



Group Health Options, Inc.
Contracts and Coverage
PO BOX 34589
Seattle, WA 98124-1589

Enclosed is the 2008 Group Health Options, Inc. medical coverage agreement.

Please have the group's representative sign this document and return that page to the Contracts department at PO Box 34589, Seattle, WA 98124-1589 or you can email it to your Marketing representative.

Benefit or contract provisions that you or Group Health might have requested or negotiated during the renewal process are included in the enclosed medical coverage agreement. The Premium schedule, which is part of the medical coverage agreement, confirms the premiums specified in a previous letter, which the group has accepted.

If you have any questions about this information or your new contract, please call your Marketing account executive:

Seattle	(206) 448-4140 or toll free in WA 1-800-542-6312
Tacoma	(253) 383-6226 or toll free in WA 1-800-854-5322
Eastern WA/NorthID	(509) 459-9100 or toll free in WA 1-800-497-2210
Central WA	(509) 783-3484 or toll free in WA 1-800-458-5450

We appreciate your business.

Sincerely,

Contract Administration



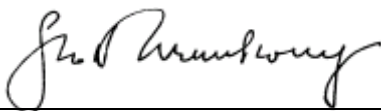
LARGE GROUP GENERAL MANAGED CARE PLAN

Group Health Options, Inc. (also referred to as "GHO") is a Disability Insurer with Managed Care Line, duly registered under the laws of the State of Idaho, furnishing health care coverage on a prepayment basis. The Group identified below wishes to purchase such coverage. This Agreement sets forth the terms under which that coverage will be provided, including the rights and responsibilities of the contracting parties; requirements for enrollment and eligibility; and benefits to which those enrolled under this Agreement are entitled.

The Agreement between GHO and the Group consists of the following:

- Standard Provisions
- Attached Benefit Booklet
- Signed Group application
- Premium Schedule
- All attachments and endorsements included or issued hereafter

Group Health Options, Inc

Signed: 

Title: President

North Idaho College, 6987800

Signed: _____

Title: _____

This Agreement will continue in effect until terminated or renewed as herein provided for and is effective July 1, 2008.

CA-159708

**Group Medical Coverage Agreement
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Standard Provisions

Attachment 1 Benefit Booklet

Attachment 2 Premium Schedule

Standard Provisions

1. GHO agrees to provide benefits as set forth in the attached Benefit Booklet to Enrollees of the Group.
2. **Monthly Premium Payments.** For the initial term of this Agreement, the Group shall submit to GHO for each Enrollee the monthly premiums set forth in the current Premium Schedule and a verification of enrollment. Payment must be received on or before the due date and is subject to a grace period of ten (10) days. Premiums are subject to change by GHO upon thirty (30) days written notice. Premium rates will be revised as a part of the annual renewal process. Any unearned premium in the event of termination shall be returned on a prorata basis in accordance with applicable Idaho state law. For the purpose of this section, “unearned health insurance premium” means that portion of any premium collected which is not used, on a prorata basis to the beginning of the next monthly billing cycle at the time of cancellation.

The Group will be responsible for costs of any claims incurred or services provided after retroactive termination of this Agreement because of non-payment of premium.

The Group will be responsible for the cost of any claims incurred for services paid or provided in reliance on inaccurate reporting of member enrollment made by the Group.

In the event the Group increases or decreases enrollment at least twenty-five percent (25%) or more, GHO reserves the right to require re-rating of the Group.

3. **Dissemination of Information.** Unless the Group has accepted responsibility to do so, GHO will disseminate information describing benefits set forth in the Benefit Booklet attached to this Agreement.

GHO will furnish to the Enrollee for delivery to each Enrollee’s Dependent, a statement in summary form of the essential features of the insurance coverage of such Enrollee and to whom benefits thereunder are payable. If Dependents are included in the coverage, only one certificate need be issued for each Family Unit.

4. **Identification Cards.** GHO will furnish cards, for identification purposes only, to all Enrollees enrolled under this Agreement.
5. **Administration of Agreement.** GHO may adopt reasonable policies and procedures to help in the administration of this Agreement. GHO reserves the right to construe the provisions of this Agreement and make all determinations regarding benefit entitlement and coverage.
6. **Modification of Agreement.** Except as required by federal and Washington or Idaho State law, this Agreement may not be modified without agreement between both parties.

Any such agreement affecting modification of benefits under this Agreement shall be communicated in writing to all affected Subscribers enrolled at the time of such change.

No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this Agreement, convey or void any coverage, increase or reduce any benefits under this Agreement or be used in the prosecution or defense of a claim under this Agreement.

7. **Indemnification.** GHO agrees to indemnify and hold the Group harmless against all claims, damages, losses and expenses, including reasonable attorney’s fees, arising out of GHO’s failure to perform, negligent performance or willful misconduct of its directors, officers, employees and agents of their express obligations under this Agreement.

The Group agrees to indemnify and hold GHO harmless against all claims, damages, losses and expenses, including reasonable attorney’s fees, arising out of the Group’s failure to perform, negligent performances or

willful misconduct of its directors, officers, employees and agents of their express obligations under this Agreement.

The indemnifying party shall give the other party prompt notice of any claim covered by this section and provide reasonable assistance (at its expense). The indemnifying party shall have the right and duty to assume the control of the defense thereof with counsel reasonably acceptable to the other party. Either party may take part in the defense at its own expense after the other party assumes the control thereof.

- 8. Compliance With Law.** The Group and GHO shall comply with all applicable state and federal laws and regulations in performance of this Agreement.

This Agreement is entered into and governed by the laws of the State of Idaho.

- 9. Governmental Approval.** If GHO has not received any necessary government approval by the date when notice is required under this Agreement, GHO will notify the Group of any changes once governmental approval has been received. GHO may amend this Agreement by giving notice to the Group upon receipt of government approved rates, benefits, limitations, exclusions or other provisions, in which case such rates, benefits, limitations, exclusions or provisions will go into effect as required by the governmental agency. All amendments are deemed accepted by the Group unless the Group gives GHO written notice of non-acceptance within thirty (30) days after receipt of amendment, in which event this Agreement and all rights to services and other benefits terminate the first of the month following thirty (30) days after receipt of non-acceptance.

- 10. Confidentiality.** Each party acknowledges that performance of its obligations under this Agreement may involve access to and disclosure of data, procedures, materials, lists, systems and information, including medical records, employee benefits information, employee addresses, social security numbers, e-mail addresses, phone numbers and other confidential information regarding the Group's employees (collectively the "information"). The information shall be kept strictly confidential and shall not be disclosed to any third party other than: (i) representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such information in order to perform the services required of such party pursuant to this Agreement, or for the proper management and administration of the receiving party, provided that such representatives are informed of the confidentiality provisions of this Agreement and agree to abide by them, (ii) pursuant to court order or (iii) to a designated public official or agency pursuant to the requirements of federal, state or local law, statute, rule or regulation. The disclosing party will provide the other party with prompt notice of any request the disclosing party receives to disclose information pursuant to applicable legal requirements, so that the other party may object to the request and/or seek an appropriate protective order against such request. Each party shall maintain the confidentiality of medical records and confidential patient and employee information as required by applicable law.

11. HIPAA.

Definition of Terms. Terms used, but not otherwise defined, in this Section shall have the same meaning as those terms have in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Transactions Accepted. GHO will accept Standard Transactions, pursuant to HIPAA, if the Group elects to transmit such transactions. If the Group sends transactions to GHO that do not comply with applicable HIPAA standards, the Group will be deemed by such action to be representing and warranting that it is not a Covered Entity or otherwise required to comply with HIPAA standards for electronic transactions, either directly, or as an agent of another individual or entity. The parties agree that all the terms, conditions, representations and warranties contained in this section are express obligations of the Group, and the Group shall indemnify GHO for any breach of this section.

- 12. Renewability of Coverage of Entire Agreement.** Coverage under this Agreement shall be renewable with respect to all Eligible Employees or Dependents at the option of the employer, except in the following cases:
- a. Nonpayment of required premium.
 - b. Fraud or intentional misrepresentation of material fact by the employer.

- c. Noncompliance with GHO's minimum participation or employer contribution requirements.
- d. Noncompliance with GHO's employer contribution requirements.
- e. In the case of Health Benefit Plans that are made available in the employer market only through one (1) or more Associations, the membership of an employer in the Association, on the basis of which the coverage is provided ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.
- f. The employer no longer meets the requirements of a Large Employer.
- g. Election by GHO not to renew any of its Health Benefit Plans, which are delivered or issued for delivery to Large Employers in the state of Idaho. In such case GHO shall:
 - i. Provide advance notice of its decision under this paragraph to the director in each state in which it is licensed; and
 - ii. Provide notice of the decision not to renew coverage to all affected Large Employers and to the director at least one hundred eighty (180) days prior to the non-renewal of any GHO Health Benefit Plans. Notice to the director under the provisions of this paragraph shall be provided at least three (3) working days prior to the notice to the affected Large Employers.
- h. In the event the Director of the Idaho Department of Insurance finds that the continuation of coverage would:
 - i. Not be in the best interests of the Enrollees; or
 - ii. Impair GHO's ability to meet its contractual obligations.In such instance, the Director shall assist affected Large Employers in finding replacement coverage.
- i. These provisions apply only to GHO's operations within the GHO Service Area.

Dear Group Health Options Subscriber:

This booklet contains important information about your healthcare plan.

This is your 2008 GHO Benefit Booklet (Certificate of Coverage). It explains the services and benefits you and those enrolled on your contract are entitled to receive from Group Health Options, Inc. Sections of this document may be ***bolded and italicized***, which identifies changes that Group Health has made to the plan. The benefits reflected in this booklet were approved by your employer or association who contracts with Group Health Options, Inc., for your healthcare coverage. If you are eligible for Medicare, please read Section IV.J. as it may affect your prescription drug coverage.

We recommend you read it carefully so you'll understand not only the benefits, but the exclusions, limitations and eligibility requirements of this certificate. Please keep this certificate for as long as you are covered by Group Health Options, Inc. We will send you revisions if there are any changes in your coverage.

This certificate is not the contract itself; you can contact your employer or group administrator if you wish to see a copy of the contract (Medical Coverage Agreement).

We'll gladly answer any questions you might have about your GHO benefits. Please call our GHO Customer Service Center at (206) 901-4636, or toll-free, (888) 901-4636.

Thank you for choosing Group Health Options. We look forward to working with you to preserve and enhance your health.

Very truly yours,

Scott Armstrong
President

CA-1597a08

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Section I. Introduction

Group Health Options, Inc. (also referred to as “GHO”) is a Disability Insurer with a Managed Care Line, duly registered under the laws of the State of Idaho, furnishing health care coverage on a prepayment basis.

Read This Benefit Booklet Carefully

This Benefit Booklet is a statement of benefits, exclusions and other provisions, as set forth in the Group Medical Coverage Agreement (“Agreement”) between GHO and the employer or Group.

A full description of benefits, exclusions, limits and Out-of-Pocket Expenses can be found in the Schedule of Benefits, Section IV; General Exclusions, Section V; and Allowances Schedule, Section II. These sections must be considered together to fully understand the benefits available under the Agreement. Words with special meaning are capitalized. They are defined in Section VIII.

A. Accessing Care

Enrollees are entitled to Covered Services from either:

- GHO’s Managed Health Care Network, referred to as “MHCN,” or
- Community Providers or Preferred Community Providers on a Self-Referred basis.

Enrollees may choose either health care delivery option at any time during or for differing episodes of illness or injury, except during a scheduled inpatient admission.

Benefits paid under one option will not be duplicated under the other option.

Under the Agreement, the level of benefits available for services received at or upon Referral by the MHCN is generally greater than the level of benefits available for services received from Community Providers. In order for services to be covered at the higher benefit level, services must be obtained by MHCN Providers at MHCN Facilities, except as follows:

- Emergency care,
- Self-Referral to women’s MHCN health care providers, as set forth below,
- Visits with MHCN-Designated Self-Referral Specialists, as set forth below,
- Care provided pursuant to a Referral. Referrals must be requested by the Enrollee’s MHCN Personal Physician and approved by GHO, and
- Other services as specifically set forth in the Allowances Schedule and Section IV.

Some services are covered only when obtained from or upon Referral by the MHCN.

All inpatient admissions prescribed by a Community Provider must be authorized in advance by GHO. Enrollee may refer to Section IV.A. for more information about inpatient admissions.

Primary Care. Enrollees must select a MHCN Personal Physician when enrolling under the Agreement. One Personal Physician may be selected for an entire family, or a different Personal Physician may be selected for each family member. If the Personal Physician is not selected at the time of enrollment, GHO will assign a Personal Physician, and a letter of explanation will be sent to the Enrollee.

Selecting a Personal Physician or changing from one Personal Physician to another can be accomplished by contacting GHO Customer Service, or accessing the GHO website at www.ghc.org. The change will be made within twenty-four (24) hours of the receipt of the request, if the selected physician’s caseload permits.

A listing of MHCN Personal Physicians, Referral specialists, women's health care providers and MHCN-Designated Self-Referral Specialists is available by contacting GHO Customer Service at (206) 901-4636 or (888) 901-4636, or by accessing GHO's website at www.ghc.org.

In the case that the Enrollee's Personal Physician no longer participates in the MHCN, the Enrollee will be provided a written notice offering the Enrollee a selection of new Personal Physicians from which to choose.

Specialty Care. Unless otherwise indicated in this section, the Allowances Schedule or Section IV., Referrals are required for specialty care and specialists inside the network.

MHCN-Designated Self-Referral Specialist. Enrollees may make appointments directly with MHCN-Designated Self-Referral Specialists at Group Health-owned or -operated medical centers without a Referral from their Personal Physician. Self-Referrals are available for the following specialty care areas: allergy, audiology, cardiology, chemical dependency, chiropractic/manipulative therapy, dermatology, gastroenterology, general surgery, hospice, manipulative therapy, mental health, nephrology, neurology, obstetrics and gynecology, occupational medicine*, oncology/hematology, ophthalmology, optometry, orthopedics, otolaryngology (ear, nose and throat), physical therapy*, smoking cessation, speech/language and learning services* and urology.

* Medicare patients need a Referral for these specialists.

Women's Health Care Direct Access Providers. Female Enrollees may see a participating General and Family Practitioner, Physician's Assistant, Gynecologist, Certified Nurse Midwife, Licensed Midwife, Doctor of Osteopathy, Pediatrician, Obstetrician or Advanced Registered Nurse Practitioner who is contracted by GHO to provide women's health care services directly, without a Referral from their Personal Physician, for Medically Necessary maternity care, covered reproductive health services, preventive care (well care) and general examinations, gynecological care and follow-up visits for the above services. Within the MHCN, women's health care services are covered as if the Enrollee's Personal Physician had been consulted, subject to any applicable Cost Shares, as set forth in the Allowances Schedule. Women's health care services obtained from a Community Provider are covered at the Community Provider benefit level. If the Enrollee's women's health care provider diagnoses a condition that requires Referral to other specialists or hospitalization, the Enrollee or her chosen provider must obtain preauthorization and care coordination in accordance with applicable GHO requirements.

