Idaho Pipe Trades Health and Welfare Plan & Summary Plan Description

January 1, 2017
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, and hearing aid benefits. The Plan was adopted for the exclusive benefit of Participants who are employed by certain companies in the pipe trades 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, 2017.

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 and never later than 12 months after the date of service or when the supply or drug is dispensed.
- Enroll your Eligible Dependents within 30 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 refer to the definitions in Section XIII.

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 from time to time. You will be notified if there are changes.

Important addresses and telephone numbers are listed on page 83 of this document.

Sincerely,

Board of Trustees

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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, 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 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.
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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 or a Special 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. Amounts over that remain in your hour bank, up to 560 hours. See Section III for details.

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>February</td>
<td>160 hours</td>
</tr>
<tr>
<td>March</td>
<td>120 hours</td>
</tr>
<tr>
<td>April</td>
<td>100 hours</td>
</tr>
<tr>
<td>Total</td>
<td>380 hours</td>
</tr>
</tbody>
</table>

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 $990. The current Contribution rate for this Plan is $6.60 per hour. John earns 150 ($990 ÷ $6.60) 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.
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 X.

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 benefits are not available, 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 XIII.* 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 Optum Rx, Inc. For contact information, see Section XV.

The chart below highlights the main features of each of the Plan’s benefits. See the definitions in Section XIII, and the other sections noted below, for details.

<table>
<thead>
<tr>
<th>Benefits Highlights</th>
<th>Highlights</th>
<th>For More Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Plan pays 80% if in-network (70%, if out-of-network) of many Covered Medical Expenses after you pay an annual calendar year deductible of $750 per person. (If 3 family members each meet the deductible, all family members’ deductibles are satisfied.) The Plan pays 50% of some Covered Medical Expenses. Two annual out-of-pocket maximums apply to Covered Medical Expenses. After you reach the In-Network Maximum ($3,720 per person / $7,440 per family), you owe no further deductible, copays, or coinsurance for in-network Covered Medical Expenses for the rest of the calendar year. After you reach the Out-Of-Network Maximum ($7,500 per person), you owe no further coinsurance for out-of-network Covered Medical Expenses for the rest of the calendar year.</td>
<td>See “Out-of-Pocket Maximums,” below.</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>You pay a copayment for each covered prescription you fill at a participating pharmacy or mail order, as follows:</td>
<td>See Section VI.</td>
</tr>
<tr>
<td></td>
<td>- Generic Drugs: $20 retail* / $40 mail order**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Preferred Brand-Name Drugs: $40 retail* / $80 mail order**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Non-Preferred Brand Name Drugs: $70 retail* / $140 mail order**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Specialty Drugs: 10% of discounted cost of drug, up to a maximum of $120 each time you have your prescription filled.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>*up to a 30-day supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>**up to a 90-day supply on maintenance drugs filled through mail order</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No deductible applies to prescription drug benefits. After you reach the annual In-Network Maximum ($2,880 per person / $5,760 per family), you owe no further copays or coinsurance for covered prescription drugs filled at a participating pharmacy for the rest of the calendar year.</td>
<td>See “Out-of-Pocket Maximums,” below.</td>
</tr>
<tr>
<td>Dental</td>
<td>The Plan pays a percentage of Covered Dental Expenses after you pay an annual deductible of $150 per person, as follows:</td>
<td>See Section VII.</td>
</tr>
<tr>
<td></td>
<td>- Two routine exams every calendar year - 80%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Other Class A services - 80% (for example: diagnosis, cleanings, extractions, most filings)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Class B services - 50% (for example: crowns, bridgework, dentures)</td>
<td></td>
</tr>
</tbody>
</table>
### Benefits Highlights

<table>
<thead>
<tr>
<th>Plan</th>
<th>Highlights</th>
<th>For More Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar year maximum benefit:</td>
<td>$1,000 per adult</td>
<td>See “Out-of-Pocket Maximums,” below.</td>
</tr>
<tr>
<td>Unlimited for individuals under age 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After you reach the annual In-Network Maximum ($3,720 per person / $7,440 per family), you owe no further deductible, copays, or coinsurance for covered pediatric dental expenses for the rest of that calendar year.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Vision

- Eye exams are covered once every calendar year.
- The Plan pays a portion of the cost of lenses and frames (once every two calendar years). No deductible applies to vision benefits.

### Hearing aid

- The Plan pays 80% of eligible hearing aid expenses; up to $750 per ear every 36 months to Covered Participants (Dependents are not eligible).
- No deductible applies to the hearing aid benefits.

### 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 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 chart below.

### In-Network Maximums

<table>
<thead>
<tr>
<th>Per Person</th>
<th>Per Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and pediatric dental</td>
<td>Prescription drugs</td>
</tr>
<tr>
<td>$3,720</td>
<td>$2,880</td>
</tr>
</tbody>
</table>

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. 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, or adult dental benefits.
- Any amounts incurred at an out-of-network provider or a non-participating pharmacy (except that 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).

- 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 $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.)
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 2017 will not apply to the In-Network Maximums
in 2018. 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 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, you and your Employer must satisfy all requirements in the Plan, Trust Agreement, and Special Agreement. The hour bank system also applies to you.

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.

<table>
<thead>
<tr>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
<th>Month 4</th>
<th>Month 5</th>
<th>Month 6</th>
<th>Month 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 hours</td>
<td>60 hours</td>
<td>60 hours</td>
<td>60 hours</td>
<td>60 hours</td>
<td>Lag Month</td>
<td>Coverage Starts</td>
</tr>
</tbody>
</table>

300 hours in 5 consecutive months

Your coverage starts on the first of this month and 140 hours are deducted from your account

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...

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 the section called “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.
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).

**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. 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.

**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 560 (enough for four 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. 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. Also, 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 a non-Contributing Employer in Montana, Oregon or Idaho; in a trade or craft in which you were employed while contributions were made on your behalf to this Plan or the Pension Plan; and in an industry in which Contributing Employers 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 14).
Dependents

Eligible Dependents

Eligible Dependents who are enrolled in the Plan may receive coverage under the Plan’s medical, prescription drug, dental and vision benefits. Dependents are not eligible for coverage under the Hearing Aid Benefit.

