Idaho Pipe Trades Health and Welfare Plan
and
Summary Plan Description

January 1, 2024

To All Participants:

This is the Health and Welfare Plan and Summary Plan Description of the Idaho Pipe Trades Trust. This Plan describes benefits funded by the Trust: medical, prescription drug, dental, vision, hearing aid, and short-term disability benefits. The Plan was adopted for the exclusive benefit of Participants who are employed by certain companies in the plumbing and pipefitting industry. Costs are funded by Contributions from these Employers. Plan benefits are designed to help cover some of your expenses when you become sick or injured. This written version of the Plan describes benefits for claims incurred on and after January 1, 2024.

Here are some important tips on using your benefits:

- To receive benefits, you must complete and return the enrollment form.
- Submit claims as soon as possible. In general, claims must be submitted within 12 months after the date of service or when the supply or drug is dispensed.
- Enroll your Eligible Dependents within 120 days of when you are first eligible. The Plan does not cover any charges your Dependents incur before they are enrolled.
- Inform the Administrative Office of any address changes to ensure that you receive updated Plan and self-pay information.
- Inform the Administrative Office of any changes in your Eligible Dependents.
- Note that capitalized terms in this document have very specific meanings. Please see Section XIV.

As your Trustees, we make every effort to administer the Trust carefully and make changes to your Plan as the Trust's financial condition changes. Eligibility provisions and benefits may be increased or decreased at any time. You will be notified if there are changes.

Important addresses and telephone numbers are listed in Section XVI of this document.

Sincerely,

Board of Trustees

Este folleto contiene un resumen en inglés de tu plan de derechos y beneficios bajo el Idaho Pipe Trades Health & Welfare Plan.

Si se te dificulta comprender alguna parte de este folleto, contacta BeneSys al (208) 288-1610 o en el 5331 S Macadam Avenue, Suite 258, Portland, Oregon 97329.

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The Board has the sole, exclusive, and discretionary authority and control to make any and all determinations under the Plan, including eligibility for benefits, amount of benefits payable, the interpretation and meaning of Plan documents, the Trust Agreement, Plan policies and rules, and factual determinations. The Plan Administrative Office is the only party authorized by the Board of Trustees to answer questions about the Trust and the Plan, except as follows. The Board may delegate its discretionary authority and control to third parties other than the Board to carry out its responsibilities under the Plan to the extent permitted by ERISA. This includes delegating ministerial and discretionary authority and control for the administration of eligibility, enrollment, and benefit claims and appeals to third parties serving as Claims Administrators and Claims Fiduciaries to the Plan. No Trustee, Employer, employer association, or labor organization, nor any of their employees or representatives, has any authority in this regard. The Trustees reserve the right to change eligibility rules, reduce or eliminate benefits or hour bank accruals, or change the Plan entirely, including benefits and coverage provided to retirees and their families. Rights under the Plan do not accrue and do not vest.

The terms of the Plan govern over oral or other written communications (including electronic communications) concerning the Plan. The Plan is not bound by any oral or written communication that conflicts with Plan documents.

I. Quick Answers

Here are some quick answers to a few commonly asked questions. However, these quick answers don't explain all of the Plan's rules and limits. To know the Plan's rules and limits, you must read the rest of this booklet.

When will I first be covered by the Plan?

If you work under a Collective Bargaining Agreement, your Employer reports and the Administrative Office tracks your Covered Hours. This is called the hour bank system. If you have 300 Covered Hours in no more than 5 consecutive months, you will participate in the Plan two months later. 140 Covered Hours are required in each month to continue coverage. Any extra hours remain in your hour bank, up to 700 hours. Different rules may apply if you're covered under a Special Agreement. See Section III for details.

Example: John begins working in February. He works as follows:

February:	160 hours
March:	120 hours
April:	100 hours
Total:	380 hours

In April, John satisfies the Initial Eligibility requirements (300 hours). His coverage begins two months later, on June 1. His hour bank is credited with 240 hours (380 total hours, less 140 hours for June coverage). In May, 140 hours will be deducted for July coverage, leaving 100 hours in John's hour bank.

What if I am working in another jurisdiction?

If your work is covered by a reciprocity agreement with the Plan, you can arrange for your health contributions for that work to be sent to this Plan. (It may take an extra month for your hours to post.) The amount received is divided by this Plan's current hourly Contribution rate, to arrive at your hours of work.

Example: John travels to Nevada to work a United Association job. The plumbers and pipefitters plan covering John's Nevada work sends this Plan $945. The current Contribution rate for this Plan is $6.30 per hour. John earns 150 ($945 ÷ $6.30) hours of work toward coverage in this Plan.

What do I have to do to continue coverage?

You must work at least 140 hours in a month, to be covered two months later.

If I lose coverage, how do I regain it?

You must work 140 Covered Hours within 5 months of the month coverage ended to regain coverage two months later. If you don't, you must reestablish Initial Eligibility by again working 300 hours.

> *Example:* In the first example above, John has coverage in June and July, with 100 hours left in his bank. He doesn't work in May or June. With only 100 hours in his bank, John has no coverage in August. But if John works 40 hours in July, he will have 140 hours in his bank (100 left over from work through April, plus another 40 for work in July). That's enough to get him coverage in September.

What if my Employer doesn't make timely Contributions?

If your Employer doesn't pay the proper Contributions to the Plan for your Covered Hours, you will receive no credit for your work. If your Employer pays the Contributions late, and you have enough Covered Hours, your coverage will be reinstated as if the Contributions were received on time.

Is my Spouse covered?

Yes, after you enroll your Spouse and if you present the Administrative Office with a marriage certificate. (In most cases, common-law marriages are not recognized by the Plan—see the definition of ***Spouse***.) If your Spouse has health coverage available through his or her employer and does not elect that coverage, your Spouse is not eligible for coverage under this Plan. Unlike many health plans, you don't pay an additional amount for family coverage. See the discussion of Dependent eligibility in Section III.

Are my children covered?

Yes, after you enroll them and if you provide birth certificates. The Plan covers your biological and adopted children, and your stepchildren, through age 25. If your child is disabled, coverage may continue past age 25. See the discussion of Dependent eligibility in Section III.

What is a deductible? What is a copayment? What is coinsurance?

You must pay a portion of the cost of your healthcare expenses that are covered by the Plan. These are your "out-of-pocket" costs and include deductibles, copayments (or copays), and coinsurance. Your deductible is the amount of your healthcare expenses you must pay each year before the Plan pays benefits. There are separate deductibles for medical and dental benefits. Your copay is the flat fee you pay each time you receive treatment or have a prescription filled. Coinsurance is the percentage you and the Plan pay for covered expenses, after payment of the deductible and copay. The out-of-pocket costs you owe each calendar year are limited by the Plan's out-of-pocket maximums. See Section II for an overview of your out-of-pocket costs.

How do I get the most value out of the Plan?

- Ask your Physician if a Generic Drug is appropriate for you. You'll pay less for Generic than for brand-name drugs. See Section VI.
- Use in-network providers. They charge less, and you pay less. See Section V.

I'm over 65. Should I enroll in Medicare Part B if I am retired?

Yes. Whether or not you enroll in Medicare Parts A and B, the Plan pays benefits as if you did enroll, and as if Medicare is reimbursing your medical expenses. See Section XI.

How about Medicare Part D?

If you are a Retiree, you should not enroll in Medicare Part D. If you do, the Plan won't pay your prescription expenses.

Can I continue coverage after I lose active coverage?

If you lose active coverage (because your hour bank runs out or your Employer stops contributing to the Plan), you may be eligible to continue your coverage on a self-pay basis through COBRA or Lifetime Self-Pay. You qualify for Lifetime Self-Pay if you are retired under the Pension Plan and you participated in this Plan for at least 10 plan years, including the 5 plan years immediately before the plan year in which your hour bank drops below 140 hours. (Different rules apply if you participate in this Plan under a Special Agreement.) If you instead elect COBRA, you will forever lose the opportunity to elect Lifetime Self-Pay coverage under the Plan. You must begin your self-pay coverage immediately after you lose active coverage. See Section IV.

How much does Lifetime Self-Pay coverage cost?

The cost of Lifetime Self-Pay coverage is established by the Board of Trustees and adjusted periodically. In making adjustments, the Board may consider the Plan's funding status, costs, anticipated contributions, and other relevant factors.

What benefits does self-pay coverage provide?

Participants with COBRA or Lifetime Self-Pay coverage receive the same benefits as Active Participants, except that safety glasses and short-term disability benefits are not available, safety glasses are not available for Lifetime Self-Pay Participants, and Lifetime Self-Pay Participants covered by Medicare have a greater Skilled Nursing Facility and home health care benefit. See the definition of Retired Participant in Section XIV. In addition, your opportunity to enroll Dependents is more limited.

II. Benefits Highlights

The Plan's medical, dental, vision and hearing aid benefits are administered by Blue Cross of Idaho. The Plan's prescription drug benefits are administered by Express Scripts. The Plan's short-term disability benefits are administered by the Administrative Office. For contact information, see Section XVI.

The table below highlights the main features of each of the Plan's benefits. See the definitions in Section XIV and the sections noted below for details.

Important: When processing medical, dental, vision, prescription drug and hearing aid benefits, the Plan reimburses only Preventive Care and Medically Necessary services and supplies up to a percentage of the Maximum Allowance, and subject to Plan requirements, exclusions, and limits. The Plan does not reimburse all health expenses.

Out-of-Pocket Maximums

The Plan limits certain amounts you pay out-of-pocket each calendar year.

In-Network Maximums. The Plan's In-Network Maximums are the most you have to pay for covered medical, pediatric dental, and prescription drug expenses incurred in-network each calendar year. If you reach the maximums, the Plan will pay 100% of these expenses for the rest of the year. The Plan's In-Network Maximums are shown in the table below.

In-Network Maximums	
Medical and pediatric dental	**Prescription drugs**
• $3,720 per person • $7,440 per family	• $2,880 per person • $5,760 per family

Only your deductibles, copays and coinsurance for medical and pediatric dental expenses apply to the In-Network Maximums for medical and pediatric dental expenses. Only your coinsurance and copays for prescription drug expenses apply to the In-Network Maximums for prescription drug expenses. However, the following amounts do not apply to any In-Network Maximum, nor will the Plan pay them at 100% after you reach the In-Network Maximums:

- Your out-of-pocket costs for vision, hearing aid, adult dental, and adult or pediatric orthodontia benefits.
- Any amounts incurred at an out-of-network provider or a non-participating pharmacy, except in the following circumstances:
  - The full amount of your medical deductible, which may include both in-network and out-of-network charges, will count toward your In-Network Maximums for medical and pediatric dental expenses.
  - In certain situations required by federal law (for example, if you get Emergency Services from an out-of-network provider), the amount you pay an out-of-network provider will count toward your In-Network Maximums for medical and pediatric dental expenses (and not toward your Out-of-Network Maximum). For more information, see *Balance Billing Protections* in Section V.
- Any amounts you pay for services, supplies or drugs that are not covered by the Plan (such as services, supplies or drugs in excess of a visit limit or other Plan limit, or that are incurred by a family member who is not properly enrolled in the Plan).

Out-of-Network Maximum. The Plan's Out-of-Network Maximum is $7,500 per person per calendar year. Only coinsurance for Covered Medical Expenses incurred out-of-network applies to the Out-of-Network Maximum. After you pay your deductible and $7,500 of coinsurance, the Plan reimburses 100% of your out-of-network Covered Medical Expenses for the rest of that year, other than copays. You will still be responsible for charges that exceed the Plan's Maximum Allowance amounts, except to the extent required by federal law (see *Balance Billing Protections* in Section V). The Out-of-Network Maximum only applies to your medical benefits—your other benefits, such as prescription drug benefits, are not impacted.

The In-Network and Out-of-Network Maximums renew each calendar year. For example, your cost sharing for in-network expenses incurred in 2023 will not apply to the In-Network Maximums in 2024. The amount of the maximums may be adjusted annually. Remember that even if you reach a maximum for a year, the Plan's other limits and exclusions continue to apply—for example, visit limits, pre-certification requirements, and the requirement that a service, supply or drug be Medically Necessary.

III. Eligibility

Active Participants

For Employees covered by a Collective Bargaining Agreement, eligibility for Plan benefits is determined under an "hour bank" system, which also lets you build up hours of eligibility for use during periods of slack employment or total layoff.

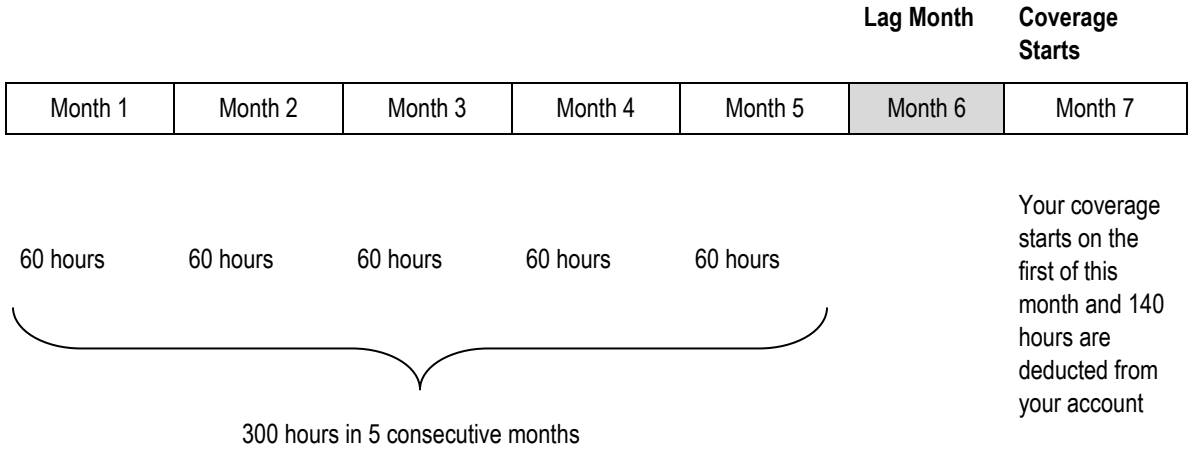
If you are covered by a Special Agreement between the Trustees and the Union, the hour bank system also applies to you. However, if you are covered by a Special Agreement between the Trustees and an Employer who contributes to the Plan pursuant to a Collective Bargaining Agreement, the hour bank system does not apply to you. Instead, your Plan coverage will begin on the first month after your Employer starts making payments to the Plan on your behalf. For example, if your Employer timely submits payments for the March work month, 2024, your coverage will begin May 1, 2024. For all Special Agreements, you and your Employer must satisfy all requirements in the Plan, Trust Agreement, and Special Agreement in order for you to be covered by the Plan.

Hour Bank Account

When you begin working for a Contributing Employer, the Plan Administrative Office sets up an hour bank account to track your Covered Hours of employment. Covered Hours are your work hours for which your Employer must contribute to the Trust Fund. Your account is credited with your Covered Hours when the Administrative Office receives Contributions for those Hours. Once you establish your Initial Eligibility, 140 Covered Hours per month are deducted from your hour bank account to provide your coverage.

Initial Eligibility

To first become eligible, you must work at least 300 Covered Hours within no more than five consecutive months. After a one month lag, 140 hours are deducted from your account and your coverage begins as shown in the example below.



If you build up 300 hours in less than five months, you'll be eligible sooner. For example, if you earn 300 hours in only three months, the fourth month is your lag month and your coverage starts on the first day of the fifth month.

The lag month is necessary for the Plan Administrative Office to receive and process reported hours.

In accordance with the Trust Agreement, the Trustees may waive these Initial Eligibility requirements for the Employees of a newly organized Contributing Employer. If a waiver is granted to your Employer, it must make an initial Contribution to the Trust in an amount equal to 300 hours times the Contribution rate then in effect for each Employee with respect to whom the Initial Eligibility requirements are waived. To qualify for waiver of the Initial Eligibility requirements, you must be employed on the date your Employer becomes signatory to a Collective Bargaining Agreement. If your Initial Eligibility requirements are waived in accordance with the above, you'll become eligible on the first day of the month after your Employer becomes signatory, and your eligibility will continue for one month. After the first month, your eligibility is determined in accordance with the normal rules (see *Continuing Eligibility* below).

If You Don't Have Enough Hours for Coverage

When a combination of your prior month's hour bank balance and your hours worked is less than 140 hours, your coverage will automatically end on the last day of the following month. See *When Coverage Ends* on ***page 11*** for more information.

You may choose to continue your health care coverage on a self-pay basis under COBRA or the Lifetime Self-Pay Option if you qualify. See ***Section IV*** for details.

When Hours Are Credited to Your Bank

Hours will not be credited to your hour bank account until the Plan Administrative Office actually receives your Employer's Contributions for them. This can cause you to lose eligibility and coverage even though you worked the necessary hours. If your Employer later makes the required Contributions or your Contributions are received through reciprocity and the Trust accepts them, your account will be retroactively adjusted. If you have enough Covered Hours, your coverage will be reinstated as if Contributions were received on time. In general, your reported hours will be posted to the actual work month and your Employer's payment will be applied first to the earliest hours on which payment is owed. However, the Plan defers to the Employers' reasonable payroll practices with respect to work or pay periods that begin before and end after the end of a month.

Continuing Eligibility

After you become eligible for the first time, your coverage will continue as long as you have at least 140 Covered Hours available in your hour bank account.

Building Up Hours for Future Eligibility

For months when you work more than 140 Covered Hours, the extra hours build up in your account. You may use these hours to continue your eligibility during months when you earn less than 140 hours. For example, let's say you work only 100 hours one month but you've built up a balance of 250 hours in your hour bank, so you have 350 total hours available — more than enough for a month's eligibility. 140 hours are deducted from your total hour bank for the month's coverage, leaving a balance of 210 hours in your account. Even if you do not work any hours next month, you have more than enough hours for another month of eligibility.

The maximum number of hours you can have in your hour bank account at any time — after deducting hours for the current month — is 700 (enough for five months of eligibility).

Losing Hours

The right to continued eligibility under the Plan based on your hour bank is not vested or accrued. The Board of Trustees has the authority to modify or cancel extended eligibility based on hours in your hour bank account. Your hour bank will be affected in the following situations:

- If your Employer's Bargaining Unit ceases participation in the Plan you will lose eligibility and all accumulated hours, whether you participate pursuant to the terms of a Collective Bargaining Agreement or Special Agreement. This cancellation would be effective as of the last day of the month in which your Employer's Bargaining Unit ended its Plan participation.
- If you have less than 140 hours in your hour bank for five consecutive months after losing coverage, you will forfeit your hour bank balance. To regain coverage, you must meet the Initial Eligibility requirements again (by working at least 300 Covered Hours in no more than 5 consecutive months). In addition, you will immediately lose eligibility and all accumulated hours if you are not available for covered employment. In general, you are not available for covered employment if you are working for an employer that has no obligation to contribute to the Plan (including for reciprocity) for your work in a trade or craft in which you were employed while contributions were made on your behalf to the Plan and in an industry and jurisdiction in which Contributing Employers may operate.
- Your hour bank balance will also be forfeited upon your death, although your Covered Dependents may be eligible to receive 6 months of free coverage (see page 13).

Also see *When Coverage Ends* on page 11.

Dependents

Eligible Dependents

Eligible Dependents who are enrolled in the Plan may receive coverage under the Plan's medical, prescription drug, dental, hearing aid, and vision benefits. Dependents are not eligible for short-term disability benefits.

If your Spouse works at least 20 hours per week or 80 hours per month and has group health coverage available through an employer but does not elect that coverage, your Spouse will not be considered an Eligible Dependent. This applies whether or not your Spouse must pay for the other coverage. Your Spouse will again be considered an Eligible Dependent as of the date they cease to be eligible for such other coverage, and you may enroll your Spouse within 60 days of that date. (*See HIPAA Special Enrollment* on page 10.) A Certificate of Creditable Coverage (or other evidence of coverage loss) from your Spouse's plan will be required by the Administrative Office to determine the coverage effective date.

The definition of Eligible Dependents includes:

- Your Spouse, unless the above paragraph applies and/or a Legal Separation is obtained.
- Your biological or adopted children and stepchildren under age 26.
- Your biological or adopted child or stepchild age 26 or older if:
  - The child is incapable of self-sustaining employment due to an intellectual disability or physical handicap that began before the child was 26, and
  - The incapacity must not result from the commission or attempted commission of a felony or engagement in an illegal occupation, whether or not charges are filed or a conviction results, and
  - The child was covered by the Plan when they turned age 26, and

If you have stepchildren, see "Coordination of Benefits" starting on page 48.

- You submit proof of the incapacity and dependency to the Administrative Office within 31 days of the child's 26th birthday. After a two-year period, the Trustees may require subsequent proof once a year.

"Adopted children" include children who are placed with you for adoption. A stepchild ceases to be an Eligible Dependent if your marriage with the biological parent terminates or a Legal Separation is obtained. The Plan does not cover children when you or your Spouse are the legal guardian or custodian.

The Plan also provides coverage to the biological or adopted child of a Participant if required by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction, as required by law. Such coverage begins on the date specified in the QMCSO or as required by law. Contact the Plan Administrative Office if you would like a free copy of the Plan's QMCSO procedures.

Enrolling your Eligible Dependents

You must enroll your Dependents for them to be covered by the Plan. No benefits will be paid for expenses your Dependents incur before they are enrolled. To enroll your Dependents, you must timely complete and submit the Plan's enrollment form (available from the Administrative Office). The enrollment will not be valid unless you also timely submit any requested legal documentation. As described further below, you may enroll your Dependents when you are initially eligible for coverage, at Annual Enrollment, or mid-year.

Legal documentation could include:

- Birth certificates
- Marriage certificates
- Final divorce decrees
- Confirmation of Social Security numbers and tax returns

Once a Dependent is enrolled the Dependent cannot be un-enrolled from coverage for that year (unless the Dependent otherwise loses coverage under the Plan, such as if a Dependent child turns age 26). However, you may un-enroll a Dependent for the following year during Annual Enrollment.

Initial Enrollment

You have 120 days to enroll your Eligible Dependents after you are first covered by the Plan. The Plan's enrollment form and any requested legal documentation must be received by the Administrative Office before the end of the 120-day period. If you timely enroll your Dependents, their coverage will begin on the same date as your coverage. If you do not timely enroll your Dependents, you may enroll them later but their coverage will not begin on the same date as your coverage (see *Mid-Year Enrollment* below).

If you lose coverage then regain eligibility in a different calendar year, you must re-enroll your Dependents in order for your Dependents to have coverage for the remainder of the calendar year. The Plan's enrollment form and any requested legal documentation must be received by the Administrative Office within 120 days of the date you regained eligibility. If you lose and regain coverage during the same calendar year, your list of enrolled Dependents will remain effective for the rest of that year.

Annual Enrollment

Your once-a-year window to enroll your Eligible Dependents for coverage during the following calendar year is called Annual Enrollment. Typically, Annual Enrollment is a 30-day window held each November. The Plan's enrollment form will be sent to your address on file with the Plan. You must return the form to the Administrative Office by the date listed on the form. In addition, you must submit any requested legal documentation within 60 days after Annual Enrollment ends. To update your address on file with the Plan, contact the Administrative Office.

If you do not timely submit the Annual Enrollment paperwork, coverage for your currently enrolled Dependents will end on December 31. You can re-enroll them later but they may have a gap in coverage (see *Mid-Year Enrollment* below).

