Bonner County
Board of Commissioners

Luke Omodt | Steve Bradshaw | Asia Williams

CONSENT AGENDA

October 10, 2023

Memorandum

To: Bonner County Commissioners

Re: Adopting the Order of the Agenda as Presented

A suggested Motion would be: **Mr. Chairman I move to adopt the order of agenda as presented.**

Consent Agenda
The Consent Agenda includes:

CONSENT AGENDA – Action Item
1) Bonner County Commissioners' Minutes for October 3, 2023
2) Liquor Licenses: 7B Wine Club, LLC, Sandpoint, ID
3) Catering Permit: Timber Town Beer Company, Sandpoint, ID
4) Plats for Approval: MLD0149-21, Hertzberg; MLD0026-23, Steele's Homestead II
5) Invoices over $5k: Technology (2 Confidential), Sheriff (Confidential), Public Works

A suggested motion would be: **Mr. Chairman, based on the information before us I move to approve the consent agenda as presented.**

Recommendation Acceptance: □ yes □ no _____ Date: _____
Steve Bradshaw, Chairman

1500 Highway 2, Ste. 308 Sandpoint, ID 83864 (208) 265-1438 Fax: (208) 265-1460

Bonner County
Board of Commissioners

Luke Omodt Steve Bradshaw Asia Williams

MINUTES FOR THE BONNER COUNTY BOARD OF COMMISSIONERS' MEETING
October 3, 2023 – 9:00 A.M.
Bonner County Administration Building
1500 Hwy 2, Suite 338, Sandpoint, ID

On Tuesday, October 3, 2023, the Bonner County Commissioners met for their regularly scheduled meeting with Commissioners Bradshaw, Omodt, and Williams present. Commissioner Omodt called the meeting to order at 9:08 a.m. The Invocation was presented by Pastor Scott Acklin and the Pledge of Allegiance followed.

PUBLIC COMMENT

- Susan Bowman for Dian Welle: See attached statement.
- Ken Moore: Lots of words thrown around: fair, liberty, justice. Elected officials take an oath of office to uphold the laws of the land and liberty, fairness, and justice. A Code of Conduct would be equitable. We all have to live under laws, the people in places of responsibility have a higher responsibility to make sure that citizens are not harmed, and we all adhere to laws.
- Stewart Hough: Wanted to know if/whether a councilman was sleeping, was there audio or video?

ADOPT ORDER OF THE AGENDA AS AMENDED

Commissioner Williams made a motion to approve the amendment and add Item #3: Ratification of the Contract with Legacy Heating and Cooling for the emergency replacement of damaged heating and air conditioning units at a cost of $149,950 and to adopt the order of agenda as amended. Commissioner Omodt stepped down from the chair and seconded the motion. Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes,

Recess for 15 minutes at 9:20 a.m.

Reconvened at 9:35 a.m.

Commissioner Bradshaw – Yes. The motion passed.

Commissioner Omodt stepped down from the chair and made a motion to adopt the order of the agenda as amended. Commissioner Williams seconded the motion. Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

DISTRICT 1 REPORT – Nothing to report at this time.

DISTRICT 2 REPORT – Commissioner Williams gave an extensive report of issues and activities. Invited public comments and questions.

- Trisha Bowlin: Why does IT not come to the meetings and if they could please come due to audio issues.
- Spencer Hutchings: Wonder why if there is a quorum of two why is the meeting stopped when Commissioner Bradshaw is not available.

DISTRICT 3 REPORT – Commissioner Omodt gave an extensive report of issues and activities

CLERK – Michael Rosedale

1) Action Item: Discussion/Decision Regarding FY23 Claims Batch #26 $1,284,968.61 & Demands in Batch #26 $867,056.54; **Totaling $2,152,025.15**

Commissioner Williams made a motion to approve payment of the FY23 Claims and Demands in Batch #26 Totaling $2,152,025.15. Commissioner Bradshaw seconded the motion.

Public Comment

- Doug Patterson: Usual questions on large items in the batch, Clerk Rosedale went over these items.

Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

2) Action Item: Discussion/Decision Regarding FY23 EMS Batch #26 $36,929.99 & Totaling **$36,929.99**

Commissioner Williams made a motion to approve payment of the FY23 EMS Claims and Demands in Batch #26 Totaling $36,929.99. Commissioner Bradshaw seconded the motion. Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

CONSENT AGENDA – Action Item

1) Bonner County Commissioners' Minutes for September 19, 2023
2) Plats for Approval: MLD0104-22, Hadler Lots
3) Ratification of the Contract with Legacy Heating and Cooling for the emergency replacement of damaged heating and air conditioning units; $149,950 – ADDED 10/2/23

Commissioner Williams made a motion to approve the consent agenda as amended. Commissioner Bradshaw seconded the motion.