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 he or she ceases to be eligible for such other coverage, and you may enroll your Spouse within 60 days of that date. (See HIPAA Special Enrollment, below.) 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 mental retardation or physical handicap which began before the child was 26. 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. In addition, the child must have been covered by the Plan when he or she turned age 26, and you must submit proof of 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 in order 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 provide a completed 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
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 30 days to enroll your Eligible Dependents after you are first covered by the Plan, and an additional 60 days to submit requested legal documentation. 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 within 30 days of the date you regained eligibility in order for your Dependents to have coverage for the remainder of the calendar year. 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. You will receive an enrollment form, which you must return 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.

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, provided you submit the requested legal documentation within 60 days of the Administrative Office’s receipt of the completed enrollment form.

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

1. 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.

2. 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.

3. 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 have 60 days to enroll your Dependent from the date of the event that triggered the HIPAA special enrollment opportunity (that is, the date the Dependent lost other coverage, the date you acquired the new Dependent through marriage birth, adoption or placement for adoption, or the date your Dependent becomes eligible for a premium assistance subsidy, as applicable). You have an additional 30 days to submit any requested legal documentation. 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 9, above);

• The date you enter full-time active duty in the United States armed forces, except as otherwise provided by law; 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 7, 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 may enter into reciprocity agreements with other health plans to require transfer of 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 Are Disabled

Coverage for certain Plan medical benefits may be extended without cost if you are Totally Disabled when your hour bank coverage ends. (“Totally Disabled” means unable to engage in substantial gainful employment in the plumbing and pipefitting industry.) Specifically, the Plan continues to cover medical benefits for the disabling condition (and Preventive Care benefits, to the extent required by law) until the end of the 12th month immediately following your coverage termination date or, if earlier, until you are no longer Totally Disabled. Extended disability benefits run concurrently with extended benefits under FMLA.

If you are Totally Disabled when your hour bank coverage ends, you may choose either COBRA coverage (assuming you are eligible for and timely elect COBRA) or extended disability benefits. If you elect extended disability benefits, you may revoke your election and instead elect COBRA at any time during the COBRA election period. If you choose extended disability benefits, you will not be able to elect COBRA when your extended disability benefits end. Similarly, if you choose COBRA, no extended disability benefits will be provided after you have exhausted your COBRA coverage.

You must notify the Administrative Office that you wish to elect the extended disability benefits within 30 days of becoming Totally Disabled. You must submit a written statement from your Physician certifying that you are Totally Disabled and indicating when your Total Disability is expected to end.

Dependents are not eligible for extended disability benefits, but may be eligible to elect COBRA (see Section IV).

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 a Covered Participant, your coverage ends due to insufficient hours in your hour bank account, 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 safety glasses portion of the Vision Benefit is not available under any self-pay program. Notification of any changes to your Self-Pay Participant status, such as divorce, Legal Separation, death of a Spouse, marriage, retirement or other insurance coverage eligibility, must be received in writing by the Plan Administrative Office no later than the 20th of the month prior to the month of implementation. No retroactive adjustments will be made to credit overpaid premiums due to status changes occurring in previous months.

Self-pay rules and rates for health benefits and uninsured welfare benefits are determined by the Trustees. The rules and rates are changed by the Trustees from time to time. Please contact the Plan Administrative Office if you have any questions concerning self-pay benefits, costs, payment time periods, etc.

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 from time to time with reasonable notice to Participants. 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 www.healthcare.gov.

If you, a Covered Participant, choose self-pay coverage, you are entitled to continue your medical, prescription drug, dental, vision, and hearing aid benefits. Covered Dependents are entitled to continue medical, prescription drug, dental, and vision 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, he or she 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 XV. 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. You must notify the Plan Administrative Office and enroll the child no later than 30 days after the birth, adoption, or placement for adoption. 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 he or she 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 83. 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 www.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.

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 1st day of each following month, for that month’s coverage. If the Plan Administrative Office does not timely receive your self-payment (the premium must be received and/or postmarked on or before the last day of the coverage month), your coverage will be dropped and 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.

The amount, timing, and other rules related to payment for Lifetime Self-Pay coverage are established by the Trustees and reviewed annually. Contact the Administrative Office for payment information.
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 covered medical services you receive. Because not all services are covered, it’s important to read this Plan carefully and understand your benefits before you receive services, whenever possible.

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 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.

Here are some highlights of the Plan’s Medical Benefit:

<table>
<thead>
<tr>
<th>Medical Benefit Highlights</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual deductible</td>
<td>$750 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.</td>
</tr>
<tr>
<td>Medical office visit</td>
<td>In-Network: 80% after a $25 copayment</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: 70% after a $25 copayment</td>
</tr>
<tr>
<td></td>
<td>The $25 medical office visit copayment is waived on in-network Preventive Care visits. The copayment applies to all other Health Care Provider services unless otherwise noted.</td>
</tr>
<tr>
<td>Annual out-of-pocket maximums</td>
<td>In-Network Maximum: $3,720 per person, $7,440 per family</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network Maximum: $7,500 per person (applies to coinsurance only)</td>
</tr>
<tr>
<td>Physician services</td>
<td>In-Network: 80%</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: 70%</td>
</tr>
<tr>
<td>Lab and x-ray</td>
<td>In-Network: 80%</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: 70%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>In-network: 100% with no deductible or copayment</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: 70% (deductible and copays apply)</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>In-Network: 80%</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: 70%</td>
</tr>
<tr>
<td>Maternity care</td>
<td>Covered the same as any other condition for the Covered Participant or Covered Spouse only. This benefit is not available for Covered Dependent children.</td>
</tr>
<tr>
<td>Emergency room and Emergency ambulance services</td>
<td>80%. Emergency room services at a Hospital are subject to a $100 copayment (copayment is waived if admitted as an inpatient). Note: Non-Emergency ambulance services are covered at 80% in-network and 70% out-of-network.</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>In-Network: 80%</td>
</tr>
<tr>
<td>(including room and board,</td>
<td>Out-of-Network: 70%</td>
</tr>
<tr>
<td>outpatient surgery, drugs while a</td>
<td></td>
</tr>
</tbody>
</table>
### Medical Benefit Highlights