There is one exception to the Annual Enrollment requirement. If you first become covered by the Plan in November or December and you timely enroll your Dependents for coverage for the remainder of the year (Year 1), you do not have to return Annual Enrollment paperwork in Year 1—coverage of your Dependents will automatically continue during Year 2. But you'll need to return all forms and documents requested during Annual Enrollment in Year 2 in order for coverage to continue in Year 3.

Mid-Year Enrollment

In the following situations, you may enroll an Eligible Dependent in Plan coverage mid-year:

New Dependents. You may enroll a Dependent who has not been previously covered by the Plan as your Dependent. Coverage will be prospective and will begin on the first day of the month following the Administrative Office's receipt of the completed enrollment form and requested legal documentation.

Previously Enrolled Dependents. You may re-enroll a Dependent whose coverage ended because you did not timely submit the Annual Enrollment paperwork. If you submit the paperwork later, the Dependent's coverage will be retroactively reinstated (by up to 12 months). But keep in mind that the Plan does not pay claims submitted more than 12 months after they are incurred.

Example: John's wife lost coverage on December 31, 2022, because he did not timely submit the Annual Enrollment paperwork. John submits the paperwork in March 2024. His wife's coverage is reinstated back 12 months, to April 1, 2023.

HIPAA Special Enrollment. You may enroll a Dependent if one of the following HIPAA special enrollment opportunities applies:

- If you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll the new Dependent. You may also enroll your Spouse, if not already enrolled.
- If you previously did not enroll your Dependent because they had other healthcare coverage, you may enroll the Dependent if:
  - The Dependent loses eligibility for the other coverage due to legal separation, divorce, death of an employee, loss of status as a dependent, termination of employment, reduction in the number of hours of employment, exhaustion of the other plan's lifetime limit on all benefits, exhaustion of the maximum COBRA period, or any other reason for which a special enrollment opportunity is required by HIPAA, or
  - The other coverage was non-COBRA coverage and employer contributions for that coverage were terminated.
- If your Dependent (a) loses eligibility under a Medicaid plan or a state child health plan offered under the State Children's Health Insurance Program ("SCHIP"), or (b) becomes eligible for a premium assistance subsidy through a Medicaid plan or a state child health plan offered under SCHIP, you may enroll that Dependent.

You will have 120 days from the date of the event that triggered the HIPAA special enrollment opportunity to enroll your Dependent (and your Spouse, if applicable). The Plan's enrollment form and any requested legal documentation must be received by the Administrative Office before the end of the 120-day period. If you timely enroll your Dependent, your Dependent's coverage will be effective retroactive to the date of the event that triggered the HIPAA special enrollment opportunity.

Enrolling Dependents in Self-Pay Coverage

See Section IV.

When Coverage Ends

Eligibility and coverage for you will end on the *earliest* of the following:

- If you are an Active Participant, the last day of the month following a month in which your hour bank account balance has fewer than 140 Covered Hours;
- The date the Plan is terminated or modified to eliminate your eligibility or coverage;
- The date of your death;
- Your or your Employer's noncompliance with material terms of the Plan, Trust Agreement, a Collective Bargaining Agreement, or a Special Agreement (including payment requirements);
- Fraud or intentional misrepresentation of fact by you, your Dependent, or your Employer;
- If you are an Active Participant, when your Employer fails to employ Employees covered by a Collective Bargaining Agreement;
- When you are not available for covered employment (as described on page 8, above);
- The date you enter full-time active duty in the United States armed forces, except as otherwise provided by law;
- If you participate under a Special Agreement with a Contributing Employer that has also signed a Collective Bargaining Agreement, the last day of the second month after you stop working, and the first month after your Employer no longer has an obligation to make payments (or stops making payments) to the Plan on your behalf; or
- The last day of the month in which your Employer's Bargaining Unit ceases to participate in the Plan).

Your Dependents' eligibility and coverage will end on the last day of the month in which:

- Your eligibility ends,
- The Covered Dependent ceases to be an Eligible Dependent, or
- The Covered Dependent enters the armed forces of any country (except as prohibited by law).
- You are responsible to notify the Administrative Office of any dependent(s) change in status. If your Covered Dependent loses eligibility under the Plan, you must notify the Administrative Office within 60 days of the event that causes the Dependent to lose eligibility. (For example, if you divorce, you must notify the Administrative Office within 60 days of the divorce.) Whether or not you timely notify the Administrative Office, your Dependent will be dis-enrolled effective as of the date Plan eligibility is lost. If you fail to properly notify the Plan when your dependent no longer qualifies as a Covered Dependent and claim payments are made for services incurred after your dependent's coverage ends, you will be held financially responsible to reimburse the Plan any and all overpayments. Late notice also means your Dependent will lose rights to COBRA continuation coverage.
- From time to time, the Administrative Office may require that you provide proof of your Covered Dependents' eligibility. In addition, you may be asked for proof that a Dependent was eligible when an expense was incurred. If you do not timely provide proof, that Dependent's eligibility will end. Also, if you are requested to return an enrollment form or confirmation in order to continue your Dependent's coverage and you do not, the Dependent's coverage will end and claims will not be paid.

Restoring Lost Coverage

If you lose coverage because you have less than 140 Covered Hours in your hour bank, you will become eligible again after you accumulate 140 Covered Hours within five consecutive months after coverage ended. A lag month will then apply; coverage is reinstated on the first of the second month following the month in which you have 140 Covered Hours in your hour bank.

If you are unable to build up 140 Covered Hours within five consecutive months after losing coverage, any remaining balance in your hour bank account will be forfeited. As described on page 6, you must re-establish Initial Eligibility again to restore coverage. You may also elect to self-pay. See Section IV for details.

If You Take a Leave of Absence

Generally, coverage ends whenever you do not have enough hours in your hour bank, regardless of the reason. However, under certain circumstances described below, you may retain coverage for a period of time while you are away from work.

Family and Medical Leave Act (FMLA)

Participants are entitled to benefits under the Plan during a family or medical leave in accordance with the provisions of the Family and Medical Leave Act of 1993, as may be amended (FMLA). The Plan will accept Contributions made by Contributing Employers as required by FMLA, but the Plan will not, without Contributions, provide coverage during a FMLA leave. To be eligible for continued coverage under FMLA, you must work for an Employer with 50 or more Employees within a 75-mile radius, among other requirements. The determination as to whether a leave of absence is a FMLA leave is made by your Employer, not the Plan, and the Plan provides coverage during a FMLA leave only to the extent it receives the appropriate Contributions. When your continued coverage under FMLA ends, you and your Covered Dependents may elect to continue your health coverage through COBRA self-payment (see Section IV).

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If you are a Participant and you leave covered employment to perform "service in the uniformed services" as defined by USERRA (hereafter "Uniformed Service") for a period of up to 30 days, your coverage will continue during such period. If you leave employment to perform Uniformed Service for a period of more than 30 days, you and your Covered Dependents may continue coverage in accordance with USERRA for up to 24 months measured from the date your absence begins. The requirements and procedure to elect continuation coverage under USERRA, the terms and conditions of such coverage, the applicable payment options, and the rules for reinstatement of Plan coverage on reemployment following Uniformed Service are described in the Plan's USERRA Procedures. Continuation coverage under USERRA runs concurrently with continuation coverage under COBRA. If there is any conflict between this section or the Plan's USERRA Procedures and the requirements of USERRA, the requirements of USERRA shall control.

Plan benefits will not be paid for any Illness or Injury determined by the Secretary of Veteran's Affairs to have been incurred or aggravated during service in the uniformed service.

Reciprocity Agreements

The Trustees have entered into a United Association Reciprocity Agreement, which requires certain other United Association health plans transfer contributions if you work outside this Plan's jurisdiction. If a reciprocity agreement requires the Plan transfer contributions made on your behalf to another plan, you will not receive any credit under this Plan with respect to the transferred contributions. However, you may

receive credit for reciprocal contributions received from another plan. The Administrative Office divides any reciprocal contributions received by the Plan's then-current hourly contribution rate, to arrive at Covered Hours to be credited to your hour bank for the month the work was performed.

Generally, you can receive credit for hours under reciprocal plans only to the extent the Plan timely receives an accurate employer report of hours and corresponding payment of contributions. However, if the other plan has not timely transferred contributions, you can receive temporary credit if you contact the other plan and request it send the proper documentation of the intended transfer to the Administrative Office, and the Administrative Office receives the contributions within 90 days after receiving the documentation. If temporary credit was posted but contributions are not received within the 90-day period, any payments the Plan has made for expenses incurred during the month(s) for which you received temporary credit will be considered overpayments. You are responsible for reimbursing the Plan for any overpayments.

If You Die While Covered by the Plan

If you die while covered by the Plan as an Active Participant, your Covered Dependents will receive **six months of coverage, free of charge**. Specifically, your Covered Dependents who qualify for and timely elect COBRA following your death will receive the first six months of the maximum 36 months of COBRA coverage without having to pay a premium. If your Covered Dependents are not eligible for COBRA or do not timely elect COBRA, they will receive six months of free coverage, after which time their coverage will end. See Section IV for details on COBRA.

If you are a Retired Participant, you qualified for the Lifetime Self-Pay option and you were married for 12 or more months immediately before your death, your surviving Covered Spouse may elect to continue coverage for himself or herself (and for your Covered Dependent children through age 25) under the Lifetime Self-Pay option as long as your Spouse does not remarry. The first six months of coverage will be premium-free.

IV. Self-Pay Options for Continuing Your Coverage

If after becoming an Active Participant your coverage ends, you may continue your coverage if you qualify to make self-payments. A Participant who wishes to self-pay must make timely payments in accordance with the rules of COBRA or Lifetime Self-Pay so that no interruption of coverage takes place. That is, **coverage must be continuous.** Self-payment is the Participant's responsibility. Any break in coverage while on self-pay requires a re-establishment of coverage as described under *Restoring Lost Coverage* on page 12.

The *Short-Term Disability Benefit* is *not* available under any self-pay program. In addition, safety glasses are not covered for Lifetime Self-Pay Participants or for Special Agreement Participants who become covered by COBRA. Notification of any changes to your Self-Pay Participant status, such as divorce, Legal Separation, death of a Spouse, marriage, retirement or other health coverage eligibility, must be received in writing by the Plan Administrative Office within the time periods described below. Except as required by law, **no retroactive adjustments will be made to credit overpaid premiums due to status changes occurring in previous months.**

Self-pay rules and rates are not guaranteed or vested and may be changed by the Trustees at any time. Please contact the Plan Administrative Office for the most recent rules and rates, or if you have any questions.

Self-Payment Under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act (COBRA), Participants and their Covered Spouses and Covered Dependent Children may self-pay and continue their group health coverage in certain situations called "Qualifying Events" where that coverage would otherwise terminate. The health benefits of this Plan are subject to COBRA. The Plan's COBRA policy and COBRA rates may be changed by the Trustees at any time. This is intended to inform you of your COBRA self-pay rights and obligations. **Both you and your family should take the time to read it carefully.**

You may have other options available to you when you lose coverage under the Plan. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for Medicaid or for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Some of these options may cost less than COBRA coverage. You can learn more about many of these options at healthcare.gov.

If you choose self-pay coverage, you are entitled to continue your medical, prescription drug, dental, vision, and hearing aid benefits.

Subject to certain conditions discussed below, COBRA coverage is available to each person who is a "**Qualified Beneficiary**."

If you are a **Covered Participant**, you will become a Qualified Beneficiary if you lose your health coverage under the Plan due to one of the following Qualifying Events:

- Your employment terminates (other than for gross misconduct); or
- Your hours of employment are reduced.

If you are the **Covered Spouse** of a Covered Participant, you will become a Qualified Beneficiary if you lose health coverage under the Plan due to one of the following Qualifying Events:

- Termination of the Participant's employment (other than for gross misconduct) or reduction in the Participant's hours of employment;
- Death of the Participant; or
- Divorce or Legal Separation from the Participant.

A **Covered Dependent child** of a Covered Participant will become a Qualified Beneficiary if his or her health coverage under the Plan is lost due to one of the following Qualifying Events:

- Termination of the Participant-parent's employment (other than for gross misconduct);
- Reduction in the Participant-parent's hours of employment;
- Death of the Participant-parent;
- Parents' divorce or Legal Separation; or
- Ceasing to be eligible for coverage under the Plan as an "Eligible Dependent."

The Plan will offer COBRA coverage to Qualified Beneficiaries only after the Plan Administrative Office has been timely and properly notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, a reduction of hours of employment or the death of the Covered Participant, your Employer must notify the Plan Administrative Office of the Qualifying Event. For Qualifying Events due to divorce or Legal Separation of the Participant and Covered Spouse or a Covered Dependent child losing eligibility for coverage as an Eligible Dependent, **you or another Qualified Beneficiary must notify the Plan Administrative Office, in writing, within 60 days after the later of the Qualifying Event or the loss of coverage using the Notice Procedures specified below. If these procedures are not followed, or if notice is not provided to the Plan Administrative Office during the 60-day notice period, any Spouse or Dependent child who loses coverage will lose the right to elect COBRA coverage.**

Notice Procedures: Any notice that you provide must be in writing. Oral notice, including notice by telephone, and notice by fax or email are not acceptable. You must mail or deliver your notice to the Plan Administrative Office at the address provided in this Summary Plan Description. Your notice must state the name and address of the Covered Participant and the name(s) and address(es) of the Qualified Beneficiaries. Your notice must also state the type of Qualifying Event and the date it occurred, including a copy of the divorce decree or Legal Separation document if applicable.

Once the Plan Administrative Office is properly and timely notified that a Qualifying Event has occurred, each Qualified Beneficiary will receive notice of his or her right to elect COBRA coverage. You will have 60 days to elect COBRA coverage from the later of the date coverage ends due to the Qualifying Event or the date the Plan Administrative Office provides you notice of your right to elect COBRA coverage. Each Qualified Beneficiary may elect COBRA coverage for himself or herself, even if other Qualified Beneficiaries do not. Covered Participants may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA on behalf of their Covered Dependent children. If a Qualified Beneficiary does not elect COBRA coverage within this 60-day period, they will lose the right to elect COBRA coverage. An election is considered made on the date it is postmarked.

If you waive your right to COBRA continued coverage, and within the 60-day election period decide to revoke your waiver, continued coverage will begin the date you elect to continue coverage. However, coverage will not be allowed for the period between the date you elect to waive COBRA and the date that election was revoked.

For each Qualified Beneficiary who elects it, COBRA coverage will begin on the date that health coverage under the Plan would otherwise have been lost. (If a Qualified Beneficiary has expressly waived COBRA coverage but then revokes that waiver before the election period deadline, COBRA coverage will begin on the date the revocation of the waiver is postmarked.) COBRA requires Participants or other Qualified Beneficiaries to make timely payment or lose coverage. You have 45 days from the date you elect COBRA coverage to pay your initial self-payment. *This initial self-payment must include the COBRA payments due from the date you lost coverage through the end of the last full month before you pay. (This could mean payment for more than one month of coverage is due at one time.)* Subsequent payments are due on the first of each month. All payments must be made by check and timely sent to the Plan Administrative Office at the address shown in Section XVI. Coverage will be cancelled if the Plan Administrative Office does not receive your payment within 30 days of each payment due date. If mailed, your payment is considered made on the date it is postmarked.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is death of the Covered Participant, the Covered Participant's divorce or Legal Separation, or a Covered Dependent child losing eligibility as an Eligible Dependent child, COBRA coverage can last up to 36 months. When the Qualifying Event is the end of employment or reduction of the Covered Participant's hours of employment, and the Covered Participant becomes entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for Qualified Beneficiaries other than the Covered Participant lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Participant becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his or her Covered Spouse and Covered Dependents can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). Otherwise, when the Qualifying Event is termination of employment or reduction of the Covered Participant's hours of employment, COBRA coverage can last up to 18 months. However, there are two ways in which this 18-month period can be extended.

If you or anyone in your family experiences another Qualifying Event while receiving 18 months of COBRA coverage, the Covered Spouse and Covered Dependent children in your family can get up to an additional 18 months of COBRA coverage, up to a total maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Covered Spouse and Covered Dependent children if the former Covered Participant dies, gets divorced or obtains a Legal Separation. This extension is also available to a Covered Dependent child when that child stops being eligible under the Plan as an Eligible Dependent child. These extensions are only available if the event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred. **You or another Qualified Beneficiary must notify the Plan Administrative Office within 60 days of the second Qualifying Event following the Notice Procedures specified above, or there will be no extension of COBRA coverage due to the second Qualifying Event**.

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA coverage, you and your entire family can receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months if your disability lasts at least until the end of the 18-month period of continuation coverage. In order to be entitled to this extension, the Qualified Beneficiary must have been determined by the Social Security Administration to be disabled at any time during (or before) the first 60 days of COBRA continuation coverage and the disability must last at least until the end of the 18-month period of COBRA coverage. **You must provide written notice of disability within the 60-day time frame specified above, following the Notice Procedures specified above**. **The notice must include a copy of the Social Security Administration's determination**. **If you fail to do so, there will be no disability extension of COBRA coverage**.

Special Second Election Period for Certain Eligible Individuals Who Did Not Elect COBRA Coverage: Special COBRA rights apply to certain employees who are eligible for the health coverage tax credit under Section 201 of the Federal Trade Act of 2002. These participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible employee becomes eligible for the health coverage tax credit, but only if the election is made within the six months immediately after the eligible employee's group health plan coverage ended. If you qualify or may qualify for the health coverage tax credit, contact the Plan Administrative Office for additional information.

If during the period of COBRA coverage you have a newborn child, adopt a child or have a child placed with you for adoption, that Dependent child may be enrolled for COBRA coverage in accordance with HIPAA special enrollment. You must enroll the child no later than 120 days after the birth, adoption, or placement for adoption. The Plan's enrollment form and any requested legal documentation must be received by the Administrative Office before the end of that 120-day period. The new child's coverage will be the same as your Covered Dependents on COBRA and will terminate when their coverage ends (or would have ended).

COBRA coverage will terminate before the end of the 18-month, 29-month, or 36-month continuation period under any one of the following circumstances:

- Payment is not made on time (taking into account the 30-day grace period);
- The date a Qualified Beneficiary becomes, after the date they elected COBRA coverage, covered under another group health plan (except Medicare) that does not impose any pre-existing condition exclusion for a pre-existing condition of the Qualified Beneficiary;
- The date the Trust no longer provides group health coverage;
- The first day of the month that is 30 days after the date of a determination by the Social Security Administration that a person on extended disability coverage is no longer disabled. This applies to the extended disability coverage of all Qualified Beneficiaries, but only to the 19th through the 29th month of extended disability coverage;
- The first day of the month that follows the date the Covered Participant's Employer stops maintaining the Plan and starts maintaining another group health plan for employees.

If you have any questions about COBRA coverage, please contact the Plan Administrative Office at the phone number or address shown on page 86. For more information about your rights under ERISA, including COBRA, the Health Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at dol.gov/ebsa. (Addresses and phone numbers of Regional and District Offices are available through EBSA's website.) In order to protect your family's rights, you should keep the Plan Administrative Office informed of any changes in the addresses of your family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrative Office.

Lifetime Self-Pay Option

Retired Participants are eligible for Lifetime Self-Pay in the following circumstances:

- If on the date you retire and your hour bank drops below 140 hours you participated in this Plan for at least 10 plan years pursuant to a Collective Bargaining Agreement, including the 5 consecutive plan years immediately preceding your retirement. For this purpose, you "participated" during a plan year if you earned at least 501 Covered Hours that year. (A plan year begins June 1 and ends the following May 31.)
- If on the date your hour bank drops below 140 hours you participated in this Plan under a Special Agreement, and you satisfy one of the following:
  - You have 20 years of service in the plumbing and pipefitting industry with an Employer that participates in this Plan and have been continuously covered as a Special Agreement Participant under this Plan for the five consecutive years immediately preceding termination as a Covered Participant.
  - You have been continuously covered as a Special Agreement Participant under this Plan for the 120 consecutive months immediately before termination of your employment under the Special Agreement.

For purposes of determining your eligibility for Lifetime Self-Pay, COBRA coverage does not count toward years of participation in the Plan.

To enroll yourself and any Dependents in Lifetime Self-Pay, you must submit your election form and first premium payment within 30 days of losing coverage due to a reduction in your hour bank. (You cannot elect Lifetime Self-Pay after COBRA coverage expires.) You have an additional 60 days to submit any requested legal documentation. If not timely received, you and your covered family members will forever lose Lifetime Self-Pay coverage.

You cannot enroll yourself or any Dependents in Lifetime Self-Pay once the 30-day enrollment period ends, except through HIPAA special enrollment. Under HIPAA special enrollment, if you are enrolled in Lifetime Self-Pay and you acquire a new Dependent due to marriage, birth, adoption or placement for adoption, you may enroll the new Dependent (and/or your Spouse, if the new Dependent is a child) within 60 days of the event. You have an additional 30 days to submit any requested legal documentation. If you are still working, you and your Dependents may be eligible for the additional HIPAA special enrollment rights described in Section III.

After you submit your first premium payment, monthly premiums are due the 20th day of each month, for the following month's coverage. If your payment is not received by the 20th day of the month, your coverage will terminate at the end of that month. You can still submit your payment and have your coverage reinstated, provided your payment is received (and/or postmarked) no later than the 15th day of the month of coverage. For example, the payment for March coverage is due by February 20th and will not be accepted after March 15th. If the premium is not received by the 15th day of the coverage month, your coverage may only be reinstated as described in *Restoring Lost Coverage* on page 12. See *When Coverage Ends* on page 11, for other circumstances in which your Lifetime Self-Pay coverage ends.

V. Medical Benefit

Plan medical benefits are designed to help you pay the cost of Covered Medical Expenses for you and your Covered Dependents. In most cases, you will pay a portion of the cost of your Covered Medical Expenses. Because not all services and supplies are covered, it's important to read this Plan carefully and understand your benefits before you receive services and supplies, whenever possible. Medical benefits are administered by Blue Cross of Idaho (BCI). See Section XVI for contact information.

How the Plan Works

The Plan reimburses you for a portion of the cost of Covered Medical Expenses after you pay an annual deductible. Many, but not all, services and supplies are covered at 80% if you use an in-network provider. Maximum Allowance limits and other exclusions also apply, whether you use an in-network or an out-of-network provider. Some services and supplies require pre-certification in order to be covered.