Second Opinions. The Enrollee may access, upon request, a second opinion regarding a medical diagnosis or treatment plan from a MHCN Provider. The Enrollee may also access a second opinion from a Community Provider, subject to the Community Provider benefit level.

Emergent and Urgent Care. Emergent care is available at MHCN Facilities. If Enrollees cannot get to a MHCN Facility, Enrollees may obtain Emergency services from the nearest hospital. Enrollees, or persons assuming responsibility for an Enrollee must notify GHO by way of the GHO Emergency Notification Line within twenty-four (24) hours of any admission, or as soon thereafter as medically possible. Enrollees may refer to Section IV. for more information about coverage of Emergency services under the MHCN and Community Provider options.

Under the MHCN option, urgent care is covered only at MHCN medical centers, MHCN urgent care clinics or MHCN Provider's offices. Urgent care received at any hospital emergency department is not covered unless authorized in advance by a MHCN Provider. Enrollees may refer to Section IV. for more information about coverage of urgent care services.

Under the Community Provider option, urgent care is covered at any medical facility. Enrollees may refer to Section IV. for more information about coverage of urgent care services.

Recommended Treatment. Under the MHCN option, *the MHCN Provider in conjunction with* GHO's Medical Director, or his/her designee, will determine the necessity, nature and extent of treatment to be covered under the MHCN benefit in each individual case and the judgment, made in good faith, will be final.

Enrollees have the right to participate in decisions regarding their health care. An Enrollee may refuse any recommended treatment or diagnostic plan to the extent permitted by law. Enrollees who obtain care not recommended by *the MHCN Provider* do so with the full understanding that such care will not be covered at the MHCN benefit level. ***Covered services received from a Community Provider are subject to the Community Provider benefit level.*** Coverage decisions may be appealed as set forth in Section VI.

Major Disaster or Epidemic. In the event of a major disaster or epidemic, GHO will pay benefits for Covered Services through the MHCN according to GHO's best judgment, within the limitations of available MHCN Facilities and personnel. GHO has no liability for delay or failure to provide or arrange Covered Services to the extent facilities or personnel are unavailable due to a major disaster or epidemic.

Unusual Circumstances. Under the MHCN option, if the provision of Covered Services is delayed or rendered impossible due to unusual circumstances such as complete or partial destruction of MHCN Facilities, military action, civil disorder, labor disputes or similar causes, GHO shall ensure that its MHCN provide and arrange for services that, in the reasonable opinion of GHO's Medical Director, or his/her designee, are emergent or urgently needed. In regard to nonurgent and routine services, GHO shall make a good faith effort to make the then-existing MHCN Facilities and personnel available. The MHCN shall have the option to defer or reschedule services that are not urgent while its facilities and services are so affected. In no case shall GHO have any liability or obligation on account of delay or failure to provide or arrange such services.

Under the Community Provider option, if the provision of Covered Services is delayed or rendered impossible due to unusual circumstances such as military action, civil disorder, labor disputes, or similar causes, in no case shall GHO have any liability or obligation on account of delay.

B. Cost Shares

The Subscriber shall be liable for the following Cost Shares when services are received by the Subscriber and any of his/her Dependents.

- 1. Copayments.** Enrollees shall be required to pay Copayments at the time of service as set forth in the Allowances Schedule. Payment of a Copayment does not exclude the possibility of an additional billing if the service is determined to be a non-Covered Service.
- 2. Annual Deductible.**
 - a. MHCN.** Unless otherwise noted, Covered Services received from a MHCN Provider are subject to the annual Deductible set forth in the Allowances Schedule.

Under the MHCN option, charges subject to the annual Deductible shall be borne by the Subscriber during each contract year until the annual Deductible is met. In order to be applied against the annual Deductible, Covered Services must be obtained at MHCN Facilities, unless the Enrollee has received a Referral from a MHCN Provider or has received Emergency services according to the Schedule of Benefits, Section IV.L.

- b. Community Provider.** Unless otherwise noted, Covered Services received from a Community Provider are subject to the annual Deductible set forth in the Allowances Schedule.

Under the Community Provider option, charges subject to the annual Deductible shall be borne by the Subscriber during each contract year until the annual Deductible is met.

There is an individual annual Deductible amount for each Enrollee and a maximum aggregate annual Deductible amount for each Family Unit. Once the aggregate annual Deductible amount is reached for a Family Unit in a contract year, the individual annual Deductibles are also deemed reached for each Enrollee during that same contract year.

3. **Individual Annual Deductible Carryover.** Under either option, charges applied toward each individual annual Deductible during the months of April, May and June are also applied in an equal amount toward the Enrollee's annual Deductible for the next contract year. The individual annual Deductible carryover will apply only when expenses incurred have been paid in full. The aggregate Family Unit Deductible does not carry over into the next contract year.

4. **Coinsurance.**

- a. **MHCN:** After the annual Deductible is satisfied, Enrollees shall be required to pay the Plan Coinsurance for Covered Services as set forth in the Allowances Schedule.
- b. **Community Provider:** After the annual Deductible is satisfied, Enrollees shall be required to pay the Plan Coinsurance for Covered Services as set forth in the Allowances Schedule.

A benefit-specific coinsurance may apply to some Covered Services, as set forth in the Allowances Schedule. Services that are subject to the benefit-specific coinsurance are not subject to the Plan Coinsurance.

5. **Out-of-Pocket Limit.** Under either the MHCN or Community Provider option, total Out-of-Pocket Expenses incurred during the same contract year shall not exceed the Out-of-Pocket Limit set forth in the Allowances Schedule. Out-of-Pocket Expenses which apply toward the Out-of-Pocket Limit are set forth in the Allowances Schedule.

6. **Deductibles.** In addition to any applicable annual Deductible, there may be service-specific Deductibles as set forth in the Allowances Schedule.

C. **Subscriber's Liability**

The Subscriber is liable for (1) payment to the Group of his/her contribution toward the monthly premium, if any; (2) payment of Cost Share amounts for Covered Services provided to the Subscriber and his/her Dependents, as set forth in the Allowances Schedule; and (3) payment of any fees charged for non-Covered Services provided to the Subscriber and his/her Dependents, at the time of service.

Payment of an amount billed by GHO must be received within thirty (30) days of the billing date.

Enrollees shall not, under any circumstances, be liable, assessable or in any way subject to payment for the debts, liabilities, insolvency, impairment or any other financial obligations of GHO.

No health care provider shall require an Enrollee to make additional payments for Covered Services under the Agreement, other than specified Deductibles, Copayments or coinsurance, once a provider has agreed in writing to accept GHO's reimbursement rate to provide a Covered Service.

D. **Claims**

Claims for benefits may be made before or after services are obtained. To make a claim for benefits under the Agreement, an Enrollee (or the Enrollee's authorized representative) must contact GHO Customer Service, or submit a claim for reimbursement as described below. Other inquiries, such as asking a health care provider about care or coverage, or submitting a prescription to a pharmacy, will not be considered a claim for benefits.

If an Enrollee receives a bill for services the Enrollee believes are covered under the Agreement, the Enrollee must, within ninety (90) days of the date of service, or as soon thereafter as reasonably possible, either (1) contact GHO Customer Service to make a claim or (2) pay the bill and submit a claim for reimbursement of Covered Services to GHO, P.O. Box 34585, Seattle, WA 98124-1585. In no event, except in the absence of legal capacity, shall a claim be accepted later than one (1) year from the date of service.

GHO will generally process claims for benefits within the following timeframes after GHO receives the claims:

- Pre-service claims – within fifteen (15) days.
- Claims involving urgently needed care – within seventy-two (72) hours.
- Concurrent care claims – within twenty-four (24) hours.
- Post-service claims – within thirty (30) days.

Timeframes for pre-service and post-service claims can be extended by GHO for up to an additional fifteen (15) days. Enrollees will be notified in writing of such extension prior to the expiration of the initial timeframe.

Section II. Allowances Schedule

MHCN: Describes coverage when care is provided by a MHCN Provider or referred by a MHCN Personal Physician. Benefits paid under the MHCN option will not be duplicated under the Community Provider option.

Community Provider: Describes coverage when care is provided by a Community Provider on a Self-Referred basis. Coverage is limited to Usual, Customary and Reasonable (UCR) charges, less any applicable Cost Share amounts as noted below. Benefits paid under the Community Provider option will not be duplicated under the MHCN option.

The benefits described in this schedule are subject to all provisions, limitations and exclusions set forth in the Group Medical Coverage Agreement.

“Welcome” Outpatient Services Waiver

Not applicable.

Annual Deductible

\$1,000 per Enrollee or \$2,000 per Family Unit per contract year. Annual Deductible does not apply to outpatient services.

Plan Coinsurance

MHCN: No Plan Coinsurance.

Community Provider: Plan Coinsurance share is 70% of the Usual, Customary and Reasonable charges; Enrollee coinsurance share is 30%, after the annual Deductible is satisfied.

Lifetime Maximum

\$2,000,000 per Enrollee for Covered Services incurred, unless otherwise indicated. Up to \$5,000 is restored automatically each July 1 for benefits paid by GHO during the prior contract year.

Hospital Services

- Covered inpatient medical and surgical services, including acute chemical withdrawal (detoxification)

MHCN: Covered in full after the annual Deductible is satisfied.

Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied. Preauthorization is required for scheduled admissions as set forth in Section IV.A.

- Covered outpatient hospital surgery (including ambulatory surgical centers)

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

Outpatient Services

- Covered outpatient medical and surgical services

MHCN: Covered subject to *the lesser of the MHCN's charge or* a \$30 outpatient services Copayment. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* a \$30 outpatient services Copayment and at the Plan Coinsurance. Annual Deductible does not apply to outpatient services.

- Allergy testing

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

- Oncology (radiation therapy, chemotherapy)

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

Drugs - Outpatient (including mental health drugs, contraceptive drugs and devices and diabetic supplies)

- Prescription drugs, medicines, supplies and devices for a supply of thirty (30) days or less

MHCN: Generic drugs listed in the GHO drug formulary (Tier 1) - Covered subject to the lesser of the MHCN's charge or a \$10 Copayment.

Brand name drugs listed in the GHO drug formulary (Tier 2) - Covered subject to the lesser of the MHCN's charge or a \$20 Copayment.

Non-formulary generic and brand name drugs (Tier 3) - Covered subject to the lesser of the MHCN's charge or a \$40 Copayment.

Community Provider: Generic drugs listed in the GHO drug formulary (Tier 1) - Covered subject to *the lesser of the allowed charge or* a \$15 Copayment.

Brand name drugs listed in the GHO drug formulary (Tier 2) - Covered subject to *the lesser of the allowed charge or* a \$25 Copayment.

Non-formulary generic and brand name drugs (Tier 3) - Covered subject to *the lesser of the allowed charge or* a \$45 Copayment.

- Over-the-counter drugs and medicines

Not covered.

- Allergy serum

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable prescription drug Cost Share (as set forth above) for each thirty (30) day supply.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable prescription drug Cost Share (as set forth above) for each thirty (30) day supply.

- Injectables

MHCN: Injections that can be self-administered are subject to *the lesser of the MHCN's charge or* the applicable prescription drug Cost Share (as set forth above). Injections necessary for travel are not covered.

Community Provider: Injections that can be self-administered are subject to *the lesser of the allowed charge or* the applicable prescription drug Cost Share (as set forth above). Injections necessary for travel are not covered.

- Mail order drugs and medicines

MHCN: Covered subject to *the lesser of the MHCN's charge or* two (2) times the applicable prescription drug Cost Share (as set forth above) for each ninety (90) day supply or less for mail order prescription drugs.

Community Provider: Not covered.

- Growth hormones

MHCN: Covered at the Plan Coinsurance after the annual Deductible is satisfied, subject to the Pre-Existing Condition waiting period.

Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied, subject to the Pre-Existing Condition waiting period.

Out-of-Pocket Limit

Limited to an aggregate maximum of \$2,000 per Enrollee or \$4,000 per family per contract year. Except as otherwise noted in the specific service categories of this Allowances Schedule, the following Out-of-Pocket Expenses apply to the Out-of-Pocket Limit:

MHCN Out-of-Pocket Expenses: Outpatient services Copayment, emergency care Copayment at a MHCN Facility and ambulance coinsurance/Copayment.

Community Provider Out-of-Pocket Expenses: Plan Coinsurance, emergency care Deductible at a non-MHCN Facility and ambulance coinsurance/Copayment.

Acupuncture

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Cost Share for Self-Referrals to a MHCN Provider up to a maximum of eight (8) visits per Enrollee per medical diagnosis per contract year. When approved by GHO, additional visits are covered. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

Ambulance Services

- Emergency ground/air transport

MHCN: Covered at 80% for transport to a MHCN Facility. Not subject to the annual Deductible.

Community Provider: Covered at 80% for transport to a non-MHCN Facility. Not subject to the annual Deductible.

- Non-emergent ground/air interfacility transfer

MHCN: Covered at 80% for MHCN-initiated transfers, except hospital-to-hospital ground transfers covered in full. Not subject to the annual Deductible.

Community Provider: Covered at 80% for transport from one medical facility to the nearest facility equipped to render further Medically Necessary treatment when prescribed by the attending physician. Not subject to the annual Deductible.

Chemical Dependency

- Inpatient services

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable inpatient services Cost Share.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable inpatient services Cost Share.

- Outpatient services

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

- Benefit period Allowance

MHCN and Community Provider benefit limits are combined and cannot be duplicated.

MHCN: Covered up to **\$14,000** per Enrollee per any twenty-four (24) consecutive calendar month period.

Community Provider: Covered up to **\$14,000** per Enrollee per any twenty-four (24) consecutive calendar month period.

Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.

Dental Services (including accidental injury to natural teeth)

MHCN: Not covered.

Community Provider: Not covered.

Devices, Equipment and Supplies (for home use)

- Durable medical equipment

- Orthopedic appliances
- Post-mastectomy bras

MHCN and Community Provider benefit limits are combined and cannot be duplicated.

MHCN: Covered at 80% up to \$5,000 (\$4,000 maximum benefit) per contract year.

Community Provider: Covered at 80% up to \$5,000 (\$4,000 maximum benefit) per contract year after the annual Deductible is satisfied.

- Ostomy supplies
- Prosthetic devices

MHCN and Community Provider benefit limits are combined and cannot be duplicated.