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network: 80%</th>
<th>Out-of-Network: 70%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic services</td>
<td></td>
<td>Maximum benefit: 10 visits per person per calendar year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Physical and occupational therapy</td>
<td></td>
<td>Maximum benefit: 24 visits per person per calendar year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Speech therapy</td>
<td></td>
<td>50% up to a maximum of 24 visits per person per calendar year.</td>
</tr>
<tr>
<td>Residential Treatment Facility,</td>
<td></td>
<td>Skilled Nursing Facility, rehabilitation facility and home health care</td>
</tr>
<tr>
<td>Substance Abuse Treatment Facility,</td>
<td></td>
<td>In-Network: 80%</td>
</tr>
<tr>
<td>Skilled Nursing Facility, rehabilitation</td>
<td></td>
<td>Out-of-Network: No coverage</td>
</tr>
<tr>
<td>facility and home health care</td>
<td></td>
<td>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).</td>
</tr>
</tbody>
</table>

### 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 $750 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 II** 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 10 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.*

**Courtesy Assessments of Medical Necessity Prior to Receiving Treatment**

Before receiving treatment, you may request a courtesy assessment of whether the treatment is considered to be Medically Necessary. Blue Cross of Idaho (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 1-800-743-1871 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. If you proceed in obtaining the service or supply, submit your claim for benefits to the Claims Administrator in accordance with the procedures described in Section XI. In the event that the claim is denied by the Claims Administrator, you will have the right to appeal in accordance with the procedures for appealing a denied claim that are described in *Section XI*.

BCI’s courtesy assessments of Medical Necessity are optional and do not guarantee coverage. Coverage is provided only to the extent it is otherwise promised under the Plan.

**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. 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. At that time, 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.

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 XIII.)

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 also pay 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).

Health Care Providers who participate in the Plan’s network are added and deleted during the year. For a current list of network providers, go to Blue Cross of Idaho’s website at www.bcidaho.com.

Covered Medical Expenses

Covered Medical Expenses are the Maximum Allowance charges for Preventive Care services and supplies, and for the following services and supplies 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.

- **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** requiring a prescription and medical services, including sterilization, are covered at 80% in-network and 70% out-of-network for Covered Participant or Covered Spouse only. Abortion and any services and expenses related to abortion are not covered.

However, for all covered women, birth control devices and services that are Preventive Care are covered 100% in-network and 70% out-of-network—see page 20 for more information. 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 10 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%. The deductible and copays are waived. 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 1-800-743-1871.

• **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. Services that are “emergency services” as defined under Health Care Reform are covered at 80%.

- **Maternity benefits** for you or your Spouse, including childbirth and complications of pregnancy, are covered the same as any other condition. 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. Dependent children are not covered for expenses related to their pregnancy, giving birth or related complications.

- **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.
  - stormy supplies.
  - 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.

- **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 abuse, 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 X.

• **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 ($750) 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 22.
  - 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 Abuse 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 Abuse inpatient treatment** (including but not limited to intensive outpatient services or supplies and partial hospitalization) is covered only when received at a Hospital, Substance Abuse Treatment Facility or Residential Treatment Facility. The Plan pays no other facility charges to treat Substance Abuse. Inpatient treatment at a Substance Abuse 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.

**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%, 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 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 (8 in first year, 3 in second year, then one per year through age 18)
- Routine adult physicals/wellness exam (one per year age 19+)
- Breast cancer screening (one mammogram per year beginning at age 40)
- Cervical cancer screening (one Pap test and routine pelvic exam per year)
- Colon and rectal cancer screening (yearly fecal occult blood test, colonoscopy every 5 years for adults ages 50 – 75)
- Prostate cancer screening (one prostate-specific antigen blood test and digital rectal exam age 50 and older)
- Birth control devices and procedures for women
- Immunizations, including annual flu shots and the shingles and pneumonia immunizations, to the extent recommended by the CDC (see [http://www.cdc.gov/vaccines/schedules/index.html](http://www.cdc.gov/vaccines/schedules/index.html))

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, see:

- [https://members.bcidaho.com](https://members.bcidaho.com) (under the “Health & Wellness” tab, select “Preventive Care Services”)
- [http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/](http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/)

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

**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 considered to be Medically Necessary. No benefits will be paid for the following, except as required by law:

- 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 that are not Preventive Care.
- Pregnancy, childbirth or related complications for Dependent children.
- 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, telephone or internet consultations when patient is not physically seen by a physician.
- Charges for routine physical exams that do not qualify as Preventive Care. Charges payable 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 X).
- 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.

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**Medically Necessary**

Throughout this booklet you will see the terms “Medically Necessary” and “Medical Necessity.” Under the terms of the Plan, services and supplies are covered only if they are Medically Necessary. Please see Section XIII for a complete definition.
- 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 on page 27.
- 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 on page 27, above) 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).
- Educational programs, services or supplies, except diabetic nutrition education.
- 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.
- Infertility and fertility treatment - Services, drugs, supplies, and any natural or artificial means to induce pregnancy or treat or diagnose infertility (male or female), such as artificial insemination, in vitro fertilization, embryo transfer, gamete intrafallopian transfer, embryo implant, and surrogate motherhood.
- Marriage, sexual, or family counseling.
- 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.
- Organ and bone marrow transplant expenses and any complications as a result of such procedures, regardless of whether you are the donor or the recipient. However, organ and bone marrow transplant anti-rejection drugs for Retired Participants and their covered Dependents who have had an organ transplant, and are eligible for—but have not elected—coverage under Medicare Part D, may be covered under the Prescription Drug Benefit as described in Section VI.
- Orthognathic surgery, treatment or supplies to correct Malocclusion and/or temporomandibular joint disorder (TMJ).
- Orthopedic shoes, orthotics, lifts, shoe inserts and casting for orthotics or inserts.
- 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, 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 X).
- 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 gender dysphoria or sexual functions or dysfunctions.
• Sterilization reversal, whether sterilization was voluntary or involuntary.
• Transsexual surgery, gender dysphoria, and any services or supplies related to sexual reassignment.
• Travel, lodging, or transportation, except as provided in the Covered Medical Expenses section beginning on page 23.
• 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 OptumRx, Inc. (see Section XV for contact information). This program features a network of participating pharmacies (excluding Walmart). Specialty drugs are provided through the OptumRx Specialty Program.