Here are highlights of the Plan's coverage of Medical Benefits:

Medical Benefit Highlights	
Annual deductible	$500 per person per calendar year. If 3 family members each meet the deductible, all family members are treated as having met their deductibles for that year. Copays do not apply toward the deductible.
Medical office visit	In-Network: 80% after your $25 copayment Out-of-Network: 70% after your $25 copayment
Annual out-of-pocket maximums	In-Network: $3,720 per person, $7,440 per family Out-of-Network: $7,500 per person (applies to coinsurance only)
Physician services	In-Network: 80% Out-of-Network: 70%
Lab and x-ray	In-Network: 80% Out-of-Network: 70%
Preventive Care	In-network: 100% with no deductible or copayment Out-of-Network: 70% (deductible and copays apply)
Medical supplies	In-Network: 80% Out-of-Network: 70%
Maternity care	Covered the same as any other condition (subject to Plan limits and exclusions)
Emergency room and Emergency ambulance services	80% Emergency room services at a Hospital are subject to a $100 copayment (waived if admitted as an inpatient) Note: Non-Emergency ambulance services are generally covered at 80% in-network and 70% out-of-network

Medical Benefit Highlights	
Hospitalization (including room and board, outpatient surgery, drugs while a patient, and medically necessary services and supplies)	In-Network: 80% Out-of-Network: 70% You or your doctor may call Blue Cross of Idaho at 800-743-1871 before an in-patient admission to obtain a courtesy assessment of Medical Necessity.
Chiropractic services	In-Network: 80% Out-of-Network: 70% Maximum benefit: 20 visits per person per calendar year Chiropractic services are covered when provided by a licensed chiropractor to detect and correct structural imbalance, distortion, misalignment, subluxation of or in the vertebral column and resulting nerve interference by manual or mechanical means (including related x-rays) only.
Physical and occupational therapy	In-Network: 80% Out-of-Network: 70% Maximum benefit: 24 visits per person per calendar year Physical and occupational therapy services are covered only when provided by a licensed physical or occupational therapist, or when provided by a licensed therapy assistant working under the direction of a licensed physical or occupational therapist.
Speech therapy	50% up to a maximum of 24 visits per person per calendar year
Residential Treatment Facility, Substance Use Disorder Treatment Facility, Skilled Nursing Facility, rehabilitation facility and home health care	In-Network: 80% Out-of-Network: No coverage Skilled Nursing Facility, rehabilitation facility and home health care benefits (combined) have the following day limits: maximum of 70 days per spell of illness. The maximum is 130 days per spell of illness under Lifetime Self-Pay coverage if you are covered by Medicare on the basis of age or disability, or you are eligible for or covered by Medicare as a result of having end-stage renal disease (ESRD).

Important Medical Benefit Provisions

Deductible

The *Medical Benefit* deductible is the amount of Covered Medical Expenses (not including copays) you must pay each calendar year before the Plan reimburses you for any further Covered Medical Expenses. The deductible is $500 per person. The deductible applies separately to each covered person. However, if three covered family members each satisfy the deductible in a calendar year, all covered family members are treated as having satisfied their deductibles for the remainder of that year. The deductible applies to all Covered Medical Expenses unless otherwise noted. Covered expenses you incur under the *Dental Benefit*, *Vision Benefit*, *Prescription Drug Benefit*, or *Hearing Aid Benefit* are not subject to the *Medical Benefit* deductible.

Out-of-Pocket Maximums

The Plan limits your out-of-pocket costs for Covered Medical Expenses. See Section V for details on the Plan's In-Network and Out-of-Network Maximums.

Visit and Day Limits

Where specifically noted in this booklet, the Plan covers certain benefits only up to a maximum number of visits per year or days of services. For example, chiropractic services are covered at 80% in-network and 70% out-of-network, up to a maximum benefit of 20 visits per person per calendar year. All visits or days of services count toward the applicable limit, regardless of whether they are incurred before or after you meet your deductible.

The Plan never pays benefits in excess of visit or day limits, even if you meet your out-of-pocket maximums.

Individual Case Management (ICM)

The Plan, through individual case management, may authorize coverage of specific services, supplies, or treatments that would not ordinarily be covered if it appears that this alternative care will reduce costs.

Acceptance of alternative benefits by the Covered Participant or Covered Dependent is voluntary. Subject to applicable law, the Plan may cease to allow alternative benefits at any time if the expected reduction of cost and/or effectiveness of the treatment are not met. The Plan will send written notice to the covered person.

The Plan's decision to provide alternative benefits will be made on a case-by-case basis. Such a decision shall not be construed to alter or change other provisions of the Plan, nor shall it be construed as a waiver of the Plan's right to administer benefits in strict accordance with its terms in other situations.

For more information or questions on individual case management, please contact Blue Cross of Idaho.

Network Providers

The Plan has contracted with Blue Cross of Idaho's PPO network of Hospitals, Physicians, laboratories, and other Health Care Providers who have agreed to provide health care services and supplies for reduced fees. These providers are called "network" providers. If you receive Medically Necessary services or supplies "in-network" (from a network provider) you will often pay a lower coinsurance percentage than if you received them "out-of-network" (from a non-network provider).

In addition, network providers have agreed to accept the Plan's payment for Covered Medical Expenses (plus any applicable deductible, copayment and coinsurance that you are responsible for paying) as payment in full. So a network provider should not bill you for amounts the Plan does not pay because the

network provider's fee is above the Maximum Allowance. Remember, in addition to any applicable deductible, copayment and coinsurance, an out-of-network provider can bill you for charges that exceed the Maximum Allowance amounts. There are some exceptions—see *Balance Billing Protections* below.

To help you find care from in-network providers and facilities, Blue Cross of Idaho (BCI) maintains a provider directory. There's a link to the provider directory on iptt.org, under the Health Care tab. BCI updates its provider directory every 90 days and will respond to your inquiry about the network status of a provider or facility within one business day. If you receive inaccurate information from BCI that an out-of-network provider or facility was in-network, the Plan will impose the in-network cost-sharing amount and will count those cost-sharing amounts toward your deductible and your In-Network Maximum for medical and pediatric dental benefits, to the extent required by law. However, it is your responsibility to confirm your provider or facility is in-network at the time you receive services or supplies.

What Are "Maximum Allowance" Charges?

The Maximum Allowance is the highest amount allowed by Blue Cross of Idaho for a service or supply covered by the Plan. Maximum Allowance may be based on pre-negotiated payment amounts or other factors. (For more information, see the definition of Maximum Allowance in Section XIV.)

The Plan pays a percentage of the Maximum Allowance charge (or, if less, of the amount actually billed). You pay the remaining percentage. If your provider is an out-of-network provider, you may also be responsible for any charges that exceed the Maximum Allowance amount. For example, let's say that the x-ray lab you use is a network provider and the Maximum Allowance charge for your x-ray is $100, but your lab normally charges $130. The benefit is 80% of the Maximum Allowance amount, or $80 (80% of $100), rather than 80% of the full charge. You pay the remaining $20. Because your lab is a network provider, your lab should not charge you for the $30 difference between the Maximum Allowance charge ($100) and the full charge ($130).

Balance Billing Protections

As described above, out-of-network providers may be permitted to bill you for the difference between the Plan's Maximum Allowance and the full amount charged for a service or supply. This is called "balance billing." However, the following exceptions apply, to the extent required by the No Surprises Act (CAA 2021):

- **Emergency Services**. If you have an emergency medical condition and get Emergency Services covered by the Plan from an out-of-network provider, the most the provider may bill you is the Plan's in-network cost-sharing amount (such as copayments, deductible and coinsurance). You can't be balance billed for these Emergency Services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.
- **Out-of-network services at an in-network hospital or ambulatory surgical center**. When you incur Covered Medical Expenses at an in-network hospital or ambulatory surgical center, certain providers there may be out of network. In these cases, the most those providers may bill you is the Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, and intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

  If you get other services covered by the Plan at an in-network hospital or ambulatory surgical center, out-of-network providers at the facility can't balance bill you unless you give written consent and give up your protections.

- **Air ambulance services**. If you receive air ambulance services covered by the Plan, the most that provider may bill you is the Plan's in-network cost-sharing amount. You can't be balance billed for these services.

When balance billing isn't allowed, you also have the following protections for services and supplies covered by the Plan:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles) that you would pay if the provider were in-network. The Plan will pay its portion to the out-of-network provider directly.
- The Plan will:
  - Cover Emergency Services without requiring you to get approval for services in advance (pre-certification).
  - Cover Emergency Services from out-of-network providers.
  - Base your share of the cost on what the Plan would pay an in-network provider and show that amount in your explanation of benefits.
  - Count any amount you pay for Emergency Services or out-of-network services toward your deductible and your In-Network Maximum for medical and pediatric expenses.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose an in-network Hospital, Physician, or other provider.

When Pre-certification Is Required

If you receive any of the services or supplies listed below, Blue Cross of Idaho (BCI) must pre-certify the service or supply to determine whether it is Medically Necessary and a Covered Medical Expense. The service or supply will not be covered by the Plan unless you (or your provider) obtain pre-certification before the service or supply is incurred. Without pre-certification, the service or supply will not be covered even if BCI later determines it is Medically Necessary and a Covered Medical Expense.

If your provider is in-network, your provider is responsible for obtaining pre-certification. If the Plan denies coverage for your service or supply because it was not pre-certified by your in-network provider, your provider should not bill you. However, if your provider is out-of-network, you are responsible for obtaining pre-certification. To request pre-certification, call BCI at 800-743-1871 and follow the procedures described in Section XII. If BCI does not pre-certify your out-of-network service or supply and you proceed with obtaining that service or supply, you will be responsible for the charges.

Pre-certification is not a guarantee of payment. After a service or supply is incurred, BCI retains the right to review the claim for Medical Necessity, eligibility, benefit limitations and exclusions, etc. Coverage is provided only to the extent it is otherwise promised under the Plan.

The following services and supplies require pre-certification, unless provided as Emergency Services. This list may change at any time. For the most up-to-date information, call BCI.

- Organ transplants
- Sleep therapy including studies, appliances and treatment
- Nuclear cardiology
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Computed Tomography (CT)
- CT Angiogram Scan (CTA)
- Positron Emission Tomography (PET) scan

- Pain management
- Musculoskeletal procedures for spine and joints

Courtesy Assessments of Medical Necessity Prior to Receiving Treatment

As noted above, certain services and supplies require pre-certification to be covered. For other services and supplies, before receiving treatment you may (but are not required to) request a courtesy assessment of whether the treatment is considered to be Medically Necessary. BCI provides these courtesy assessments for Hospital admissions and certain other services and supplies. You, your doctor, or your Hospital may call BCI medical management at 800-743-1871 to request a courtesy assessment.

If you are covered by Medicare and Medicare is primary, you should also follow Medicare's pre-certification procedure before being admitted to a Hospital. If you choose to request a courtesy assessment that a service or supply is considered Medically Necessary and BCI denies your request for any reason, you may ask BCI to review its decision.

BCI's courtesy assessments of Medical Necessity are optional and do not guarantee coverage. After a service or supply is incurred, BCI retains the right to review the claim for Medical Necessity, eligibility, benefit limitations and exclusions, etc. Coverage is provided only to the extent it is otherwise promised under the Plan.

Continuity of Coverage

To the extent required by the No Surprises Act (CAA 2021), the Plan will provide "continuity of coverage" in certain situations where a termination of a contractual arrangement changes the in-network status of a provider or facility to out-of-network (except in the case of a termination of the contract for failure to meet applicable quality standards or for fraud).

Specifically, if you are a "Continuing Care Patient," you will be notified of the contract termination and your right to elect continued transitional care from the provider or facility. You will be allowed 90 days of transitional care from the provider or facility at in-network cost sharing to allow you time to transition to a new in-network provider or facility (provided you remain eligible for Plan coverage).

A Continuing Care Patient is an individual, who, with respect to a provider or facility:

- Is undergoing a course of treatment for an acute illness (serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm) or chronic illness or condition (life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time),
- Is undergoing a course of institutional or inpatient care from the provider or facility,
- Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility,
- Is pregnant or undergoing a course of treatment for the pregnancy from the provider or facility, or
- Is or was determined to be terminally ill (under Social Security Act § 1862(dd)(3)(A), a medical prognosis that the individual's life expectancy is six months or less) and is receiving treatment for such illness from such provider or facility.

Covered Medical Expenses

Covered Medical Expenses are the Maximum Allowance charges for Preventive Care services and supplies, and for the services and supplies listed below when Medically Necessary and ordered by a Physician or other Health Care Provider. *Unless otherwise noted, Covered Medical Expenses are subject to the annual deductible, copays, coinsurance, and other Plan limits, exclusions, and requirements.* In addition, in limited situations required by federal law (such as if you receive Emergency Services), your share of the cost for services and supplies received from an out-of-network provider will be covered at the in-network level. See *Balance Billing Protections* in Section V.

- Ambulance services — Emergency ambulance services are covered at 80%. Non-Emergency ambulance services are covered at 80% in-network and 70% out-of-network.
- Covered ambulance services include only:
  - Immediate, direct transport to the Hospital where first treated.
  - Round-trip ambulance, a regularly scheduled commercial airline flight, or reasonable air ambulance charges, to the closest Hospital providing treatment (equipment and/or services) required that is not available at the nearest Hospital, if specifically requested in writing by a licensed MD.

  There is no coverage for transportation to a Physician or institution of greater renown or degree of specialization.
- **Anesthesia** including supplies and administration by an anesthesiologist or anesthetist is covered at 80% in-network and 70% out-of-network.
- **Birth control devices and services** that are Preventive Care are covered 100% in-network and 70% out-of-network—see *Preventive Care* in Section V for more information. Vasectomies are also covered at 80% in-network and 70% out-of-network. In addition, oral contraceptives that are Preventive Care may be covered under the "Prescription Drug Benefit" as described in Section VI.
- **Chiropractic treatment** by a licensed chiropractor to diagnose and correct structural imbalance, distortion, misalignment, or subluxation of or in the vertebral column, and resulting nerve interference by manual or mechanical means (including related x-rays) is covered at 80% in-network and 70% out-of-network, up to a maximum benefit of 20 visits a calendar year per person. (Tests ordered but not performed by a chiropractor are covered under the diagnostic x-ray and lab benefit.)
- **Diagnostic x-ray and lab tests** are covered at 80% in-network and 70% out-of-network.
- **Diabetes education** and self-management training are covered at 100% in-network, with no deductible, and 70% out-of-network. Usually, this type of training is provided by a Hospital, health agency or provider specializing in diabetes management.
- **Durable medical equipment** rental or purchase when prescribed by a Physician, including equipment required for the administration of oxygen, hospital bed, wheelchair, walker or similar hospital-type equipment, and replacement when purchased equipment is no longer serviceable as documented by a Physician, is covered at 80% in-network and 70% out-of-network. Maintenance of equipment and deluxe items are not covered. A purchase of durable medical equipment will not be covered unless Medically Necessary and unless you have first rented the equipment for at least two months (assuming the durable medical equipment is of a type that is available for rent). The costs of rental are applied toward the purchase price. To obtain a courtesy assessment of Medical Necessity prior to purchasing durable medical equipment, contact Blue Cross of Idaho at 800-743-1871.
- **Emergency room treatment** is covered at 80% after a $100 copayment; this copayment is waived if you are admitted to the Hospital. The copayment does not count toward the medical deductible.

Charges must be incurred at a Hospital emergency room, not a stand-alone urgent care or minor emergency center, for the copayment to apply.

- **Home health care** provided in your home by an approved Home Health Care Agency is covered at 80% in-network and 70% out-of-network, up to a maximum of 70 days (combined with Skilled Nursing Facility care) per spell of illness. However, if you have Lifetime Self-Pay coverage the maximum benefit is 130 days (combined with Skilled Nursing Facility care) per spell of illness if you are covered by Medicare on the basis of age (over 65) or disability, or you are eligible for or covered by Medicare as a result of having end-stage renal disease (ESRD). For this purpose, a "spell of illness" is a period of consecutive days that begins with a hospitalization and ends when you have not been an inpatient of a hospital or a skilled nursing facility for 60 consecutive days.
- The following limits apply:
  - Services must be for the treatment of a covered Illness or Injury and specially ordered by a Physician.
  - Your Physician must establish and periodically review a written treatment plan and periodically certify that inpatient care in a Hospital or convalescent/Skilled Nursing Facility would be required in the absence of home health care benefits.
  - You must be homebound, which means that leaving home involves a considerable and taxing effort and you are unable to use public transportation without assistance.
  - Medical supplies, drugs, and medicines must be prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital or convalescent/Skilled Nursing Facility will be covered only to the extent that they would have been covered if you remained hospitalized or remained in the convalescent/Skilled Nursing Facility.

  Home health care is limited to medical services and supplies that would have been provided on a Hospital/skilled nursing or convalescent facility inpatient basis performed by Nurses, registered physical therapists, certified speech therapists, and certified inhalation therapists acting within the lawful scope of their licenses.

  The following are excluded from the home health care benefit:

  - Homemaker or housekeeping services.
  - Supportive environmental materials such as hand rails and wheelchair ramps.
  - Services performed by household members, family, or friends.
  - Psychiatric care for family members.
  - Maintenance or Custodial Care.
  - Unnecessary and inappropriate services.
  - Social services.
  - Separate transportation charges.
  - Any service or supply not specifically mentioned as covered.
- **Hospice care** by an approved hospice provider is covered at 80% in-network and 70% out-of-network, up to a maximum of six months. Hospice care is available only for the terminally ill with a life expectancy of six months or less. Hospice care in the home is only covered if inpatient care at a hospice facility or Hospital would be required without it. Except for Physicians, all providers must be employees of a Hospice Agency and their services must be billed by a Hospice Agency.

  The following are excluded from the hospice care benefit:

  - Homemaker or housekeeping services.

- Supportive environmental materials such as hand rails and wheelchair ramps.
- Services performed by household members, family, or friends.
- Psychiatric care and other services for family members (other than bereavement and family counseling if Medically Necessary).
- Service of volunteers.
- Food, clothing, or housing (other than room and board at a hospice facility).
- Financial or legal counseling.
- Any service or supply not included in the written treatment plan or not specifically mentioned as covered.

- **Hospital charges** for room and board and services and supplies to treat an Illness or Injury are covered at 80% in-network and 70% out-of-network. Covered Hospital services include care in a coronary or intensive care unit. Other covered services include outpatient surgery at a Hospital and medication while an inpatient. Emergency Services are covered at 80% (see *Balance Billing Protections* on page 22).
- **Maternity benefits,** including childbirth and complications of pregnancy, are covered the same as any other condition, subject to Plan limits and exclusions. As required by federal law, the Plan does not restrict Hospital benefits for covered mothers and newborns to less than 48 hours following normal delivery (96 hours following cesarean delivery). You may call Blue Cross of Idaho for coverage questions if a longer stay is medically required. Maternity benefits (other than Preventive Care) are not covered for any Participant or Dependent acting as a surrogate or gestational carrier.
- **Medical supplies** prescribed by a Physician are covered at 80% in-network and 70% out-of-network. Covered medical supplies include but are not limited to the following:
  - Casts
  - Splints
  - Braces
  - Crutches
  - Oxygen
  - Blood transfusions, including cost of blood and blood plasma if not available free from a blood bank or voluntary donor
- Mental health outpatient treatment to treat a Mental Illness is covered at 80% in-network and 70% out-of-network.

  Outpatient treatment is covered only if provided by a Doctor of Medicine (MD), psychologist (PhD), social worker (MSW), licensed clinical social worker (LCSW), professional mental health nurse practitioner (PMHNP), licensed clinical professional counselor (LCPC), or licensed professional counselor (LPC).
- Mental health inpatient treatment (including but not limited to intensive outpatient services or supplies and partial hospitalization) to treat a Mental Illness is covered only when received at a Hospital or Residential Treatment Facility. Inpatient treatment at a Residential Treatment Facility is covered at 80% in-network and is not covered out-of-network; inpatient treatment at a Hospital is covered at 80% in-network and 70% out-of-network. The Plan pays no other facility charges for inpatient treatment to treat Mental Illness.
- **Midwife services** provided by a midwife who is duly licensed within his/her respective geographic area and acting within the lawful scope of his/her license are covered at 80% in-network and 70% out-of-network.

- **Nursing services** by a Nurse acting within the lawful scope of his or her license are covered at 80% in-network and 70% out-of-network.
- **Organ transplant services and supplies** covered at 80% for transplants of corneas, kidneys, bone marrow, livers, hearts, lungs, pancreas, islet tissue, hematopoietic, heart/lung and pancreas/kidney combinations, and autotransplants of arteries, veins, ear bones, cartilage, muscles, skin, tendons, teeth or tooth buds.
  - The recipient must have the transplant performed at an appropriate Recognized Transplant Center, which include Blue Distinction Centers or Blue Distinction Centers+ ("Blue Distinction Centers") and certain other facilities designated by Blue Cross of Idaho (BCI). For a list of Recognized Transplant Centers, call BCI at 800-627-1188. If the recipient is eligible for Medicare and Medicare is paying primary to the Plan, the recipient must have the transplant performed at a Recognized Transplant Center that is approved by the Medicare program. In addition, certain types of transplants must be performed at a Blue Distinction Center in order to be covered by the Plan. Call BCI for details.
  - If the transplant recipient is eligible to receive Plan transplant benefits, organ procurement charges (that is, charges for the surgical removal of the organ or tissue to be transplanted) are paid for the donor, even if the donor is not a Participant or Covered Dependent. Benefits for the donor will be charged to the recipient's Plan coverage and the recipient will be responsible for the applicable cost share.
  - When a transplant is performed at a Blue Distinction Center, the Plan reimburses reasonable transportation and lodging expenses that qualify as "medical expenses" under IRS rules and are necessary to the recipient's medical care. Costs for hotels or other lodging are reimbursed up to $50 per day for the transplant recipient and up to $50 per day for one adult travel companion. The Plan will also reimburse the recipient's reasonable transportation expenses to and from the Blue Distinction Center (e.g., the cost of a regular roundtrip bus, train or commercial airline ticket or rental car). If a car is used, the Plan will reimburse fuel expenses actually incurred or per the IRS' medical mileage rate, and for parking fees and tolls. IRS rules do not permit reimbursement of a companion's transportation costs except for a parent who must accompany a child or a nurse or other person who can give injections, medications, or other treatment required by the recipient and the recipient is unable to travel alone. These travel benefits are only available for covered transplant services, when traveling to and from a Blue Distinction Center. Donors' travel expenses are not covered.
- **Orthognathic surgery, treatment or supplies** to correct Malocclusion and/or temporomandibular joint disorder (TMJ) are covered at 80% in-network and 70% out-of-network.
- **Orthopedic shoes and shoe inserts** for Participants and Covered Dependents with diabetes are covered at 80% in-network and 70% out-of-network with the following limits per calendar year: one pair of custom-molded shoes and inserts, one pair of extra-depth shoes, two additional pairs of inserts for custom-molded shoes, and three pairs of inserts for extra-depth shoes.
- **Outpatient facility charges,** including fees for ambulatory surgical facilities and minor emergency centers, are covered at 80% in-network and 70% out-of-network. However, there is no coverage for inpatient or outpatient facility charges made by the following types of facilities, unless they are in-network: residential treatment, skilled nursing, substance use disorder, rehabilitation, and other similar facilities.
- **Physical/Occupational therapy,** charges by Doctors of Medicine, licensed physical therapists or licensed occupational therapists, or licensed therapy assistants working under the direction of a licensed physical or occupational therapist to restore an ability that was lost or impaired due to Illness

or Injury, are covered at 80% in-network and 70% out-of-network, with a maximum benefit of 24 visits per person per calendar year.

- **Physician and covered Health Care Provider** services to treat an Illness or Injury are covered at 80% in-network and 70% out-of-network.
- **Prescription drugs** that can be obtained only by a Physician's written prescription, and insulin, that are administered while you are an inpatient at a Hospital, that are administered under medical supervision in an outpatient center, or that are administered while you are in your Physician's office are covered at 80% in-network and 70% out-of-network. In addition, when a Participant or Covered Dependent has other prescription drug coverage not sponsored by the Idaho Pipe Trades that pays as primary, covered outpatient prescription drug unpaid expenses (copays) will be reimbursed under the Plan's *Medical Benefit*. See Section XI.
- **Prostheses** (artificial limbs and eyes) required as a result of an Illness or Injury are covered at 80% in-network and 70% out-of-network.
- **Reconstructive breast surgery and associated procedures**. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health & Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided, in a manner determined in consultation with the attending physician and the patient, for:
  - All stages of reconstruction of the breast on which the mastectomy was performed.
  - Surgery and reconstruction of the healthy breast to produce a symmetrical appearance.
  - Prostheses, and treatment of physical complications of all stages of the mastectomy, including lymphedemas.