MHCN: Covered at 80% up to \$40,000 (\$32,000 maximum benefit) per contract year. Breast prostheses are covered in full after the annual Deductible is satisfied.

Community Provider: Covered at 80% up to \$40,000 (\$32,000 maximum benefit) per contract year after the annual Deductible is satisfied. Breast prostheses are covered at the Plan Coinsurance after the annual Deductible is satisfied.

Diabetic Supplies

MHCN: Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.

Community Provider: Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.

Diagnostic Laboratory and Radiology Services

MHCN: Covered in full after the annual Deductible is satisfied. Annual Deductible does not apply to outpatient services.

Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied. Annual Deductible does not apply to outpatient services.

Emergency Services

MHCN: Covered subject to *the lesser of the MHCN's charge or* a \$75 Copayment per Enrollee per Emergency visit at a MHCN Facility after the annual Deductible is satisfied. Copayment is waived if the Enrollee is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services Cost Share.

Community Provider: Covered subject to a \$125 Deductible or total charge of services, whichever is less, at a non-MHCN Facility, after the annual Deductible is satisfied. Emergency admissions are covered subject to the applicable inpatient services Cost Share.

Emergency care Deductible is not waived if the Enrollee is admitted as an inpatient to a non-MHCN hospital directly from the emergency department. The Enrollee must notify GHO within twenty-four (24) hours following admission, or as soon thereafter as medically possible, and agree to have care managed by the MHCN in order to

have inpatient services covered at the MHCN benefit level. If the Enrollee does not notify GHO as required, or declines to have care managed by the MHCN, all inpatient services the Enrollee receives are covered subject to the applicable inpatient services Cost Share.

Hearing Examinations and Hearing Aids

- Hearing examinations to determine hearing loss

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

- Hearing aids, including hearing aid examinations

MHCN: Not covered.

Community Provider: Not covered.

Home Health Services

MHCN: Covered in full up to 130 visits per Enrollee per contract year.

Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied for up to 130 visits per contract year.

Hospice Services

MHCN: Covered in full. Inpatient respite care is covered for a maximum of five (5) consecutive days per occurrence.

Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied. Inpatient respite care is covered for a maximum of five (5) consecutive days per occurrence. Preauthorization is required for scheduled hospice admissions, as set forth in Section IV.A.

Infertility Services (including sterility)

MHCN: Not covered.

Community Provider: Not covered.

Manipulative Therapy

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Cost Share for Self-Referrals to a MHCN Provider for manipulative therapy of the spine and extremities in accordance with GHO clinical criteria up to a maximum of twenty (20) visits per Enrollee per contract year. When approved by GHO, additional manipulation visits are covered. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share for manipulative therapy of the spine or extremities up to a maximum of twenty (20) visits per Enrollee per contract year. Annual Deductible does not apply to outpatient services.

Maternity and Pregnancy Services

- Delivery and associated Hospital Care

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable inpatient services Cost Share.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable inpatient services Cost Share.

- Routine prenatal and postpartum care

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

- Pregnancy termination

MHCN: *Voluntary termination of pregnancy is not covered. Voluntary termination of pregnancy means termination of pregnancy for any reason other than to preserve the life of the female upon whom the termination of pregnancy is performed.*

Community Provider: *Voluntary termination of pregnancy is not covered. Voluntary termination of pregnancy means termination of pregnancy for any reason other than to preserve the life of the female upon whom the termination of pregnancy is performed.*

Mental Health Services

- Inpatient services

MHCN and Community Provider benefit limits are combined and cannot be duplicated.

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable inpatient services Cost Share for up to twelve (12) days per Enrollee per contract year at a GHO-approved mental health care facility.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable inpatient services Cost Share for up to twelve (12) days per Enrollee per contract year.

- Outpatient services

MHCN and Community Provider benefit limits are combined and cannot be duplicated.

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Cost Share for up to twenty (20) visits per Enrollee per contract year. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share for up to twenty (20) visits per Enrollee per contract year. Annual Deductible does not apply to outpatient services.

Naturopathy

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Cost Share for Self-Referrals to a MHCN Provider up to a maximum of three (3) visits per Enrollee per medical diagnosis per contract year. When approved by GHO, additional visits are covered. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

Nutritional Services

- Phenylketonuria (PKU) supplements

MHCN: Covered in full.

Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied.

- Enteral therapy (formula)

MHCN: Covered at 80% for elemental formulas after the annual Deductible is satisfied. Necessary equipment and supplies are covered under Devices, Equipment and Supplies. Coinsurance does not apply to the Out-of-Pocket Limit.

Community Provider: Covered at the Plan Coinsurance for elemental formulas after the annual Deductible is satisfied. Necessary equipment and supplies are covered under Devices, Equipment and Supplies. Coinsurance does not apply to the Out-of-Pocket Limit.

- Parenteral therapy (total parenteral nutrition)

MHCN: Covered for parenteral formulas after the annual Deductible is satisfied. Necessary equipment and supplies are covered under Devices, Equipment and Supplies.

Community Provider: Covered at the Plan Coinsurance for parenteral formulas after the annual Deductible is satisfied. Necessary equipment and supplies are covered under Devices, Equipment and Supplies.

Obesity Related Services

MHCN: Services directly related to obesity, including bariatric surgery, weight loss programs, medications and related physician visits for medication monitoring are not covered.

Community Provider: Services directly related to obesity, including bariatric surgery, weight loss programs, medications and related physician visits for medication monitoring are not covered.

On the Job Injuries or Illnesses

MHCN: Not covered, including injuries or illnesses incurred as a result of self-employment.

Community Provider: Not covered, including injuries or illnesses incurred as a result of self-employment.

Optical Services

- Routine eye examinations

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Copayment once every twelve (12) months. Eye examinations, including contact lens examinations, for eye

pathology are covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Copayment and at the Plan Coinsurance as often as Medically Necessary. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share once every twelve (12) months. Eye examinations, including contact lens examinations, for eye pathology are covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share as often as Medically Necessary. Annual Deductible does not apply to outpatient services.

- Lenses, including contact lenses, and frames

Eyeglass frames, lenses (any type), lens options such as tinting, or prescription contact lenses, contact lens evaluations and examinations associated with their fitting - Covered up to \$100 per twelve (12) month period per Enrollee. The benefit period begins on the date services are first obtained and continues for twelve (12) months.

Lenses and frames are not subject to the annual Deductible or Plan Coinsurance.

- Contact lenses for eye pathology, including following cataract surgery:

MHCN: Covered in full.

Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied.

Organ Transplants

MHCN and Community Provider benefit limits are combined and cannot be duplicated.

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable Cost Share up to a \$250,000 lifetime benefit maximum (including organ acquisition, matching and donor costs up to \$50,000) and the Pre-Existing Condition wait period. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable Cost Share up to a \$250,000 lifetime benefit maximum (including organ acquisition, matching and donor costs up to \$50,000) and the Pre-Existing Condition wait period. Annual Deductible does not apply to outpatient services.

Plastic and Reconstructive Services (plastic surgery, cosmetic surgery)

- Surgery to correct a congenital disease or anomaly, or conditions following an injury or resulting from surgery

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable Cost Share. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable Cost Share. Annual Deductible does not apply to outpatient services.

- Cosmetic surgery, including complications resulting from cosmetic surgery

MHCN: Not covered.

Community Provider: Not covered.

Podiatric Services

- Medically Necessary foot care

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

- Foot care (routine)

MHCN: Not covered, except in the presence of a non-related Medical Condition affecting the lower limbs.

Community Provider: Not covered, except in the presence of a non-related Medical Condition affecting the lower limbs.

Pre-Existing Condition

Covered subject to a twelve (12) month wait.

Preventive Services (well adult and well child physicals, immunizations, pap smears, mammograms and prostate/*colorectal* cancer screening)

MHCN: Covered in full when in accordance with the well care schedule established by GHO. Not subject to the annual Deductible or any applicable Plan Coinsurance. Eye refractions are not included under preventive care. Physicals for travel, employment, insurance or license are not covered. Services provided during a preventive care visit which are not in accordance with the well care schedule are covered subject to *the lesser of the MHCN's charge or* any applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

Community Provider: Not covered, except for routine mammography services which are covered at the Plan Coinsurance, after the annual Deductible is satisfied. Annual Deductible does not apply to outpatient services.

Rehabilitation Services

- Inpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under

MHCN and Community Provider benefit limits are combined and cannot be duplicated.

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable inpatient services Cost Share for up to sixty (60) days per contract year.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable inpatient services Cost Share for up to sixty (60) days per contract year. Preauthorization is required (see Section IV.G.).

- Outpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under

MHCN and Community Provider benefit limits are combined and cannot be duplicated.

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Cost Share for up to sixty (60) visits per contract year. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share for up to sixty (60) visits per contract year. Annual Deductible does not apply to outpatient services.

Sexual Dysfunction Services

MHCN: Not covered.

Community Provider: Not covered.

Skilled Nursing Facility (SNF)

MHCN and Community Provider benefit limits are combined and cannot be duplicated.

MHCN: Covered in full for up to 120 days per Enrollee per contract year, after the annual Deductible is satisfied.

Community Provider: Covered at the Plan Coinsurance for up to 120 days per Enrollee per contract year after the annual Deductible is satisfied. Preauthorization is required (see Section IV.A.).

Sterilization (vasectomy, tubal ligation)

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable outpatient services Cost Share. Annual Deductible does not apply to outpatient services.

Temporomandibular Joint (TMJ) Services

- Inpatient and outpatient TMJ services

MHCN and Community Provider benefit limits are combined and cannot be duplicated.

MHCN: Covered subject to *the lesser of the MHCN's charge or* the applicable Cost Share for up to \$1,000 maximum per Enrollee per contract year. Annual Deductible does not apply to outpatient services.

Community Provider: Covered subject to *the lesser of the allowed charge or* the applicable Cost Share for up to \$1,000 maximum per Enrollee per contract year. Annual Deductible does not apply to outpatient services.

- Lifetime benefit maximum

MHCN and Community Provider benefit limits are combined and cannot be duplicated.

MHCN: Covered up to \$5,000 per Enrollee.

Community Provider: Covered up to \$5,000 per Enrollee.

Tobacco Cessation

- Individual/group sessions

MHCN: Covered in full.

Community Provider: Not covered.

- Approved pharmacy products

MHCN: *Covered in full when prescribed as part of the GHO-designated tobacco cessation program and dispensed through the GHO mail order service.*

Community Provider: Not covered.

Section III. Eligibility, Enrollment and Termination

A. Eligibility

In order to be accepted for enrollment and continuing coverage under the Agreement, individuals must meet any eligibility requirements imposed by the Group, reside or work in the Service Area and meet all applicable requirements set forth below, except for temporary residency outside the Service Area for purposes of attending school, court-ordered coverage for Dependents or other unique family arrangements, when approved in advance by GHO. GHO has the right to verify eligibility.

1. **Subscribers.** Bona fide employees who have been continuously employed on a regularly scheduled basis of not less than twenty (20) hours per week shall be eligible for enrollment.
2. **Dependents.** The Subscriber may also enroll the following:
 - a. The Subscriber's legal spouse.
 - b. The Subscriber's domestic partner, provided that the application has been submitted to and approved by the Group and GHO, and that the Subscriber and domestic partners:
 - i. Share the same regular and permanent residence;
 - ii. Have a close personal relationship;
 - iii. Are jointly responsible for "basic living expenses" as defined by the Group;
 - iv. Are not married to anyone;
 - v. Are each eighteen (18) years of age or older;
 - vi. Are not related by blood closer than would bar marriage in the State of Idaho;
 - vii. Were mentally competent to consent to contract when the domestic partnership began; and
 - viii. Are each other's sole domestic partner and are responsible for each other's common welfare.

Following termination of a domestic partnership a statement of termination must be filed with the Group. Application for another domestic partnership cannot be filed for ninety (90) days following a filing of the statement of termination of domestic partnership with the Group, unless such termination is due to the death of the domestic partner.

- c. Unmarried dependent children who are under the age of twenty-five (25) and are dependent on the Subscriber for support and maintenance, provided proof of such dependency is furnished to GHO upon request.

"Children" means the children of the Subscriber, including adopted children, stepchildren, children for whom the Subscriber has a qualified court order to provide coverage, children of a domestic partner and any other children for whom the Subscriber is the legal guardian.

Eligibility may be extended past the Dependent's limiting age as set forth above if the Dependent is totally incapable of self-sustaining employment because of a developmental or physical disability incurred prior to attainment of the limiting age set forth above, and is chiefly dependent upon the Subscriber for support and maintenance. Enrollment for such a Dependent may be continued for the duration of the continuous total incapacity, provided enrollment does not terminate for any other reason. Medical proof of incapacity and proof of financial dependency must be furnished to GHO upon request, but not more frequently than annually after the two (2) year period following the Dependent's attainment of the limiting age.

3. **Temporary Coverage for Newborns or Adoptive Children.** Newborn children, including adopted newborn children that are Placed within sixty (60) days of the adopted child's date of birth, are entitled to the benefits set forth in the Agreement from and after the moment of birth through sixty (60) days of age.

Adoptive children that are Placed more than sixty (60) days after birth are entitled to the benefits set forth in the Agreement from the date the adoptive child is Placed through the first sixty (60) days of placement. After the first sixty (60) days of temporary coverage, no benefits are available unless the newborn or adoptive child qualifies as a Dependent and is enrolled under the Agreement.

GHO will not refuse to enroll or terminate an Enrollee's coverage under the Agreement on the basis of age, sex, race, religion, occupation or health status.

B. Enrollment

- 1. Application for Enrollment.** Application for enrollment must be made on an application approved by GHO. Applicants will not be enrolled or premiums accepted until the completed application has been approved by GHO. The Group is responsible for submitting completed applications to GHO.

GHO reserves the right to refuse enrollment to any person whose coverage under any Medical Coverage Agreement issued by Group Health Options, Inc. or Group Health Cooperative has been terminated for cause.

- a. Newly Eligible Persons.** Newly eligible Subscribers and their Dependents may apply for enrollment in writing to the Group within thirty-one (31) days of becoming eligible.
- b. Newborns or Adoptive Children.** A written application for enrollment of a newborn or adoptive child must be made to the Group within thirty-one (31) days after temporary coverage terminates.
- c. Open Enrollment.** GHO will allow enrollment of Subscribers and Dependents, who did not enroll when newly eligible as described above, during an annual period of thirty (30) days or more specified by the Group and GHO.
- d. Special Enrollment.**
 - 1) GHO will allow special enrollment for persons:
 - a. who initially declined enrollment when otherwise eligible because such persons had other health care coverage and have had such other coverage terminated due to *one of the following events*:
 - cessation of employer contributions,
 - exhaustion of COBRA continuation coverage,
 - loss of eligibility, except for loss of eligibility for cause; or
 - b. who have had such other coverage exhausted because such person reached a Lifetime Maximum limit.