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 OptumRx Specialty Program.

If You Use a Participating Pharmacy

When you use a participating pharmacy, the copayments are:

<table>
<thead>
<tr>
<th>Type of Drug or Supply</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drug</td>
<td>Retail: $20 (up to a 30-day supply)</td>
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<tr>
<td></td>
<td>Mail order: $20 (up to a 30-day supply)</td>
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<tr>
<td></td>
<td>$40 (up to a 90-day supply)</td>
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<tr>
<td>Preferred Brand-Name Drug</td>
<td>Retail: $40 (up to a 30-day supply)</td>
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<tr>
<td></td>
<td>Mail order: $40 (up to a 30-day supply)</td>
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<td></td>
<td>$80 (up to a 90-day supply)</td>
</tr>
<tr>
<td>Non-Preferred Brand-Name Drug</td>
<td>Retail: $70 (up to a 30-day supply)</td>
</tr>
<tr>
<td></td>
<td>Mail order: $70 (up to a 30-day supply)</td>
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<tr>
<td></td>
<td>$140 (up to a 90-day supply)</td>
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<tr>
<td>Maintenance drugs</td>
<td>Generally covered only when filled through mail order (see Maintenance Drugs, below)</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>10% of the discounted cost of the drug through OptumRx Specialty Program, to a maximum of $120 each time you have your prescription filled.</td>
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<tr>
<td>(self-injectable medications (excluding insulin) or medications for cancer or other serious conditions)</td>
<td></td>
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<tr>
<td>PKU (phenylketonuria) prescribed food supplements</td>
<td>$70</td>
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<tr>
<td></td>
<td>Covered only when for Covered Dependent children and filled at a pharmacy.</td>
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<tr>
<td>Diabetic blood sugar testing devices and supplies filled through a pharmacy or by mail order</td>
<td>Filled through a pharmacy:</td>
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<tr>
<td></td>
<td>-$40 for Accu-Check or One-Touch</td>
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<tr>
<td></td>
<td>-$70 for other testing devices or supplies</td>
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<tr>
<td></td>
<td>Filled through mail order:</td>
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<tr>
<td></td>
<td>-$80 for Accu-Check or One-Touch</td>
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<tr>
<td></td>
<td>-$140 for other testing devices or supplies</td>
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<tr>
<td>Preventive Care drugs and supplements</td>
<td>$0 (covered only if filled through a participating pharmacy)</td>
</tr>
</tbody>
</table>
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 OptumRx to obtain a current list of participating pharmacies.

You will be responsible for the full cost of a covered drug if the applicable copay is more than OptumRx’s maximum allowable rate or the pharmacy charge. 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 listed above, 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 list of preferred drugs changes from time to time. You can obtain a copy of the current list at the OptumRx website phone number listed in Section XV. The specialty drug list is also available on OptumRx’s website (www.optumrx.com) or by calling OptumRx. You may also obtain a copy from the Administrative Office.

Certain drugs require prior authorizations (PA) and/or have quantity limits (QL). (All drugs at risk of abuse have QL and require PA.) The current list of these drugs is posted on the OptumRx website at www.optumrx.com, or you may contact OptumRx at the address or phone number listed in Section XV to request a free copy. If you are advised by your pharmacist that a PA is required on a particular drug, please contact OptumRx to request a PA form be faxed to your Physician for completion.

If filled at a participating pharmacy, the Plan also covers drugs that are Preventive Care. 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 OptumRx to send you a current list of Preventive Care drugs.

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

**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**

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 OptumRx Specialty Program. (See Specialty Drugs, below.)
**Specialty Drugs**

Self-injectable medications (excluding insulin) or medications for oncology (cancer) or other serious medical conditions are not covered under the retail or mail order pharmacy benefit. These specialty drugs are dispensed through the *OptumRx Specialty Program*, which is administered by OptumRx. The *OptumRx Specialty Program* 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 discounted cost of the drug through the *OptumRx Specialty Program*, 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. The *OptumRx Specialty Program* will then send you information on how to fill the prescription in the future. For a free copy of the OptumRx specialty drug list, contact OptumRx at the address or phone number listed in Section XV. The specialty drug list is also available on OptumRx’s website (www.optumrx.com).

**Maintenance Drugs**

Maintenance drugs are those drugs you use on an ongoing basis that are listed on the OptumRx maintenance list, such as insulin. The list of maintenance drugs changes from time to time. You can obtain a current list on the OptumRx website at www.optumrx.com, or you may contact OptumRx at the address or phone number listed in Section XV 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. In order to ensure the drug will be effective for you, the first time you fill a prescription for a maintenance drug at a retail pharmacy, OptumRx will authorize only a 30-day supply. Your second fill at a retail pharmacy can be for a 60-day supply for two (2) copays. 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. If you opt out, you may 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 OptumRx at 1-800-797-9791.

**Mail Order Pharmacy**

The Plan’s mail order pharmacy, administered by OptumRx, fills maintenance drugs and certain other covered drugs. (See Section XV for OptumRx’s contact information.) You may order up to a 90-day supply for delivery to a location of your choosing. Standard shipping is free, and you usually will receive your order within 10-14 days (new prescriptions may take longer). Expedited shipping options are available for a fee.

A prescription order form is available at www.optumrx.com, or by calling or writing to OptumRx. For a refill, call OptumRx, order online, or mail in another order form. Note that your Physician can phone in or fax a prescription to OptumRx for you.

**Participating PBM Pharmacies**

To find a participating pharmacy, call the OptumRx Help Desk telephone number listed on page 83 or visit www.optumrx.com. A few of the current participating pharmacies include:

- Albertsons/Savon
- Costco Pharmacy
- Fred Meyer
- K-Mart
- Rite Aid Drug
- Safeway
- Shopko
- Smith’s
- Walgreens

There are also many independent pharmacies in the network. Keep in mind, the list of participating pharmacies shown above may change from time to time. If you’re not sure if your pharmacy participates, contact OptumRx

**If You Use a Non-Participating Pharmacy**

If you fill your prescription at a pharmacy (other than Walmart) *outside* the network, 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 OptumRx for reimbursement. Claim forms are available from OptumRx.