Public Comment

- Doug Patterson: How long prior to the meeting was Item #3 added? Clerk Rosedale answered 24-25 hours prior.
- Brandon Cramer: Wishes to address items on the agenda. Commissioner Omodt advised that he could ask questions for each item as they are presented.

Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

SOLID WASTE – Bob Howard

1) Action Item: Discussion/Decision Regarding Acceptance of Wood Grinding Bid from Cannon Hills

Commissioner Williams made a motion to award Cannon Hills the contract for the grinding, removal, and disposal of the wood piles at the Dickensheet, Idaho Hill, and Colburn sites for the 2023-2024 fiscal year in the amount of $55.00 per ton. Commissioner Bradshaw seconded the motion. Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

2) Action Item: Discussion/Decision Regarding Acceptance of Metal Bailing Bid from Pacific Steel and Recycling

Commissioner Williams made a motion to award Pacific Steel and Recycling the contract for the removal of the metal piles at the Dickensheet, Idaho Hill, and Colburn sites for the 2023-2024 fiscal year; Pacific Steel and Recycling has agreed to pay Bonner County $93.00 per ton. Commissioner Bradshaw seconded the motion. Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

3) Action Item: Discussion/Decision Regarding Acceptance of Household Hazardous Waste Contract with GrayMar Environmental

Commissioner Williams made a motion to award GrayMar Environmental the Household Hazardous Waste contract allowing GrayMar to collect, package, transport, and dispose of Bonner County residential household hazardous waste from October 1, 2023 through September 30, 2024. Commissioner Bradshaw seconded the motion. Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

JUSTICE SERVICES – Ron Stultz

1) Action Item: Discussion/Decision Regarding Idemia Identity and Security Maintenance Agreement Addendum; **$133.25/month**

Commissioner Williams made a motion to approve Idemia Addendum for the term of September 23, 2023 until September 22, 2024 as set forth above and previously approved by legal. Commissioner Bradshaw seconded the motion.

Public Comment

- Doug Patterson: Did the cost increase and if so, how much? Ron Stultz, no changes to price, just renewal.

Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

ASSESSORS – Dennis Englehardt

1) Action Item: Discussion/Decision Regarding the Surplus of a Swingline 6375 Burster; **Resolution**

Commissioner Williams made a motion to approve Resolution 2023-73 Assessors equipment surplus of a Swingline 6375 Burster. Commissioner Bradshaw seconded the motion. Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

ROAD & BRIDGE – Jason Topp

1) Action Item: Discussion/Decision Regarding Unanticipated Funds; **Resolution**

Commissioner Williams made a motion to approve Resolution 2023-74 authorizing the Clerk to open the Road and Bridge FY2024 budget and add unanticipated revenues to the Bonner County Road and Bridges "B" Budget for the sum of $995,815.85 as detailed in the Resolution. Commissioner Bradshaw seconded the motion.

Public Comment

- Sheryl Messer: Safety concerns near Oden on Highway 200, is there accommodation for that? Jason Topp responded.

Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

2) Discussion/Decision Regarding Budget Adjustment; **Resolution**

Commissioner Williams made a motion to approve Resolution 2023-75 authorizing the Clerk to open the Road and Bridge FY 2024 budget and add funds as outlined in the resolution from FY 2023 to FY 2024 002-8490 Plant Asphalt Mix for the sum of $1,231,679.00 as detailed in the Resolution. Commissioner Bradshaw seconded the motion.

Public Comment

- Brandon Cramer: When these items are agendized they should be listed with more details. Will this cost (for the asphalt work) increase or is it a fixed amount? Jason Topp responded it's a contract so there will not be an increase in cost.

Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

3) Discussion/Decision Regarding Budget Adjustment; **Resolution**

Commissioner Williams made a motion to approve Resolution 2023-76 authorizing the Clerk to open the Road and Bridge FY 2024 budget and add funds as outlined in the resolution from FY 2023 to FY 2024 002-8552 Guardrail for the sum of $34,321.00 as detailed in the Resolution. Commissioner Bradshaw seconded the motion. Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

4) Discussion/Decision Regarding Budget Adjustment; **Resolution**

Commissioner Williams made a motion to approve Resolution 2023-77 authorizing the Clerk to open the Road and Bridge FY 2024 budget and add funds as outlined in the resolution from FY 2023 to FY 2024 002-9000 Grant County Match for the sum of $276,000.00 as detailed in the Resolution. Commissioner Bradshaw seconded the motion. Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