  These benefits will be provided subject to the same deductible ($500) and coinsurance (80% in-network and 70% out-of-network) applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call the Administrative Office at 208-288-1610.
- **Skilled Nursing Facility** room and board is covered at 80% in-network and no coverage out-of-network, up to a maximum of 70 days (combined with home health care) per spell of illness. However, if you have Lifetime Self-Pay coverage the maximum benefit is 130 days (combined with home health care) per spell of illness if you are covered by Medicare on the basis of age (over 65) or disability, or you are eligible for or covered by Medicare as a result of having end-stage renal disease (ESRD). For this purpose, a "spell of illness" is a period of consecutive days that begins with a hospitalization and ends when you have not been an inpatient of a Hospital or a Skilled Nursing Facility for 60 consecutive days.
- The following limits apply:
  - Services must be for the treatment of a covered Illness or Injury.
  - You must be receiving therapeutic treatment which could not be administered in the home by an unskilled person, such as a friend or relative.
  - You must have been hospitalized for at least three days and be admitted to the Skilled Nursing Facility within 14 days after Hospital discharge. See *Individual Case Management* on page 21.
  - Custodial Care is not covered.
- **Speech therapy** by a certified speech therapist is covered at 50%—up to a maximum benefit of 24 visits per person per calendar year—when ordered by a Physician to restore lost or impaired speech due to Illness or Injury.

- **Substance Use Disorder outpatient treatment** is covered at 80% in-network and 70% out-of-network. Outpatient treatment is covered only if provided by a Doctor of Medicine (MD), psychologist (PhD), licensed clinical social worker (LCSW), social worker (MSW), professional mental health nurse practitioner (PMHNP), licensed clinical professional counselor (LCPC), or licensed professional counselor (LPC).
- **Substance Use Disorder inpatient treatment** (including but not limited to intensive outpatient services or supplies and partial hospitalization) is covered only when received at a Hospital, Substance Use Disorder Treatment Facility or Residential Treatment Facility. The Plan pays no other facilities to treat Substance Use Disorder. Inpatient treatment at a Substance Use Disorder Treatment Facility or a Residential Treatment Facility is covered at 80% in-network and is not covered out-of-network; inpatient treatment at a Hospital is covered at 80% in-network and 70% out-of-network.

  There is no coverage for educational materials or programs, referral services, or school programs.
- **U.S. Dept. of Veteran's Affairs hospital and medical facility charges** are paid at 80% for network providers and 70% for non-network providers, provided, to the extent permitted by law, that the charges do not relate to Illness or Injury resulting from military service, declared or undeclared war, invasion, civil insurrection, riot, or hostilities. Charges are subject to the annual deductible.
- **X-ray, radium, and radioactive isotope therapy** (including CT scans, MRI, PET scans and other imaging studies) is covered at 80% in-network and 70% out-of-network.

Telehealth services

Telehealth Visits for In-Network Providers. For in-network providers, telehealth (phone or video) visits are covered to the same extent as in-person visits. The same cost sharing (deductible, copay, and/or coinsurance) and other Plan terms that would normally apply to an in-person visit will apply to the telehealth visit.

MDLive Virtual Visits. Virtual office visits through MDLIVE are available with no copay. You can ask MDLIVE for a telemedicine office visit 24/7. Activate your MDLIVE account at mdlive.com/bcidaho or by phone at (888) 920-2975.

Nurse Advice Line. Blue Cross of Idaho offers a 24/7 Nurse Advice Line at (888) 993-7120.

Preventive Care

Preventive Care means those services and supplies designated as "preventive care" in published guidelines under Health Care Reform and which the Plan is required by law to provide. Preventive Care services and supplies provided in-network are covered at 100%, with no copay or deductible. Preventive Care services and supplies provided out-of-network are covered at 70% and are subject to copays and deductible. The Plan uses reasonable medical management techniques (such as age, frequency, location, method) to determine whether a service or supply is Preventive Care and the extent to which it is covered by the Plan. Preventive Care is also subject to the Plan's Maximum Allowance limits.

In general, Preventive Care includes (but is not limited to) the following:

- Well-child visits (6 in first year, 3 in second year, 2 in third year, then 1 per year through age 18)
- Routine adult physicals/wellness exam (one per year age 19+)
- Breast cancer screening (one mammogram every 2 years age 50+)
- Cervical cancer screening (one per year age 21-65)
- Colon and rectal cancer screening (for adults age 45-75)

- Lung cancer screening (age 50-80 at high risk)
- Birth control devices and procedures for women
- Immunizations, including annual flu shots, COVID-19 shots, and shingles vaccines

This list of covered Preventive Care services and supplies changes from time to time, according to published guidelines under Health Care Reform. For a current list of covered Preventive Care services and supplies, go to bcidaho.com (under the "Health & Wellbeing" tab, select "Preventive Care Benefits").

When both Preventive Care services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the Preventive Care services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. For more information about preventive services, contact BCI.

In addition, certain Preventive Care prescription drugs, supplements and immunizations are covered under the Plan's *Prescription Drug Benefit*. See Section VI.

End-Stage Renal Disease (ESRD) Education

If Blue Cross of Idaho receives information from a provider that you have a diagnosis of ESRD, they will reach out to you. They can offer assistance understanding the Plan's benefits and in-network dialysis care providers, care options, and out-of-pocket costs. This program is optional; you are not required to participate.

Exclusions

The following treatments and supplies are not covered under the medical Plan and do not apply toward your annual deductible and/or out-of-pocket maximums, even if they are Medically Necessary. No benefits will be paid for the following, except as required by law:

Medically Necessary

Throughout this booklet you will see the terms "Medically Necessary" and "Medical Necessity." Under the terms of the Plan, services and supplies that are not Preventive Care are covered only if they are Medically Necessary. Please see Section XIII for a complete definition.

- Acupuncture or acupressure.
- Services or supplies to treat autism, Asperger's syndrome, dyslexia, attention deficit/hyperactivity disorder, pervasive developmental disorder, neurodevelopmental delay, a learning disorder, or delays in a child's language, cognitive, motor or social skills.
- Appliances or equipment primarily for comfort, convenience, environmental control or education; including but not limited to, air filters, allergenic pillows or mattresses, athletic or fitness equipment, blood pressure cuffs, central or unit air conditioners, commodes, elevators, escalators, heat lamps, humidifiers, saunas, shower benches, spas, tanning lights, water purifiers, waterbeds, and whirlpools.
- Birth control, birth control devices, or sterilization procedures other than Preventive Care and vasectomies.
- Blood storage (autologous blood charges) unless related to a planned surgical or ongoing cancer treatment.
- Charges submitted to the Plan for payment more than 12 months after the date incurred. A charge is incurred when the service is rendered or the supply is dispensed.
- Charges for preparing reports or forms and submitting claims.
- Charges for missed appointments.

- Charges for routine physical exams that do not qualify as Preventive Care.
- Charges payable (or that would be payable in the absence of Plan coverage) under any other program, plan or insurance, or charges for which a third party is responsible for paying (except that the Plan may coordinate benefits or advance payment of expenses as described in Section XI).
- Charges that you are not obligated to pay or are not billed or would not have been billed, except for the fact that you are covered under this Plan.
- Charges in connection with, arising from, contributed to, caused by, or occurring during the course of any work for compensation, wages, pay or profit.
- Cosmetic services or supplies, and any complications from such treatment, except that benefits will be provided within Plan limits for:
  - Emergency surgery that is needed due to an accidental Injury.
  - Covered Dependent children, when related to a congenital condition.
  - Mastectomies as described under *Reconstructive breast surgery* in Section V.
- Custodial Care, except for the terminally ill if approved as part of a written treatment plan through the hospice care benefit.
- Dental treatment and services (may be covered under the *Dental Benefit* as described in Section VII), except for the repair of damage to tissues of the mouth or jaw caused by Injury, or for services to remove tumor, cyst, torus or redundant tissue of the mouth. In addition, if a Physician certifies that a non-dental medical condition requires that the dental treatment or services be performed at a Hospital to safeguard the patient's health, or that the patient is a child under age 10 who requires general anesthetic, the Hospital's charges may be covered under the *Medical Benefit* (see *Hospital charges* in Section V) and the charges for the dental treatment or services may be covered under the *Dental Benefit* (see Section VII). For example, the Plan may cover dental treatment or services that must be performed in a Hospital because you have one of the following:
  - Brittle diabetes;
  - History of a life-endangering heart condition;
  - History of uncontrollable bleeding; or
  - Severe bronchial asthma.
- Diabetic blood sugar testing devices and supplies (however, *may* be covered under the *Prescription Drug Benefit* as described in Section VI).
- Drugs available without a Physician's prescription (except insulin), and outpatient drugs that are payable under the *Prescription Drug Benefit* as described in Section VI.
- Drugs, devices or supplies not approved for marketing or for prescribed use by the Food and Drug Administration (including drugs that are in the Food and Drug Administration Phases I, II or III testing).

See the Prescription Drug Section

Outpatient prescription drugs are covered only under the *Prescription Drug Benefit*, unless administered at an outpatient center, while you are at your Physician's office, or if you have prescription drug coverage through another plan that pays primary (see Section VI and Section XI for details).

- Educational programs, services or supplies, except diabetic nutrition education.
- Elective abortions, except to preserve the life of the mother or in cases of rape or incest.
- Expenses incurred or treatment received before your coverage begins, or after it has ended.

- Experimental or Investigational procedures, services and supplies.
- Foot care that is routine, Palliative, or cosmetic, such as paring calluses or corns and trimming toenails.
- Genetic tests that are not Preventive Care or indicated for determining plan of care
- Hearing aid benefits of any type (however, *may* be covered under the *Hearing Aid Benefit* as described in Section IX).
- Habilitative therapy, services or supplies.
- Illness or Injury resulting from or arising out of the commission or attempted commission of a felony or engagement in an illegal occupation, whether or not charges are filed or a conviction results.
- Illness or Injury received while incarcerated.
- Illness or Injury or complications caused by a medical service or procedure for which the Plan provides no benefits.
- Illness or Injury resulting from military service, declared or undeclared war, invasion, civil insurrection, riot, or hostilities, except as required by law.
- Services, drugs, supplies, and any natural or artificial means to assist, facilitate, permit or promote conception or fertilization, or to treat or diagnose infertility (male or female), such as artificial insemination, in vitro fertilization, embryo transfer, gamete intrafallopian transfer, embryo implant, and surrogate or gestational carrier.
- Massage or massage therapy.
- Naturopathy and/or homeopathy services or supplies.
- Obesity or weight control treatment, including drugs and surgery, and any complications from such treatment, even if you have other medical conditions related to or caused by obesity or its treatment, except that the Plan covers obesity treatment that is Preventive Care. Obesity includes morbid or gross obesity.
- Orthopedic shoes, orthotics, lifts, shoe inserts and casting for orthotics or inserts, except that orthopedic shoes and inserts for Participants and Covered Dependents with diabetes are covered as described in Covered Medical Expenses above.
- Replacement of a lost or stolen prosthesis.
- Services of a personal nature, such as radio, television, telephone, guest meals, private rooms (except if Medically Necessary), and housekeeping.
- Services or supplies that are not Medically Necessary (other than Preventive Care).
- Services or supplies received at school or an educational facility.
- Services or supplies that exceed the Maximum Allowance or other Plan limits.
- Services and supplies that require pre-certification but were not pre-certified.
- Services and supplies for which benefits are recoverable under motor vehicle or other insurance (except that the Plan may coordinate benefits or advance payment of expenses as described in Section XI).

- Services provided by a relative (by blood or marriage) who is a licensed Physician or Health Care Provider and ordinarily resides in your home, or by an individual who is not a Health Care Provider practicing within the confines of their license.
- Services performed outside the scope of a Health Care Provider's license.
- Services or supplies not listed as a Covered Medical Expense.
- Services or supplies for which coverage is available or furnished under any federal, state, or other government program, except as required by law.
- Services or supplies an Employer is required to provide under a labor agreement or that are a condition of employment.
- Services or supplies to treat sexual dysfunction, deviations, disorders, inadequacies, or to enhance the function, sensitivity, or alter the shape or appearance of a sex organ, except those Medically Necessary services or supplies to treat gender dysphoria according to Blue Cross of Idaho's Medical Policy entitled *Gender Affirming Services*.
- Sterilization reversal, whether sterilization was voluntary or involuntary.
- Transplant and autotransplant services as follows:
  - Transplants of brain tissue or brain membrane, intestine, pituitary and adrenal glands, hair transplants, or any other transplant or autotransplant not specifically listed as a Covered Medical Expense; or for artificial organs including, but not limited to, an artificial heart or pancreas.
  - Any expenses of a donor related to donating or transplanting an organ or tissue (except for organ procurement charges when the recipient is a Participant or Covered Dependent 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 transportation service or air service) for the donor, or to transport a donated organ or tissue.
  - Living expenses for the recipient, donor, or family members, except for the travel and lodging benefits specifically listed as a Covered Medical Expense.
  - Costs covered or funded by governmental, foundation or charitable grants or programs.
  - Any complication to the donor arising from organ procurement surgery is not a covered benefit under the recipient's Plan coverage. If the donor is a Participant or Covered Dependent, benefits for medical complications to the donor arising from organ procurement surgery will be allowed under the donor's Plan coverage, to the extent the charges are otherwise payable under Plan terms.
  - Costs related to the search for a suitable donor.
  - No benefits are available for services, expenses, or other obligations of or for a deceased donor (even if the donor is a Participant or Covered Dependent).
- Travel, lodging, or transportation, except as provided in *Covered Medical Expenses* in Section V.

- Vision treatment or services (except surgical and medical treatment for diseases of the eye, such as cataract, strabismus and glaucoma) including orthoptics, eye therapy, visual training or eye surgery to correct refractive issues such as LASIK or radial keratotomy. (See the *Vision Benefit*, Section VIII, for regular exams and eyewear.)
- Vitamins, food, and dietary supplements including special formulas, food supplements (except life sustaining), special diets or donor breast milk. Prenatal vitamins, phenylketonuria (PKU) supplements, and Preventive Care drugs and supplements are covered to the extent provided under the *Prescription Drug Benefit* (see Section VI) and required by law.

VI. Prescription Drug Benefit

The Plan covers prescription drugs through a Pharmacy Benefit Manager (PBM) drug card program. The current PBM is Express Scripts (see Section XVI for contact information). This program features a network of participating pharmacies (excluding Walmart). Specialty drugs are provided through Accredo, an Express Scripts specialty pharmacy.

Prescription drugs dispensed while you are an inpatient at a Hospital or administered at an outpatient facility or at your Physician's office are covered under the Plan's *Medical Benefit* (see Section V). Except when covered under the Plan's *Medical Benefit*, specialty drugs are covered only if filled through the Accredo specialty pharmacy.

If You Use a Participating Pharmacy

When you use a participating pharmacy, your copayments are:

Type of Drug or Supply	Copayment
Generic Drug	Retail: $20 (up to 30-day supply) Mail order: $20 (up to 30-day supply) $40 (up to 90-day supply)
Preferred Brand-Name Drug	Retail: $40 (up to 30-day supply) Mail order: $40 (up to 30-day supply) $80 (up to 90-day supply)
Non-Preferred Brand-Name Drug	Retail: $70 (up to 30-day supply) Mail order: $70 (up to 30-day supply) $140 (up to 90-day supply)
Maintenance drugs	Generally covered only when filled through mail order (see *Maintenance Drugs* on page 38)
Specialty drugs (self-injectable medications (excluding insulin) or medications for cancer or other serious conditions)	10% of the cost of the drug through the Accredo specialty pharmacy, to a maximum of $120 each time you have your prescription filled
PKU (phenylketonuria) prescribed food supplements (covered only when for Covered Dependent children and filled at a pharmacy)	$70
Diabetic blood sugar testing devices and supplies filled through a pharmacy or mail order	Filled through a pharmacy: • $40 for Accu-Check or One-Touch • $70 for other testing devices or supplies Filled through mail order: • $80 for Accu-Check or One-Touch • $140 for other testing devices or supplies
Preventive Care drugs and supplements (covered only if filled through a participating pharmacy)	$0

If you receive a Non-Preferred Brand-Name Drug when a Preferred Brand-Name Drug is available, you will have to pay the higher copayment. Your participating pharmacy can tell you if a preferred drug is available. Contact Express Scripts to obtain a current list of participating pharmacies.

For covered drugs other than specialty drugs, the copay is the applicable amount listed in the chart above or, if less, Express Scripts' maximum allowable rate. Certain drugs may cost less than the amount you pay. Also, if you choose to purchase a brand-name drug when a Generic Drug equivalent is available, the plan will only pay the amount it would have paid for the Generic Drug. In addition to the copay, you will have to pay the additional cost of the brand-name drug (and the additional cost will not count toward your out-of-pocket maximum).

The Plan's formulary (list of preferred drugs) and conditions of drug coverage are subject to change at any time. To find out whether a particular medicine is included on the formulary or covered under the Plan, and what conditions of coverage (if any) may apply, visit express-scripts.com or call Express Scripts Member Services at the phone number listed in Section XVI.

If filled at a participating pharmacy, drugs that are Preventive Care are also covered by the Plan. Preventive Care drugs are covered at 100% at participating pharmacies, but you must have a prescription from your doctor (even for over-the-counter items). There is no coverage for Preventive Care drugs obtained elsewhere. Also, not all items are covered for everybody—for example, there are age restrictions, and some items are limited to generic only. You may ask Express Scripts to send you a current list of Preventive Care drugs.

Also, you may get free Preventive Care immunizations at certain Express Scripts participating pharmacies (contact Express Scripts to see which ones participate in the immunization network). There is no coverage for immunizations or other Preventive Care obtained elsewhere.

Pre-certification, quantity limits, and step therapy

Certain drugs require pre-certification (also called preauthorization) to be covered and/or have quantity limits. All drugs at risk of abuse have quantity limits and require pre-certification. The current list of these drugs is posted on express-scripts.com, or you may contact Express Scripts at the address or phone number listed in Section XVI to request a free copy.

If your prescription drug requires pre-certification, ask your doctor to call the Express Scripts pre-certification line at 800-753-2851. Only doctors can give Express Scripts the information needed to determine if the drug may be covered. Express Scripts answers its pre-certification phone lines 24/7, and a determination can be made right away. If the medication is not pre-certified, it will not be covered by the Plan.

Certain drugs, called "second-line medications," are subject to step therapy. A second-line medication is typically a higher-cost brand name drug. A second-line medication will only be eligible for Plan coverage if you have tried a "first-line medication" (typically a generic or a lower-cost brand name drug) and your doctor does not feel that the medication treats your condition effectively, OR you can't take a first-line medication (e.g., due to an allergy), OR your doctor decides you need the second-line medication for medical reasons. If you fill a prescription for a second-line medication without having satisfied one of these conditions, your medication will not be covered by the Plan. You may review the list of first-line medications online at express-scripts.com or by calling Express Scripts at the number on your member ID card.

Out-of-Pocket Maximum

Once you reach the In-Network Maximum for prescription drugs ($2,880 per person / $5,760 per family), you owe no further copays for covered drugs and supplies filled at participating pharmacies for the remainder of the calendar year. See Section II for details. The Plan's Out-of-Network Maximum does not apply to the *Prescription Drug Benefit*.

Retail Pharmacy

To find a list of participating retail pharmacies, visit express-scripts.com and use the Pharmacy Locator tool. You can also download the Express Scripts mobile app. To download the mobile app for free, search for "Express Scripts" in smartphone app stores or call Express Scripts Member Services.

When you use a participating retail pharmacy, simply take your prescription and your Drug Identification Card to the pharmacy and make the appropriate copayment to receive up to a 30-day supply; no claim forms are required. Note that you may only fill a maintenance drug at a retail pharmacy twice. After that, you must use mail order, unless you opt out of the mail order program. (See *Maintenance Drugs* below.) Also, you may only fill a specialty drug at a retail pharmacy once. After that, you must use the Accredo specialty pharmacy.

Specialty Drugs

Self-injectable medications (**excluding insulin**), medications for oncology (cancer) or other serious medical conditions, and other specialty drugs are not covered under the retail or mail order pharmacy benefit. These specialty drugs are dispensed through the Accredo specialty pharmacy. Accredo will send these medications directly to your home and provide you with unlimited access to skilled specialty pharmaceutical consultation. The copay for specialty drugs is 10% of the total cost of the drug through Accredo (including any applicable ingredient cost and fees, and before application of any coupon, rebate, or other manufacturer financial assistance), up to a maximum of $120 each time you have your prescription filled.

The first time you take your specialty drug prescription to a retail pharmacy you will be able to fill it. Accredo will then send you information on how to fill the prescription in the future. For a free copy of the specialty drug list, contact Express Scripts at the address or phone number listed in Section XVI. The specialty drug list is also available on Express Scripts' website.

If the Accredo specialty pharmacy can use a manufacturer's financial assistance program, such as a coupon, rebate, or similar method, Accredo may arrange for your copay to increase by the financial assistance amount and for the Plan to pay less for your prescription drugs. A coupon, rebate, or other financial assistance will not require you to pay more, will not entitle you to cash back, and will not count toward your out-of-pocket maximum.

Maintenance Drugs

Maintenance drugs are those drugs you use on an ongoing basis that are listed on the Express Scripts maintenance list, such as insulin. The list of maintenance drugs changes from time to time. You can obtain a current list at express-scripts.com or by contacting Express Scripts at the address or phone number listed in Section XVI to request a free copy.

The first two times you fill your maintenance drug, you may fill it at a retail pharmacy or through the mail order pharmacy. Express Scripts will authorize only a 30-day supply for each of your first two fills at a retail pharmacy. After your first two fills, you must use the Plan's mail order pharmacy (up to a 90-day supply) unless you opt out of the mail order pharmacy program. To opt out, you must notify Express Scripts that you want to continue using the retail pharmacy instead of mail order after your second retail

fill. If you do not notify Express Scripts, you could be charged a penalty equal to 100% of the retail cost for each retail fill beginning with your third.

If you opt out, you may continue to fill your maintenance drug at a retail pharmacy (up to a 30-day supply), subject to retail pharmacy copays. You may resume use of the mail order pharmacy at any time. To opt out (or resume use) of the mail order pharmacy program, call Express Scripts Member Services at 800-716-3751.

Mail Order

Express Scripts offers a mail order (home delivery) pharmacy service for maintenance drugs and certain other covered drugs. With mail order, you can receive up to a 90-day supply of medicine from the Express Scripts mail order pharmacy. Standard shipping is free, and you usually will receive your order within 5-7 days once shipped. If expedited shipping is required, contact Express Scripts to discuss availability and costs.

Your doctor can submit a new prescription to the Express Scripts mail order pharmacy, or you can mail in an order form (available on the Express Scripts website). Refills can be ordered electronically using the Express Scripts mobile app or website, through the mail, or by phone. Visit express-scripts.com to learn more.