If your non-network pharmacy charges more than OptumRx’s maximum allowable rate for the same drug, you pay the difference. For example, let’s assume OptumRx’s 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 OptumRx maximum allowance for this drug. OptumRx 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 page 27 and Section X for more information.

**Exclusions**

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

- Amounts in excess of OptumRx’s 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.
- 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).

• Organ and bone marrow transplant expenses and any complications as a result of such procedures are excluded under the Plan. However, the Prescription Drug Benefit does cover organ and bone marrow transplant anti-rejection drugs for Retired Participants and their covered Dependents who have had an organ transplant, and are eligible for—but have not elected—coverage under Medicare Part D.

• 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 29) apply to the Prescription Drug Benefit, except as specifically provided to the contrary under this Section VI.
VII. Dental Benefit

The Dental Benefit pays a percentage of Covered Dental Expenses after an annual deductible of $150 of Covered Dental Expenses per person. The deductible and coinsurance for individuals age 18 and under will count towards their In-Network Maximum for medical benefits (see Section II for details). Dental benefits for adults are capped at $1,000 per year, and their deductible and coinsurance do not count toward any out-of-pocket maximum.

Covered Dental Expenses

<table>
<thead>
<tr>
<th>Dental Benefit Highlights</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual deductible</td>
<td>$150 per person per calendar year.</td>
</tr>
<tr>
<td>Annual maximum benefit</td>
<td>$1,000 per adult per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Unlimited for pediatric dental services (age 18 and under).</td>
</tr>
</tbody>
</table>

Class A expenses
- Routine services (two exams every calendar year) including:
  - Exam
  - X-rays, except panoramic or full mouth, which are covered once every 24 months
  - Prophylaxis and fluoride
- Periodontal scaling/prophylaxis (no more than two every calendar year unless Medically Necessary)
- 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 Plan
- Sealants (no age limit)
- Surgical placement of implants (surgical procedure only)

Class B expenses
- Inlays, onlays, crowns and gold fillings
- Repair or recementing of crowns, inlays, bridgework, or dentures
- Implant hardware
- Mouth/nigthguards
- 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

*Maximum Allowance limits apply.
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 1-800-743-1871. If BCI denies your request for any reason, you may ask BCI to review its decision. If you proceed with obtaining the service, submit your claim for benefits to the Claims Administrator in accordance with the procedures described in Section XI. In the event your claim is denied by the Claims Administrator, you will have the right to appeal in accordance with the appeal procedures described in Section XI. Please note that BCI’s courtesy assessment of Medical Necessity is optional and does not guarantee coverage. 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; rather, they must be delivered within 30 days after termination of coverage.

**Exclusions**

The Plan does not cover:

- Orthodontic care, including space maintainers.
- Services and supplies not specifically listed above.
- Treatment for cosmetic purposes, including but not limited to bleaching or veneers.
- The *Medical Benefit* exclusions (beginning on page 29) also apply to the *Dental Benefit*, except as specifically provided to the contrary under this Section VII.
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:

<table>
<thead>
<tr>
<th>Vision Benefit Highlights</th>
<th>Adult (age 19+)</th>
<th>Pediatric (under age 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eye exam</strong> (every calendar year)</td>
<td>Covered 100% in network. Out-of-network exams are covered up to $150.</td>
<td>Covered 100% in-network, 50% out-of-network.</td>
</tr>
<tr>
<td><strong>Lenses</strong> (one pair every two calendar years)</td>
<td>The Plan pays up to:</td>
<td>Covered 100% in-network, 50% out-of-network.</td>
</tr>
<tr>
<td>• Single vision</td>
<td>$70.</td>
<td></td>
</tr>
<tr>
<td>• Bifocal</td>
<td>$100.</td>
<td></td>
</tr>
<tr>
<td>• Trifocal and Progressive</td>
<td>$140.</td>
<td></td>
</tr>
<tr>
<td>• Lenticular</td>
<td>$160.</td>
<td></td>
</tr>
<tr>
<td><strong>Frames</strong> (once every two calendar years)</td>
<td>The Plan pays up to $50.</td>
<td>Covered 100% in-network, 50% out-of-network.</td>
</tr>
<tr>
<td><strong>Contact lenses instead of glasses</strong>, and</td>
<td>The Plan pays up to $150</td>
<td>Covered 100% in-network, 50% out-of-network, subject to the</td>
</tr>
<tr>
<td>contact lens fitting (every two calendar years)</td>
<td></td>
<td>following quantity limits:***</td>
</tr>
<tr>
<td><strong>Safety glasses</strong> (one pair every two</td>
<td>Covered 100% in-network for ProTec safety glasses. For out-of-network or non-</td>
<td></td>
</tr>
<tr>
<td>calendar years)</td>
<td>ProTec frames and lenses, the Plan pays up to:</td>
<td></td>
</tr>
<tr>
<td>Lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$35</td>
<td></td>
</tr>
<tr>
<td>Bifocal</td>
<td>$45</td>
<td></td>
</tr>
<tr>
<td>Trifocal</td>
<td>$60</td>
<td></td>
</tr>
<tr>
<td>Lenticular</td>
<td>$90</td>
<td></td>
</tr>
<tr>
<td>Progressive</td>
<td>$45</td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>$25</td>
<td></td>
</tr>
</tbody>
</table>

* No coverage for Special Agreement Participants, Self-Pay Participants or Covered Dependents.

** Charges for Photo-Grey No. 1 and No. 2 tinted lenses are covered as long as payment does not exceed the maximums listed above.

*** 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.
  - Optomaps and other retinal imaging (may, however, be available under the Medical Benefit if not excluded under “Vision treatment or services” on page 32).
  - 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 32).
- 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.
- The Medical Benefit exclusions (beginning on page 29) also apply to the Vision Benefit, except as specifically provided to the contrary in this Section VIII.
IX. Hearing Aid Benefit

For Covered Participants, 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 Dependents are not eligible for this benefit (however, Medically Necessary hearing tests may be covered under the Plan’s Medical Benefit).