5) Action Item: Discussion/Decision Regarding Unanticipated Funds; **Resolution**

Commissioner Williams made a motion to approve Resolution 2023-78 authorizing the Clerk to open the Road and Bridge FY2024 budget and add unanticipated revenues to the Bonner County Road and Bridges "B" Budget for the sum of $31,158.00 as detailed in the Resolution. Commissioner Bradshaw seconded the Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

SHERIFF – Ror Lakewold

1) Action Item: Discussion/Decision Regarding Awarding Sergeant Anna Marie Moe Handgun, Badge and Retired ID Card; **Resolution**

Commissioner Williams made a motion to approve Resolution 2023-79 authorizing Undersheriff Ror Lakewold to award Sergeant Anna Marie Moe her Handgun, Badge and Retired ID Card. Commissioner Bradshaw seconded the motion.

Public Comment

- Doug Patterson: Thank you to Sgt Moe for her service and clarification on the Resolution number.

Commissioner Bradshaw recommended the Board send a letter of thanks for Sgt Moe's service.
Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

2) Discussion/Decision Regarding Awarding Lieutenant Cindy M Wright Handgun, Badge and Retired ID Card; **Resolution**

Commissioner Williams made a motion to approve Resolution 2023-80 authorizing Undersheriff Ror Lakewold to award Lieutenant Cindy M. Wright her Handgun, Badge and Retired ID Card. Commissioner Bradshaw seconded the motion. Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.
Commissioner Bradshaw recommended the Board send a letter of thanks for Lt. Wright's service.

Public comment regarding Executive Sessions:

- Brandon Cramer: ES Item #3: is this for retiring employees or something different. is there any elaboration on Item #5 for HR, who added this item? Commissioner Omodt answered that item #3 is another matter and he was unable to elaborate on item #5 that was added by the HR department.

Commissioner Omodt recessed the meeting for 10 minutes at 10:38 a.m.

Reconvened at 10:48 a.m.

EXECUTIVE SESSION – Human Resources

1) Executive Session under Idaho Code § 74-206 (1) (B) Personnel
   1) Action Item: Discussion/Decision Regarding Approval of Tuition Reimbursement
   2) Action Item: Discussion/Decision Regarding 911
   3) Action Item: Discussion/Decision Regarding Sheriff's Office
   4) Action Item: Discussion/Decision Regarding BOCC Staffing
   5) Action Item: Discussion/Decision Regarding HR Matters

At 10:49 a.m. Commissioner Williams made a motion to go into Executive Session under Idaho Code § 74 206 (1) (B) Personnel. Commissioner Omodt stepped down from the chair and seconded the motion. Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

Commissioner Omodt reconvened the meeting at 12:14 p.m.

Commissioner Williams made a motion to proceed as discussed on Items 1, 2, 3, 4, and 5. Commissioner Bradshaw seconded the motion. Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – Yes, Commissioner Bradshaw – Yes. The motion passed.

Commissioner Omodt adjourned the meeting at 12:15 p.m.

The following is a summary of the Board of County Commissioners
Special Meetings, (including Tax Cancellations, Assistance Meetings/Admin and other) Executive Sessions,
Emergency Meetings and Hearings held during the week of September 19, 2023 – October 2, 2023
Copies of the complete meeting minutes are available upon request.

On Wednesday, September 20, 2023, Tax Cancellations were held pursuant to Idaho Code §74-204 (2). Denied: MH54N04W08010A

On Thursday, September 21, 2023, an Executive Session was held pursuant to Idaho Code §74-204 (2) and Idaho Code § 74-206 (1) (F) Litigation.