Participating Pharmacies

To find a participating pharmacy, call Express Scripts Member Services at the telephone number listed in Section XVI or visit express-scripts.com. A few of the current participating pharmacies include:

- Albertsons/Savon
- Costco Pharmacy
- K-Mart
- Rite Aid Drug
- Safeway
- Shopko
- Walgreens

There are also many independent pharmacies in the network. Keep in mind, the list of participating pharmacies may change at any time. If you're not sure if your pharmacy participates, contact Express Scripts.

If You Use a Non-Participating Pharmacy

If you fill your prescription at a pharmacy *outside* the network (other than Walmart), or if your eligibility is not currently effective but is later reinstated for the period in which the claim was incurred, the same copayments generally apply **but you must pay the full cost of the drug up front when you make the purchase**. Then, submit a claim form and the receipt to Express Scripts for reimbursement. Claim forms are available from Express Scripts.

If your non-network pharmacy charges more than Express Scripts' maximum allowable rate for the same drug, you pay the difference. For example, let's assume the maximum allowable rate for your Generic Drug is $50, but your non-network pharmacy charges $85. At the time of purchase, you will need to pay the full $85 cost. Then, you may file a claim. You must pay the $20 Generic Drug copayment plus the $35 difference between the non-network pharmacy cost and the Express Scripts maximum allowance for this drug. Express Scripts will reimburse you $30; your final cost is $55.

If you or your Covered Dependent has other primary prescription drug coverage, your prescription drug copays may be reimbursed under the *Medical Benefit*. See Section XI for more information.

Exclusions

The following are not covered under the *Prescription Drug Benefit*:

- Amounts in excess of Express Scripts' maximum allowable rate for a covered drug, service or supply.
- Any prescription filled at Walmart.
- Anabolic steroids, unless deemed Medically Necessary by a covered Physician.
- Birth control that is not Preventive Care.
- Digital therapy, which is a non-medication treatment that uses digital technology (usually internet-based) to drive patients to change their behavior in order to prevent, manage, or treat an Injury or Illness.
- Drugs not requiring a Physician's written prescription, except insulin or Preventive Care drugs that are purchased with a prescription at a participating pharmacy.
- Drugs, devices or supplies not approved for marketing or for prescribed use by the Food and Drug Administration (FDA).
- Drugs the FDA has not approved for marketing or sale to individuals with, or for treatment of, your Illness or Injury.
- Drugs administered while you are an inpatient or at an outpatient facility or a Physician's office (may, however, be covered under the Medical Benefit as described in Section V).
- Fluoride preps.
- Minoxidil topical applications such as Rogaine.
- Nutritional and dietary supplements, except for prescribed food supplements to treat Phenylketonuria (PKU) (which are covered when prescribed for Covered Dependent children and filled at a pharmacy).
- Prostheses (may be covered under the Medical Benefit as described in Section V).
- Vitamins, except prenatal vitamins that are Preventive Care and purchased with a prescription at a participating pharmacy.
- Weight loss drugs.
- All drugs related to services and supplies or Illnesses or Injuries that are excluded under the Medical Benefit. Medical Benefit exclusions (beginning on page 31) apply to the Prescription Drug Benefit, except as specifically provided to the contrary in this section.

VII. Dental Benefit

The *Dental Benefit* pays a percentage of Covered Dental Expenses after an annual deductible of $75 of Covered Dental Expenses per person. For individuals age 18 and under, their deductible and coinsurance for Covered Dental Expenses (other than orthodontia expenses) will count towards their In-Network Maximum for medical benefits (see Section V for details). Dental benefits for adults are capped at $1,500 per year, and their deductible and coinsurance do not count toward any out-of-pocket maximum.

Covered Dental Expenses

Dental Benefit Highlights	
Annual deductible	$75 per person per calendar year.
Annual maximum benefit This is the maximum the Plan pays for Class A and Class B expenses. Orthodontia expenses are subject to a different maximum (see below).	$1,500 per adult per calendar year. Unlimited for pediatric dental services (age 18 and under).
Class A expenses (Preventive) • Routine services (twice every calendar year) including: – Exam – X-rays, except panoramic or full mouth, which are covered once every 24 months – Prophylaxis and fluoride • Sealants (no age limit)	Covered 100%* after the deductible.
Class A expenses (Other) • Periodontal scaling/prophylaxis (non-routine) • Fillings other than Class B fillings (see below) • Extractions • Root canal therapy • Root planing • Oral and Periodontal surgery (tissue supporting teeth) • Anesthetics administered for Oral Surgery or another covered dental service. If administered by an anesthesiologist or anesthetist, charges are covered under the *Medical Benefit* • Surgical placement of implants (surgical procedure only)	Covered 80%* after the deductible.

Dental Benefit Highlights	
Class B expenses • Inlays, onlays, crowns and gold fillings • Repair or recementing of crowns, inlays, bridgework, or dentures • Implant hardware • Mouth/nightguards • Bridgework and dentures (full or partial), including: – Initial installation – Additions following extraction of injured or diseased natural teeth – Replacement or alteration of bridgework or dentures when necessary after treatment that is covered by the Plan's *Medical Benefit* to repair an Injury. – Replacement or relining of a full denture because of structural change within the mouth, if done more than five years after installation. Relining is covered no more than once in any 24-month period	Covered 50%* after the deductible.
Orthodontic Benefit	Covered 50% after the deductible. $1,500 lifetime limit per person

*Subject to Maximum Allowance limits, and the Plan's annual maximum benefit of $1,500 per adult per calendar year.

Blue Cross of Idaho (BCI) can provide a courtesy assessment of whether certain services are Medically Necessary before you receive the services. BCI can provide courtesy assessments for: bonding, bridgework, crowns or veneers, Periodontal surgery, dentures, surgical removal of impacted teeth, inlays/onlays, and implants. To request a courtesy assessment, call BCI medical management at 800-743-1871. Please note that BCI's courtesy assessment of Medical Necessity is optional and does not guarantee coverage. After a service or supply is incurred, BCI retains the right to review the claim for Medical Necessity, eligibility, benefit limitations and exclusions, etc. Services are covered only to the extent otherwise provided under the Plan.

Extension of Benefits

If you incur a dental expense within 90 days after losing eligibility, and the expense relates to a dental procedure that started while you were still eligible, the Plan will cover that expense as if you were still eligible, provided the Plan still covers that expense. For this purpose, x-rays and prophylaxis are not considered a start of dental procedure. The 90-day extension does not apply to prosthetic devices (artificial replacement of natural teeth and/or associated structures); rather, they must be delivered within 30 days after termination of coverage.

Exclusions

The Plan does not cover:

- Services and supplies not specifically listed above.
- Treatment for cosmetic purposes, including but not limited to bleaching or veneers.
- The *Medical Benefit* exclusions outlined in Section V also apply to the *Dental Benefit*, except as specifically provided to the contrary under this section.

VIII. Vision Benefit

The Plan pays for a vision exam and either glasses or contact lenses up to specific Plan limits. In addition, for Active and Retiree Participants eligible through their hour bank account balance*, the Plan covers prescription safety glasses. Vision benefits are summarized as follows, and are subject to Maximum Allowance limits:

Vision Benefit Highlights		
	Adult (age 19+)	Pediatric (under age 19)
Eye exam (every calendar year)	Covered 100% in network and up to $45 out-of-network. Routine retinal screening subject to a copay of up to $39.	Covered 100% in-network, 50% out-of-network.
Lenses (one pair) • Single vision • Lined Bifocal • Lined Trifocal • Standard Progressive	Covered 100% in-network. Out-of-network: • Up to $30 • Up to $50 • Up to $65 • Up to $50 Covered every calendar year.	Covered 100% in-network, 50% out-of-network. Covered every 2 calendar years.
Lens enhancements	Premium progressive lenses are covered in network subject to a $95-105 copay. Custom progressive lenses are covered in network subject to a $150-175 copay. The Plan pays up to $50 out of network for premium or custom progressive lenses. Covered every calendar year.	Impact-resistant lenses, scratch-resistant coating, and UV protection are covered 100% in network, 50% out of network. Covered every 2 calendar years.
Frames (every two calendar years)	The Plan pays up to $150 in-network (up to $170 for featured brands; up to $80 for frames purchased at Costco). The Plan pays up to $70 out-of-network.	Covered 100% in-network, 50% out-of-network.
Contact lenses and fitting (instead of glasses)	The Plan pays up to $150 in-network and up to $105 out-of-network. Covered every calendar year.	Contact lens exam and minimum three-month supply of contacts lenses are covered 100% in-network, 50% out-of-network, subject to the following quantity limits** *Type of lens:* — *Covered every 2 years:* Standard — One lens per eye (one-year supply) Monthly — Six lenses per eye (six-month supply) Bi-weekly — Six lenses per eye (three-month supply) Dailies — Ninety lenses per eye (three-month supply)

Vision Benefit Highlights	
Safety glasses* (one pair every two calendar years)	Covered 100% in-network for ProTec safety glasses. For out-of-network or non-ProTec frames and lenses, the Plan pays up to: *Lenses* Single Vision $35 Bifocal $45 Trifocal $60 Lenticular $90 Progressive $45 *Frames* $25

* No coverage for Special Agreement Participants (including those who become covered by COBRA), Lifetime Self-Pay Participants, or Covered Dependents.

** Quantity limits don't apply if you have a medical condition for which contact lenses provide better visual correction than eyeglasses.

Exclusions

The Plan does not cover, and no benefits are paid for:

- Services and supplies not specifically listed above, including but not limited to:
  - Special procedures (other than an eye exam and test for glaucoma) such as orthoptics, eye therapy, or visual training.
  - Keratotomy or lasik surgery.
  - Plano lenses.
  - Optomaps and other retinal imaging (*may*, however, be available under the *Medical Benefit* if not excluded under "Vision treatment or services" on page 35).
  - Other medical or surgical treatment for diseases of the eye (*may*, however, be available under the *Medical Benefit* if not excluded under "Vision treatment or services" on page 35).
- Sunglasses, including Photo-Sun, even if prescribed.
- Replacement of lost, stolen, or broken lenses or frames.
- Vision exams by someone who is not a Physician or optometrist, and vision aids prescribed by someone who is not a Physician or optometrist.
- Refitting of contact lenses after the initial ninety (90) day fitting period.
- Contact lens modification, polishing or cleaning.
- The *Medical Benefit* exclusions (beginning on page 31) also apply to the *Vision Benefit*, except as specifically provided to the contrary in this section.

IX. Hearing Aid Benefit

The Plan pays covered hearing aid expenses at 80% in-network and 70% out-of-network of the Maximum Allowance charge, up to $750 per ear in any one consecutive period of every 36 months. There is no deductible.

Covered Expenses

The following expenses are covered:

- Otologic exam by a Physician
- Audiological exam and hearing evaluation by a certified or licensed audiologist and follow-up exam
- Hearing aids prescribed as a result of the exam, including:
  - Ear molds
  - Hearing aid instruments
  - Initial batteries, cords, and other necessary accessories
  - Warranty
  - Follow-up consultation within 30 days after delivery of hearing aid

Exclusions

The Plan does not cover, and no benefits are paid for:

- Replacement of a hearing aid unless 36 months have elapsed since your last one.
- Batteries or other accessories obtained after purchase of a hearing aid.
- Charges not meeting professionally accepted standards of practice.
- A hearing aid which exceeds the specifications prescribed for correction of hearing loss.
- Repair of a hearing aid.
- The *Medical Benefit* exclusions (beginning on page 31) also apply to the *Hearing Aid Benefit* except as specifically provided to the contrary in this section.

X. Short-Term Disability Benefit

The Short-Term Disability (STD) benefit is designed to help protect you from loss of income if you're unable to work due to an Injury, Illness, or your pregnancy.

Benefit

The Plan will pay you a weekly benefit of $300 ($277.05 net after FICA tax) if all of the following apply:

- You are an Active Participant, have never been a Retiree, and are eligible for the Plan's health coverage when you become disabled;
- You are "disabled" for purposes of the STD benefit (that is, you cannot perform the duties of your own occupation because you have sustained an Injury, contracted an Illness, or because of your pregnancy);
- You are under the direct and continuous care of a Physician to treat your Injury, Illness or pregnancy; and
- You became disabled on or after February 1, 2022.

Benefits begin the 8th day after you become disabled and continue for up to 26 weeks for each week in which you are disabled, whether your disability is for one or multiple causes (a "disability period"). The benefit is not paid for days you are not disabled during a disability period.

To comply with federal law, FICA taxes (also known as employment taxes for Social Security and Medicare), currently 7.65%, will be withheld from your benefit (making the net weekly benefit rate $277.05). Applicable income and state and local taxes may also be withheld. For your records, the FICA tax will appear on a Form W-2 issued by the Trust Office.

If multiple disabilities are due to the same or related Illness, Injury, or pregnancy, not separated by either your return to active work or your availability to work for two weeks, the Plan will consider it one disability period.

You will have Plan coverage without reduction of hours from your hour bank while you are receiving the STD benefit. In other words, your hour bank will be frozen. This extended coverage will continue until the last day of the month for which you are entitled to receive the weekly benefit. However, there is no hour bank freeze if you are covered by a Special Agreement. As a result, if you participate in the Plan by reason of a Special Agreement, Plan coverage will terminate the last day of the second month after you stop working, and the first month after your Employer no longer has an obligation to make payments (or stops making payments) to the Plan.

Exclusions

The Plan does not pay STD benefits for any disability caused by:

- Illness or Injury in connection with, arising from, contributed to by, caused by, or occurring during the course of, any work for compensation, wages, pay or profit;
- Illness or Injury resulting from military service for any country;
- Illness or Injury for which you're entitled to benefits under any workers' compensation or occupational disease law;
- Illness or Injury resulting from or arising out of the commission or attempted commission of a felony or engagement in an illegal occupation, whether or not charges are filed or a conviction results; or

- Illness or Injury or complications caused by a medical service or procedure for which the Plan's health coverage provides no benefits.

In addition, you are not eligible for STD benefits if:

- You are on COBRA or are a COBRA Qualified Beneficiary when you become disabled;
- Your disability is due in whole or in part to a possible or probable future Illness, Injury, event or risk; or
- You are not an Active Participant when you become disabled.

Termination of Benefits

STD benefits will terminate immediately if any of the following events occur:

- Performing work in your own occupation, or in any trade, craft, or employment covered by the Plan;
- Expiration of the maximum benefit period of 26 weeks;
- The Plan does not, upon request, receive a certification from your attending Physician that states you are unable to work, you are no longer under the care of a Physician, or you fail to submit to examination by the Plan's Physician;
- The last day of the month before you retire or begin to receive a normal, early or disability retirement benefit from the Idaho Plumbers and Pipefitters Pension Plan; or
- You die.

XI. Coordination of Benefits and the Plan's Recovery Rights

If you are covered by another health plan, let Blue Cross of Idaho know. The Plan will then coordinate benefits, which usually results in you paying for less of your health expenses. You can never receive more from your health plans than you are charged by your doctor and other providers.

Many people enroll in more than one health care plan in order to protect themselves against the high costs of medical or dental care. To keep the cost of Plan benefits as low as possible, the Plan coordinates benefit payments with other health care plans, Medicare, other governmental plans, and in situations where a person has dual coverage under the Plan.

If you or your Dependents are covered under another health plan, Medicare, or other governmental plan, you must submit itemized bills to both plans. Coordination of Benefits operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan (called the secondary plan) pays after the primary plan and may reduce the benefits it pays so that all the payments from all plans do not exceed 100% of the total allowable expenses. An "allowable expense" is a health care expense covered by one of the plans, including copayments, coinsurance and deductibles. Sometimes the combined benefits that are paid will be less than total allowable expenses.

Effect on Plan Benefits

When the Plan is primary, it pays its regular benefits in full. When the other plan is primary, the Plan pays a reduced amount. If your primary plan reduced benefits because you did not use a primary plan preferred provider or you did not comply with the primary plan's provisions, such as pre-certification requirements, the Plan will not pay those reductions.

In no event will the Plan reimburse an expense that is or should be covered by another plan, government program, insurance, or other source. If you have dual coverage under the Plan (for example, because you are a Participant and you are married to another Participant), the Plan will reimburse an allowable expense only once. If you have otherwise obtained reimbursement for a health expense, the Plan will not again reimburse you for that same expense.

To administer coordination of benefits, the Plan has the right to: exchange information with other plans involved in paying claims; require that you and your Health Care Provider furnish information; reimburse any plan that made payments this Plan should have made; and recover overpayments.

Coordination With Other Health Plans

The following rules determine which plan is primary. If the first rule does not determine which plan is primary, the next rule is applied, and so on until the order of benefits is determined.

- If the other plan does not have a coordination of benefits provision, or if it has a coordination of benefits provision different from these rules, that plan is primary.
- If a person is covered by a plan as a dependent and by another plan other than as a dependent (for example, as an employee, member, subscriber, policyholder, or retiree), the plan covering the person other than as a dependent is primary.
- However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person other than as a dependent, then the order of benefits between the two plans is reversed (so the plan

covering the person as a dependent is primary and the plan covering the person other than as a dependent is secondary).

- If a child is covered under more than one plan and a court decree provides that one plan shall be primary, that plan is primary.
- For a child of parents who are married or living together, whether or not they have ever been married, the "birthday rule" applies: the plan of the parent whose birthday comes first in the calendar year is primary (unless the parents' birthdays are the same, in which case the plan of the parent that has provided coverage to that parent for the longer period is primary).
- For a child of parents who are divorced or separated or are not living together, whether or not they have ever been married, the following rules apply:
  - If a court decree states that *one* of the parents is responsible for the child's health care expenses or coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the child's health care expenses, but that parent's spouse does, the spouse's plan is primary.
  - If a court decree states that *both* of the parents are responsible for the child's health care expenses or coverage, or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the child's health care expenses or coverage, then the birthday rule applies.
  - If there is no court decree allocating responsibility for the child's health care expenses or coverage, benefit payments are made in the following order by the plan covering:
    - The custodial parent;
    - The custodial parent's spouse;
    - The non-custodial parent; and then
    - The non-custodial parent's spouse.
- The "custodial parent" means the parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides for more than one-half of the calendar year without regard to any temporary visitation.
- For a child covered under more than one plan of individuals who are not the child's parents, the order of benefits shall be determined, as applicable, under the birthday rule or the above rule for children of parents who are divorced or separated or are not living together, as if those individuals were the child's parents.
- A plan covering a person as an active employee (that is, an employee who is neither laid-off nor retired and, if the plan is a multiemployer plan, for whom employer contributions are being made to the plan) or as a dependent of an active employee is primary over a plan covering the person as other than an active employee or as a dependent of an active employee. However, if the other plan does not have this rule—resulting in a conflicting order of benefits determination—this rule will not apply.
- If a person has COBRA or other continuation coverage pursuant to state or other federal law and is covered by another plan, the plan providing the continuation coverage is secondary to the plan covering the person as an employee, member, subscriber or retiree (or as a dependent of an employee, member, subscriber or retiree). However, if the other plan does not have this rule—resulting in a conflicting order of benefits determination—this rule will not apply.
- The plan that has covered the person for the longer period of time is primary.

- If none of the above rules determines which plan is primary, expenses shall be shared equally between the plans.

If You Are Eligible for Medicare

Medicare is a health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (ESRD). When you or your Spouse reaches age 65, Medicare Part A (hospital coverage) is generally automatic if you apply for Social Security benefits. Medicare Part B (medical coverage) requires enrollment and monthly premium payments. Medicare Part D (prescription drug coverage) requires enrollment and monthly premium payments. Contact your local Social Security Administration Office for information about enrolling in Medicare.

You need to enroll for both Part A and Part B to receive maximum available benefits under this Plan. If you do not enroll in and utilize Medicare Parts A and B when eligible, benefits payable under this Plan will be reduced by the amount Medicare would have paid under Medicare Parts A and B. If you enroll in Part D and you are a Retiree, the Plan won't pay your prescription expenses.

Coordination With Medicare

Medicare is primary if:

- You or your Dependent are covered by Medicare on the basis of age (65 or over), and you are not a working Participant, or
- You or your Dependent are covered by Medicare on the basis of a disability, and you are not a working Participant, or
- After being covered by Medicare on the basis of age (65 or over) or disability, you or your Dependent become eligible for or covered by Medicare because of end stage renal disease (ESRD), and you are not a working Participant. In these circumstances, Medicare will continue to pay benefits as the primary provider.

This Plan is primary if:

- You or your Dependent are covered by Medicare on the basis of age (65 or over) and you are a working Participant (unless the exemption below applies), or
- You or your Dependent are covered by Medicare on the basis of a disability, and you are a working Participant, or
- You or your Dependent become eligible for or covered by Medicare as a result of having end-stage renal disease (ESRD). Medicare acts as the secondary payer for the first 30 months after you become eligible for or covered by ESRD-based Medicare coverage, and becomes the primary payer after those 30 months. (However, if Medicare was already primary due to your or your Dependent's age or disability, Medicare will remain primary.)

The Plan may apply for an exemption that allows a working Participant and his or her Dependents who are receiving Medicare benefits on the basis of age to receive Medicare benefits as primary benefits, and for the Plan to be secondary. This exemption is available only if the Participant works for a Contributing Employer with fewer than 20 Employees for 20 or more weeks in both the prior calendar year and the current calendar year, and the government grants the Plan's application for the exemption.

Coordination with Medicaid, TRICARE, Veterans Affairs facility, or other state or federal coverage

This Plan is always primary to Medicaid, TRICARE, and any other coverage provided by any other state or federal law that requires the Plan pay primary.

However, if you receive services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related Illness or Injury, benefits are not payable by this Plan. If you receive services in a U.S. Department of Veterans Affairs Hospital or facility on account of an Illness or Injury that is *not* related to military service, benefits are payable by this Plan to the extent that care is a Covered Medical Expense.

Coordination of Prescription Drugs

If you have other prescription drug coverage that pays primary, the Plan reimburses covered expenses for outpatient prescription drugs (e.g., copays) the other plan did not pay. The Plan's reimbursement is 100% up to $200 per covered person per calendar year, and no medical deductible will apply. After the Plan reimburses $200, it reimburses any remaining expenses at 80%, also with no medical deductible.

For example, if you have prescription drug copays from your primary plan totaling $300 and this Plan is secondary, this Plan would reimburse you 100% of the first $200 and 80% of the remaining $100. In other words, it would pay $280 of your $300 copays and the out-of-pocket expense for you would be $20.

Requests for copay reimbursement should be submitted to Blue Cross of Idaho.

Notifying the Plan of Other Coverage

It is your responsibility to notify Blue Cross of Idaho and Idaho Pipe Trades Trust if you or your Dependents have coverage other than Plan coverage, or if your other coverage terminates. Failure to provide this notice may result in loss of your Plan benefits. In addition, you will be required to fully reimburse the Plan for any claims paid in excess of the amount that should have been paid under the Plan.

By participating in the Plan, you agree that if the Plan pays primary and later determines that it is the secondary plan, the Plan will be subrogated to all the rights you may have against the other plan, and you agree to execute any documents required or requested by the Plan to pursue its claims for reimbursement of the amount advanced.

Plan's Rights to Recovery

Payment is made for claims based upon your representations and those of your Covered Dependents and/or providers concerning the services rendered and is contingent upon benefits being covered under the terms of the Plan.