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.
- Charges for any services or supplies incurred by a Dependent of a Covered Participant.
- The Medical Benefit exclusions (beginning on page 29) also apply to the Hearing Aid Benefit except as specifically provided to the contrary in this Section IX.
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 he or she is 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 the expenses are recoverable from someone else (a “third party”). The Plan may refuse to pay any health expenses the Plan believes are or may be the responsibility of a third party. Alternatively, the Plan may advance payment of benefits while you pursue recovery 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 acting on your behalf 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 pay the Plan directly first 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 in 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 designated as payment for medical or disability expenses. This includes the following payments:

- Any judgment, settlement, or other payment relating to the Illness or Injury, from whatever source.
- Any payment made by your insurance or a third party’s insurance, including vehicle insurance, no-fault automobile insurance, uninsured or under insured motorist coverage, business insurance, homeowner’s insurance, personal umbrella insurance, or any other type of insurance or insurance-type coverage.
- Payments designated as medical benefits, as disability payments, as compensation for pain and suffering, as attorney’s fees, 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 requested by the Administrative Office to help the Plan enforce these rights.

You must notify the Administrative Office 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.

In addition, the Administrative Office 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 Administrative Office. 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/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. 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. 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 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 also apply to your covered spouse and other family members and to your (or their) estates or heirs in the event of death.
- The Plan’s subrogation and reimbursement rights apply even if you receive a third-party payment before the Plan has paid any health expenses relating to the Injury or Illness. In that case, you are responsible to use the third-party payment to pay the health 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).
- The Plan is an employee welfare benefit plan governed by ERISA. The Plan’s medical benefits are self-funded.
- The Administrative Office’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.
- The Plan may share information regarding your and your Dependents’ claims with third parties 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 doctrine applies under any statute or common law. The Plan disclaims all such doctrines and defenses.

By accepting Plan benefits, you agree to these conditions and covenant not to raise any contrary claims in any action by the Plan to enforce its reimbursement or recovery rights.
XI. How to File a Claim

This section tells you how to file a claim for benefits under the Plan. 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 X or call Blue Cross of Idaho.

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 an enrollment form to the Plan Administrative Office each calendar year before your claims will be processed. If you do not have a form to complete, please call the Plan Administrative Office at 208-288-1610 or the form can be downloaded from the website at www.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 & Trustee Appeals Committee

In general, the Claims Administrators decide initial claims, and decide first-level and second-level appeals of denied claims. The Trustee Appeals Committee decides optional third-level appeals. The Trustee Appeals Committee can be contacted at: Trustee Appeals Committee, Idaho Pipe Trades Trust, Administrative Office, 1220 SW Morrison Street, Suite 300, Portland, Oregon 97205. The Claims Administrators for medical benefit claims are shown in the chart below.

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Claims Administrator – Medical Benefit Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical, Dental &amp; Hearing Aid Benefit</td>
<td>Blue Cross of Idaho&lt;br&gt;Blue Cross of Idaho Claims Control&lt;br&gt;Blue Cross of Idaho&lt;br&gt;P.O. Box 7408&lt;br&gt;Boise, ID 83707&lt;br&gt;Phone: (208) 331-7347 or 1-800-627-1188&lt;br&gt;Website: <a href="http://www.bcidiaho.com">www.bcidiaho.com</a></td>
</tr>
<tr>
<td>Vision Benefit</td>
<td>Blue Cross of Idaho (BCI) is the Claims Administrator for vision benefits. However, BCI contracts with Vision Service Providers for processing and deciding initial claims.&lt;br&gt;&lt;em&gt;Submit initial in-network claims to:&lt;/em&gt;&lt;br&gt;Vision Service Providers&lt;br&gt;P.O. Box 997105&lt;br&gt;Sacramento, CA 95899-7105</td>
</tr>
</tbody>
</table>
| Vision Benefit cont. | Phone: (800) 877-7195  
Website: [www.vsp.com](http://www.vsp.com)  
Submit initial out-of-network claims to:  
Vision Service Providers  
Out-of-Network Claims  
P.O. Box 395018  
Birmingham, AL 35238-5018  
Submit appeals to:  
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: [www.bcidaho.com](http://www.bcidaho.com) |
|---|---|
| Prescription Drug Benefit | OptumRx, Inc.  
OptumRx, Inc.  
P.O. Box 509075  
San Diego, CA 92150-9075  
Phone: (800) 797-9791  
Labor and Trust Line: (866) 328-2005  
Website: [www.optumrx.com](http://www.optumrx.com) |

For disability claims, however, the Administrative Office is the Claims Administrator with respect to initial claims, and there is only one required appeal level. The Plan Administrator decides first-level appeals of disability claims, and the Trustee Appeals Committee decides optional second-level appeals. See Section XIV for the Plan Administrator’s contact information, and Section XV for the Administrative Office’s contact information.

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 as if it were a disability claim. The internal appeal procedures need to be exhausted for such disputes before you can bring a civil action under Section 502(a) of ERISA. However, if a claim for medical benefits 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. The Plan Administrator is the Claims Administrator with respect to first-level appeals of such claim denials, and the Trustee Appeals Committee decides optional second-level appeals.

The Claims Administrators for medical benefit claims, the Plan Administrator and the Trustee Appeals Committee make final determinations on review of appeals of denied claims, and 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.

**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*, in order 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 it's 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 (www.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. 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, see page 50, 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 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.
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.

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), 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.

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.

Please note that there are different claim and appeal procedure requirements for medical benefit claims and disability claims. 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 temporary extended medical benefits for a disabbling condition (see Section III). 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 medical claim other than a disability claim.

General Provisions Regarding Medical Benefit Claim 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, including medical experts or review organizations, involved in making decisions and no hiring or retention decisions 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.

**Disability Claim Determinations**

The following procedures apply to any disability claim.

**Timing of written notice of benefit determination**

If your claim is a disability 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 (the Administrative Office). If matters beyond the control of the Claims Administrator require an extension of the time for processing your disability 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 for a benefit is denied, 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 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 copy of any internal rule, guideline, protocol 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
• 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.

Medical Benefit Claim Determinations

The following procedures apply to any medical benefit claim. Note that claims for pre-certification are handled differently than medical benefit claims that are post-service.

Timing of written notice of benefit determination — Pre-Certification 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’s Prescription Benefit Manager (PBM) may require pre-certification for certain drugs. The Plan does not require that you get pre-certification for other medical services or procedures. (You may, however, 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. Please refer to Courtesy Assessments of Medical Necessity Prior to Receiving Treatment in Section V for further 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 Plan’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.