On Thursday, September 28, 2023, a Special Meeting for the Sheriff's Office was held pursuant to Idaho Code §74-204 (4). Commissioner Williams made a motion to approve Resolution #2023 – 71. Commissioner Omodt stepped down from the chair and seconded the motion. Roll Call Vote: Commissioner Williams – Aye, Commissioner Omodt – Aye. All in favor. The motion passed. Commissioner Williams made a motion to declare an emergency and to accept and approve the contract with Legacy Heating and Cooling. Commissioner Omodt stepped down from the chair and seconded the motion. Roll Call Vote: Commissioner Williams – Aye, Commissioner Omodt – Aye. All in favor. The motion passed. On Monday, October 2, 2023, a Planning Hearing was held pursuant to Idaho Code §74-204 (2). Commissioner Omodt made a motion to approve project FILE S0002-23: Providence Subdivision, requesting the creation of 116 residential lots on an approximately 39.57-acre property zoned Suburban and located in Section 1, Township 57 North, Range 2 West, Boise Meridian, Bonner County, Bonner County, Idaho, finding that it is in accord with the Bonner County Revised Code based on the following Conclusions of Law. This decision is subject to the Conditions of Approval as set forth in the staff report as amended during this hearing. The decision is based on the evidence submitted up to the time the Staff Report was prepared and testimony received at this hearing. I further move to adopt the Findings of Fact and Conditions of Approval as amended during this hearing and direct the Planning staff to draft written findings and conclusions to reflect this decision and transmit to all interested parties. This action does not result in a taking of private property. The action that could be taken to obtain the approval of preliminary plat is to complete the Conditions of Approval as adopted. Commissioner Williams/Omodt seconded the motion. Roll call vote: Commissioner Omodt – Yes, Commissioner Williams – No, based on conclusions 1,2,3,5,8 are not in compliance in her review of this record. Commissioner Bradshaw – Yes. The motion passed. Commissioner Williams made a motion to approve this project, FILE AM0010-23, requesting a comprehensive land use plan map amendment from Ag/Forest Land to Rural Residential, finding that it is in accord with the general and specific objectives of the Bonner County Comprehensive Plan and Bonner County Revised Code as enumerated in the following conclusions of law and based upon the evidence submitted up to the time the Staff Report was prepared and testimony received at this hearing. I further move to adopt the findings of fact and conclusions of law as set forth in the Staff Report (or as amended during this hearing) and direct planning staff to draft written findings and conclusions to reflect this motion, have the Chairman sign, and transmit to all interested parties. This action does not result in the taking of private property. Commissioner Omodt seconded the motion. Roll call Vote: Commissioner Omodt – Aye, Commissioner Williams – Aye, Commissioner Bradshaw – Aye. The motion passed. Commissioner Williams made a motion approve Resolution 2023-72 the Bonner County Projected Land Use Map from Ag/ Forest to Rural-Residential for the three parcels outlined in this File AM0010-23, totaling an approximate 25 acres. Commissioner Bradshaw seconded the motion. The motion passed. Roll call Vote: Commissioner Omodt – Aye, Commissioner Williams – Aye, Commissioner Bradshaw – Aye. The motion passed.

ATTEST: Michael W. Rosedale

By_____
Chairman Steve Bradshaw

By_____
Deputy Clerk

_____
Date

2024

BONNER COUNTY
STATE OF IDAHO

No. 2024-01

RETAIL ALCOHOL BEVERAGE LICENSE

THIS IS TO CERTIFY THAT 7B WINE CLUB LLC
doing business as 7B WINE CLUB
at 1134 W ODEN BAY RD, SANDPOINT, ID 83864
a(n) LLC , is licensed to sell Alcoholic Beverages as stated below, subject to the provisions of Chapters 23-903 and 23-916 Idaho Code Annotated, and the laws of the State of Idaho, Municipal Ordinances, and the regulations of the Commissioner in regard to sale of Alcoholic Beverages and the resolution passed by the Commissioners of said County, on file in the office of the Clerk of the Board at the Bonner County Courthouse, Sandpoint, Idaho.

Dated: 12/01/2023

Bottled/canned beer, Consumed off premise	$0.00
Bottled/canned beer, Consumed on premise	$75.00
Draft beer, Includes draft, bottled, and/or canned	$0.00
Wine by the glass	$100.00
Wine by the bottle	$25.00
Liquor	$0.00
Application Fee	$5.00
Total	**$205.00**

(SEAL) By Cynthia Brannon
Clerk of the Board of County Commissioners

Signature of Licensee or Officer of Corporation

This license is TRANSFERABLE and EXPIRES 12/31/2024.
Witness my hand and seal this 10th of October, 2023.

Chairman

Commissioner

Commissioner

(This license must be conspicuously displayed)

Bonner County Recorder
Michael W. Rosedale - County Clerk
1500 Highway 2
Suite 335
Sandpoint, ID 83864
Phone: (208) 265-1490
Fax: (208) 255-7849

FOR OFFICE USE ONLY
Premise No. 7B-103
State Lic No. 3903
Issue Date: 12/01/2023
County No. 2024-01
Total Fees: $205.00
Deputy Initials: cbrannon

Retail Alcohol Beverage License Application

You must provide a copy of your newly issued State of Idaho Retail Alcohol Beverage License

1. Application Type
- [X] Renewal
- [ ] Seasonal (month open_____.)
- [ ] New (complete page 2)
- [ ] Transfer (complete page 2)
  (include transfer fee of $20.00)

