunity to elect COBRA continuation coverage.

Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage. The duration of the coverage depends on the nature of the qualifying event that causes the loss of coverage:

- When the loss of coverage is on account of the death of the employee, the employee's becoming entitled to (actually covered under) Medicare benefits (under Part A, Part B or both), divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage for the employee's spouse and/or dependent child may last for up to a total of 36 months.
- When the loss of coverage is on account of the employee's termination of employment

or reduction of hours or terms of employment, COBRA continuation coverage for the employee and his or her spouse and dependent children generally may last for up to a total of 18 months.

A special rule applies if the employee becomes entitled to (actually covered under) Medicare benefits less than 18 months before the end of employment or reduction in hours. In that situation, the employee is still entitled to up to 18 months of COBRA continuation coverage under the general rule described above. However, COBRA continuation coverage for qualified beneficiaries other than the employee may last up to 36 months after the date of the employee's Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement. Thus, their COBRA continuation coverage may continue for up to 28 months after the date of the qualifying event (36 months minus eight months).

If the employee becomes entitled to (actually covered under) Medicare more than 18 months prior to the end of employment or reduction hours, the general rules apply.

Extension of the 18-Month Period of Continuation Coverage

There are two ways in which the 18-month period of COBRA continuation coverage can be extended.

Disability extension. If the Social Security Administration (SSA) determines that you or a family member covered under the plan is disabled and the University receives timely notice of that determination, you and your other family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months of COBRA coverage. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the initial 18-month period of COBRA continuation coverage. For the extension to be available, you must notify the COBRA Administrator in writing of the disability determination during the first 18 months of COBRA continuation coverage and no more than 60 days after the latest of: (i) the date of the SSA determination, (ii) the date of the qualifying event or (iii) the date coverage would end on account of the qualifying event.

The notice must be sent to the COBRA Administrator at the address specified in the section *How to Contact the COBRA Administrator*. It must include the employee's name and the name of the disabled individual, as well as a copy of the Social Security Administration disability determination.

A notice mailed to the COBRA Administrator will be considered provided on the date of mailing.

If notice is not provided within the above time frames, the 18-month maximum coverage period will not be extended.

The disability extension is available only for as long as the family member remains disabled. The COBRA Administrator must be notified if the Social Security Administration makes a final determination that the individual is no longer disabled. Continuation coverage will end on the first day of the month that begins more than 30 days after the date of the determination.

Second qualifying event. If your family experiences a second qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months of COBRA coverage. This extension may be available if the employee or former employee dies, is divorced, or legally separated, or if a child no longer qualifies as a dependent child under the terms of the plan, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred. Coverage will be extended only if you or your family members provide notice of the second qualifying event to the

COBRA Administrator no more than 60 days after the event occurs.

This notice should be sent to the COBRA Administrator at the address specified in the section *How to Contact the COBRA Administrator*. The notice must include the employee's name, the name of the spouse and/or dependent child, the nature of the second qualifying event (e.g., divorce, legal separation, or a child's loss of dependent status) and the date the qualifying event occurred (date of divorce or legal separation or the date the dependent child reached the plan's limiting age or gets married).

A notice mailed to the COBRA Administrator will be considered provided on the date of mailing.

If notice is not provided during this 60-day notice period, COBRA continuation coverage will not be extended beyond the initial 18-month period.

Electing COBRA Continuation of Coverage

To elect continuation coverage, you must contact the University of Idaho Benefits Center, the COBRA Plan Administrator, within 60 days of the qualifying event and your receipt of the COBRA enrollment forms. COBRA applications for coverage are mailed from the University of Idaho Benefits Center to the home address on file as soon as they receive notice of eligibility either from the University or the plan participant.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several or all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

Paying for COBRA Continuation of Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in your COBRA notice.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of contributions paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at **1-866-628-4282**. TTD/TTY callers may call toll-free at **1-866-626-4282**. More information about the Trade Act is also available at **www.dol.gov**.

First payment for continuation coverage: If you elect continuation coverage, you do not have to send any payment with your enrollment. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date the election notice is post-marked, if mailed.) You are responsible for making sure that the amount of

your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment. Your coverage will not become effective until payment in full is received.

IMPORTANT!

If you do not make your first payment for continuation coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the plan. Once COBRA continuation coverage is cancelled, it cannot be reinstated.