Timing of written notice of benefit determination — Claims after service or treatment
If your claim for a benefit does not require pre-certification in advance of receiving medical care, written notice of a denial 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).

Timing of written notice of benefit determination — Concurrent care decision

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.

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:

- 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, including 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;
- 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 available internal appeal and external review processes for denied claims, including information regarding how to initiate an appeal and the applicable time limits for submitting your appeal (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;
- Any internal rule, guideline, protocol 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;
- 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; 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.

Appeal Procedures for Disability Claims
Procedure for appeal of denied claim

If you wish to appeal an initial denial of a disability claim, you or your authorized representative must file a written appeal with the Plan Administrator within 180 days after receipt of written notice of the denial. 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 to disability claims:

- The appeal decision will not defer to the initial decision denying your claim and will be made by the Plan Administrator who is not a 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 Plan Administrator 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; and
- 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.

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

Timing of written notice of appeal decision

Your appeal generally will be addressed at the next regularly scheduled quarterly meeting of the Trustees after an appeal is received. If, however, your appeal is received within 30 days prior to such a meeting, it will be considered by the second regularly scheduled quarterly meeting after it is received. In addition, if special circumstances require an extension of time for processing your appeal, a decision will be rendered no later than the third regularly scheduled quarterly meeting after your appeal is received. You will be notified of the decision no later than 5 days after it is made.

Optional second-stage appeal requesting a hearing

If your appeal is denied by the Trustees at your first-stage appeal review and your claim is not a pre-certification claim, you may request a second-stage appeal hearing before the Trustee Appeals Committee. Either you or a representative may present your claim at the appeal hearing. You must submit your request for such a hearing to the Plan Administrator within 60 days after notice of the first-stage appeal decision. Your appeal will be addressed by the next quarterly meeting of the Board of Trustees, unless your appeal is received within 30 days prior to such a meeting, in which case it will be addressed by the second regularly scheduled quarterly meeting after it is received.
The second-stage appeal hearing is optional, and you are not required to undertake it before pursuing legal action. If you request a second-stage appeal hearing, any applicable statute of limitations or other timelines will be tolled while the appeal is pending. The Trustee Appeals Committee will be impartial. Whether or not you seek a second-stage appeal hearing 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 second-stage appeal hearing, 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 second-stage hearing appeal.

Contents of written notice of appeal decision
If your disability claim is denied on appeal, the decision on review 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 your right to bring a civil action under Section 502(a) of ERISA;
- A copy of 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;
- 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; 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.”

Appeal Procedures for Medical Benefit Claims

Procedure for appeal of denied claim
A denial of a medical benefit 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 a denial of a claim, you or your authorized representative must file a written appeal with the applicable Claims Administrator within 180 days after receiving notice of 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 Administrator 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, free of charge upon request, have reasonable access to and copies of Relevant Documents (defined below). 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.
In addition:

- 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 or a subordinate of such person;
- If the initial denial decision was based in whole or in part on a medical judgment, the Claims Administrator 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 by telephone or in writing (including by facsimile), 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 Administrator or at the direction of the Claims Administrator in connection with the claim, and such information will be provided as soon as possible and sufficiently in advance of the date the final internal appeal decision is required to be issued to provide a reasonable opportunity for you to respond prior to that date; and
- If a final 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 final 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 written notice of appeal decision – pre-certification claims involving urgent care**

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

**Timing of written notice of appeal decision – claims denied due to failure to meet the Plan’s eligibility or enrollment requirements**

If your claim was denied due to failure to meet the Plan’s eligibility or enrollment requirements, your appeal will be generally will be addressed at the next regularly scheduled quarterly meeting of the Board of Trustees after an appeal is received. If, however, your appeal is received within 30 days prior to such a meeting, it will be considered by the second regularly scheduled quarterly meeting after it is received. In addition, if special circumstances require an extension of time for processing your appeal, a decision will be rendered no later than the third regularly scheduled quarterly meeting after your appeal is received. You will be notified of the decision no later than 5 days after it is made.

**Optional second-stage appeal requesting a hearing**

If your appeal is denied by the Trustees at your first-stage appeal review, you may request a
second-stage appeal hearing before the Trustee Appeals Committee. Either you or a representative may present your claim at the appeal hearing. You must submit your request for such a hearing to the Plan Administrator within 60 days after notice of the first-stage appeal decision. Your appeal will be addressed by the next quarterly meeting of the Board of Trustees, unless your appeal is received within 30 days prior to such a meeting, in which case it will be addressed by the second regularly scheduled quarterly meeting after it is received.

The second-stage appeal hearing is optional, and you are not required to undertake it before pursuing legal action. If you request a second-stage appeal hearing, any applicable statute of limitations or other timelines will be tolled while the appeal is pending. The Trustee Appeals Committee will be impartial. Whether or not you seek a second-stage appeal hearing 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 second-stage appeal hearing, 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 second-stage hearing appeal.

**Timing of written notice of appeal decision – other claims**

For all other claims, there is a two-level appeal process. 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 decision by the Trustee Appeals Committee or an external review. Nor will you be able to bring a lawsuit in court regarding your claim.

**Optional third-level appeal requesting a hearing**

If your appeal is denied by the Claims Administrator at your first-level and second-level appeal reviews, you may request a third-level appeal hearing before the Trustee Appeals Committee. Either you or a representative may present your claim at the appeal hearing. You must request such a hearing to the Trustee Appeals Committee within 60 days after notice of the second-level appeal decision. Your appeal will be addressed by the next quarterly meeting of the Board of Trustees, unless your appeal is received within 30 days prior to such a meeting, in which case it will be addressed by the second regularly scheduled quarterly meeting after it is received.
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 hearing, any applicable statute of limitations or other timelines will be tolled while the appeal is pending. The Trustee Appeals Committee will be impartial. Whether or not you seek a third-level appeal hearing 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 hearing, 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 hearing appeal.

Contents of written notice of appeal decision
If you appeal a denied medical benefit claim, the decision on review will be in writing and will include the following information:

- 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, including 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;
- 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;
- 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;
- A statement of your right to bring a civil action under Section 502(a) of ERISA;
- A copy of 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;
- 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; 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.