By accepting benefits, you and your Covered Dependents agree:

- To promptly refund to the Plan any amount that exceeds the amount covered by the Plan or any amount that is subject to the Plan's subrogation or reimbursement rights, discussed in the following section
- That the Plan may reduce or deny coverage of your claims or the claims of your Covered Dependents as a way of obtaining reimbursement, even if any such claims do not relate to the overpayment, and
- To reimburse the Plan in full for any benefits from the Plan to which the individual is later found not to be entitled.

The Plan may also recover interest on the amounts paid by the Plan from the time of the payment until the time the Plan is reimbursed.

Furthermore, whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan will be authorized to pay such benefits to the other party. Any payment made by the Plan in accordance with this provision will fully release the Plan of any liability to you. Any Participant or individual who receives (or whose family receives) benefits from the Plan to which they are later found not to be entitled will be required to reimburse the Plan in full.

Plan's Right to Subrogation, Reimbursement, and Equitable Lien

The Plan does not cover any health expenses for an Injury or Illness if someone else (a "third party") is responsible to pay the expenses or other damages related to the Injury or Illness. If the Plan believes a third party is or may be liable for an Injury or Illness, the Plan may refuse to pay any health expenses. Alternatively, the Plan may advance payment of benefits while you pursue recovery of the health expenses or other damages from a third party, subject to the Plan's right to be fully reimbursed out of any payment that a third party makes to you, your family members, your attorney or to anyone else in connection with the Injury or Illness (a "third-party payment"). Third-party payments are assets of the Plan and cannot be transferred or paid to you or any other person until the Plan has been fully reimbursed. This is called the Plan's *right to reimbursement*.

In addition, the Plan has the right to take your place in recovering payments directly from the third party. The Plan's right to do this is called its *right of subrogation*.

For instance, if you are injured in an automobile accident, the Plan is entitled to both subrogation and reimbursement as follows:

- If your insurance company or the other driver's insurance company is responsible for making a payment to you because of the accident, the Plan has the right to demand that the insurance company first pay the Plan directly for the expenses covered by the Plan, before you get any excess amount.
- If you make a claim or file a lawsuit against the other driver and get any kind of recovery, the Plan again has the right to be paid first, even if you don't agree it should. If you obtain any kind of payment before the Plan gets its share, you must reimburse the Plan immediately.

Under its rights of subrogation, the Plan may make a claim or file a lawsuit for you, or act on your behalf in any claim or legal proceeding, and would be entitled to reimbursement for court costs, expenses, and attorney's fees, in addition to the benefits advanced by the Plan.

The Plan's rights to subrogation and reimbursement also constitute a "constructive trust" or "equitable lien" against any and all third-party payments made now or in the future, regardless of how the payments are characterized. The Plan's lien is in the full amount of all the health expenses paid by the Plan in connection with the Illness or Injury, regardless of when the expenses are paid or incurred (including, for example, expenses incurred after you receive a third-party payment). In the Plan's sole discretion, the Plan's lien may also include interest on the amounts paid by the Plan from the time of payment until the time the Plan is reimbursed. The Plan is not required to pay any fees to the attorney you hire to pursue a third-party payment, or to reduce its lien for any costs or attorney's fees you incur or for any other reason.

The Plan's rights to third-party payments

The Plan is entitled to *full* reimbursement for all health expenses it pays relating to the Illness or Injury and has a "first dollar" right of reimbursement. That is, the Plan has the right to be reimbursed first from the total amount of any and all third-party payments, without reduction for any attorney's fees or costs that you may incur in pursuit of the recovery. The Plan has the right to be reimbursed even if the third-party payments are not payment for medical or disability expenses. This includes, for example, the following payments:

- Any judgment, settlement, or other payment relating to the Illness or Injury, from any source.
- Any payment made by your insurance or a third party's insurance, including vehicle insurance, no-fault automobile insurance, uninsured or underinsured motorist coverage, business insurance, homeowner's insurance, personal umbrella insurance, or any other insurance or insurance-type coverage, or a payment made under any workers' compensation program.
- Payments designated as medical benefits, as disability payments, as compensation for pain and suffering, as attorney's fees, as economic, non-economic, or punitive damages, or as other specified or general damages.
- Any partial payment made for any reason, even if you are not "made whole." This means that the Plan has the right to be repaid in full first, even if you do not expect to receive full compensation for your damages from the third party.

Your notification and cooperation are required

By accepting benefits under the Plan, you agree that the Plan has the rights of subrogation and reimbursement, and you agree to promptly provide information and execute documents as requested by the Claims Administrator and to take no action that may prejudice the Plan's rights.

You must notify the Claims Administrator within 45 days of the date that you have an Injury or Illness that might be the responsibility of a third party and when you or your attorney gives notice to any third party that you intend to investigate or pursue a claim to recover damages. You must also notify the third party of the Plan's lien against any recovery.

The Claims Administrator may require that as a condition of the Plan advancing further benefits relating to the Illness or Injury, you or your covered spouse or other family members, as well as any attorney or authorized representative for you or your covered spouse or other family members, sign a reimbursement agreement within 45 days of request by the Claims Administrator. This reimbursement agreement may: (1) incorporate any or all of the rules of the Plan regarding the Plan's rights to subrogation and reimbursement, (2) require that your attorney agree to honor the Plan's lien on third-party payments and agree that the Plan is not required to pay any portion of your attorney's fees or costs, and/or (3) contain any other terms necessary or appropriate to enforce the Plan's rights or to ensure that the contract will be enforceable in state or federal court, at the Plan's election. Any benefits the Plan advances in absence of a signed reimbursement agreement will nonetheless be fully subject to the Plan's subrogation and reimbursement rights.

If you receive a third-party payment, you must promptly notify the Plan and hold the total amount of the payment in an escrow or trust account acceptable to the Plan (or, if you are represented by an attorney, you must direct your attorney to hold such funds in trust) until the Plan has been fully reimbursed for the current amount of its lien. You must promptly reimburse the Plan in full, regardless of the manner in which the third-party payment is structured. A third-party payment constitutes Plan assets under ERISA, to the extent of the Plan's lien. That means that you have a fiduciary responsibility to protect the Plan's lien and reimbursement rights.

If you or your attorney do not timely provide requested information, do not timely sign the Plan's reimbursement agreement, do not timely reimburse the Plan following receipt of a third-party payment, or otherwise fail to cooperate, the Plan will stop advancing benefits related to the Injury or Illness, and any expenses previously advanced by the Plan will be considered an overpayment of Plan benefits. To recoup the overpayment, the Plan may reverse (i.e., deny) payment of such benefits, deny coverage of your other benefit claims or the claims of your covered family members (even if the claims do not relate to the Injury or Illness), and/or take legal action. You will be responsible for all reasonable attorney's fees and costs the Plan incurs due to your failure to cooperate with the Plan. In addition, the Plan may treat recoveries in excess of claims incurred as a special deductible and pay no future benefits related to the Illness or Injury until the special deductible is satisfied. The Plan's lien continues to apply to a third-party payment regardless of whether the funds have been disbursed or commingled with other funds. In addition, failure to reimburse the Plan or other violation of the Plan's subrogation and reimbursement rights may result in termination of Plan coverage for you and your family members.

More about subrogation and reimbursement

- After you have received a third-party payment, the Plan may pay no further expenses relating to the Illness or Injury, regardless of when the expenses are incurred. As a condition of advancing payment of any further expenses, the Plan may require that you continue to hold all or a portion of the total third-party payment in trust for the purpose of reimbursing the Plan.
- The Plan's subrogation and reimbursement rights (and your obligations related to the Plan's rights) also apply to: your covered spouse and other family members; your (or their) guardians or other representatives in the event of incapacity; your (or their) estates, personal representatives of estates, and beneficiaries or heirs in the event of death; and, if the covered spouse or family member is a minor, to the minor's parents, guardians, or other representatives. Any recovery they obtain that relates to or arises out of an Illness or Injury for which the Plan has paid health expenses (including, for example, a recovery for wrongful death) is a third-party payment that is subject to the Plan's reimbursement rights. In the event of a wrongful death or survival claim, no allocation of a third-party payment shall be valid if it does not fully reimburse the Plan for its lien, unless the Plan provides written consent to the allocation.
- If disbursements from a third-party payment are subject to approval by a probate or other court, you must take all reasonable action to obtain court approval of full reimbursement of the Plan's lien. The Plan's lien is not affected by any allocation or similar court order that is inconsistent with the Plan's reimbursement rights.
- If you file a petition for bankruptcy, you acknowledge that the Plan's lien existed prior to the creation of the bankruptcy estate.
- If requested by the Plan, you will instruct the third party to reimburse the Plan's lien via a check made payable and mailed directly to the Plan, or via a joint check made payable to you and the Plan, at the Plan's option.
- The Plan's subrogation and reimbursement rights apply even if you receive a third-party payment before the Plan has paid any expenses relating to the Injury or Illness. In that case, you are responsible to use the third-party payment to pay the expenses.
- Where the Plan advances benefits related to an Illness or Injury, it pays secondary to any other insurance coverage (for example, personal injury protection (PIP), medical payments, specific loss, or homeowner's insurance). Charges that are payable by such other coverage, or that would be payable in the absence of Plan coverage, are not covered by the Plan. The Plan will pay secondary even if benefits under such other coverage are paid directly to you instead of to your health care provider, or if you choose to use the benefits for a purpose other than payment of health expenses.

- The Plan is an employee welfare benefit plan governed by ERISA. The Plan's medical benefits are self-funded.
- The Claims Administrator's determination of whether a health expense is related to the Illness or Injury controls. For purposes of the Plan's subrogation and reimbursement rights, an "Illness" also includes a disability. A health expense will not be removed from the Plan's lien if you treated the expense as related to the Injury or Illness while pursuing a third-party payment, or if you released a third party from liability for the health expense (or related treatment) in connection with obtaining a third-party payment.
- The Plan may reject a reimbursement agreement that has been signed on your behalf pursuant to a power of attorney unless you are incapacitated, legally incompetent, or on military leave and the power of attorney is valid under applicable state law.
- The Plan may share information (including, but not limited, information relating to its lien, a third-party payment, or the Illness or Injury) with others for purposes of administering or enforcing its subrogation and reimbursement rights.
- The Plan's rights of subrogation and reimbursement are not affected in any way by claims that you must be made whole, or that a "common fund" or any other apportionment or equitable doctrine applies under any statute, regulation, or common law, or that the third-party payment was limited by a collateral source rule or any other law, or by your comparative fault or contributory negligence, pre-existing conditions, or other factors. The Plan disclaims all such doctrines and defenses. In addition, the Plan's rights are not dependent on a finding or admission of the third party's negligence or wrongdoing, or on whether you made a claim for health expenses against the third party.

The Plan Administrator has the sole and exclusive discretionary authority and control over interpretation of the terms of the Plan relating to subrogation and reimbursement and of the terms of reimbursement agreements. To the extent any such term is determined to be invalid or unenforceable for any reason, it shall be fully severable and shall not affect the other terms.

By accepting Plan benefits, you agree to these conditions and you agree not to raise any contrary claims in any action impacting the Plan's subrogation or reimbursement rights.

XII. Claim and Appeal Procedures

These claim and appeal procedures tell you how to file a claim for benefits under the Plan. A "**claim for benefits**" means a request for Plan benefits made in accordance with the procedures described below.

For purposes of these procedures, a **"disability claim"** means any claim that requires the Claims Administrator to make a determination regarding whether you are disabled (within the meaning of the particular Plan provision at issue). For example, a disability claim includes a determination of whether you qualify for Short-Term Disability benefits. A disability claim does not include a claim in which disability is based solely on an external standard, such as entitlement to Social Security Disability Benefits. For purposes of these procedures, a **"medical benefit claim"** means a claim for medical, prescription drug, vision, dental, or hearing aid benefits, other than a disability claim.

A dispute solely as to whether you have met the requirements for enrollment or eligibility under the Plan is subject to the Plan's claim and appeal procedures that apply to disability claims, to the extent applicable. However, if a medical benefit claim is denied due to failure to meet the Plan's eligibility or enrollment requirements, the claim remains subject to the Plan's internal claim and appeal procedures for medical benefit claims.

Note that deadlines to submit initial benefit claims, to appeal claim denials, or to request external review were temporarily extended in connection with the COVID-19 pandemic. For details, see the January 2017 Summary Plan Description and Summaries of Modifications thereto.

General Claims Information

If you have coverage under another health plan which is primary payer, submit your claim to the other plan first. Then file a claim with the Claims Administrator for the unpaid balance. To find out which plan is primary, see Section XI or call Blue Cross of Idaho.

All claims must be filed with the applicable Claims Administrator and all appeals of denied claims filed with the applicable Claims Fiduciary (identified in the table below). If you or your service provider or other agent submits a claim that is fraudulent or knowingly false, you and your Dependents will cease to be eligible for Plan benefits and will lose eligibility for benefits paid that relate to the false or fraudulent claim. In addition, your Plan coverage may be retroactively terminated if you (or a person seeking coverage on your behalf) perform an act, practice or omission that constitutes fraud or make an intentional misrepresentation of material fact. If your coverage is retroactively terminated, you are responsible for reimbursing the Plan for any overpaid benefits. In addition, the Plan reserves the right to take all legal and criminal action to recoup and prevent losses related to false and fraudulent claims.

You **must** complete and submit the Plan's enrollment form to the Administrative Office each calendar year before your claims will be processed. If you do not have a form to complete, please call the Administrative Office at 208-288-1610 or the form can be downloaded from the Trust website at iptt.org. You must also submit all information requested by the Administrative Office that is reasonably necessary to administer the Plan and pay benefits, such as social security numbers for you and your Dependents, proof of marriage, divorce, death, or birth, and evidence of employment. Claims will not be paid by the Plan if the enrollment form and information is not timely received by the Administrative Office.

Claims Administrators & Fiduciaries

The Claims Administrators outlined in the table below decide initial claims and the Claims Fiduciaries decide appeals of denied claims. The Claims Fiduciaries have the discretionary authority to administer, construe and interpret the terms and provisions of the Plan, SPD, and Trust Agreement in order to

determine benefits or eligibility under the Plan with respect to such appeals. If the Board of Trustees is the Claims Fiduciary, it may allocate its responsibility to review such appeals to a committee of Trustees.

Medical Benefit Claims	**Claims Administrator**	**Claims Fiduciary**
Medical, Dental & Hearing Aid Benefit	Initial claim: Blue Cross of Idaho Blue Cross of Idaho Claims Control Blue Cross of Idaho P.O. Box 7408 Boise, ID 83707 Phone: (208) 331-7347 or 800-627-1188 Website: bcidaho.com	1st level appeal: Blue Cross of Idaho (contact information at left) 2nd level appeal: Board of Trustees Board of Trustees, Idaho Pipe Trades Trust c/o Blue Cross of Idaho Claims Control Blue Cross of Idaho P.O. Box 7408 Boise, ID 83707 However, the Claims Fiduciary for 2nd level appeals of pre-certification and concurrent care claims is Blue Cross of Idaho (contact information at left).
Vision Benefit	Initial claim: Blue Cross of Idaho is the Claims Administrator for vision benefits. However, BCI contracts with Vision Service Providers for processing and deciding initial claims. Submit initial in-network claims to: Vision Service Providers P.O. Box 997105 Sacramento, CA 95899-7105 Phone: (800) 877-7195 Website: vsp.com Submit initial out-of-network claims to: Vision Service Providers Out-of-Network Claims P.O. Box 395018 Birmingham, AL 35238-5018	1st level appeal: Blue Cross of Idaho (contact information above left) 2nd level appeal: Board of Trustees Board of Trustees, Idaho Pipe Trades Trust c/o Blue Cross of Idaho Claims Control Blue Cross of Idaho P.O. Box 7408 Boise, ID 83707

Medical Benefit Claims	Claims Administrator	Claims Fiduciary
Prescription Drug Benefit	Initial claim: Express Scripts Express Scripts 1 Express Way St. Louis, MO 63121 Phone: 800-716-3751 Website: express-scripts.com	1st and 2nd level appeals: Express Scripts (contact information at left) Optional 3rd level appeal: Board of Trustees, Idaho Pipe Trades Trust, c/o Administrative Office: Idaho Pipe Trades Trust Claims Department PMB#116 5331 S Macadam Ave. Suite 258 Portland, OR 97329 Email: pdxflexclaims@benesys.com Fax: 503.208.9223 Trust Website member portal: iptt.org
Other Claims	**Claims Administrator**	**Claims Fiduciary**
Disability claims & Claims relating solely to eligibility or enrollment	Initial claim: Administrative Office: Idaho Pipe Trades Trust Claims Department PMB#116 5331 S Macadam Ave. Suite 258 Portland, OR 97329 Email: pdxflexclaims@benesys.com Fax: 503.208.9223 Trust Website member portal: iptt.org	Appeal: Board of Trustees: Board of Trustees, Idaho Pipe Trades Trust c/o the Administrative Office (contact information at left)

How to File a Claim for Benefits

Medical Benefit

You must submit a claim to Blue Cross of Idaho (BCI), the Claims Administrator for the *Medical Benefit*, to receive benefits for Covered Medical Expenses. There are two ways you can submit a claim:

1. Your Health Care Provider or Hospital can file the claim for you. Most providers will submit a claim on your behalf if you show them your BCI identification card and ask them to send BCI the claim.

Or

2. You can send BCI the claim by following the procedure below:

    - Ask your provider for an itemized billing. The itemized billing should show each service received and its treatment code and its diagnosis code, the date it was furnished, and the

charge for each service. BCI cannot accept billings that only say "Balance Due," "Payment Received" or some similar statement.

- Obtain a Member Claim Form and follow the instructions. You may obtain a Member Claim Form from network providers, by contacting BCI at the address or phone number above, or on BCI's website (bcidaho.com). Use a separate Member Claim Form for each patient involved.
- Attach the billing(s) to the Member Claim Form and send it to BCI at the address above.

You must submit your claim within 12 months of the date you incur the expense; claims made after this deadline will not be reimbursed. However, claims covered by Medicare must be submitted within 12 months after the date Medicare decides the claim. You must incur the expense when services are rendered or supplies and equipment are dispensed.

You should review each provider bill you receive. If you find an error, send a copy of the itemized provider bill with a written note about the error to Blue Cross of Idaho Customer Service, PO Box 7408, Boise, ID 83707. Any Participant detecting and reporting an overcharge receives half the amount saved by the Plan, up to a maximum of $500 per Participant.

If you are also eligible for Medicare benefits or covered by another medical plan, please contact Blue Cross of Idaho so primary payer status may be determined and benefits coordinated. See Section XI for more information. If this Plan is determined to be the primary payer, follow the steps outlined above.

If Medicare or the other medical plan is determined to be primary payer:

- Be sure the annual IPTT enrollment form is completed, then obtain itemized Hospital and doctor bills as described above.
- Hold these billings until you receive the other plan's Explanation of Benefits (EOB).
- Submit the itemized bills and EOB to Blue Cross of Idaho within 12 months of the date you incur the expense; claims made after this deadline will not be reimbursed.

Prescription Drug Benefit

See Section VI for additional information on filing a claim under the *Prescription Drug Benefit*. You must file your claim with the Pharmacy Benefit Manager within 12 months of the date you fill the prescription, or expenses will not be reimbursed. Claim forms are available on Express Scripts' website and can be submitted by mail or online. See https://www.express-scripts.com/prescription-reimbursement-claim-form.

Dental, Vision, and Hearing Aid Benefits

For dental benefits, ask your Dentist to submit your claims either electronically or on a standard American Dental Insurance Form or comparable form to Blue Cross of Idaho showing:

- Covered Participant's name, social security number and/or unique identifier (UID),
- Patient's name and relationship to the Covered Participant,
- Dates of service,
- ADA code and tooth numbers (if applicable), and
- Itemized charges.

If you have a dental claim for an out-of-network dentist, you will need to submit the claim yourself. You may obtain a Member Claim Form by contacting BCI at the address or phone number above, or on BCI's website (bcidaho.com).

For vision benefits, you or your provider must file a statement or billing with Vision Service Providers showing:

- Covered Participant's name, social security number and/or unique identifier (UID),
- Patient's name and relationship to the Covered Participant, and
- Itemized charges (for example, cost and type of lenses, frames, or exam).

For hearing aid benefits, you or your provider must file an itemized bill with Blue Cross of Idaho showing the Covered Participant's name, social security number and/or unique identifier (UID), patient's name and relationship to the Covered Participant, and itemized charges.

You must file your dental, vision, or hearing aid claim within 12 months of the date you incur the expenses, or expenses will not be reimbursed.

Disability Claim

In order to file a claim for the Short-Term Disability benefit, you must obtain a claim form by visiting the Trust website at iptt.org (available under the documents tab) or by contacting the Claims Administrator to request a paper form. You must complete and sign your portion of the claim form and your doctor must complete the physician portion of the form. Your claim must be submitted to the Claims Administrator within 12 months following the date you first became disabled.

A claim for coverage of an age 26 or older child as an Eligible Dependent on the basis of their disability must be submitted to the Claims Administrator, along with proof of their incapacity and dependency, within 31 days of the child's 26th birthday. See Section III for more information.

Eligibility Claim

A claim based solely on whether you have met the requirements for enrollment or eligibility under the Plan should be filed with the Claims Administrator shown in the table above.

If Your Claim Is Denied

A claim for benefits under the Plan arises only if you have filed a written request for a benefit determination with the applicable Claims Administrator. The following sets forth the Plan's timelines for deciding your claim, and your appeal rights if your claim for benefits is denied.

General Provisions For All Claim and Appeal Determinations

Initial denial decisions and appeal decisions on review will be provided in a culturally and linguistically appropriate manner in a non-English language upon request, but only if you live in a county where 10 percent or more of the population is literate only in the same non-English language as determined by applicable federal guidance. If the above percentage standard is met, the following three conditions will apply to claimants in such counties: Oral language services such as a telephone hotline in the applicable non-English language will be available to answer questions and assist in filing claims and appeals; the Plan will provide upon request a notice in the applicable non-English language; and the Plan will include in the English version of all notices a statement in the applicable non-English language clearly indicating how to access the language services.

The Plan ensures that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of persons involved in making decisions, such as medical or vocational experts or claims adjudicators, and no decisions regarding hiring, compensation, termination, promotion, or similar matters will be based upon the likelihood that the person will support a denial of benefits.

If the Plan fails to adhere to all the requirements of the claims review process, you may be deemed to have exhausted the internal claims and appeal process and may submit a request for external review if applicable. A deemed exhaustion, however, does not occur if violations of the claims review process are *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the violations were for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing good-faith exchange of information between you and the Plan. You may request a written explanation of the violation from the Plan, which must be provided within 10 days, including the bases for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. In case there is a deemed exhaustion, you may also be entitled to remedies under Section 502 of ERISA by filing a case in court. Unless otherwise specified herein, you are required to exhaust the internal claim and appeal process before filing a request for external review or filing a lawsuit.

Timing of Initial Benefit Determinations

Pre-certification of medical benefit claims before service or treatment

"Pre-certification" is a review program that *requires* you get prior approval for a service or procedure as a condition to receiving reimbursement. The Plan requires pre-certification for certain prescription drugs (see Section VI). The Plan also requires pre-certification for certain medical services or supplies (see Section V).

Note: You also may request a courtesy assessment of whether certain services—for example, Hospital admissions—are Medically Necessary before you obtain the services. You may choose to contact Blue Cross of Idaho to request a courtesy assessment of Medical Necessity. See Section V for more information. Because courtesy assessments are not required as a condition to receiving reimbursement, a request for a courtesy assessment is not a pre-certification claim.