Periodic payments for continuation coverage: After you make your first payment for continuation coverage, you will be required to make monthly payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary will be billed monthly and the payments can be made on a monthly basis. Under the plan, each of these monthly payments for continuation coverage is due on the date shown in the notice. If you make a monthly payment on or before the first day of the coverage period to which it applies, your coverage under the plan will continue for that coverage period without any break.

Grace periods for monthly payments: Although monthly payments are due on the required date, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made on or before the date that the grace period for that payment ends.

However, if you make a monthly payment later than the first day of the coverage period to which it applies, but before or on the date that the grace period ends for the coverage period, your coverage under the plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the plan.

Your first payment and all monthly payments for continuation coverage should be sent to the COBRA Administrator listed in the *Plan Administration and Contact Information* section at the end of this document.

When COBRA Coverage Ends

A qualified beneficiary's COBRA continuation coverage will end before the expiration of the maximum coverage period if any of the following events occurs:

- The contribution for coverage is not paid in a timely manner,
- After electing COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition that the individual may have,
- After electing COBRA continuation coverage, the qualified beneficiary enrolls for Medicare,
- If coverage is extended on account of disability, the Social Security Administration makes a determination that the individual is no longer disabled, and/or
- The University no longer provides group health coverage to any of its employees.

Keep the Plan Informed of Address Changes

To protect your and your family's rights, you should keep the COBRA Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

How to Contact the COBRA Administrator

All required notices should be mailed to the COBRA Administrator at the following address:

University of Idaho Benefits Center
P.O. Box 644447
Pittsburgh, PA 15264-4447
1-800-646-6174

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

The University is required to continue your benefits during your period of FMLA leave just as if you were still employed. Continued coverage ends while you are on leave if you:

- Fail to make any required contributions for the health coverage, or
- Terminate employment.

If your employment does not terminate during your leave but you do not return to work once your leave ends, you can elect to continue coverage under the COBRA continuation rules, even if your coverage ended during your FMLA leave. See earlier in this *COBRA Continuation of Coverage* section for details. Your COBRA continuation period begins on the last day of your approved FMLA leave.

If you do not return to covered employment after your leave, the University may recover the value of contributions paid to maintain your health coverage during your FMLA period of leave. (This does not apply if your failure to return to work is due to a continuation, recurrence or onset of a serious health condition that affects you or a family member and for which you would normally qualify for a leave under the FMLA.) The University will provide you with additional information about your rights under the FMLA and applicable state law requiring similar leave (if any), as well as the payment options available to you for continuing any required contributions at the time you request leave under the FMLA.

Continuation of Coverage Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If you are absent from work because of your service in the uniformed services (including Reserve and National Guard duty), you may elect to continue medical, prescription drug and dental/vision coverage for yourself and your eligible dependents under the provisions of USERRA.

Termination of Continuation Coverage: The period of coverage for you and your eligible dependents ends on the earlier of:

- The end of the 24-month period starting on the day your military leave of absence begins,
- The day after the day on which you are required but fail to apply for or return to work; under USERRA, you must apply to return to work within different time periods — depending on the duration of your uniformed service:
 - **If your uniformed service is less than 31 days:** You are generally required to apply to return to work on the first full calendar day of the first full scheduled work period following your period of uniformed service (your period of uniformed service ends after you return from your place of service to your residence).

- **If your uniformed service is between 31 and 180 days:** You are generally required to apply to return to work within 14 days of your discharge.
- **If your uniformed service is at least 181 days:** You are generally required to apply to return to work within 90 days of your discharge.

You may be required to pay all or a portion of the cost of your coverage:

- **If your service is 31 days or less:** You are required to pay no more than your usual share of the cost for this period of coverage.
- **If your service is more than 31 days:** You must pay the entire cost of the coverage (not to exceed 102% of the applicable contributions — similar to the manner in which the cost for COBRA continuation coverage is calculated).

Your coverage may also be terminated for cause under the terms of the Plan 9e.g. the submission of fraudulent benefits claims).

Election Rights: You have sixty (60) days to elect USERRA continuation coverage, measured from the date of your absence from employment for the purpose of performing an election is considered made on the postmark date. If USERRA continuation coverage is elected within this period, coverage is retroactive to the date coverage otherwise would have been lost. If USERRA continuation coverage is not elected within this period, coverage under the Plan ends (unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable). In circumstances where it is impossible, unreasonable, or you are precluded by service necessity, your coverage will be reinstated on a retroactive basis upon election regardless of when it is received) and payment of all unpaid amounts due. You must also notify your employer that you want to elect continuation coverage for yourself and/or your eligible dependents under the USERRA provisions. Unlike COBRA, USERRA does not give your Spouse and Dependent child(ren) an independent right to elect USERRA continuation coverage. Their coverage may be continued only if you elect USERRA continuation coverage.