GHO or the Group may require confirmation that when initially offered coverage such persons submitted a written statement declining because of other coverage. Application for coverage under the Agreement must be made within thirty-one (31) days of the termination of previous coverage.

- 2) In the event a Subscriber or person eligible to be a Subscriber acquires a person eligible to be a Dependent by marriage, GHO will allow special enrollment for the person eligible to be a Subscriber, his/her spouse and the newly acquired Dependent. Application for coverage under the Agreement must be made within thirty-one (31) days of the acquisition of the new Dependent.
- 2. Limitation on Enrollment.** The Agreement will be open for applications for enrollment as set forth in this Section III.B. Subject to prior approval by the Director of the Department of Insurance of the State of Idaho, GHO may limit enrollment, establish quotas or set priorities for acceptance of new applications if it determines that GHO's capacity, in relation to its total enrollment, is not adequate to provide services to additional persons.

C. Effective Date of Enrollment

1. Provided eligibility criteria are met and applications for enrollment are made as set forth in Sections III.A. and III.B. above, enrollment will be effective as follows:
 - Enrollment for a newly eligible Subscriber and listed Dependents is effective on the first (1st) of the month following or coinciding with the date of hire provided the Subscriber's application has been submitted to and approved by GHO.
 - Enrollment for a newly dependent person, other than a newborn or adoptive child, is effective on the first (1st) of the month following the date eligibility requirements are met.
 - Enrollment for a newborn or adoptive child is effective from the date temporary coverage begins provided an application for enrollment is made as set forth in subsection B.1.b. above.
2. **Commencement of Benefits for Persons Hospitalized on Effective Date.** Enrollees who are admitted to an inpatient facility prior to their enrollment under the Agreement, and who do not have coverage under another agreement, will receive covered benefits beginning on their effective date, as set forth in subsection C.1. above. If an Enrollee is hospitalized in a non-MHCN Facility, GHO reserves the right to require transfer of the Enrollee to a MHCN Facility. The Enrollee will be transferred when a MHCN Provider, in consultation with the attending physician, determines that the Enrollee is medically stable to do so. If the Enrollee refuses to transfer to a MHCN Facility, all services received will be covered under the Community Provider option of the Inpatient Hospital Services section set forth in the Allowances Schedule.

D. Eligibility for Medicare

Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), actively employed Enrollees and their spouses who are eligible for Medicare benefits must decide whether to choose the benefits of the Agreement or the Medicare program as their primary source of health care coverage. The Group is responsible for providing the Enrollee with necessary information regarding TEFRA eligibility and the selection process.

For purposes of this section, an individual shall be deemed eligible for Medicare when he/she has the option to receive Part A Medicare benefits.

Except as otherwise required by TEFRA, GHO will only provide benefits for Covered Services, subject to the Coordination of Benefits provision under the Agreement as set forth in Section VII.

E. Termination of Coverage

Certificate of Creditable Coverage. Unless the Group has chosen to accept this responsibility, a certificate of creditable coverage (which provides information regarding the Enrollee's length of coverage under the Agreement) will be issued automatically upon termination of coverage, and may also be obtained upon request.

F. Services After Termination of Agreement

1. Extension of Covered Services.

Discontinuance. Discontinuance means the termination of the Agreement by the Subscriber or GHO due to failure to pay premium, or mutual agreement to terminate the Agreement. Extension of Covered Services will apply under the following circumstances when discontinuation has occurred.

- a. An Enrollee who is totally disabled on the date of termination shall continue to be eligible for Covered Services incurred as a result of the disabling condition for up to a maximum of twelve (12) months from the date of termination. Any extension of benefits may be terminated at such time as the Enrollee is no longer totally disabled or when Plan limits are met.

- b. An Enrollee who is pregnant at the time of termination, and is not eligible for any replacement Group coverage within sixty (60) days of discontinuance, shall continue to be eligible for Covered Services in connection with pregnancy, childbirth or miscarriage, but not beyond a period of twelve (12) months following the date of termination.
- c. If GHO replaces coverage for a Group within sixty (60) days from the date of discontinuance of a prior Agreement, coverage shall begin immediately for all employees and dependents validly covered and within the definitions of eligibility under the previous Agreement at the date of discontinuance, regardless of any limitations or exclusions relating to active employment or non-confinement.

GHO shall deduct from any benefits becoming payable under the Agreement the amount of benefits payable by the prior Agreement as set forth above in this subsection for an Enrollee who is totally disabled on the date of discontinuance of a prior Agreement.

2. **Services Provided After Termination.** The Subscriber shall be liable for payment of all charges for services and items provided to the Subscriber and all Dependents after the effective date of termination, except those services covered under subsection F.1. above. Any services provided by the MHCN will be charged according to the Fee Schedule.

G. Continuation of Coverage Options

1. **Leave of Absence.** While on a Group approved leave of absence, the Subscriber and listed Dependents can continue to be covered under the Agreement provided:
 - They remain eligible for coverage, as set forth in Section III.A.,
 - Such leave is in compliance with the Group's established leave of absence policy that is consistently applied to all employees,
 - The Group's leave of absence policy is in compliance with the Family and Medical Leave Act when applicable, and
 - The Group continues to remit premiums for the Subscriber and Dependents to GHO.
2. **Self-Payments During Labor Disputes.** In the event of suspension or termination of employee compensation due to a strike, lock-out or other labor dispute, a Subscriber may continue uninterrupted coverage under the Agreement through payment of monthly premiums directly to the Group. Coverage may be continued for the lesser of the term of the strike, lock-out or other labor dispute, or for six (6) months after the cessation of work.

If the Agreement is no longer available, the Subscriber shall have the opportunity to apply for the individual GHO Group Conversion Plan or, if applicable, continuation coverage (see subsection 3. below).

The Group is responsible for immediately notifying each affected Subscriber of his/her rights of self-payment under this provision.

3. **Continuation Coverage Under Federal Law.** This section applies only to Groups who must offer continuation coverage under the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, and only applies to grant continuation of coverage rights to the extent required by federal law.

Upon loss of eligibility, continuation of Group coverage may be available to an Enrollee for a limited time after the Enrollee would otherwise lose eligibility, if required by COBRA. The Group shall inform Enrollees of the COBRA election process and how much the Enrollee will be required to pay directly to the Group.

4. **GHO Group Conversion Plan.** Enrollees whose eligibility for coverage under the Agreement, including continuation coverage, is terminated for any reason other than cause, as set forth in Section III.F.1., and

who are not eligible for Medicare or covered by another group health plan, may convert to GHO's Group Conversion Plan. If the Agreement terminates, any Enrollee covered under the Agreement at termination may convert to a GHO Group Conversion Plan, unless he/she is eligible to obtain other group health coverage within thirty-one (31) days of the termination of the Agreement.

An application for conversion must be made within thirty-one (31) days following termination of coverage under the Agreement. Coverage under GHO's Group Conversion Plan is subject to all terms and conditions of such plan, including premium payments. A physical examination or statement of health is not required for enrollment in GHO's Group Conversion Plan. The Pre-Existing Condition limitation under GHO's Group Conversion Plan will apply only to the extent that the limitation remains unfulfilled under the Agreement.

Section IV. Schedule of Benefits

Benefits are subject to all provisions of the Group Medical Coverage Agreement, including, without limitation, the Accessing Care provisions and General Exclusions. Enrollees must refer to Section II., the Allowances Schedule, for Cost Shares and specific benefit limits that apply to benefits listed in this Schedule of Benefits. Enrollees are entitled to receive only benefits and services that are Medically Necessary and clinically appropriate for the treatment of a Medical Condition as determined by the Enrollee's provider in conjunction with GHO's Medical Director, or his/her designee, and as described herein. All Covered Services are subject to case management and utilization review at the discretion of GHO.

A. Hospital Care

The following hospital services are covered, (1) under the MHCN option when provided or referred by the MHCN, or (2) under the Community Provider option when authorized in advance by GHO:

1. Room and board, including private room when prescribed, and general nursing services.
2. Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services).
3. Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization, or other covered Medically Necessary institutional care. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined to be appropriate and Medically Necessary based upon the Enrollee's Medical Condition. Coverage must be authorized in advance by GHO as appropriate and Medically Necessary. Such care will be covered to the same extent the replaced Hospital Care is covered under the Agreement.
4. Drugs and medications administered during confinement.
5. Special duty nursing, when prescribed as Medically Necessary.

Except as specifically provided below, all inpatient admissions prescribed by a Community Provider must be authorized by GHO at least seventy-two (72) hours in advance.

Enrollees receiving the following nonscheduled services are required to notify GHO by way of the GHO Notification Line within twenty-four (24) hours following a nonscheduled admission, or as soon thereafter as medically possible: labor and delivery, Emergency care services, and inpatient admissions needed for treatment of Urgent Conditions that cannot reasonably be delayed until preauthorization can be obtained.

Enrollees may not transfer to a MHCN hospital during a nonemergent, scheduled admission to a non-MHCN hospital. Coverage for Emergency care in a non-MHCN Facility and subsequent transfer to a MHCN Facility is set forth in Section IV.L.

B. Medical and Surgical Care

The following medical and surgical services are covered (1) under the MHCN option when provided or referred by a MHCN Provider, or (2) under the Community Provider option when provided by a Community Provider:

1. Surgical services.
2. Diagnostic x-ray, nuclear medicine, ultrasound and laboratory services. Mammography services are covered when prescribed by a MHCN Provider or Community Provider or upon request by the Enrollee *for medical cause*.
3. Family planning counseling services.
4. Hearing examinations to determine hearing loss.
5. Blood and blood derivatives and their administration.
6. Preventive care (well care) services for health maintenance in accordance with the well care schedule established by GHO for the following:

MHCN: Routine physical examinations and routine laboratory tests for cancer screening in accordance with the well care schedule established by GHO, and immunizations and vaccinations listed as covered in the GHO drug formulary (approved drug list). A fee may be charged for health education programs. The well care schedule is available in Group Health clinics, by accessing GHO's website at www.ghc.org, or upon request.

Covered Services provided during a preventive care visit, which are not in accordance with the GHO well care schedule, are subject to the applicable Cost Shares.

Routine mammography services shall include:

- a. One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
 - b. A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.
 - c. A mammogram every year for any woman who is fifty (50) years of age or older.
- Such coverage shall not exceed the cost of the examination.

Community Provider: Routine mammography services shall include:

- a. One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
 - b. A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.
 - c. A mammogram every year for any woman who is fifty (50) years of age or older.
- Such coverage shall not exceed the cost of the examination.

7. Radiation therapy services.
8. Reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or non-dental cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth; and incision of salivary glands and ducts.
9. Medical implants.

Excluded: internally implanted insulin pumps, artificial hearts, artificial larynx and any other implantable device that has not been approved by GHO's Medical Director, or his/her designee.

10. Respiratory therapy.

11. Outpatient total parenteral nutritional therapy; outpatient elemental formulas for malabsorption; and dietary formula for the treatment of phenylketonuria (PKU). Coverage for PKU formula is not subject to a Pre-Existing Condition waiting period, if applicable.

Equipment and supplies for the administration of enteral and parenteral therapy are covered under Devices, Equipment and Supplies.

Excluded: any other dietary formulas, oral nutritional supplements, special diets, prepared foods/meals and formula for access problems.

12. Visits with providers, including consultations and second opinions, in the hospital or provider's office.

13. Optical services.

MHCN: Routine eye examinations and refractions received at a MHCN Facility once every twelve (12) months, except when Medically Necessary. Routine eye examinations to monitor Medical Conditions are covered as often as necessary upon recommendation of a MHCN Provider.

Contact lenses for eye pathology, including contact lens exam and fitting, are covered subject to the applicable Cost Share. When dispensed through MHCN Facilities, one contact lens per diseased eye in lieu of an intraocular lens, including exam and fitting, is covered for Enrollees following cataract surgery performed by a MHCN Provider, provided the Enrollee has been continuously covered by GHO since such surgery.

Replacement of lenses for eye pathology, including following cataract surgery, will be covered only once within a twelve (12) month period and only when needed due to a change in the Enrollee's Medical Condition. Replacement for loss or breakage is subject to the Lenses and Frames benefit Allowance.

Community Provider: Routine eye examinations and refractions once every twelve (12) months, except when Medically Necessary. Routine eye examinations to monitor Medical Conditions are covered when Medically Necessary.

One contact lens per diseased eye in lieu of an intraocular lens, including exam and fitting, is covered for Enrollees following cataract surgery provided the Enrollee has been continuously covered by GHO since such surgery.

Replacement of lenses for eye pathology, including following cataract surgery, will be covered only once within a twelve (12) month period when needed due to a change in the Enrollee's Medical Condition.

Lenses and Frames

Benefits may be used toward the following in any combination, over the benefit period, until the benefit maximum is exhausted:

- Eyeglass frames
- Eyeglass lenses (any type) including tinting and coating
- Corrective industrial (safety) lenses
- Sunglass lenses and frames when prescribed by an eye care provider for eye protection or light sensitivity

- Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations
- Replacement frames, for any reason, including loss or breakage
- Replacement contact lenses
- Replacement eyeglass lenses

Excluded: evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures.

14. Maternity care, including cesarean section delivery and care for involuntary complications of pregnancy and prenatal and postpartum visits.

Involuntary complications of pregnancy includes, but is not limited to:

- a. Conditions requiring hospital confinement (when the pregnancy is not terminated), who diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; and
- b. Cesarean section delivery, ectopic pregnancy which is terminated, spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia and toxemia.

Prenatal testing for the detection of congenital and heritable disorders when Medically Necessary as determined by *the Enrollee's provider and* GHO's Medical Director, or his/her designee.

Hospitalization and delivery, including home births for low risk pregnancies. Hospitalization of the mother and newborn following childbirth shall not be limited to less than forty-eight (48) hours for a vaginal delivery, or ninety-six (96) hours for a cesarean section delivery, unless it is determined by the medical provider directly caring for the Enrollee or her newborn child, in consultation with the Enrollee, that an earlier discharge is medically appropriate. Planned home births must be authorized in advance by GHO.

Pregnancy will not be excluded as a Pre-Existing Condition under the Agreement. Treatment for post-partum depression or psychosis is covered only under the mental health benefit.

Excluded: birthing tubs and genetic testing of non-Enrollees for the detection of congenital and heritable disorders.