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; or a determination that treatment is Experimental or Investigational), as determined by the external reviewer; or (b) a rescission of coverage, regardless whether the rescission has any effect on a benefit at that time. 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 this section (“How to File a Claim”), “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 procedure of medical benefit claims, please contact the applicable Claims Administrator. However, any questions about the optional third-level appeal hearing for medical benefit claims, about the claim procedure for disability claims, or about Plan enrollment or eligibility, should be directed to the Plan’s Administrative Office.
XII. 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 shall 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 XII or as otherwise required or permitted by HIPAA.

Definitions
For purposes of this Section XII, 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, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

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 XII 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.
XIII. Definitions

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

Administrative Office: The Trust administrative office located at 1220 SW Morrison Street, Suite 300, Portland, Oregon 97205.

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 XI.

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 9) 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 his or her hour bank account balance (see page 7). Benefits for Collectively Bargained Active Participants include medical, prescription drug, dental, vision (including safety glasses), 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 to continue the safety glasses benefit. Covered Dependents (of all Active Participants) are eligible for the same benefits as Active Participants except that safety glasses and hearing aids are not available and Dependent children do not have coverage for contraceptives (except to the extent required by law), pregnancy, birth of a child, or related complications.

- **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 as Active Participants except that safety
glasses benefits are not available, 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 7) 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 9.

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

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 abuse 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 which is licensed by the state in which it is located as a Hospital, operated for the care and treatment of resident inpatients, and has a laboratory, Registered Graduate Nurses always on duty and an operating room where major surgical operations are performed by legally qualified Physicians.

The term “Hospital” does not include an institution or part of an institution which is used principally as a clinic; convalescent, rest, or nursing home; or as a home for the aged or for persons suffering from Substance Abuse.

**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 otherwiseCovered 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; 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.

**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 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 International Classification of Diseases as psychoses, neuroses, personality disorders, eating disorders and other nonpsychotic mental disorders. 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.

**Orthodontics:** Correction of malposed teeth, for any reason.

**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.

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 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 Sections V & VI.

Prosthetics: Artificial replacement of limbs, eyes or natural teeth and/or associated structures.

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 abuse-related 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, 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 (beginning on page 9) for Spouses who are eligible for coverage.

Substance Abuse: Those disorders listed in the International Classification of Diseases as mental and behavioral disorders due to dependence on alcohol or other drugs (including the nondependent abuse of drugs). No other disorders or conditions are included in the term “Substance Abuse” for purposes of the benefit provisions of this Plan.

Substance Abuse Treatment Facility: A facility, including a residential treatment center, that provides treatment for chronic alcoholism or other Substance Abuse 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.
XIV. 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.

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. Both the Board of Trustees and the Administrative Office can be reached at:

Idaho Pipe Trades Trust
c/o Administrative Office
1220 SW Morrison Street, Suite 300
Portland, Oregon 97205
(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 (OptumRx, Inc.). See page 83 for contact information. The Trustees may, from time to 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, and vision benefits for Covered Participants and Covered Dependents; hearing aid coverage is for Covered 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  John Kierce, Secretary
Melvin Cromwell  Mark Hosick
Teresa Paige  Dave Anderson

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, 1220 SW Morrison Street, Suite 300, Portland, Oregon 97205. 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 OptumRx, Inc. Stop Loss coverage is insured by Blue Cross of Idaho. For contact information, see Section XV.

**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
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.

**Discrimination is Against the Law**
The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with the Plan, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats); and

- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the Administrative Office. You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you, or someone you’re helping, has questions about Idaho Pipe Trades Health and Welfare Plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (800) 808-1687.
Falls Sie oder jemand, dem Sie helfen, Fragen zum Idaho Pipe Trades Health and Welfare Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 808-1687 an.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Idaho Pipe Trades Health and Welfare Plan, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa (800) 808-1687.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Idaho Pipe Trades Health and Welfare Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (800) 808-1687.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Idaho Pipe Trades Health and Welfare Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (800) 808-1687.

ご本人様、またはお客様の身の回りの方でも、Idaho Pipe Trades Health and Welfare Planについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(800) 808-1687 までお電話ください。

Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind Idaho Pipe Trades Health and Welfare Plan, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la (800) 808-1687.

To aan, malla goɗɗo mo mbellata, e ƙarma dow Idaho Pipe Trades Health and Welfare Plan, a woodi baawɗe heɓuki habaru malla wallireeki wolde maɗa naa maa a yoɓii. Mbolda e pirtoowo, nodda (800) 808-1687.

، داشتە باشيد حق اين را داريد كە ھەکم Idaho Pipe Trades Health and Welfare Plan

اگر شما، يا كمسي كە شما بە او كمک ميکنيد ، سوال در مورد
و اطلاعات به زبان خود را به طور رایگان دریافت نماييد . (800) 1687-808 تامس حاصل نمایید.

Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про Idaho Pipe Trades Health and Welfare Plan у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв’язатись з перекладачем, задзвоніть на (800) 808-1687.
XV. Contact Information

Following is some useful contact information:

Contact Information

Call the Plan Administrative Office for eligibility and Self-Pay questions. Blue Cross of Idaho is the third-party 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  
1220 SW Morrison Street, Suite 300  
Portland, Oregon 97205  
Phone: (208) 288-1610  
Toll Free: (800) 808-1687  
Fax: (208) 288-1670  
www.iptt.org

Pharmacy Benefit Manager (PBM)& Mail Order Pharmacy  
OptumRx, Inc.  
PO Box 509075,  
San Diego, CA 92150-9075  
Labor & Trust Help Desk: (866) 328-2005  
www.optumrx.com

Claims Administrator (Medical, Dental, Vision & Hearing Aids)  
Blue Cross of Idaho  
P.O. Box 7408  
Boise, Idaho 83707  
For claims questions, call  
Toll Free: (800) 627-1188 (Medical & Hearing Aid)  
(800) 289-7929 (Dental)  
(800) 877-7195 (Vision)  
You can access a list of network providers at:  
www.bcidaho.com

Hospital Preadmission and Other Courtesy Assessments, Utilization Management and Case Management  
Call Blue Cross of Idaho at (800) 743-1871 before treatment or Hospital admission to obtain a courtesy assessment of Medical Necessity and determine if case management services are appropriate.

Written communications (including written communications made 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  
www.iptt.org.