Plan Administration and Contact Information

This section provides some additional details on the benefits described in this booklet.

Plan	Claim Administrator/ Insurer	Contact Information	Insured by	Funded by
Medical and Benefits Plan – Standard PPO – High Deductible Health Plan (HDHP)	Blue Cross of Idaho Contract # 10030497	3000 East Pine Avenue Meridian, ID 83642 1-866-685-2258Error! Hyperlink reference not valid.	Self-insured	University and employee contributions
Prescription Drug Plan	CVS Caremark	888-202-1654 www.caremark.com	Self-insured	University and employee contributions
Health Savings Accounts	HealthEquity	2561 Bernville Road Reading, PA 19605 1-888-769-8696 www.healthequity.com	Self-insured	University and employee contributions

Mental Health and Substance Use Disorder Plan	Blue Cross of Idaho Contract # 10030497	3000 East Pine Avenue Meridian, ID 83642 1-866-685-2258 Error! Hyperlink	Self-insured	University and employee contributions
Employee Assistance Plan	KEPRO	44 South Broadway Suite 1200 White Plains, NY 10601 1-800-999-1077 Error! Hyperlink reference not valid.(code UI1)	Fully insured	University contributions
Dental Plan	Delta Dental of Idaho, Inc. Contract #s: – Standard Dental 1530-0102 – Dental 1530-0103 Willamette Dental Group	P.O. Box 2870 Boise, ID 83701 1-800-356-7586 www.deltadentalid.com 1-855-4DENTAL (433-6825) www.willamettedental.com	Self-insured	University and employee contributions
Vision Care Plan	VSP Contract #: 010-301274	7311 Greenhaven Dr. Ste 165 Sacramento, CA 95831 1-800-877-7195 VSP www.VSP.com	Self-insured	University and employee contributions
Disability Coverage (Short- and Long-term)	The Standard Policy # 649326-C (Short-term disability) 649326-D (Long-term disability)	1100 SW Sixth Avenue Portland OR 97204 1-888-937-4783 www.standard.com	Fully insured	University and employee contributions
Death Benefit Plan	The Standard Life Insurance Company Policy # 645262	To file claims, contact: University of Idaho Benefit Services 875 Perimeter Dr. MS 4332 Moscow, ID 83844-4332 1-800-628-8600 www.standard.com	Fully insured	University and employee contributions
Flexible Spending Account Plan	Health Equity	2561 Bernville Road Reading, PA 19605 1-888-769-8696 www.healthequity.com	Self-insured	Employee contributions
COBRA	University of Idaho Benefits Center	P.O. Box 644447 Pittsburgh, PA 15264-4447 800-646-6174	Self-insured	Employee contributions

Plan Administrator

University of Idaho
875 Perimeter Drive, MS 4332
Moscow, ID 83844-4332

Plan Year

The plan records are administered on a contract year basis beginning January 1 and ending December 31 of each year.

Agent for Service of Legal Process

University of Idaho (Physical Address)
415 West 6th Street
Moscow, ID 83844-4332

University of Idaho (Mailing Address)
875 Perimeter Drive, MS 4332
Moscow, ID 83844-4332

Employer Identification Number

82-6000945

Employee Rights Not Implied

Your participation in the program does not give you the right to be retained in employment with the University, nor does it interfere with the University's right to discharge or terminate an employee without regard to the effect the discharge or termination would have on an employee's rights under the program.

In addition, participation in the program is neither a contract nor a guarantee of future employment.

Changes to the Program

While the University expects to continue the program indefinitely, it reserves the right to amend, modify, suspend, or terminate the program or any of the plans at any time in its sole discretion for active or former employees, as well as for COBRA participants. The University also reserves the right to change the amount of required employee contributions for coverages under the benefit programs described in this document.

An amendment or termination of the program may affect not only the coverage of active employees (and their covered dependents) but also of COBRA participants and former employees, who retired, died or otherwise terminated employment.

A plan change may transfer plan assets and debt to another plan or split the plan into two or more parts. If the University does change or end a plan, it may decide to set up a different plan.