Involuntary complications of pregnancy shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

15. Transplant services, including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, bone marrow, liver transplants and stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy. Services are limited to the following:

- a. Inpatient and outpatient medical expenses listed below for transplantation procedures. Covered Services must be directly associated with, and occur at the time of, the transplant. The following transplantation expenses are subject to the organ recipient's lifetime benefit maximum set forth in the Allowances Schedule:
 - Evaluation testing to determine recipient candidacy,
 - Donor matching tests,

- Hospital charges,
 - Procurement center fees,
 - Professional fees,
 - Travel costs for a surgical team,
 - Excision fees, and
 - Donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees.
- b. Follow-up services for specialty visits,
 - c. Re-hospitalization, and
 - d. Maintenance medications.

Under the Community Provider option, transplant services must be authorized in advance by GHO.

Excluded: donor costs to the extent that they are reimbursable by the organ donor's insurance, treatment of donor complications, living expenses and transportation expenses, except as set forth under Section IV.M.

16. Manipulative therapy.

MHCN: Self-Referrals for manipulative therapy of the spine and extremities are covered as set forth in the Allowances Schedule when provided by MHCN Providers.

Additional visits are covered when approved by GHO.

Community Provider: Manipulative therapy is covered as set forth in the Allowances Schedule.

Excluded: supportive care rendered primarily to maintain the level of correction already achieved, care rendered primarily for the convenience of the Enrollee, care rendered on a non-acute, asymptomatic basis and charges for any other services that do not meet GHO clinical criteria as Medically Necessary.

17. Medical and surgical services and related hospital charges, including orthognathic (jaw) surgery, for the treatment of temporomandibular joint (TMJ) disorders. Such disorders may exhibit themselves in the form of pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food. TMJ appliances are covered as set forth under Section IV.H.1., Orthopedic Appliances.

Orthognathic (jaw) surgery for the treatment of TMJ disorders, radiology services and TMJ specialist services, including fitting/adjustment of splints are subject to the benefit limit set forth in the Allowances Schedule.

Excluded are the following: orthognathic (jaw) surgery in the absence of a TMJ or severe obstructive sleep apnea diagnosis, treatment for cosmetic purposes, dental services, including orthodontic therapy and any hospitalizations related to these exclusions.

18. Treatment of growth disorders by growth hormones.

19. Diabetic training and education.

20. Detoxification services for alcoholism and drug abuse.

For the purposes of this section, "acute chemical withdrawal" means withdrawal of alcohol and/or drugs from an Enrollee for whom consequences of abstinence are so severe that they require medical/nursing assistance in a hospital setting, which is needed immediately to prevent serious impairment to the Enrollee's health.

Coverage for acute chemical withdrawal is provided without prior approval. If an Enrollee is hospitalized in a non-MHCN Facility/program, coverage is subject to payment of the Emergency Deductible. The Enrollee or person assuming responsibility for the Enrollee must notify GHO by way of the GHO Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible. Furthermore, if an Enrollee is hospitalized in a non-MHCN Facility/program, GHO reserves the right to require transfer of the Enrollee to a MHCN Facility/program upon consultation between a MHCN Provider and the attending physician. If the Enrollee refuses transfer to a MHCN Facility/program, all services received will be covered under the Community Provider option.

21. Circumcision.
22. Nutritional counseling provided by MHCN staff.
23. Sterilization procedures.
24. Self-Referrals to licensed acupuncturists and naturopaths for Covered Services, as set forth in the Allowances Schedule.

For coverage under the MHCN option, Covered Services must be provided by a MHCN Provider. Additional visits are covered when approved by GHO. Laboratory and radiology services are covered only when obtained through a MHCN Facility.

Excluded: herbal supplements, preventive care visits to acupuncturists and any services not within the scope of their licensure.

25. Once Pre-Existing Condition wait periods, if any, have been met, Pre-Existing Conditions are covered in the same manner as any other illness.

C. Chemical Dependency Treatment.

Chemical dependency means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages, and where the user's health is substantially impaired or endangered or his/her social or economic function is substantially disrupted.

For the purposes of this section the definition of Medically Necessary shall be expanded to include those services necessary to treat a chemical dependency condition that is having a clinically significant impact on an Enrollee's emotional, social, medical and/or occupational functioning.

Chemical dependency treatment services are covered as set forth below (1) under the MHCN option when provided at a MHCN Facility or MHCN-approved treatment program, or (2) under the Community Provider option when provided at an approved treatment facility. Services are subject to the benefit period Allowance set forth in the Allowances Schedule. Any Cost Shares for chemical dependency services under the terms of the Agreement shall not be applied toward the benefit period Allowance.

- 1. Chemical Dependency Treatment Services.** All alcoholism and/or drug abuse treatment services must be: (a) provided at a facility as described above; and (b) deemed Medically Necessary as defined above. Chemical dependency treatment may include the following services received on an inpatient or outpatient basis: diagnostic evaluation and education, organized individual and group counseling and/or prescription drugs and medicines, unless excluded under the Agreement.

Court-ordered treatment shall be covered only if determined to be Medically Necessary as defined above.

- 2. Benefit Period.** For the purposes of this section, "benefit period" shall mean a twenty-four (24) consecutive calendar month period during which the Enrollee is eligible to receive covered chemical dependency treatment services, as set forth in this section. The first benefit period shall begin on the first

day the Enrollee receives covered chemical dependency services and shall continue for twenty-four (24) consecutive calendar months, provided that coverage under the Agreement remains in force. All subsequent benefit periods thereafter will begin on the first day Covered Services are received after the expiration of the previous twenty-four (24) month benefit period.

D. Plastic and Reconstructive Services. Plastic and reconstructive services are covered as set forth below:

1. Congenital Disease or Congenital Anomaly.

All eligible Enrollees are covered for correction of congenital diseases or congenital anomalies.

2. Reconstructive Surgery.

a. To correct a Medical Condition following an injury or incidental to surgery covered by GHO which has produced a major effect on the Enrollee's appearance, provided:

- The Enrollee has been continuously enrolled with GHO since the date of such injury or surgery; and
- When in the opinion of the MHCN Provider, such services can reasonably be expected to correct the condition.

b. For post-mastectomy services:

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

Coverage will be provided as determined in consultation with the attending physician and the Enrollee.

Excluded: complications of noncovered surgical services.

E. Home Health Care Services. Home health care services, as set forth in this section, shall be covered (1) under the MHCN option, when provided by MHCN's Home Health Services or referred in advance by a MHCN Personal Physician to a MHCN-authorized home health agency, or (2) under the Community Provider option, when provided by a State-licensed home health agency, prescribed by a Community Provider and authorized in advance by GHO's Medical Director, or his/her designee.

In order to be covered, the following criteria must be met:

1. The Enrollee is unable to leave home due to his/her health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home.
2. The Enrollee requires intermittent skilled home health care services, as described below.
3. A MHCN Provider under the MHCN option, or *a Community Provider in conjunction with* GHO's Medical Director, or his/her designee, under the Community Provider option, has determined that such services are Medically Necessary and are most appropriately rendered in the Enrollee's home.

For the purposes of this section, "skilled home health care" means reasonable and necessary care for the treatment of an illness or injury which requires the skill of a nurse or therapist, based on the complexity of the service and the condition of the patient and which is performed directly by an appropriately licensed professional provider.

Covered Services for home health care may include the following when rendered pursuant to an approved home health care plan of treatment: nursing care, physical therapy, occupational therapy, respiratory therapy, restorative speech therapy and medical social worker and limited home health aide services. Home health

services are covered on an intermittent basis in the Enrollee's home. "Intermittent" means care that is to be rendered because of a medically predictable recurring need for skilled home health care services.

Excluded: custodial care and maintenance care, private duty or continuous nursing care in the Enrollee's home, housekeeping or meal services, care in any nursing home or convalescent facility, any care provided by or for a member of the patient's family and any other services rendered in the home which do not meet the definition of skilled home health care above.

F. Hospice Care. Hospice care, as set forth in this section, shall be covered (1) under the MHCN option when provided by MHCN's Hospice Program or when referred in advance by a MHCN Personal Physician to a MHCN-approved hospice agency, or (2) under the Community Provider option when provided by a licensed non-MHCN hospice agency. Hospice care is covered in lieu of curative treatment for terminal illness for Enrollees who meet all of the following criteria:

- A physician has determined that the Enrollee's illness is terminal and life expectancy is six (6) months or less.
- The Enrollee has chosen a palliative treatment focus (emphasizing comfort and supportive services rather than treatment aimed at curing the Enrollee's terminal illness).
- The Enrollee has elected in writing to receive hospice care through a hospice program.
- The Enrollee has available a primary care person who will be responsible for the Enrollee's home care.
- A physician and the hospice agency have determined that the Enrollee's illness can be appropriately managed in the home.

Hospice care shall mean a coordinated program of palliative and supportive care for dying Enrollees by an interdisciplinary team of professionals and volunteers centering primarily in the Enrollee's home.

1. Covered Services. Care may include the following as prescribed by a physician and rendered pursuant to an approved hospice plan of treatment:

a. Home Services

- i. Intermittent care by a hospice interdisciplinary team which may include services by a physician, nurse, medical social worker, physical therapist, speech therapist, occupational therapist, respiratory therapist, limited services by a Home Health Aide under the supervision of a Registered Nurse and homemaker services.
- ii. Continuous care services in the Enrollee's home when prescribed by a physician, as set forth in this paragraph. "Continuous care" means skilled nursing care provided in the home during a period of crisis in order to maintain the terminally ill Enrollee at home. Continuous care may be provided for pain or symptom management by a Registered Nurse, Licensed Practical Nurse or Home Health Aide under the supervision of a Registered Nurse. Continuous care is covered up to twenty-four (24) hours per day during periods of crisis. Continuous care is covered only when a physician determines that the Enrollee would otherwise require hospitalization in an acute care facility.

b. Inpatient Hospice Services. For short-term care, inpatient hospice services shall be covered according to the provisions set forth in Section IV.A.

Inpatient respite care is covered for a maximum of five (5) consecutive days per occurrence in order to continue care for the Enrollee in the temporary absence of the Enrollee's primary care giver(s).

c. Other covered hospice services may include the following:

- i. Drugs and biologicals that are used primarily for the relief of pain and symptom management.
- ii. Medical appliances and supplies primarily for the relief of pain and symptom management.

- iii. Counseling services for the Enrollee and his/her primary care-giver(s).
- iv. Bereavement counseling services for the family.

2. Hospice Exclusions.

- a. Financial or legal counseling services.
- b. Meal services.
- c. Custodial or maintenance care in the home or on an inpatient basis, except as provided above.
- d. Any services provided by members of the patient's family.
- e. All other exclusions listed in Section V., General Exclusions, apply.

G. Rehabilitation Services.

- 1. Rehabilitation services are covered as set forth in this section, limited to the following: physical therapy; occupational therapy; and speech therapy to restore function following illness, injury or surgery. Services are subject to all terms, conditions and limitations of the Agreement including the following:
 - a. All services must be (1) prescribed and provided by a MHCN-approved rehabilitation team at a MHCN or MHCN-approved rehabilitation facility under the MHCN option, or (2) prescribed and provided by a rehabilitation team under the Community Provider option, that may include medical, nursing, physical therapy, occupational therapy, massage therapy and speech therapy providers.
 - b. Under the Community Provider option, inpatient rehabilitation services must be authorized in advance by GHO.
 - c. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Such services are provided only when significant, measurable improvement to the Enrollee's condition can be expected within a sixty (60) day period as a consequence of intervention by covered therapy services described in paragraph a., above.
 - d. Coverage for inpatient and outpatient services is limited to the Allowance set forth in the Allowances Schedule.

Excluded: specialty rehabilitation programs; long-term rehabilitation programs; physical therapy, occupational therapy and speech therapy services when such services are available (whether application is made or not) through programs offered by public school districts; therapy for degenerative or static conditions when the expected outcome is primarily to maintain the Enrollee's level of functioning (except as set forth in subsection 2. below); recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs; programs for treatment of learning problems; any services not specifically included as covered in this section; and any services that are excluded under Section V.

- 2. **Neurodevelopmental Therapies for Children Age Six (6) and Under.** Physical therapy, occupational therapy and speech therapy services for the restoration and improvement of function for neurodevelopmentally disabled children age six (6) and under shall be covered. Coverage includes maintenance of a covered Enrollee in cases where significant deterioration in the Enrollee's condition would result without the services. Coverage for inpatient and outpatient services is limited to the Allowances set forth in the Allowances Schedule.

Excluded: specialty rehabilitation programs; long-term rehabilitation programs; physical therapy, occupational therapy and speech therapy services when such services are available (whether application is made or not) through programs offered by public school districts; recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs; programs for treatment of learning problems; any services not specifically included as covered in this section; and any services that are excluded under Section V.

H. Devices, Equipment and Supplies.

Devices, equipment and supplies, which restore or replace functions that are common and necessary to perform basic activities of daily living, are covered as set forth in the Allowances Schedule. Examples of basic activities of daily living are dressing and feeding oneself, maintaining personal hygiene, lifting and gripping in order to prepare meals and carrying groceries.

1. **Orthopedic Appliances.** Orthopedic appliances, which are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function.

Excluded: arch supports, including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; and orthopedic shoes that are not attached to an appliance.

2. **Ostomy Supplies.** Ostomy supplies for the removal of bodily secretions or waste through an artificial opening.
3. **Durable Medical Equipment.** Durable medical equipment is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and used in the Enrollee's home. Durable medical equipment includes: hospital beds, wheelchairs, walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen and oxygen equipment. GHO, in its sole discretion, will determine if equipment is made available on a rental or purchase basis.
4. **Prosthetic Devices.** Prosthetic devices are items which replace all or part of an external body part, or function thereof.

When authorized in advance, repair, adjustment or replacement of appliances and equipment is covered.

Excluded: items which are not necessary to restore or replace functions of basic activities of daily living; and replacement or repair of appliances, devices and supplies due to loss, breakage from willful damage, neglect or wrongful use, or due to personal preference.

I. Tobacco Cessation.

MHCN: When provided through the MHCN, services related to tobacco cessation are covered, limited to (1) participation in one individual or group program per contract year; (2) educational materials; and (3) approved pharmacy products provided the Enrollee is actively participating in a GHO-designated tobacco cessation program.

Community Provider: Not covered.

- J. **Drugs, Medicines, Supplies and Devices.** This benefit, for purposes of creditable coverage, is actuarially equal to or greater than the Medicare Part D prescription drug benefit. Eligible Enrollees who are also eligible for Medicare Part D pharmacy benefits can remain covered under the Agreement and not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D pharmacy plan at a later date.

An Enrollee who discontinues coverage under the Agreement must meet eligibility requirements in order to re-enroll.