2. Type of Business
- [ ] Individual
- [ ] Partnership
- [ ] Corporation
- [X] LLC
- [ ] LLP

3. Location of Facility
- [ ] Inside city limits
- [ ] Outside city limits

4. License Type

		County Fee	FOR OFFICE USE ONLY Prorated Fee (If applicable)
[ ] Bottled/canned beer (retail only)	Consumed off premise	$ 0.00	$
[X] Bottled/canned beer	Consumed on or off premise	$ 75.00	$
[ ] Draft beer	Includes draft, bottled, and/or canned	$ 0.00	$
[X] Wine by the glass		$ 100.00	$
[X] Wine by the bottle		$ 25.00	$
[ ] Liquor		$ 0.00	$
[X] Application Fee		$ 5.00	
Total Fees		$ $205.00	

5. Applicant Information
Doing Business As: 7B WINE CLUB
Business Phone Number: (208) 263-4164
Business Physical Address: 1134 W ODEN BAY RD
City: SANDPOINT State: ID Zip Code: 83864

6. Business Information
Business Name: 7B WINE CLUB LLC
Primary Contact Name: CATHERINE PLANK
Primary Contact Phone Number: (208) 263-4164
Mailing Address: 1134 W ODEN BAY RD
City: SANDPOINT State: ID Zip Code: 83864
Email Address:
Please indicate address to send future correspondence: [ ] Business Physical Address [X] Mailing Address [ ] Email

APPLICANT'S SIGNATURE: Catherine Plank
Signer must be authorized to sign for documents pertaining to the Alcohol Beverage Control.

APPROVED: _____ **DATE:** _____
Board of County Commissioners Call Catherine 263-4164

IDAHO ALCOHOL BEVERAGE CATERING PERMIT

BUSINESS NAME: TIMBER TOWN BEER COMPANY

TOTAL DAYS (Up to 3 days total): 1. [X] 2. [ ] 3. [ ] TOTAL FEES ($20/day): $20 [X] $40 [ ] $60 [ ]

FACILITY ADDRESS: 50 MAIN STREET CITY: SANDPOINT COUNTY: BONNER

STATE OF IDAHO ALCOHOL BEVERAGE LICENSE NUMBER: 3497 PREMISE NUMBER: 7B-66

DATES PERMIT TO BE USED: FROM 10/14/2023 TO 10/14/2023 **TIME:** FROM 12:00 P M TO 06:00 P M.

LOCATION WHERE PERMIT WILL BE USED (ADDRESS & ROOM NUMBER): 513 OAK STREET SANDPOINT ID 83864

TYPE OF EVENT: OKTOBERFEST EVENT NAME (IF APPLICABLE): SANDPOINT OKTOBERFEST

EVENT BEING HELD FOR (ORGANIZATION, GROUP, OR INDIVIDUAL NAME): MATCHWOOD

ALCOHOL TO BE SERVED (Must match the State Liquor License):

[ ] Bottled/canned beer [X] Draft beer [ ] Wine by the glass [ ] Wine by the bottle [ ] Liquor

_____
Signature of Licensee

Unless licensee is disqualified, approval of this permit does certify that the licensee is entitled to hold and use this Idaho Alcohol Beverage Catering Permit at the above premises, subject to provisions of Title 23-1.C.

_____ or _____, _____
Sheriff Chief of Police

_____ or _____ or _____
Council Board of Trustees Chairman County Commissioners

BONNER COUNTY CLERK 1500 HIGHWAY 2 SUITE 335 SANDPOINT, ID 83864 (208) 265-1490

Bonner County Planning Department
"Protecting property rights and enhancing property value"
1500 Highway 2, Suite 208, Sandpoint, Idaho 83864
Phone (208) 265-1458 - Fax (208) 265-1463
Email: planning@bonnercountyid.gov - Web site: www.bonnercountyid.gov

September 28, 2023

Memorandum

To: Board of County Commissioners

From: Alex Feyen, Bonner County Planner

Re: Final plat, MLD0149-21 - Hertzberg

Hertzberg is a minor land division dividing one (1) 20.022 acre parcel into one (1) 10.017 acre lot and one (1) 10.005 acre lot. The property is zoned R-10 and meets the requirements of that zone. The property is served by individual septic, individual well and Inland Power. The property is accessed by Hidden Valley Road, a graveled 50' wide public right-of-way; and an unnamed 40' wide private easement. The plat was approved by Bonner County on September 13, 2021. The parcel is located in a portion of Section 13, Township 54 North, Range 05 West situated between Blanchard and Clagstone.