Urgent pre-certification claims

If your pre-certification claim is determined by the Claims Administrator to be a claim involving urgent care (as defined below), notice of the Claim Administrator's decision will be provided to you as soon as possible taking into account medical exigencies, but no later than 72 hours after receipt of your claim by the Claims Administrator. For this purpose, the Claims Administrator shall defer to a determination of urgent care by the attending provider. If, however, you do not provide sufficient information to decide your claim, a notice requesting specific additional information will be provided to you within 24 hours of receipt of your claim. The Claims Administrator's decision regarding your claim will then be issued no later than 48 hours after the earlier of the Claims Administrator's receipt of the requested information or the expiration of the time period set by the Plan for you to provide the requested information (at least 48 hours). Benefit denials may be oral or in writing. If the denial is provided orally, written notice will also be provided within 3 days after the oral notice.

A claim involving "urgent care" is a claim for pre-certification where application of the normal time periods for deciding your claim could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot adequately be managed without the care or treatment being sought. If a Physician with knowledge of your medical condition determines that your claim meets this definition of urgent care, the claim will be treated by the Plan as involving urgent care.

Regular pre-certification claims

If your pre-certification claim is not an urgent care claim, written notice of the Claims Administrator's decision will generally be provided to you within a reasonable period of time, but no later than 15 days after receipt of your claim by the Claims Administrator. If matters beyond the control of the Claims Administrator so require, one 15-day extension of time for processing the claim beyond the initial 15 days may be taken. Written notice of the extension will be furnished to you before the end of the initial 15-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

If an extension is required because you have not provided the information necessary to decide your claim, the notice of extension will specifically describe the required information, and the time period for processing your claim will not run from the date of such notice until the earlier of the date the Claims Administrator receives your response to a request for additional information or the date set by the Plan for your requested response (at least 45 days).

Failure to follow pre-certification procedures

If your communication to the Claims Administrator concerning pre-certification does not comply with the Plan's procedures for filing pre-certification claims, notice of the proper procedures will be provided to you within five days of the communication. If, however, the communication involves urgent care, notice will be provided within 24 hours. Such corrective notice will be provided only if your communication specifically names the claimant, medical condition or symptoms, and the treatment, service or product being requested. Notice may be oral, unless you request written notice.

Medical benefit claims after service or treatment

Written notice of the Claim Administrator's decision will generally be provided to you within a reasonable period of time, but no later than 30 days after receipt of your claim by the Claims Administrator. If matters beyond the control of the Claims Administrator so require, one 15-day extension of time for processing the claim beyond the initial 30 days may be taken. A written notice of the extension will be furnished to you before the end of the initial 30-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

If an extension is required because you have not provided the information necessary to decide your claim, the notice of extension will specifically describe the required information, and the time period for processing your claim will not run from the date of such notice until the earlier of the date the Plan receives your response to a request for additional information or the date set by the Plan for your requested response (at least 45 days).

Concurrent care decisions for medical benefit claims

Reduction or termination of ongoing course of treatment

If the Plan has previously approved an ongoing course of treatment to be provided over a period of time or a number of treatments, notice of any later decision to reduce or terminate the ongoing course of treatment (other than by Plan amendment or termination) shall be treated as an adverse benefit determination that you can appeal. Such notice will be provided to you sufficiently in advance of the reduction or termination to allow you to appeal and receive a determination on appeal before the treatment is reduced or terminated, so that generally your benefits for an ongoing course of treatment would continue pending an appeal.

Extension of ongoing course of treatment involving urgent care

If your request that the Plan extend an ongoing course of treatment beyond the previously approved period of time or number of treatments involves urgent care, you will be notified of the decision by the

Claims Administrator within 24 hours after its receipt of the request, provided the request is received at least 24 hours prior to the expiration of the pre-approved period of time or number of treatments.

Disability or eligibility claims

If your claim is a disability or eligibility claim, a written denial notice will be provided to you within a reasonable period of time, but not later than 45 days after receipt of your claim by the Claims Administrator. If matters beyond the control of the Claims Administrator require an extension of the time for processing your disability or eligibility claim, the initial period may be extended for up to 30 days. Written notice of an extension will be sent before the end of the initial 45-day period. In addition, another 30-day extension of time for processing your claim due to matters beyond the control of the Claims Administrator may be taken. Written notice of such second extension will be sent before the end of the first 30-day extension period. The extensions shall not exceed a period of 60 days from the end of the initial 45-day period.

An extension notice will explain the reasons for the extension, the expected date of a decision, the standards for a benefit entitlement, any unresolved issues that prevent a decision on your claim, and any additional information needed to resolve those issues. If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of the date the Plan receives your response to a request for additional information or the date set by the Plan for your requested response (at least 45 days).

Contents of Written Notice of Benefit Denial

If your claim is denied, in whole or in part, you will be notified in writing by the Claims Administrator. The written notice will include the following:

- The specific reason or reasons for the denial;
- References to the specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary in order for you to perfect the claim, and an explanation of why such material or information is needed;
- An explanation of the Plan's review procedure for denied claims, including information regarding how to initiate a claim for review and the applicable time limits for submitting your claim for review (claims involving urgent care will have a description of expedited appeal procedures);
- A statement of your right to bring a civil action under Section 502(a) of ERISA if your claim is denied on appeal;
- A statement that you are entitled to receive, upon request, free access to and copies of all Relevant Documents;
- If the decision was based on a Medical Necessity or Experimental treatment or other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request.

For medical benefit claims, the notice will also include the following:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings;

- The specific reason or reasons for the denial will include, to the extent applicable, the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used in denying the claim;
- Any internal rule, guideline, protocol, standard, or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such was relied upon and a copy will be provided free of charge upon request; and
- The availability of, and contact information for, any applicable office of health insurance consumer ombudsman established under the Public Health Services Act section 2793 to assist individuals with the internal and external claims and appeals process.

For disability claims, the notice will also include the following:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following the views presented by you to the Plan of health care professionals that treated you and vocational professionals that evaluated you, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the decision, without regard to whether the advice was relied upon in making the decision, and a disability determination made by the Social Security Administration about yourself; and
- Any internal rule, guideline, protocol, standard, or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such internal rule, guideline, protocol, standard, or other similar criterion does not exist.

Appeal Procedures for All Claims

A denial of a claim includes a denial in whole or in part, and for purposes of appeal rights, includes a rescission of coverage whether or not the rescission has an adverse impact on any particular benefit at that time. If you wish to appeal an initial denial of a claim, you or your authorized representative must file a written appeal with the appropriate Claims Fiduciary (see the above table) within 180 days after receipt of written notice of the denial, unless your claim concerns the reduction or termination of a previously approved ongoing course of treatment. In that case, you must file a written appeal within a shorter time period that permits the Claims Fiduciary to issue an appeal decision before the treatment is reduced or terminated. You or your authorized representative may submit a written statement, documents, records, and other information. You may also have reasonable access to and copies of Relevant Documents free of charge upon request. The review will consider all statements, documents, and other information submitted by you or your authorized representative, whether or not such information was submitted or considered under the initial denial decision. Claim determinations are made in accordance with Plan documents and, where appropriate, Plan provisions are applied consistently to similarly situated claimants. In addition, the following apply:

- The appeal decision will not defer to the initial decision denying your claim and will not be made by the person who made the initial decision, nor a subordinate of such person;
- If the initial denial decision was based in whole or in part on a medical judgment, the Claims Fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Any health care professional engaged for such consultation will not be a person consulted in the initial decision, nor a subordinate of any such person;
- Any medical or vocational expert whose advice was obtained in connection with the decision to deny your claim will be identified upon request, whether or not the advice was relied upon;

- If your claim involves urgent care, your request for an appeal may be submitted orally or in writing, and all necessary information, including the appeal decision, is to be transmitted between the Plan and you by telephone, facsimile, or other similarly expeditious method;
- You will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by the Claims Fiduciary or at the direction of the Claims Fiduciary in connection with the claim, and such information will be provided as soon as possible and sufficiently in advance of the date the internal appeal decision is required to be issued to provide a reasonable opportunity for you to respond prior to that date; and
- If an internal appeal decision is based on a new or additional rationale, you will be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the internal appeal decision is required to be issued to provide a reasonable opportunity for you to respond prior to that date.

Bringing an appeal within applicable timelines is a prerequisite to filing a lawsuit in court regarding your claim.

Timing of Appeal Decisions

Disability or eligibility claims

A decision on your appeal will be made no later than 45 days after your appeal is received, unless there are special circumstances that require an extension of time for processing your appeal, in which case a decision will be made not later than 90 days after your appeal is received. Written notice of any extension of time will be sent before the end of the initial 45-day period explaining the reason for the extension and the expected date of an appeal decision.

If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Medical benefit claims

If your claim is a pre-certification claim that involves urgent care, the Claims Fiduciary will notify you of its decision on your appeal as soon as possible, but no later than 72 hours after the appeal is received.

For all other medical benefit claims, there is a two-level appeal process (with an optional third level for claims under the *Prescription Drug Benefit*). The Claims Administrator will notify you of the first-level decision on your appeal for denial of:

- *Pre-certification claims for non-urgent care,* no later than 15 days after the appeal is received.
- *Denial of other claims,* no later than 30 days after the appeal is received.

If your first-level appeal is denied, you will then have 60 days after receiving notice of the denial to appeal the denial to the second-level appeal stage. A second-level appeal decision will be issued to you within the same time period set out above for the timing of first-level appeal decisions (that is, within 15 days for pre-certification claims for non-urgent care, and 30 days for other claims). The appeal decision will not defer to the prior decisions denying your claim and will be made by a person(s) who is not a person who made the prior decisions, nor a subordinate of such person.

If you do not appeal the denial of your first-level appeal to the second-level appeal stage, you have not completed the administrative appeal process and you will not be allowed to request an optional third-level appeal (for *Prescription Drug Benefit* claims) or an external review. Nor will you be able to bring a lawsuit in court regarding your claim.

Optional third-level appeal for Prescription Drug Benefit claims

If your appeal is denied at your first-level and second-level appeal reviews, you may request a third-level appeal. You must request a third-level appeal with the Claims Fiduciary (the Board of Trustees) within 60 days after notice of the second-level appeal decision. A decision on your appeal will be made no later than 60 days after your appeal is received, unless there are special circumstances that require an extension of time for processing your appeal, in which case a decision will be made not later than 120 days after your appeal is received. Written notice of any extension of time will be sent before the end of the initial 60-day period explaining the reason for the extension and the expected date of an appeal decision.

The third-level appeal process is optional, and you are not required to undertake it before pursuing legal action. If you request a third-level appeal, any applicable statute of limitations or other timelines will be tolled while the appeal is pending. The Board of Trustees will be impartial. Whether or not you seek a third-level appeal will have no effect on your rights to any other benefits under the Plan or information about applicable rules. If you choose not to request a third-level appeal, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice. You will not be charged a fee for the third-level appeal.

Contents of Written Notice of Appeal Decision

If your claim is denied on appeal, the appeal decision will be in writing and will include the following information:

- The specific reason or reasons for the decision;
- Reference to the specific Plan provisions on which the decision is based;
- A statement of your right to receive, upon request free of charge, reasonable access to and copies of all Relevant Documents;
- A statement of any optional appeal procedures available under the Plan and your right to information about such procedures, and a statement of your right to bring a civil action under Section 502(a) of ERISA, including a statement of the Plan's limitations period that applies and the calendar date on which the limitations period expires for the claim; and
- If the decision on review was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request.
- For medical benefit claims, the notice will also include the following:
- Any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits on review, or a statement that such was relied upon and that a copy will be provided free of charge upon request;
- Information sufficient to identify the claim involved, including the date of service, the Health Care Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings;
- The specific reason or reasons for the decision will include, to the extent applicable, the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used in denying the claim that includes a discussion of the decision;
- An explanation of the Plan's available external review process for denied claims, including information regarding how to initiate the external review and the applicable time limits;

- The availability of, and contact information for, any applicable office of health insurance consumer ombudsman established under the Public Health Services Act section 2793 to assist individuals with the internal and external claims and appeals process; and
- 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."

For disability claims, the notice will also include the following:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following the views presented by you to the Plan of health care professionals that treated you and vocational professionals that evaluated you, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the decision, without regard to whether the advice was relied upon in making the decision, and a disability determination made by the Social Security Administration about yourself; and
- Any internal rule, guideline, protocol, standard, or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such internal rule, guideline, protocol, standard, or other similar criterion does not exist.

Standard External Review Process

If your medical benefit claim is denied and you have exhausted the Plan's internal appeal process or are not required to exhaust that process, you may submit a request for external review of the denial but only if the denial involves (a) medical judgment (including but not limited to requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; a determination that treatment is Experimental or Investigational; or a determination of whether the Plan complies with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) under ERISA § 712 and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer; (b) consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in ERISA §§ 716 and 717 and U.S. Department of Labor regulations §§ 2590.716-4 through 2590.716-5 and 2590.717-1 (including whether pre-authorization was improperly required for Emergency Services, and whether Emergency Services by an out-of-network provider, treatment at an in-network hospital or ambulatory surgical center by an out-of-network provider, or out-of-network air ambulance services should have been covered by the Plan at its in-network rate and your cost sharing applied to your deductible and your In-Network Maximum for medical and pediatric dental expenses); or (c) a rescission of coverage, regardless whether the rescission has any effect on a benefit at that time. A denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that you fail to meet the requirements for eligibility under the terms of the Plan is not eligible for external review.

The request must be submitted to the applicable Claims Administrator within four months after the date of receipt of the denial decision. If there is no corresponding date four months after the date of receipt of the denial decision, the request must be filed by the first day of the fifth month following the receipt of the denial decision. If the last filing date falls on a weekend or federal holiday, the filing date is extended to the next week day that is not a weekend or federal holiday.

Within five business days following the date of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether:

- the claim was covered under the Plan at the time the health care item or service was requested or, in the case of retrospective review, was covered under the Plan at the time the health care item or service was provided;
- the denial decision does not relate to the claimant's failure to meet eligibility requirements under the terms of the Plan;
- you have exhausted the Plan's internal appeal process unless you are not required to exhaust the internal appeals process under applicable final regulations; and
- you have provided all the information and forms required to process an external review.

Within one business day after completing the preliminary review, the Claims Administrator shall issue a written notice to you as to whether your claim is eligible for external review. If your request is complete but not eligible, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)) at the Department of Labor. If the request is not complete, the notice will describe the information or materials needed to make the request complete. You will be allowed to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notice, whichever is later.

If your request for external review is complete and eligible, it will be assigned to an independent review organization ("IRO") that has been accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Claims Administrator has contracted with IROs for assignments under the Plan and uses unbiased methods for selecting the IRO for your claim.

The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan. It will provide you a written notice of your request's eligibility and acceptance for external review which will include a statement that you may submit within ten business days after receipt of the notice additional information that the IRO must consider when conducting its review. The IRO is not required to, but may consider, information submitted after ten business days. Within five business days after assignment of the IRO, the Plan shall provide the IRO the documents and information considered in making the denial decision. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the denial decision. The IRO shall notify you and the Claims Administrator of its decision within one business day after it is made. The IRO shall forward information submitted by you to the Claims Administrator within one business day. Upon receipt of the information, the Claims Administrator may reconsider its denial decision and if it decides to reverse its decision, notify you and the IRO within one business day after making such a decision. The IRO shall terminate its external review upon receipt of such notice.

The IRO will review your claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claim and appeal process. In addition to the documents and information provided, the IRO to the extent such information is available and the IRO considers them appropriate, will consider the following in its decision:

- your medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and documents submitted by the Plan, you and your treating provider;
- the terms of the Plan;
- appropriate practice guidelines, which must include applicable evidence-based standards and may include other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;

- applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with terms of the Plan or applicable law; and
- the opinion of the IRO's clinical reviewer after considering documents and information to the extent they are available and the clinical reviewer considers them appropriate.

The IRO shall provide written notice of the final external review decision to you and the Claims Administrator within 45 days after the IRO receives the request for external review. The IRO's decision shall include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim (including the dates of service, health care provider, claim amount if applicable, the diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial);
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act Section 2793.

After a final external review decision, the IRO shall maintain records of the claim and notices for six years. Such records are available for examination by you, the Plan or applicable governmental oversight agencies upon request, except where such disclosure would violate applicable privacy laws.

Upon receipt of a final external review decision reversing a denial decision, the Plan shall immediately provide coverage or payment for the claim.

Expedited External Review Process

If your medical benefit claim is eligible for the external review process, you may request an expedited external review if:

- an initial determination involves a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- a final internal decision on review involves a medical condition where the timelines for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the appeal decision concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Claims Administrator shall determine whether the request meets the reviewability standards set for preliminary reviews under the Standard External Review Process discussed above. The Claims Administrator shall immediately send

you a notice that complies with the requirements for standard external reviews as to whether your request for an expedited external review is eligible.

If your request for an expedited external review is complete and eligible, it will be assigned to an IRO. The Claims Administrator shall provide all necessary documents and information considered in making its denial decision to the IRO electronically or by telephone or facsimile or other available expeditious method. The IRO, to the extent information or documents are available and the IRO considers them appropriate, shall consider the documents and information described above for standard external reviews. The IRO shall review the claim de novo and is not bound by any decision or conclusions reached during the Plan's internal claims and appeals process.

The IRO shall provide a notice of its final expedited external review decision in accordance with the requirements for standard external review decisions as expeditiously as your medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours of the notice, the IRO shall provide written confirmation of the decision to you and the Claims Administrator.

Relevant Documents

For purposes of these claim and appeal procedures, "Relevant Document" means any document, record or other information that:

- Was relied upon in making a decision to deny benefits.
- Was submitted, considered, or generated in the course of making the decision to deny benefits, whether or not it was relied upon in making the decision to deny benefits.
- Demonstrates compliance with any administrative processes and safeguards designed to confirm that the benefit determination was in accord with the Plan and that Plan provisions, where appropriate, have been applied consistently regarding similarly situated individuals.
- Constitutes a statement of policy or guidance with respect to the Plan concerning a denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the decision to deny benefits.
- Limitations Period for Lawsuits

You must exhaust the Plan's internal claims and appeal process before filing a request for external review or filing a lawsuit. In order to bring a lawsuit in court regarding your claim, you must file suit within two years after your appeal is denied or, if earlier, the date your cause of action first accrued. If a different limitations period is specified in a contract for an insured benefit, then that limitations period applies to that benefit.

If You Have Questions

If you have any questions regarding the claim procedures for medical benefit claims, please contact the applicable Claims Administrator. However, any questions about the second-level appeal for medical benefit claims, about the claim and appeal procedures for disability claims, or about Plan enrollment or eligibility, should be directed to the Administrative Office.

XIII. HIPAA Privacy and Security

This section is intended to meet the requirements of 45 C.F.R. § 164.504(f) and other applicable provisions of the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and will be construed and administered in accordance with applicable laws and regulations. The Trustees shall have access to PHI and Electronic PHI from the Plan only as permitted under this section or as otherwise required or permitted by HIPAA.

Definitions

For purposes of this section, the following definitions apply:

- *Protected Health Information.* The term "Protected Health Information" ("PHI") has the same meaning as in 45 CFR § 164.501.
- *Electronic PHI.* The term "Electronic PHI" has the same meaning as in 45 C.F.R. § 160.103, and generally refers to PHI that is transmitted or maintained in an electronic media.
- *Summary Health Information.* The term "Summary Health Information" has the same meaning as in 45 C.F.R. § 164.504.

Permitted Disclosure of Enrollment Information and Summary Health Information

The Plan may disclose to the Trustees information on whether an individual is participating in the Plan, is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan, or other enrollment information.

The Plan may disclose Summary Health Information to the Trustees, provided that the Trustees request the Summary Health Information for the purpose of (1) obtaining premium bids from health insurers for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

Request, Use and Disclosure of PHI by Trustees

Subject to the Trustee Certification requirement described below, the Plan may provide to the Trustees, and the Trustees are permitted to receive, use, and disclose PHI and Electronic PHI from the Plan, to the extent necessary to perform plan administration functions (as defined in 45 C.F.R. § 164.504(a)) on behalf of the Plan, such as quality assurance, claims appeals, auditing and monitoring.

Trustee Certification

The Plan shall disclose PHI to the Trustees only upon the receipt of a certification by the Trustees that the Plan has been amended to incorporate, and that the Trustees agree to the conditions of disclosure set forth in, the provisions of 45 C.F.R. § 164.504(f)(2)(ii). To that end, the Trustees agree with respect to any PHI received from the Plan (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 C.F.R. § 164.508, which are not subject to these restrictions) that:

- The Trustees will not use or disclose any PHI received from the Plan, except as permitted in this amendment or required by law;
- The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Plan, agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees;
- The Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Trustees;
- The Trustees will report to the Plan any known impermissible or improper use or disclosure of PHI of which they become aware;

- The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purpose of determining the Plan's compliance with HIPAA;
- When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible;
- The Trustees will make PHI available to the Plan to permit participants to inspect and copy their PHI contained in a designated record set, in accordance with 45 C.F.R. § 164.524;
- The Trustees will make a participant's PHI available to the participant to amend or correct PHI contained in a designated record set that is inaccurate or incomplete, and the Trustees will incorporate any such amendments, in accordance with 45 C.F.R. § 164.526;
- The Trustees will make a participant's PHI available to permit the Plan to provide an accounting of disclosures, in accordance with 45 C.F.R. § 164.528; and
- The Trustees shall ensure that the adequate separation between the Plan and the Trustees (i.e., the firewall) required by 45 C.F.R. § 164.504(f)(2)(iii) is established.
- The Trustees further agree that if they create, receive, maintain, or transmit any Electronic PHI on behalf of the Plan (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 C.F.R. § 164.508, which is not subject to these restrictions) that:
- The Trustees shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that they create, receive, maintain, or transmit on behalf of the Plan;
- The Trustees shall ensure that the adequate separation between the Plan and the Trustees (i.e., the firewall) required by 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- The Trustees shall ensure that any agent, including a subcontractor, to whom they provide Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- The Trustees shall report to the Plan any security incident (as defined in 45 C.F.R. § 164.304) of which they become aware, as required by HIPAA.

Minimum Necessary Request

The Trustees will make reasonable efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

Adequate Separation

Individuals employed at the Administrative Office may assist the Trustees in carrying out plan administration functions. Any such employees will only have access to and use of PHI to the extent necessary to perform such functions. The Trustees shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain or transmit Electronic PHI on behalf of the Plan.

Effective Mechanism for Resolving Issues of Noncompliance

The Trustees certify that any individual or entity who suspects an improper use or disclosure of PHI may report that occurrence to any Trustee or to the Plan's HIPAA Privacy Official. An Administrative Office employee who has improperly used or disclosed PHI is subject to the Administrative Office's internal policies and procedures. A Trustee who has improperly used or disclosed PHI may be barred from receiving further PHI, barred from Trust conferences, and/or reported to the entity which appointed him.

XIV. Definitions

When used in this Plan, certain terms have specific meanings. These terms are defined below:

Administrative Office: The Trust administrative office (BeneSys, Inc.) located at 5331 S Macadam Avenue, Suite 258, Portland, Oregon 97329.

Bargaining Unit: A group of Employees working for an Employer and represented by the Union.

Claims Administrator: The Claims Administrators for the Plan's benefits are listed in Section XII.