Legend medications are drugs which have been approved by the Food and Drug Administration (FDA) and which can, under federal or state law, be dispensed only pursuant to a prescription order. These drugs,

including off-label use of FDA-approved drugs (provided that such use is documented to be effective in one of the standard reference compendia; a majority of well-designed clinical trials published in peer-reviewed medical literature document improved efficacy or safety of the agent over standard therapies, or over placebo if no standard therapies exist; or by the federal secretary of Health and Human Services), contraceptive drugs and devices and their fittings, diabetic supplies, including insulin syringes, lancets, urine-testing reagents, blood-glucose monitoring reagents and insulin, are covered as set forth below.

Generic and brand name drugs and medicines must be listed as covered in the GHO drug formulary. Formulary and non-formulary drugs are covered as set forth in the Allowances Schedule. The prescription drug Cost Share as set forth in the Allowances Schedule applies to each thirty (30) day supply. Cost Shares for single and multiple thirty (30) day supplies of a given prescription are payable at the time of delivery. Injectables that can be self-administered are also subject to the prescription drug Cost Share. Drug formulary (approved drug list) is defined as a list of preferred pharmaceutical products, supplies and devices developed and maintained by GHO.

Generic drugs will be dispensed whenever available. Brand name drugs will be dispensed if there is not a generic equivalent. In the event the Enrollee elects to purchase brand-name drugs instead of the generic equivalent (if available), or if the Enrollee elects to purchase a different brand-name or generic drug than that prescribed by the Enrollee's provider, and it is not determined to be Medically Necessary, the Enrollee will also be subject to payment of the additional amount above the applicable pharmacy Cost Share set forth in the Allowances Schedule. A generic drug is defined as a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. A brand name drug is defined as a prescription drug that has been patented and is only available through one manufacturer.

"Standard reference compendia" means the American Hospital Formulary Service -- Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia -- Drug Information, or other authoritative compendia as identified from time to time by the federal secretary of Health and Human Services. "Peer-reviewed medical literature" means scientific studies printed in health care journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

Under the MHCN option, all drugs, supplies, medicines and devices must be prescribed by a MHCN Provider for conditions covered by the Agreement and obtained at a MHCN pharmacy.

Under the Community Provider option, all drugs, supplies, medicines and devices must be obtained at a Contracted Network Pharmacy, except when a Contracted Network Pharmacy is not available within a thirty (30) mile radius or for drugs dispensed by a provider for Emergency care.

Average Wholesale Price (AWP) as determined by GHO based upon national prescription drug pricing directories, such as First Data Bank.

Excluded: over-the-counter drugs, medicines, supplies and devices not requiring a prescription under state law or regulations; drugs used in the treatment of sexual dysfunction disorders; medicines and injections for anticipated illness while traveling; and vitamins, including Legend (prescription) vitamins.

The Enrollee will be charged for replacing lost or stolen drugs, medicines or devices.

K. Mental Health Care Services. Services that are provided by a mental health practitioner will be covered as mental health care, regardless of the cause of the disorder.

1. Outpatient Services. Outpatient mental health services place priority on restoring the Enrollee to his/her level of functioning prior to the onset of acute symptoms or to achieve a clinically appropriate level of stability as determined by *the Enrollee's provider in conjunction with* GHO's Medical Director, or his/her

designee. Treatment for clinical conditions may utilize psychiatric, psychological and/or psychotherapy services to achieve these objectives.

Coverage for each Enrollee is provided according to the outpatient mental health care Allowance set forth in the Allowances Schedule. Psychiatric medical services, including medical management and prescriptions, are covered as set forth in Sections IV.B. and IV.J.

Under the Community Provider option, outpatient mental health services are limited to the services rendered by a licensed physician; a licensed psychologist; or a community mental health provider licensed by the Idaho Board of Health and Welfare.

2. **Inpatient Services.** Charges for services described in this section, including psychiatric Emergencies resulting in inpatient services, shall be covered up to the maximum benefit set forth in the Allowances Schedule. This benefit shall include coverage for acute treatment and stabilization of psychiatric Emergencies provided in a (a) MHCN-approved hospital under the MHCN option, and (b) hospital or facility approved specifically for treatment of mental or nervous disorders under the Community Provider option. Under the Community Provider option, all inpatient mental health care must be authorized in advance by GHO. When medically indicated, outpatient electro-convulsive therapy (ECT) is covered in lieu of inpatient services.

Partial hospitalization is covered subject to the maximum inpatient benefit limit described in the Allowances Schedule. Every two (2) partial hospitalization days are equivalent to one inpatient hospital day. The total maximum annual benefit under this section shall not exceed the number of inpatient days described in the Allowances Schedule.

Subject to the maximum inpatient mental health care Allowance set forth in the Allowances Schedule, services provided under involuntary commitment statutes shall be covered at facilities approved by GHO. Services for any involuntary court-ordered treatment program beyond seventy-two (72) hours shall be covered only if determined to be Medically Necessary by *the Enrollee's provider in conjunction with* GHO's Medical Director, or his/her designee.

Coverage for voluntary/involuntary Emergency inpatient psychiatric services is subject to the Emergency care benefit set forth in Section IV.L., including the twenty-four (24) hour notification and transfer provisions.

Outpatient electro-convulsive therapy treatment is covered subject to the outpatient surgery Cost Share.

3. **Exclusions and Limitations for Outpatient and Inpatient Mental Health Treatment Services.** Covered Services are limited to those authorized by the attending mental health provider and GHO's Medical Director, or his/her designee, for covered clinical conditions for which the reduction or removal of acute clinical symptoms or stabilization can be expected given the most clinically appropriate level of mental health care intervention.

Partial hospitalization programs are covered only under subsection K.2. (Inpatient Services).

Excluded: learning, communication and motor skills disorders; mental retardation; academic or career counseling; sexual and identity disorders; and personal growth or relationship enhancement. Also excluded: assessment and treatment services that are primarily vocational and academic; court-ordered or forensic treatment, including reports and summaries, not considered Medically Necessary; work or school ordered assessment and treatment not considered Medically Necessary; counseling for overeating; nicotine related disorders; relationship counseling or phase of life problems (V code only diagnoses); and custodial care.

All other provisions, exclusions and limitations under the Agreement also apply.

L. Emergency/Urgent Care.

All services are covered subject to the Cost Shares set forth in the Allowances Schedule.

Emergency Care (See Section VIII. for a definition of Emergency.)

1. At a MHCN Facility. GHO will cover Emergency care for all Covered Services.

Inpatient Emergency care received at a MHCN Facility is also subject to:

- a. Notification of GHO by way of the GHO Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible;
- b. Transfer of care to a MHCN Provider; and
- c. Transfer to another MHCN Facility if transferability is medically possible as determined by the MHCN.

2. At a Non-MHCN Facility. Usual, Customary and Reasonable charges for Emergency care for Covered Services are covered subject to:

- a. Payment of the Emergency care Deductible; and
- b. Notification of GHO by way of the GHO Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible.

3. Waiver of Emergency Care Cost Share.

- a. **Waiver for Multiple Injury Accident.** If two or more members in the same Family Unit require Emergency care as a result of the same accident, coverage for all Enrollees will be subject to only one (1) Emergency care Cost Share.
- b. **Emergencies Resulting in an Inpatient Admission.** If the Enrollee is admitted to a MHCN Facility directly from the emergency room, the Emergency care Copayment is waived. However, coverage will be subject to the inpatient services Cost Share.

4. Transfer and Follow-up Care. If an Enrollee is hospitalized in a non-MHCN Facility, GHO reserves the right to require transfer of the Enrollee to a MHCN Facility, upon consultation between a MHCN Provider and the attending physician. If the Enrollee refuses to transfer to a MHCN Facility, all services received will be covered under the Community Provider option of the Inpatient Hospital Services section set forth in the Allowances Schedule.

Under the MHCN option, follow-up care which is a direct result of the Emergency must be received from MHCN Providers, unless a MHCN Provider has authorized such follow-up care from a non-MHCN Provider in advance. Follow-up care for services received under the Community Provider option, that is a direct result of the Emergency, is covered subject to the Cost Shares set forth in the Allowances Schedule.

Urgent Care (See Section VIII. for a definition of Urgent Condition.)

Under the MHCN option, care for Urgent Conditions is covered only at MHCN medical centers, MHCN urgent care clinics or MHCN Providers' offices, subject to the applicable Cost Share. Urgent care received at any hospital emergency department is not covered unless authorized in advance by a MHCN Provider.

Under the Community Provider option, charges for Urgent Conditions received at any medical facility are covered subject to the applicable Cost Share.

M. Ambulance Services.

1. **Emergency Transport to any Facility.** Each Emergency is covered as set forth in the Allowances Schedule. Ambulance services under the MHCN option are covered provided that the service is authorized in advance by a MHCN Provider or meets the definition of an Emergency (see Section VIII.).
2. **Interfacility Transfers.**
 - a. **MHCN-Initiated Transfers.** MHCN-initiated non-emergent transfers to or from a MHCN Facility are covered as set forth in the Allowances Schedule.
 - b. **Community Provider-Initiated Transfers.** When prescribed by the attending physician, transport from a medical facility to the nearest facility equipped to render further Medically Necessary treatment is covered as set forth in the Allowances Schedule.

N. Skilled Nursing Facility (SNF). Skilled nursing care in a GHO-approved skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending physician, is covered as set forth in the Allowances Schedule. Under the Community Provider option, skilled nursing care must be authorized in advance by GHO.

When prescribed by the Enrollee's physician, such care may include room and board; general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by a skilled nursing facility; and short-term physical therapy, occupational therapy and restorative speech therapy.

Excluded: personal comfort items such as telephone and television, rest cures and custodial, domiciliary or convalescent care.

Section V. General Exclusions

In addition to exclusions listed throughout the Agreement, the following are not covered:

1. Except as specifically listed and identified as covered in Sections IV.B., IV.D., IV.H. and IV.J., corrective appliances and artificial aids including: eyeglasses; contact lenses and services related to their fitting; hearing devices and hearing aids, including related examinations; and take-home drugs, dressings and supplies following hospitalization.
2. Cosmetic services, including treatment for complications resulting from cosmetic surgery, except for congenital diseases or congenital anomalies, reconstructive surgery and post-mastectomy services as provided in Section IV.D.
3. Convalescent or custodial care.
4. Durable medical equipment such as hospital beds, wheelchairs and walk-aids, except while in the hospital or as set forth in Section IV.B., IV.F. or IV.H.
5. Services rendered as a result of work-related injuries, illnesses or conditions, including injuries, illnesses or conditions incurred as a result of self-employment.
6. Those parts of an examination and associated reports and immunizations required for employment, unless otherwise noted in Section IV.B., immigration, license, travel or insurance purposes that are not deemed Medically Necessary by GHO for early detection of disease. Under the Community Provider option, those services that are deemed Medically Necessary for early detection of disease and well-adult and well-child care, including routine physical examinations and vaccinations and immunizations (Preventive Care), are also excluded.
7. Services and supplies related to sexual reassignment surgery, such as sex change operations or transformations and procedures or treatments designed to alter physical characteristics.

8. Diagnostic testing and medical treatment of sterility, infertility and sexual dysfunction, regardless of origin or cause, unless otherwise noted in Section IV.B.
9. Any services to the extent benefits are “available” to the Enrollee *as defined herein* under the terms of any vehicle, homeowner’s, property or other insurance policy, *except for individual or group health insurance*, whether the Enrollee asserts a claim or not, pursuant to medical coverage, medical “no fault” coverage, Personal Injury Protection coverage or similar medical coverage contained in said policy. For the purpose of this exclusion, benefits shall be deemed to be “available” to the Enrollee if the Enrollee is a named insured, comes within the policy definition of insured, or otherwise has the right to receive first party benefits under the policy.

The Enrollee and his/her agents must cooperate fully with GHO in its efforts to enforce this exclusion. This cooperation shall include supplying GHO with information about, **or related to, the availability of other** insurance coverage. The Enrollee and his/her agent shall permit GHO, at GHO’s option, to associate with the Enrollee or to intervene in any action filed against any party related to the injury. The Enrollee and his/her agents shall do nothing to prejudice GHO’s right to enforce this exclusion. In the event the Enrollee fails to cooperate fully, **GHO reserves the right to deny coverage and** the Enrollee shall be responsible for reimbursing GHO for such medical expenses.

GHO shall not enforce this exclusion as to coverage available under uninsured motorist or underinsured motorist coverage until the Enrollee has been made whole, unless the Enrollee fails to cooperate fully with GHO as described above.

GHO shall not pay any attorneys’ fees or collection costs to attorneys representing the injured person where it has retained its own legal counsel or acts on its own behalf to represent its interests and unless there is a written fee agreement signed by GHO prior to any collection efforts. Under no circumstances will GHO pay legal fees for services which were not reasonably and necessarily incurred to secure recovery and/or which do not benefit GHO.

10. Voluntary termination of pregnancy. Voluntary termination of pregnancy means termination of pregnancy for any reason other than to preserve the life of the female upon whom the termination of pregnancy is performed.
11. The cost of services and supplies resulting from an Enrollee’s loss of or willful damage to appliances, devices, supplies and materials covered by GHO for the treatment of disease, injury or illness.
12. Orthoptic therapy (i.e., eye training).
13. Specialty treatment programs such as weight reduction, “behavior modification programs” and rehabilitation, including cardiac rehabilitation.
14. Services *or care* needed for injuries or conditions resulting from active or reserve military service, *whether such injuries or conditions result from war or otherwise. This exclusion will not apply to conditions or injuries resulting from previous military service unless the condition has been determined by the U.S. Secretary of Veterans Affairs to be a condition or injury incurred during a period of active duty. Further, this exclusion will not be interpreted to interfere with or preclude coordination of benefits under Tri-Care.*
15. Nontherapeutic sterilization, unless otherwise noted in Section IV.B., and procedures and services to reverse a therapeutic or nontherapeutic sterilization.
16. Dental care, surgery, services and appliances, including: treatment of accidental injury to natural teeth, reconstructive surgery to the jaw in preparation for dental implants, dental implants and periodontal surgery. **The Enrollee’s provider in conjunction with** GHO’s Medical Director, or his/her designee, will determine whether the care or treatment required is within the category of dental care or service.

Under the MHCN option, if *the MHCN Provider in conjunction with* GHO's Medical Director, or his/her designee, determines that an unrelated Medical Condition requires that an Enrollee be hospitalized for a dental procedure which is normally done in a dentist's office, GHO will cover associated hospital and anesthesia costs at a MHCN Facility.

Under the Community Provider option, if the Enrollee's physician determines that an unrelated Medical Condition requires that an Enrollee be hospitalized for a dental procedure which is normally done in a dentist's office, associated hospital and anesthesia costs will be covered as shown in the Allowances Schedule when authorized in advance by GHO.