The conditions of approval for Hertzberg have been completed. Notes and easements required by plat approval are shown on the final plat.

Legal Review: _____

Distribution: Jake Gabell
Janna Berard
Alex Feyen

(Recommendation)
Staff recommends the Board approve the final plat of File # MLD0149-21 - Hertzberg.

Consent Agenda

Recommendation Acceptance: □ Yes □ No _____ Date: _____
Commissioner Steve Bradshaw, Chairman

Bonner County Planning Department

"Protecting property rights and enhancing property value"
1500 Highway 2, Suite 208, Sandpoint, Idaho 83864
Phone (208) 265-1458 - Fax (866) 537-4935
Email: planning@bonnercountyid.gov - Web site: www.bonnercountyid.gov

Board of County Commissioners Memorandum

October 10, 2023

To: Board of County Commissioners

From: Rob Winningham, Bonner County Planning Tech

Subject: Final plat, MLD0026-23 – STEELE'S HOMESTEAD II

Steele's Homestead II is a minor land division dividing a 4.95 acre parcel into two (2) 1.01 acre lot and one (1) 2.93 acre lot. The property is zoned Recreation and meets the requirements of that zone. The property is served by individual septic, a shared well and Northern Lights, Inc. The property is accessed off Willow Bay Road, a gravel 60' wide public right-of-way and Swift Way, a gravel 30' wide private right-of-way. The plat was approved by Bonner County on July 11, 2023. The parcel is located in a portion of Section 4, Township 55 North, Range 4 West, Boise Meridian.

The conditions of approval for this file have been completed. Notes and easements required by plat approval are shown on the final plat.

Legal Review: _____

Distribution: Jake Gabell
Janna Berard
Rob Winningham

Recommendation: Staff recommends the Board approve the final plat of the above referenced file.

Consent Agenda

Recommendation Acceptance: ☐ Yes ☐ No

_____
Commissioner Steve Bradshaw, Chairman

Date: _____

BONNER COUNTY FACILITIES DEPARTMENT

1500 Highway 2, Suite 101 • Sandpoint, Idaho 83864-1303
Phone (208) 255-5681 • Fax 844-965-9700 • www.bonnercountyid.gov

October 10, 2023

Consent Agenda

Memorandum

To: Commissioners

From: Teddi Lupton, Director of Public Works

Re: Change order proposal #09

The Facilities and Engineering Department is requesting permission to accept and move forward with Change Order Proposal #09/ added steel angle and blocking at the elevator shaft per RFI#29. This change is to fabricate steel angle and blocking for reinforcement of the second floor elevator shaft in the new EMS Station 1/Office complex project. This additional cost is $5,489.43 for this change order. $3,842.61 will post to 00118/9480 Capitol Construction and $746.82 posted to 99918/9480 capitol Construction.

Auditor Review _____

Distribution: Original to BOCC
Email copy to Teddi Lupton and Spencer Ferguson

Recommendation Acceptance: ☐ yes ☐ no _____ Date: _____
Commissioner Steve Bradshaw, Chairman

KCI
KILGORE CONSTRUCTION, INC.
GENERAL CONTRACTOR
P.O. Box 367 • 18621 N. Yale • Colbert, WA 99005 • office: 509-238-0703 • fax: 509-238-0704 • www.kcispokane.com

CHANGE ORDER PROPOSAL SUMMARY

PROJECT: Bonner Count EMS and Office Complex
DATE: 9/13/2023
REVISION: N/A
DESCRIPTION 1. Added steel angle and blocking at elevator shaft per RFI #29.

COP: #09

A. - SUMMARY

	Craft	Amount
1. -	GENERAL CONTRACTOR	3,863.94
2. -	SUBCONTRACTOR	845.25
3. -	PROFIT & OVERHEAD	621.85
4. -	BOND & INSURANCE	158.39

TOTAL COST 5,489.43 excludes WSST

B - CONTRACTOR

KILGORE CONSTRUCTION, INC. AGREES TO PERFORM ALL WORK AS DESCRIBED IN THIS CHANGE ORDER PROPOSAL FOR THE AMOUNT AS SHOWN ABOVE.

Signed JAD KILGORE Date: 9/13/23
Jad Kilgore - President

Printed Name: JAD KILGORE

C - ARCHITECT

ARCHITECT REVIEW AND ACCEPTANCE OF PROPOSED PRICING.

Signed Date: 9-28-23
Architect

Printed Name: R.J. Colburn

D - OWNER / REPRESENTATIVE

OWNER HEREBY AGREES TO THE ABOVE CHANGES TO THE CONTRACT SCOPE AND CONTRACT AMOUNT.