Claims Fiduciary: The Claims Fiduciaries for the Plan's benefits are listed in Section XII.

Collective Bargaining Agreement or Collectively Bargained: An arms-length contract between an employer and Idaho Plumbers and Pipefitters Local Union No. 296 or 648 that provides the employer will contribute to the Trust for a Bargaining Unit, and that is accepted by the Trustees in writing.

Contribution: The amount an Employer is required by Collective Bargaining Agreement or Special Agreement to contribute to the Trust.

Covered Dental Expenses: Maximum Allowance charges incurred for Medically Necessary dental services and supplies that the Plan reimburses.

Covered Dependent: An Eligible Dependent (see page 8) whose Dependent coverage has begun and not been lost.

Covered Hours: The hours you work for which your Employer must contribute (and has contributed) to the Trust Fund, under a Collective Bargaining Agreement or Special Agreement that is accepted by the Trustees.

Covered Medical Expenses: Maximum Allowance charges incurred for Preventive Care and Medically Necessary medical services and supplies that the Plan reimburses.

Covered Participant or Participant: A person who is currently eligible for and has performed all tasks (including completed all required forms and paid all amounts) required to obtain Plan coverage as a result of his or her own past or current employment as follows:

- **Active Participant:** An Employee who is currently entitled to participate in the Plan due to their hour bank account balance (see page 6). Benefits for Collectively Bargained Active Participants include medical, prescription drug, dental, vision (including safety glasses), short-term disability, and hearing aid benefits. Plan benefits are the same for active Special Agreement Participants (those covered by virtue of an approved Special Agreement) except that safety glasses are not included. When Active Participants become Self-Pay Participants, they are not eligible for short-term disability benefits and Lifetime Self-Pay Participants are not eligible for safety glasses. Covered Dependents (of all Active Participants) are eligible for the same benefits as Active Participants except for safety glasses and short-term disability benefits.
- **Retiree or Retired Participant:** A Participant who is receiving a pension benefit or permanent disability benefit under the Idaho Plumbers and Pipefitters Pension Plan. When Retiree Participants become Self-Pay Participants covered through COBRA or Lifetime Self-Pay (see Section IV), they receive the same benefits except that short-term disability benefits are not available, Lifetime Self-Pay Participants are not eligible for safety glasses, and Lifetime Self-Pay Participants covered by Medicare have a greater Skilled Nursing Facility and home health care benefit (see Section V).

Retiree Participants still working and covered through their hour bank account balance (see page 6) receive the same benefits as Active Participants.

- Covered Dependents of all Retiree Participants are eligible for the same benefits as Covered Dependents of Active Participants, except that Dependents covered by Lifetime Self-Pay and Medicare have a greater Skilled Nursing Facility and home health care benefit (see Section V).
- **Self-Pay Participant:** A Participant by virtue of COBRA or Lifetime Self-Pay (see Section IV).

Covered Spouse: A Spouse whose coverage has begun and not been lost.

Custodial Care: Care that is designed primarily to assist you in activities of daily living. This includes institutional care that primarily supports self-care and provides room and board. Types of Custodial Care include, but are not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparation of special diets, and the supervision of medications that are ordinarily self-administered.

Dentist: A duly licensed person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD). Licensed Denturists are also included in this definition. The Plan covers Dentist services only when the Dentist is acting within the lawful scope of his or her license.

Dependent/Eligible Dependent: A person eligible for coverage as the Participant's Spouse or child. See page 8.

Emergency: An unforeseen Injury or Illness that requires immediate medical attention to avoid serious risk to health.

Emergency Services: Emergency services as defined in ERISA Section 716 and regulations issued thereunder.

Employee: An employee on behalf of whom an Employer is required to contribute to the Trust pursuant to Collective Bargaining Agreement or Special Agreement.

Employer/Contributing Employer: A business entity that is required by a Collective Bargaining Agreement or Special Agreement to make payments into the Trust. The Board of Trustees must accept a Collective Bargaining Agreement or Special Agreement before the Plan may cover an Employer's Employees.

Explanation of Benefits (EOB): A printed statement addressed to the Participant and provider itemizing services performed and benefit payment information related to those services.

Generic Drug: Prescription drugs approved by the FDA to be considered as Generic and that contain the same active ingredients as the equivalent brand name drug.

Health Care Provider: A Physician, Dentist or Nurse; or any of the following: 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 marriage and family therapist (LMFT), licensed occupational therapist, licensed physical therapist, lithotripsy provider, Hospital, diagnostic imaging provider, durable medical equipment supplier, freestanding diabetes facility, freestanding dialysis facility, home health agency, independent laboratory, licensed general hospital, optometrist/optician, physician assistant, podiatrist, prosthetic and orthotic supplier, radiation therapy center, registered dietitian, Skilled Nursing

Facility. The Plan covers services by the before mentioned only when the Health Care Provider is duly certified or licensed, and acts within the lawful scope of his or her license.

Providers whose services are not covered under the Plan include, but are not limited to, massage therapists, hypnotists, acupuncturists, doctors of naturopathy and/or homeopathy, Christian Science or other religion-based practitioners, any therapist not listed in the above paragraph and any practitioner for whom the state in which the individual practices does not require a medical-related license.

Health Care Reform: "Health Care Reform" means the Patient Protection and Affordable Care Act of 2010, as amended, and applicable agency regulations.

Home Health Care Agency: A public or private agency or organization that administers and provides home health care and is certified by Medicare or an appropriate state agency.

Hospice Agency: A public or private agency or organization that administers and provides hospice care and is certified by Medicare or an appropriate state agency.

Hospital: A place that is licensed by the state in which it is located and operates as a general, acute care Hospital; that is primarily engaged in providing care and treatment of injured and sick persons by (or under the supervision of) physicians; that has functioning departments of medicine and surgery; and that provides 24-hour nursing services by (or under the supervision of) licensed R.N.s.

The term "Hospital" does not include: Skilled Nursing Facilities; nursing homes; Custodial Care homes; health resorts, spas, or sanitoriums; Residential Treatment Facilities; transitional living centers; or places for rest, for the treatment or rehabilitative care of mental or nervous conditions or of alcoholism, substance use disorder, or addiction, or for hospice care.

Illness: A disease or infection and all related symptoms or conditions.

Initial Eligibility: The Participant must accumulate 300 Covered Hours within no more than five consecutive months. This is required for new participants or those who have been unable to build up 140 Covered Hours within five consecutive months after losing coverage.

Injury: Condition resulting from an external violent force and all related symptoms and conditions resulting from the same force, independent of sickness and all other causes.

Investigational or Experimental: Any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes such as length of life, quality of life, and functional ability. A technology is considered investigational or experimental if 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 the Claims Administrator is evaluating.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of current published medical literature and investigations published in peer-reviewed journals. The quality of the studies and consistency of results will be considered. The evidence should demonstrate that the technology can measure or alter physiological

changes related to a disease, Injury, Illness, or condition. In addition, there should be evidence that such measurement or alteration affects health outcomes.

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

All phases of clinical trials shall be considered Experimental (except that expenses for otherwise Covered Medical Expenses that are incurred while participating in a clinical trial will be covered to the extent legally required).

In determining whether a technology is investigational or experimental, the Claims Administrator considers 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 (BCI) also considers the following source documents: Blue Cross BlueShield Association 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.

Legal Separation: A decree of Legal Separation in lieu of divorce.

Malocclusion: Abnormality in the positioning and relationship of teeth.

Maximum Allowance: The Maximum Allowance is the highest amount allowed by BCI for a service or supply covered by the Plan. The Maximum Allowance for an in-network service or supply is the applicable rate established under the agreement between the provider and BCI (or BCI's affiliate). The Maximum Allowance for an out-of-network service or supply is determined as follows:

- For medical providers in Idaho, the Maximum Allowance is the lowest of the applicable rates under BCI's variable fee schedules for that provider type and service or supply.*
- For medical providers in other states, Maximum Allowance is established by the applicable BCI affiliate using a variety of factors, 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; qualifying payment amount; amount determined under an Independent Dispute Resolution (IDR) in accordance with surprise medical billing requirements under the federal No Surprises Act; Medicare reimbursement amounts; and/or the cost of rendering the service.
- For dental services, the Maximum Allowance is the lowest of BCI's regional contracted rates for that service or supply.*

*Maximum Allowance may be higher if the provider qualifies for an enhanced fee schedule due to any willing provider laws.

BCI (or its affiliate) may also separately negotiate with a provider to determine the Maximum Allowance for a service or supply.

In addition, as part of its claims administration, BCI may, from time to time, enter into financial settlements and actuarially determined settlements for claims with Health Care Providers for, among other reasons, routine claims adjustments, delayed rate adjustments, or cost rate adjustments. The outcome of these settlements could result in an additional charge or credit being issued to the Plan. Any such charge or credit will not be applied to a Participant's or Covered Dependent's cost sharing or a past medical claim.

Medically Necessary or Medical Necessity: A supply or service is Medically Necessary or meets Medical Necessity if it meets all of the following:

- Must be ordered by a Physician. However, the fact that a Physician has performed, prescribed, ordered, recommended, or approved a service does not, in itself, establish Medical Necessity for purposes of the benefit provisions of this Plan.
- Must be provided in the most appropriate setting and must be provided at the most appropriate level of service and care for the patient's medical condition.
- Must not be Experimental or Investigational or provided for medical or other research.
- Must be required to diagnose or treat the patient's Illness or Injury.
- Must be consistent with the symptoms or diagnosis and treatment.
- Must be appropriate under the standards of good medical practice.
- Must be in accordance with accepted medical practices and standards and appropriate in the amount, duration, and frequency for the symptoms, diagnosis, or treatment of a non-occupational injury or illness.
- Must be consistent with Blue Cross of Idaho's Medical Policies (relevant for claims under the Medical Benefit).
- Must not be possible to safely provide the service or supply on an outpatient basis (relevant when determining Medical Necessity of inpatient treatment).

Mental Illness: Those disorders listed in the most current version of the International Classification of Diseases as mental, behavioral and neurodevelopmental disorders, except those listed under *Medical Benefit* exclusions (beginning on page 31). No other disorders or conditions are included in the term "Mental Illness" for purposes of the benefit provisions of this Plan.

Non-Preferred Brand-Name Drug: Drugs that are not Generic and are not included on the Preferred Drug List maintained by the Pharmacy and Therapeutics Committee of the PBM.

Nurse: A Registered Nurse (RN), Nurse Practitioner (NP), Licensed Practical Nurse (LPN), or Certified Nurse's Assistant (CNA) acting within the lawful scope of his or her license.

Oral Surgery: Tooth extractions and similar operations, including pre-operative and post-operative care.

PBM: Pharmacy Benefit Manager.

Palliative Care: Care primarily for the relief or control of symptoms, not the cure.

Pension Plan: The Idaho Plumbers and Pipefitters Pension Plan.

Periodontal: Treatment of tissues supporting the teeth.

Physician: A Doctor of Medicine (MD), Doctor of Medical Dentistry (DMD), Doctor of Osteopathy (DO), Doctor of Chiropractic (DC), or a Doctor of Psychology (PsyD) acting within the lawful scope of his or her license.

Plan: Idaho Pipe Trades Health and Welfare Plan.

Preferred Brand-Name Drug: Brand-name drugs included on the Preferred Drug List maintained by the Pharmacy and Therapeutics Committee of the PBM.

Preventive Care: Those services, drugs, and supplies designated as "preventive care" in published guidelines under Health Care Reform, and which the Plan is required by law to provide. For more information, see Section V and Section VI.

Residential Treatment Facility (or Program): A licensed facility provider acting under the scope of its license primarily engaged in providing 24-hour level of care that provides individuals with long-term or severe mental disorders or substance use disorders with residential care. Care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs.

Skilled Nursing Facility: A facility primarily providing convalescent care for patients transferred from a Hospital and which has approval of the Joint Commission on Accreditation of Healthcare Organizations.

Special Agreement: A written agreement between a Contributing Employer and the Trustees obligating the Employer to contribute to the Trust Fund for the purpose of providing Plan benefits to non-Bargaining Unit Employees, and that is accepted by the Trustees in writing. Contributions for Special Agreement Participants will not be accepted by the Plan Administrative Office if the Employer is delinquent in contributing for Collectively Bargained Employees. More information is available from the Plan Administrative Office in the "Rules and Procedures for Admitting Non-Bargaining Unit Employees."

Spouse: The person to whom a Participant is legally married and who is recognized as a spouse under the Tax Code. For purposes of the Plan, a "Spouse" does not include a spouse by a common law marriage, other than a spouse of a Retired Participant by reason of a common law marriage existing before January 1, 1996, and continuously thereafter. See the *Dependents* section in Section III for Spouses who are eligible for coverage.

Substance Use Disorder: Those disorders listed in the International Classification of Diseases as mental and behavioral disorders due to psychoactive substance use (including alcohol or other drugs and the nondependent use of drugs). No other disorders or conditions are included in the term "Substance Use Disorder" for purposes of the benefit provisions of this Plan.

Substance Use Disorder Treatment Facility: A facility, including a residential treatment center, that provides treatment for chronic alcoholism or other Substance Use Disorder and is operated under the direction and control of the appropriate licensing or regulatory agency in the jurisdiction where it is located.

Trust, Trust Fund or Idaho Pipe Trades Trust: The Idaho Pipe Trades Health and Welfare Trust.

Trust Agreement: The Idaho Pipe Trades Health and Welfare Fund Trust Agreement.

Trustees: Those persons designated as Trustees pursuant to the terms of the Trust Agreement, and their successors.

UID: Unique identification number assigned to participants by the Administrative Office and Blue Cross of Idaho.

Union: Idaho State Pipe Trades Association Local Union 296 or 648.

XV. Important Information

Administration of the Plan

Governing Law

This Plan is construed in accordance with ERISA and other applicable federal law, and to the extent not otherwise preempted, the laws of the State of Idaho. The Plan provides benefits as required by law, notwithstanding anything in this document to the contrary.

Severability

If any provision of this Plan is held illegal or invalid for any reason, such determination shall not affect the remaining provisions of the Plan, which shall be construed as if such illegal or invalid provision had never been included.

No Assignment

Health benefits and other rights related to the Plan may not be sold, transferred, pledged or assigned, and any attempt to do so will be void. The payment of benefits directly to a Health Care Provider, if any, is done as a convenience for you and your Covered Dependents and does not constitute an assignment of health benefits or other rights under the Plan.

Provider and Clinical Trial Nondiscrimination

The Plan will comply with applicable law on clinical trial and provider nondiscrimination. These rules are subject to reasonable medical management techniques, such as frequency, method, treatment or setting for an item or service.

Name of Plan

This Plan is known as the Idaho Pipe Trades Health and Welfare Plan.

Plan Administrator

This Plan is maintained and administered by a joint labor-management Board of Trustees.

The Board of Trustees is the "Plan Administrator," as defined under ERISA. The Trustees have engaged BeneSys, Inc. to serve as the Plan's Administrative Office. **All inquiries for the Board of Trustees and the Administrative Office should be sent to**:

Idaho Pipe Trades Trust
c/o Administrative Office
5331 S Macadam Avenue, Suite 258
Portland, Oregon 97329
(208) 288-1610
(800) 808-1687
(208) 288-1670 fax

Participants and Dependents may obtain a complete list of the Employers and Employee organizations sponsoring the Plan or whether a particular Employer or Employee organization sponsors the Plan and the sponsor's address, by writing to the Trustees. You may also examine this list at the Plan Administrative Office or your local Union office upon 10 days advance written request. The Plan may impose a

reasonable charge for providing copies. If you wish, you can ask the Plan Administrative Office the cost before requesting copies.

Type of Administration

This Plan is administered by the Board of Trustees with the assistance of the Plan Administrative Office (BeneSys, Inc.), a third-party claims administrator (Blue Cross of Idaho), and a Prescription Drug Manager (Express Scripts). See Section XVI for contact information. The Trustees may, at any time, contract with other third parties.

Identification Numbers

The employer identification number assigned to the Trust by the Internal Revenue Service is 82-6030679. The Plan number is 501.

Type of Plan

This Plan is an employee welfare benefit plan providing medical, prescription drug, dental, hearing aid, and vision benefits for Covered Participants and Covered Dependents; short-term disability benefits are for Active Participants only.

This document serves as both the written Plan document and the Summary Plan Description required under ERISA.

Plan Year

This Plan operates on a June 1 through May 31 plan year.

Board of Trustees

The Plan's current Trustees are listed below. This list may change from time to time—for a current list, contact the Administrative Office. Individual Trustees may be contacted by mailing correspondence care of the Administrative Office, at the address above.

Employer Trustees	**Union Trustees**
Bill Magnuson, Chairman	Mark Hosick, Secretary
Melvin Cromwell	Nick Saunders
Teresa Paige	Dave Anderson

The Board of Trustees is the "plan sponsor" as defined under ERISA. The plan sponsor is located at: Board of Trustees of the Idaho Pipe Trades Health and Welfare Plan, c/o Plumbers & Pipefitters LU#296, 575 N. Ralstin Street, Suite A, Meridian, ID 83642-4095. However, this address is not for correspondence. Any correspondence should be mailed care of the Administrative Office to the address listed under *Plan Administrator*, above.

The Board of Trustees may take action to terminate, replace or amend any part of the Plan. Such action may impact, for example, Plan coverage, retiree coverage, benefits and/or eligibility for benefits. Such action will be taken in accordance with the applicable provisions of the Trust Agreement.

Service of Legal Process

The name and address of the person designated as agent for the service of legal process is Kim Gould, Idaho Pipe Trades Trust, Administrative Office, 5331 S Macadam Avenue, Suite 258, Portland, Oregon 97329. Legal process may also be served upon the Plan Administrator or any member of the Board of Trustees.

Collective Bargaining Agreements

This Plan is maintained under Collective Bargaining Agreements. These agreements specify the rate at which Employers must contribute to the Idaho Pipe Trades Trust to provide Plan coverage for their Collectively Bargained Employees.

Participants and Dependents may obtain a copy of relevant Collective Bargaining Agreements by writing to the Trustees. You may also examine these agreements at the Plan Administrative Office or your local Union office upon 10 days advance written request. The Plan may impose a reasonable charge for providing copies. If you wish, you can ask the Plan Administrative Office the cost before requesting copies.

Source of Contributions

This Plan is funded through Employer Contributions as specified in Collective Bargaining Agreements and Special Agreements (for non-bargained Employees). Self-payments by Participants are also permitted as described in this document (see Section IV). The amount of self-payments is fixed from time to time by the Board of Trustees.

Funding Medium and Administration

All Employer Contributions and self-payments are held by the Trust pending the payment of benefits, insurance premiums, and administrative expenses. Medical, dental, vision, and hearing aid benefits are paid from Trust assets and are administered by Blue Cross of Idaho. Prescription drug benefits are paid from Trust assets and are administered by Express Scripts. Stop Loss coverage is insured by Blue Cross of Idaho. Short-term disability benefits are administered by the Administrative Office. For contact information, see Section XVI.

Your Rights as a Plan Participant

As a Plan Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Coverage

- Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Hospital length of stay for newborns and mothers

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, 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). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Dependents. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone

directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Notice Regarding Wellness Programs

This notice applies to wellness programs that involve disease-related inquiries or medical examinations. These programs may ask you questions about your health-related activities and behaviors and whether you have or had certain medical conditions. For example, if you take a Blue Cross of Idaho (BCI) Health Assessment, BCI will ask health-related questions in order to provide you with a personalized report. For details on the information that may be requested in connection with a particular program, please contact the provider of that program. Contact information can be found in Section XVI.

Wellness programs are completely voluntary. If you choose to participate, the health information you provide to these programs is protected by federal law, including HIPAA. The Board of Trustees respects your right to keep your health information private and only accesses, uses and discloses your health information for certain limited purposes. See Section XIII of the SPD for more information. In no event will the health information you provide to these programs be used to discriminate against you, nor will you be subject to retaliation if you choose not to participate.

Assistance Communicating with the Plan

The Plan complies with applicable federal civil rights laws with respect to discrimination on the basis of race, color, national origin, age, disability, or sex. For example, the Plan provides, free of charge, certain aids and services to help people with disabilities communicate effectively with the Plan, as well as certain language services to people whose primary language is not English (such as qualified interpreters and information written in other languages), to the extent required by federal law. To inquire about available services, contact the Administrative Office.

Online Security Tips

The United States Department of Labor has provided online security tips to reduce the risk of benefit fraud and identity theft. A copy of those tips is included at the end of this booklet.

Policy Statement on Benefits Fraud

Knowingly defrauding the Plan can be a crime under § 1027 of Title 18 of the United States Code. Violations of this law may result in a fine of up to $250,000, imprisonment for up to five years, or both.

In addition, your Plan coverage may be retroactively terminated if you (or a person seeking coverage on your behalf) perform an act, practice or omission that constitutes fraud or make an intentional misrepresentation of material fact. See Section XIII for more information.

XVI. Contact Information

Call the Plan Administrative Office for eligibility, short-term disability, and Self-Pay questions. Blue Cross of Idaho is the Claims administrator for the Plan. You can call Blue Cross of Idaho for claim questions or to obtain the names of providers and facilities who participate in the network and offer discounted rates to participants in our Plan. Call the Prescription Benefit Manager's help desk for prescription drug and participating pharmacy questions, also to request a claim form if you filled a prescription at a nonparticipating pharmacy.

Administrative Office (BeneSys)

Idaho Pipe Trades Trust
5331 S Macadam Avenue, Suite 258
Portland, Oregon 97329
Phone: (208) 288-1610
Toll Free: (800) 808-1687
Fax: (208) 288-1670
iptt.org

Pharmacy Benefit Manager (PBM)& Mail Order Pharmacy

Express Scripts
1 Express Way
St. Louis, MO 63121
Member Services: 800-716-3751
Pharmacy Help Desk: 800-922-1557
Accredo Specialty Pharmacy: 800-803-2523
express-scripts.com

Claims Administrator (Medical, Dental, Vision & Hearing Aids)

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

For claims questions, call:

(800) 627-1188 (Medical & Hearing Aid)
(800) 289-7929 (Dental)
(800) 877-7195 (Vision)

Access a list of network providers at: bcidaho.com

Pre-certification, Hospital Preadmission and Other Courtesy Assessments, Utilization Management and Case Management

Call Blue Cross of Idaho at (800) 743-1871 before treatment to request pre-certification or Hospital preadmission to obtain a courtesy assessment of Medical Necessity and determine if case management services are appropriate.

Written communications (including those sent electronically) to the Administrative Office, the Trustees, or their delegees, agents or representatives, must be received before the expiration of any time period expressed in this booklet or any modifications to this booklet. These parties' records will be conclusive as to whether a communication has been received and the date of such receipt, unless you procure a United States Postal Service return receipt. So the common law "mailbox rule" does not apply to determine receipt by these parties. The common law mailbox rule does apply for all other purposes under the Plan. From time to time, the above parties may communicate with you via telephone rather than in writing. The Plan's rules on content and date of sending/receiving written communications also apply to telephonic communications.

A copy of the Health and Welfare Plan and Summary Plan Description is also available online at iptt.org.

Administrative Office
BeneSys

Idaho Pipe Trades Trust
5331 S Macadam Avenue, Suite 258
Portland, Oregon 97329

Phone: (208) 288-1610
Toll Free: (800) 808-1687
Fax: (208) 288-1670
iptt.org