Dentist's or oral surgeon's fees are not covered.

17. Drugs, medicines and injections, except as set forth in Section IV.J. Any exclusion of drugs, medicines and injections, including those not listed as covered in the GHO drug formulary (approved drug list), will also exclude their administration.
18. Experimental or investigational services.

GHO consults with GHO's Medical Director and then uses the criteria described below to decide if a particular service is experimental or investigational.

- a. A service is considered experimental or investigational for an Enrollee's condition if any of the following statements apply to it at the time the service is or will be provided to the Enrollee.
 - i. The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted.
 - ii. The service is the subject of a current new drug or new device application on file with the FDA.
 - iii. The service is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity or efficacy of the service.
 - iv. The service is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy as among its objectives.
 - v. The service is under continued scientific testing and research concerning the safety, toxicity or efficacy of services.
 - vi. The service is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy.
 - vii. The prevailing opinion among experts, as expressed in the published authoritative medical or scientific literature, is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity or efficacy of the service.
- b. In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively:
 - i. The Enrollee's medical records,
 - ii. The written protocol(s) or other document(s) pursuant to which the service has been or will be provided,
 - iii. Any consent document(s) the Enrollee or Enrollee's representative has executed or will be asked to execute, to receive the service,
 - iv. The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
 - v. The published authoritative medical or scientific literature regarding the service, as applied to the Enrollee's illness or injury, and
 - vi. Regulations, records, applications and any other documents or actions issued by, filed with or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

Appeals regarding denial of coverage can be submitted to the Member Appeals Department, or to GHO's Medical Director at P.O. Box 34593, Seattle, WA 98124-1593. GHO will respond in writing within twenty (20) working days of the receipt of a fully documented appeal request. An expedited appeal is available if a delay would jeopardize the Enrollee's life or health.

19. Mental health care, except as specifically provided in Section IV.K.
20. Hypnotherapy, and all services related to hypnotherapy.
21. Genetic testing and related services unless determined Medically Necessary by *the Enrollee's provider in conjunction with* GHO's Medical Director, or his/her designee, or specifically provided in Section IV.B. Testing for non-Enrollees is also excluded.
22. Follow-up visits related to a non-Covered Service.
23. Fetal ultrasound in the absence of medical indications.
24. Routine foot care, except in the presence of a non-related Medical Condition affecting the lower limbs.
25. Complications of non-Covered Services.
26. Obesity treatment and treatment for morbid obesity, including any medical services, drugs, supplies or any bariatric surgery (such as gastroplasty, gastric banding or intestinal bypass), regardless of co-morbidities, complications of obesity or any other Medical Condition, except as set forth in Section IV.B.
27. Services or supplies for which no charge is made, or for which a charge would not have been made if the Enrollee had no health care coverage or for which the Enrollee is not liable; services provided by a member of the Enrollee's family.
28. Autopsy and associated expenses.
29. Services provided by government agencies, except as required by federal or state law.
30. Services related to temporomandibular joint disorder (TMJ) and/or associated facial pain or to correct congenital conditions, including bite blocks and occlusal equilibration, except as specified as covered in Section IV.B.
31. Services covered by the national health plan of any other country.
32. Other than services for maternity care and those provided for enrolled newborn and adopted children, Pre-Existing Conditions shall be excluded from coverage until the Enrollee has been continuously covered under the Agreement for twelve (12) consecutive months, except as described below.

This Pre-Existing Condition wait will be credited for an Enrollee whose date of application for coverage under the Agreement is within sixty-three (63) days of termination of a prior similar coverage to the extent that the Enrollee has satisfied the Pre-Existing Condition wait under such prior coverage.

Section VI. Grievance Processes for Complaints and Appeals

The grievance processes to express a complaint and appeal a denial of benefits are set forth below.

Filing a Complaint or Appeal

The complaint process is available for an Enrollee to express dissatisfaction about customer service or the quality or availability of a health service.

The appeals process is available for an Enrollee to seek reconsideration of a denial of benefits.

Complaint Process

Step 1: The Enrollee should contact the person involved, explain his/her concerns and what he/she would like to have done to resolve the problem. The Enrollee should be specific and make his/her position clear.

Step 2: If the Enrollee is not satisfied, or if he/she prefers not to talk with the person involved, the Enrollee should call the department head or the manager of the medical center or department where he/she is having a problem. That person will investigate the Enrollee's concerns. Most concerns can be resolved in this way.

Step 3: If the Enrollee is still not satisfied, he/she should call the GHO Customer Service Center toll free at (888) 901-4636. Most concerns are handled by phone within a few days. In some cases the Enrollee will be asked to write down his/her concerns and state what he/she thinks would be a fair resolution to the problem. A Customer Service Representative or Member Quality of Care Coordinator will investigate the Enrollee's concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Enrollee Rights and Responsibilities statement. This process can take up to thirty (30) days to resolve after receipt of the Enrollee's written statement.

If the Enrollee is dissatisfied with the resolution of the complaint, he/she may contact the Member Quality of Care Coordinator or the Customer Service Center.

Appeals Process

Step 1: If the Enrollee wishes to appeal a decision denying benefits, he/she must submit a request for an appeal either orally or in writing to the Member Appeals Department, specifying why he/she disagrees with the decision. The appeal must be submitted within 180 days of the denial notice he/she received. Appeals should be directed to GHO's Member Appeals Department, P.O. Box 204, Spokane, WA 99210-0204, (509) 241-7622 or toll free (888) 901-4636.

A grievance board will review the appeal request. GHO will then notify the Enrollee of its determination or need for an extension of time within *thirty (30)* days of receiving the request for appeal. Under no circumstances will the review timeframe exceed thirty (30) days without the Enrollee's written permission.

There is an expedited appeals process in place for cases which meet criteria or where the Enrollee's provider believes that the standard thirty (30) day appeal review process will seriously jeopardize the Enrollee's life, health or ability to regain maximum function or subject the Enrollee to severe pain that cannot be managed adequately without the requested care or treatment. The Enrollee can request an expedited appeal in writing to the above address, or by calling GHO's Member Appeals Department at (509) 241-7622 or toll free (888) 901-4636. The Enrollee's request for an expedited appeal will be processed and a decision issued no later than seventy-two (72) hours after receipt.

Step 2: If the Enrollee is not satisfied with the decision in Step 1 regarding a denial of benefits, or if GHO fails to grant or reject the Enrollee's request within the applicable required timeframe, he/she may request a second level review by an external independent review organization. A request for a review by an independent review organization must be made within 180 days after the date of the Step 1 decision notice. An independent review organization is not legally affiliated or controlled by GHO. Once a decision is made through an independent review organization, the decision is final and cannot be appealed through GHO.*

If GHO fails to make payment for a claim for covered services in accordance with the provisions of this Agreement, the Enrollee has the right to file a lawsuit. If the court finds for the Enrollee and notwithstanding any other

provision of this Agreement to the contrary, GHO shall pay reasonable attorney fees as determined by the court consistent with Idaho law, in addition to the claim payment justly due under the terms of the Agreement.

* If the Enrollee's health plan is governed by the Employee Retirement Income Security Act, known as "ERISA" (most employment related health plans, other than those sponsored by governmental entities or churches – ask employer about plan), the Enrollee has the right to file a lawsuit under Section 502(a) of ERISA to recover benefits due to the Enrollee under the plan at any point after completion of Step 1 of the appeals process. Enrollees may have other legal rights and remedies available under state or federal law.

Section VII. General Provisions

A. Coordination of Benefits

The coordination of benefits (COB) provision applies when an Enrollee has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits according to its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

If the Enrollee is covered by more than one health benefit plan, the Enrollee or the Enrollee's provider should file all the Enrollee's claims with each plan at the same time. If Medicare is the Enrollee's primary plan, Medicare may submit the Enrollee's claims to the Enrollee's secondary carrier.

1. Definitions.

a. Plan. A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Enrollees of a Group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

1) Plan includes: group, individual or blanket disability insurance contracts and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

2) Plan does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans; unless permitted by law.

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

b. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract

may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

- c. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the Enrollee has health care coverage under more than one plan.*

When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim. This means that when this plan is secondary, it must pay the amount which, when combined with what the primary plan paid, totals 100% of the highest allowable expense. In addition, if this plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the primary plan) and record these savings as a benefit reserve for the covered Enrollee. This reserve must be used to pay any expenses during that calendar year, whether or not they are an allowable expense under this plan. If this plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

- d. Allowable Expense. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the Enrollee is not an allowable expense.*

The following are examples of expenses that are not allowable expenses:

- 1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.*
 - 2) If an Enrollee is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.*
 - 3) If an Enrollee is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.*
- e. Closed panel plan is a plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.*
- f. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.*

2. Order of Benefit Determination Rules.

When an Enrollee is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- a. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.*

- b. *Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both plans state that the complying plan is primary.*

Coverage that is obtained by virtue of membership in a Group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the plan provided by the Subscriber. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

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

- d. *Each plan determines its order of benefits using the first of the following rules that apply:*

1) *Non-Dependent or Dependent. The plan that covers the Enrollee other than as a Dependent, for example as an employee, member, policyholder, Subscriber or retiree is the primary plan and the plan that covers the Enrollee as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Enrollee as a Dependent, and primary to the plan covering the Enrollee as other than a Dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the Enrollee as an employee, member, policyholder, Subscriber or retiree is the secondary plan and the other plan is the primary plan.*

2) *Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:*

- a) *For a dependent child whose parents are married or are living together, whether or not they have ever been married:*

- *The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or*
- *If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.*

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

(1) *If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;*

(2) *If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;*

(3) *If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of a) above determine the order of benefits;*

(4) *If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection a) above determine the order of benefits;*
or

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

- *The plan covering the custodial parent, first;*

- *The plan covering the spouse of the custodial parent, second;*
- *The plan covering the non-custodial parent, third; and then*
- *The plan covering the spouse of the non-custodial parent, last.*

c) *For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subsection a) or b) above determine the order of benefits as if those individuals were the parents of the child.*

- 3) *Active employee or retired or laid-off employee. The plan that covers an Enrollee as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same Enrollee as a retired or laid off employee is the secondary plan. The same would hold true if an Enrollee is a Dependent of an active employee and that same Enrollee is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section d 1) can determine the order of benefits.*
- 4) *COBRA or State Continuation Coverage. If an Enrollee whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the Enrollee as an employee, member, Subscriber or retiree or covering the Enrollee as a Dependent of an employee, member, Subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section d 1) can determine the order of benefits.*
- 5) *Longer or shorter length of coverage. The plan that covered the Enrollee as an employee, member, Subscriber or retiree longer is the primary plan and the plan that covered the Enrollee the shorter period of time is the secondary plan.*
- 6) *If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.*

3. *Effect on the Benefits of this Plan.*

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expenses for that claim. Total allowable expense is the highest allowable expenses of the primary plan or the secondary plan. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

4. *Right to Receive and Release Needed Information.*

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. GHO may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the Enrollee claiming benefits. GHO need not tell, or get the consent of, any Enrollee to do this. Each Enrollee claiming benefits under this plan must give GHO any facts it needs to apply those rules and determine benefits payable.

5. *Facility of Payment.*

If payments that should have been made under this plan are made by another plan, GHO has the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other plan are considered benefits paid under this plan. To the extent of such payments, GHO is fully discharged from liability under this plan.

6. Right of Recovery.

GHO has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. GHO may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Questions about Coordination of Benefits? Contact the State Insurance Department.

7. Effect of Medicare.

Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status, and will be adjudicated by GHO as set forth in this section.

- a. When the MHCN renders care to an Enrollee who is eligible for Medicare benefits, and Medicare is deemed to be the primary bill payer under Medicare secondary payer guidelines and regulations, GHO will seek Medicare reimbursement for all Medicare covered services.*
- b. When an Enrollee, who is a Medicare beneficiary and for whom Medicare has been determined to be the primary bill payer under Medicare secondary payer guidelines and regulations, seeks care on a Self-Referred basis from Community Providers, GHO has no obligation to provide any benefits except as specifically outlined in the Community Provider option under Section IV.*

B. Subrogation and Reimbursement Rights

The benefits under this Agreement will be available to an Enrollee for injury or illness caused by another party, subject to the exclusions and limitations of this Agreement. If GHO provides benefits under this Agreement for the treatment of the injury or illness, GHO will be subrogated to any rights that the Enrollee may have to recover compensation or damages related to the injury or illness. This section VII.B. more fully describes GHO's subrogation and reimbursement rights.

"Injured Person" under this section means an Enrollee covered by the Agreement who sustains an injury and any spouse, dependent or other person or entity that may recover on behalf of such Enrollee including the estate of the Enrollee and, if the Enrollee is a minor, the guardian or parent of the Enrollee. When referred to in this section, "GHO's Medical Expenses" means the expenses incurred and the reasonable value of the benefits provided by GHO for the care or treatment of the injury sustained by the Injured Person.

If the Injured Person's injuries were caused by a third party giving rise to a claim of legal liability against the third party and/or payment by the third party to the Injured Person and/or a settlement between the third party and the Injured Person, GHO shall have the right to recover GHO's Medical Expenses from any source available to the Injured Person as a result of the events causing the injury, including but not limited to funds available through applicable third party liability coverage and uninsured/underinsured motorist coverage. This right is commonly referred to as "subrogation." GHO shall be subrogated to and may enforce all rights of the Injured Person to the extent of GHO's Medical Expenses.

GHO's subrogation and reimbursement rights shall be limited to the excess of the amount required to fully compensate the Injured Person for the loss sustained, including general damages.

Subject to the above provisions, if the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury, including but not limited to any party's liability insurance or uninsured/underinsured motorist funds, then GHO's Medical Expenses provided or to be provided to the

Injured Person are secondary, not primary. As a condition of receiving benefits under the Agreement, the Injured Person agrees that acceptance of GHO services is constructive notice of this provision in its entirety and agrees to reimburse GHO for the benefits the Injured Person received as a result of the events causing the injury.

The Injured Person and his/her agents shall cooperate fully with GHO in its efforts to collect GHO's Medical Expenses. This cooperation includes, but is not limited to, supplying GHO with information about any third parties, defendants and/or insurers related to the Injured Person's claim and informing GHO of any settlement or other payments relating to the Injured Person's injury. The Injured Person and his/her agents shall permit GHO, at GHO's option, to associate with the Injured Person or to intervene in any legal, quasi-legal, agency or any other action or claim filed. If the Injured Person takes no action to recover money from any source, then the Injured Person agrees to allow GHO to initiate its own direct action for reimbursement or subrogation, including, but not limited to, billing the Injured Person directly for GHO's Medical Expenses.