Signed Date: 9-28-23
Owner or Owners Representative

KCI
KILGORE CONSTRUCTION, INC.
GENERAL CONTRACTOR
P.O. Box 367 • 18621 N. Yale • Colbert, WA 99005 • office: 509-238-0703 • fax: 509-238-0704 • www.kcispokane.com

COP BREAKDOWN

PROJECT: Bonner Count EMS and Office Complex
DATE: 9/13/2023
REVISION: N/A
COP: #09
DESCRIPTION 1. Added steel angle and blocking at elevator shaft per RFI #29.

A. - LABOR COST

	Craft	Hours	Rate per HR.	Amount
1 -	Management	2.0	77.27	154.54
2 -	Supervision	4.0	80.70	322.80
3 -	Carpenter	16.0	73.58	1177.28
4 -	Laborer	4.0	63.58	254.32

Total Labor Cost 1,908.94

B. - Material / Misc - Cost

	Description	Amount
1 -	Mountain Metals - Steel Materials Fabricated	1,205.00
2 -	Wood Blocking Material / Fasteners / Equipment	750.00
3 -		0.00
4 -		0.00

Total Material Cost 1,955.00

C. - Equipment Cost

	Description	Amount
1. -		0.00

Total Equip. Cost 0.00

Subtotal of Contractor Work 3,863.94

D. - Subcontractor Work

	Contractor	Description	Amount
1 -	Mountain Metals	Erection	845.25
2. -			0.00
3 -			0.00
4 -			0.00

Total Sub Cost 845.25

E. - Profit & Overhead

	Rate	Cost Above	Amount
1 -Own Work	15%	$3,863.94	579.59
2 - Sub Work	5%	$845.25	42.26

Total Profit & Overhead 621.85

Subtotal 5,331.04

F. - Insurance / Bond / Tax

	Rate	Cost Above	Amount
1 - Liability Insur	1.250%	$5,331.04	66.64
2 - B&O Tax	0.471%	$5,331.04	25.11
3 - Bond	1.250%	$5,331.04	66.64

Total Insurance / Bond / Tax 158.39

Subtotal 5,489.43

Grand Total $5,489.43

FAB

COP#29-1

774 Triangle Drive
Ponderay, Idaho 83852
Phone: 208-263-6031
Fax: 208-263-9377
Email: TimW@Mountain-Metals.com
www.Mountain-Metals.com
Public Works License #027015
United States Cage Code #7JXG5

DATE	9/7/2023
QUOTE #	P0002037-COP29
CUSTOMER ID	BONNER EMS
VALID UNTIL	10/15/2023

CUSTOMER

Bonner County EMS Station 1
COP Per RFI#29

DESCRIPTION	UNIT PRICE	QTY	TAXED	AMOUNT
Structural Steel Per ~~RFI#01~~ 29	1,205.00	1		1,205.00

Subtotal	$	1,205.00
Taxable	$	-
Tax rate		6.000%
Tax due	$	-
Other	$	-
TOTAL	**$**	**1,205.00**

Make checks payable to
Mountain Metals, LLC

TERMS AND CONDITIONS

1. Customer will be billed after indicating acceptance of this quote
2. Payment Terms: Net 30
3. FOB Factory
4. Only items listed are included

Customer Acceptance (sign below):

x _____

Print Name:

Balances over 30 days past due will be charged 1.5% per month

Thank You For Your Business!

MOUNTAIN METALS LLC
DESIGN AND FABRICATION

774 Triangle Drive
Ponderay, Idaho 83852
Phone: 208-263-6031
Fax: 208-263-9377
Email: TimW@Mountain-Metals.com
www.Mountain-Metals.com
Public Works License #027015
United States Cage Code #7JXG5

INSTALL

COP#29-2

DATE	9/7/2023
QUOTE #	P0002037-COP29
CUSTOMER ID	BONNER EMS
VALID UNTIL	10/15/2023

CUSTOMER

Bonner County EMS Station 1
COP Per RFI#29

DESCRIPTION	UNIT PRICE	QTY	TAXED	AMOUNT
RFI#29 Steel Installation - 7 Hrs @ $105/Hr * Includes 15% O&P	845.25	1		845.25

Subtotal	$	845.25
Taxable	$	-
Tax rate		6.000%
Tax due	$	-
Other	$	-
TOTAL	**$**	**845.25**

Make checks payable to
Mountain Metals, LLC

TERMS AND CONDITIONS

1. Customer will be billed after indicating acceptance of this quote
2. Payment Terms: Net 30
3. FOB Factory
4. Only items listed are included

Customer Acceptance (sign below):

x _____
Print Name:

Balances over 30 days past due will be charged 1.5% per month

Thank You For Your Business!