The Injured Person and his/her agents shall do nothing to prejudice GHO's subrogation and reimbursement rights. The Injured Person shall promptly notify GHO of any tentative settlement with a third party and shall not settle a claim without protecting GHO's interest. If the Injured Person fails to cooperate fully with GHO in recovery of GHO's Medical Expenses, the Injured Person shall be responsible for directly reimbursing GHO for GHO's Medical Expenses and GHO retains the right to bill the Injured Person directly for GHO's Medical Expenses.

To the extent that the Injured Person recovers funds from any source *that may serve to compensate for medical injuries or medical expenses*, the Injured Person agrees to hold such monies in trust or in their possession until GHO's subrogation and reimbursement rights are fully determined.

GHO shall not pay any attorneys' fees or collection costs to attorneys representing the Injured Person unless there is a written fee agreement signed by GHO prior to any collection efforts. When reasonable collection costs have been incurred with GHO's prior written agreement to recover GHO's Medical Expenses, there shall be an equitable apportionment of such collection costs between GHO and the Injured Person subject to a maximum responsibility of GHO equal to one-third of the amount recovered on behalf of GHO. Under no circumstance will GHO pay legal fees for services which were not reasonably and necessarily incurred to secure recovery, which do not benefit GHO or where no written fee agreement has been entered into with GHO.

To the extent the provisions of this Subrogation and Reimbursement section are deemed governed by ERISA, implementation of this section shall be deemed a part of claims administration under the Agreement and GHO shall therefore have sole discretion to interpret its terms.

C. Miscellaneous Provisions

- 1. Identification Cards.** GHO will furnish cards, for identification purposes only, to all Enrollees enrolled under the Agreement.
- 2. Administration of Agreement.** GHO may adopt reasonable policies and procedures to help in the administration of the Agreement. GHO reserves the right to construe the provisions of the Agreement and to make all determinations regarding benefit entitlement and coverage.
- 3. Modification of Agreement.** No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of the Agreement, convey or void any coverage, increase or reduce any benefits under the Agreement or be used in the prosecution or defense of a claim under the Agreement.

In the absence of fraud, all statements made by applicants or Enrollees shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the Enrollee, a copy of which has been furnished to such Enrollee.

4. **Confidentiality.** GHO and the Group shall keep Enrollee information strictly confidential and shall not disclose any information to any third party other than: (i) representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such information in order to perform the services required of such party pursuant to the Agreement, or for the proper management and administration of the receiving party, provided that such representatives are informed of the confidentiality provisions of the Agreement and agree to abide by them, (ii) pursuant to court order or (iii) to a designated public official or agency pursuant to the requirements of federal, state or local law, statute, rule or regulation.
5. **Written Notice of Sickness or Injury.** A written notice of sickness or injury must be given to GHO within twenty (20) days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

GHO will furnish to the Enrollee any forms required by GHO for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Agreement as to proof of loss upon submitting within the time fixed in the Agreement for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

All benefits payable under the Agreement other than benefits for loss of time will be payable immediately upon receipt of due written proof of such loss, and that, subject to due proof of loss, all accrued benefits payable under the Agreement for loss of time will be paid not later than at the expiration of each period of thirty (30) days during the continuance of the period for which GHO is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

GHO, at its own expense, shall have the right and opportunity to examine the Enrollee and so often as may reasonably be determined during the pendency of claim under the Agreement, and also the right and opportunity to make any autopsy in case of death where it is not prohibited by law.

No action at law or in equity shall be brought to recover under the Agreement prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the Agreement and that no such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

6. **Nondiscrimination.** GHO does not discriminate on the basis of physical or mental disabilities in its employment practices and services.

D. Utilization Management

All benefits under the Agreement are limited to Covered Services that are Medically Necessary and set forth in Section IV. GHO may review an Enrollee's medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent or retrospective review, GHO may deny coverage if, in its determination, such services are not Medically Necessary and in the case of out of network services, Usual, Customary and Reasonable. Such determination shall be based on established clinical criteria.

Section VIII. Definitions

Agreement: The Medical Coverage Agreement between GHO and the Group.

Allowance: The maximum amount payable by GHO for certain Covered Services under the Agreement, as set forth in the Allowances Schedule.

Association: An Association, including a labor union, which shall have a constitution and by-laws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, insuring members, employees, or employees of members of the Association for the benefit of persons other than the Association or its officers or trustees. The term “employees” as used herein may include retired employees.

Community Provider: Licensed physicians, registered nurses, podiatrists, midwives, naturopaths and acupuncturists to the extent they provide a service or treat Enrollees within the scope of their licenses. For purposes of the Agreement, Community Providers do not include individuals employed by or under contract with the MHCN.

Contracted Network Pharmacy: A pharmacy that has contracted with GHO to provide covered legend (prescription) drugs and medicines for outpatient use under the Agreement.

Copayment: The specific dollar amount an Enrollee is required to pay at the time of service for certain Covered Services under the Agreement, as set forth in the Allowances Schedule.

Cost Share: The portion of the cost of Covered Services the Enrollee is liable for under the Agreement. Cost Shares for specific Covered Services are set forth in the Allowances Schedule. Cost Share includes Copayments, coinsurances and/or Deductibles.

Covered Services: The services for which an Enrollee is entitled to coverage under the Agreement.

Deductible: A specific amount an Enrollee is required to pay for certain Covered Services before benefits are payable under the Agreement. The applicable Deductible amounts are set forth in the Allowances Schedule.

Dependent: Any member of a Subscriber's family who meets all applicable eligibility requirements, is enrolled hereunder and for whom the premium prescribed in the Premium Schedule has been paid.

Emergency: Health care services that are provided in a hospital or other emergency facility after the sudden onset of a Medical Condition that manifests itself by symptoms of sufficient severity including, but not limited to, severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent person who possesses an average knowledge of health and medicine, to result in: (a) placing the Enrollee's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Enrollee: Any Subscriber or Dependent enrolled under the Agreement.

Family Unit: A Subscriber and all his/her Dependents.

Fee Schedule: A fee-for-service schedule adopted by the MHCN, setting forth the fees for the MHCN medical and hospital services.

Group: An employer, union, welfare trust or bona-fide association which has entered into a Group Medical Coverage Agreement with GHO.

Health Benefit Plan: Any Group hospital or medical policy or certificate, any Group Subscriber contract provided by a hospital or professional service corporation, or group health maintenance organization Subscriber contract. Health Benefit Plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, student health benefits-only coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

Hospital Care: Those Medically Necessary services generally provided by acute general hospitals for admitted patients. Hospital Care does not include convalescent or custodial care, which can, in the opinion of the provider, be provided by a nursing home or convalescent care center.

Large Employer: Any person, firm, corporation, partnership or association that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar year, employed no less than fifty-one (51) eligible employees, the majority of whom were employed within Idaho. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.

Late Enrollee: An eligible employee or Dependent who requests enrollment in a Health Benefit Plan of a Large Employer following the initial enrollment period during which the Enrollee is entitled to enroll under the terms of the Health Benefit Plan, provided that the initial enrollment period is a period of at least thirty (30) days. However, an eligible employee or Dependent shall not be considered a Late Enrollee if: (a) the Enrollee meets each of the following i) the Enrollee was covered under Qualifying Previous Coverage at the time of the initial enrollment, ii) the Enrollee lost coverage under Qualifying Previous Coverage as a result of termination of employment or eligibility, the involuntary termination of the Qualifying Previous Coverage, and iii) the Enrollee requests enrollment within thirty (30) days after termination of the Qualifying Previous Coverage; (b) the Enrollee is employed by a Large Employer which offers multiple Health Benefit Plans and the Enrollee elects a different plan during an open enrollment period; (c) a court has ordered coverage be provided for a spouse or a minor or Dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order; or (d) the Enrollee first becomes eligible.

Lifetime Maximum: The maximum value of benefits provided for Covered Services under the Agreement after which benefits under the Agreement are no longer available as set forth in the Allowances Schedule. The value of Covered Services received from the MHCN is based on the MHCN Fee Schedule, as defined above. The Lifetime Maximum of Covered Services received from a Community Provider is based on benefits paid. The lifetime maximum applies to this Agreement or in combination with any other medical coverage agreement between GHO and Group.

Managed Health Care Network (MHCN): The participating provider with which GHO has entered into a written participating provider agreement for the provision of Covered Services. GHO's participating provider is Group Health Cooperative.

Medical Condition: A disease, illness or injury.

Medically Necessary: *In order to be Medically Necessary, services and supplies must be* appropriate and clinically necessary according to generally accepted principles of good medical practice, must be rendered to an Enrollee for the diagnosis, care or treatment of a Medical Condition ***and must meet the following standards:*** (a) are not solely for the convenience of the Enrollee, his/her family or the provider of the services or supplies; (b) are the most appropriate level of service or supply which can be safely provided to the Enrollee; (c) are for the diagnosis or treatment of an actual or existing Medical Condition unless being provided under GHO's schedule for preventive services; (d) are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions; (e) are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Idaho, could not have been omitted without adversely affecting the Enrollee's condition or the quality of health services rendered; (f) as to inpatient care, could not have been provided in a provider's office, the outpatient department of a hospital or a non-residential facility without affecting the Enrollee's condition or quality of health services rendered; (g) are not primarily for research and data accumulation; and (h) are not experimental or investigational. The length and type of the treatment program and the frequency and modality of visits covered shall be determined by ***the Enrollee's provider in conjunction with*** GHO's Medical Director, or his/her designee. ***In addition to being medically necessary, to be covered, services and supplies must be otherwise included as a Covered Service as set forth in Section IV. of the Agreement and not excluded from coverage. The cost of non-covered services and supplies shall be the responsibility of the Enrollee.***

Medicare: The federal health insurance program for the aged and disabled.

MHCN-Designated Self-Referral Specialist: A MHCN specialist specifically identified by GHO to whom Enrollees may self-refer.

MHCN Facility: A facility (hospital, medical center or health care center) owned, operated or otherwise designated by the MHCN.

MHCN Personal Physician: A provider who is employed by or contracted with the MHCN to provide primary care services to Enrollees and is selected by each Enrollee to provide or arrange for the provision of all non-emergent Covered Services, except for services set forth in the Agreement which an Enrollee can access without a Referral. Personal Physicians must be capable of and licensed to provide the majority of primary health care services required by each Enrollee.

MHCN Provider: The medical staff, clinic associate staff and allied health professionals employed by the MHCN and any other health care professional or provider with whom the MHCN has contracted to provide health care services to Enrollees enrolled under the Agreement, including, but not limited to, physicians, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists and other professionals engaged in the delivery of healthcare services who are licensed or certified to practice.

Out-of-Pocket Expenses: Those Cost Shares paid by the Subscriber or Enrollee for Covered Services which are applied to the Out-of-Pocket Limit.

Out-of-Pocket Limit: The maximum amount of Out-of-Pocket Expenses incurred and paid during the contract year for Covered Services received by the Subscriber and his/her Dependents within the same contract year. The Out-of-Pocket Limit amount and Cost Shares that apply are set forth in the Allowances Schedule. Charges in excess of UCR, services in excess of any benefit level and services not covered by the Agreement are not applied to the Out-of-Pocket Limit.

Placed: Physical placement of a child in the care of the Subscriber for the purpose of adoption. When physical placement is prevented due to medical needs requiring placement of the child in a medical facility, it shall mean when the Subscriber signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

Plan Coinsurance: The percentage amount the Enrollee and GHO are required to pay for Covered Services received under the Agreement. Percentages for Covered Services are set forth in the Allowances Schedule.

Pre-Existing Condition: A physical or mental condition for which there has been diagnosis, treatment or medical advice within the six (6) month period prior to the effective date of coverage. The Pre-Existing Condition wait period will begin on the first day of coverage, or the first day of the enrollment waiting period if earlier. Genetic information shall not be considered as a Pre-Existing Condition as described above in the absence of a diagnosis of the condition related to such information.

Qualifying Previous Coverage/Qualifying Existing Coverage: Benefits or coverage provided under (a) Medicare or Medicaid, civilian health and medical program for uniformed services (*Tri-Care*), the Indian health service program, a state health benefits risk pool, or any other similar publicly sponsored program; or (b) any other group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a health maintenance organization, hospital or professional service corporation, or a fraternal benefit society.

Referral: A written temporary agreement requested in advance by a MHCN Personal Physician and approved by GHO that entitles an Enrollee to receive Covered Services from a specified health care provider at the MHCN benefit level. Entitlement to such services shall not exceed the limits of the Referral and is subject to all terms and conditions of the Referral and the Agreement. Enrollees who have a complex or serious medical or psychiatric condition may receive a standing Referral for specialist services. Any Referral to a specialist that requires or results in an additional Referral to another specialist or provider, must be approved by the Enrollee's Personal Physician and the MHCN in order to be covered at the MHCN benefit level.

Self-Referred: Covered Services received by an Enrollee from a Community Provider, designated women's health care specialist, or MHCN-Designated Self-Referral Specialist that are not referred by a MHCN Personal Physician.

Service Area: Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima; Idaho counties of Kootenai and Latah; and any other areas designated by GHO.

Subscriber: A person employed by or belonging to the Group who meets all applicable eligibility requirements, is enrolled under the Agreement and for whom the premium specified in the Premium Schedule has been paid.

Urgent Condition: The sudden, unexpected onset of a Medical Condition that is of sufficient severity to require medical treatment within twenty-four (24) hours of its onset.

Usual, Customary and Reasonable (UCR): Expenses are considered Usual, Customary and Reasonable if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies. Amounts charged by a Community Provider in excess of UCR rates are the responsibility of the Subscriber and/or Enrollee.

PREMIUM SCHEDULE

Group Name	North Idaho College		
Group Number (Primary)	6987800		
GROUP HEALTH OPTIONS INC. - Options ID benefit description			
Inside the Network: Managed Care Providers		Outside the Network: Non Managed Care Providers	
Coinsurance	None	Coinsurance	70/30%
Deductible	\$1000	Deductible	Shared with in-network
Emergency Copay	\$75	Office Visit Copay	\$30
Family Ded & OOP Max	2x	Out Of Pocket Threshold	Shared with in-network
Hospital Inpatient Copay	None	Outpatient Surgery Copay	Same as OON OV
Office Visit Copay	\$30		
Optical Rider	\$100/12 months		
Out Of Pocket	\$2000		
Outpatient Surgery Copay	Same as OV		
Prescription Drug Copay	\$10/\$20/\$40		
12 Month PEC Wait		Group Offering	Dual Choice
MONTHLY HEALTHCARE PREMIUM			
<i>This Schedule reflects from: 07/01/2008 to 07/01/2009</i>			
Subscriber	\$285.38		
Subscriber and 1 Dependent	\$675.85		
Subscriber and 2 Dependents	\$824.10		