Bonner County Human Resources

1500 Highway 2, Suite 337 • Sandpoint, ID 83864

Oct 10, 2023

Memorandum

To: Bonner County Commissioners

From: Kevin Rothenberger, Human Resources

Re: Plan Documents Update and Amendments

Bonner County Human Resource office is seeking approval for the Pacific Source plan document changes. Our broker MarshMcLennan, and legal have reviewed the changes. These amendments and updates represent clean up of the 2022 Plan document, and incorporate those changes into the 2023 Plan. This is minor language cleanup per MarshMcLennan. There is no affect on price.

Distribution: ___ Original to BOCC Office
___ Copy to Human Resources

Approved by Legal: _____

A suggested motion would be: **Mr. Chairman based on the information before us I make a motion to approve the amendments and document changes for Pacific Source Plan 10/2022 and 10/2023.**

Recommendation Acceptance: □ yes □ no _____ Date: _____
Commissioner Steve Bradshaw, Chairman

Plan Amendment #2

Client Name: Bonner County
Group Number: G0039089
IRS Tax ID Number: 82-6000285
Plan Name: Voyager 1500+30-45_20

Effective 10/01/2022, the Plan Document is amended as follows, all other language and sections remains the same:

The Out-of-network Pharmacy section of the Prescription Drug Benefit Summary has been amended to read as follows:

Service/Supply	Incentive Drugs:	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
Out-of-network Pharmacy				
Up to a 30 day supply:	No Deductible, 0%	No Deductible, $15	After Deductible, $30	After Deductible, $45
31 – 60 day supply:	No Deductible, 0%	No Deductible, $30	After Deductible, $60	After Deductible, $90
61 – 90 day supply:	No Deductible, 0%	No Deductible, $45	After Deductible, $90	After Deductible, $135

"Plan Sponsor"
Bonner County

By:_____

Print:_____

Title:_____

Date:_____

Plan Amendment #2

Client Name: Bonner County
Group Number: G0039089
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Service/Supply	Incentive Drugs:	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
Out-of-network Pharmacy				
Up to a 30 day supply:	No Deductible, 0%	No Deductible, $150~~%~~	~~No~~ After Deductible, $300~~%~~	~~No~~ After Deductible, $450~~%~~
31 – 60 day supply:	No Deductible, 0%	No Deductible, $300~~%~~	~~No~~ After Deductible, $600~~%~~	~~No~~ After Deductible, $900~~%~~
61 – 90 day supply:	No Deductible, 0%	No Deductible, $450~~%~~	After~~No~~ Deductible, $900~~%~~	After~~No~~ Deductible, $1350~~%~~

"Plan Sponsor"
Bonner County

By:_____

Print:_____

Title:_____

Date:_____

Plan Amendment #2

Client Name: Bonner County
Group Number: G0039089
IRS Tax ID Number: 82-6000285
Plan Name: Medical HSA

Effective 10/01/2022, the Plan Document is amended as follows, all other language and sections remains the same:

The Out-of-network Preventive Care section of the Voyager HSA 2800_20+Rx Benefit Summary have been amended to read as follows:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No Deductible, 0%	No Deductible, 40%
Preventive physicals	No Deductible, 0%	No Deductible, 40%
Well woman visits	No Deductible, 0%	No Deductible, 40%
Preventive mammograms	No Deductible, 0%	No Deductible, 40%
Immunizations	No Deductible, 0%	No Deductible, 40%
Preventive colonoscopy	No Deductible, 0%	No Deductible, 40%
Prostate cancer screening	No Deductible, 0%	No Deductible, 40%

The Out-of-network benefits for Chiropractic manipulation/spinal manipulation and Acupuncture under the Professional Services section of the Voyager HSA 2800_20+Rx Benefit Summary have been amended to read as follows:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Professional Services		
Chiropractic manipulation/Spinal manipulation (20 visits per Benefit Year)	After Deductible, 20%	After Deductible, 20%
Acupuncture (20 visits per Benefit Year)	After Deductible, 20%	After Deductible, 20%

The Out-of-network Preventive Care section of the Voyager HSA 2000_20+Rx Benefit Summary have been amended to read as follows:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No Deductible, 0%	No Deductible, 40%
Preventive physicals	No Deductible, 0%	No Deductible, 40%
Well woman visits	No Deductible, 0%	No Deductible, 40%

Plan Amendment #2

Client Name: Bonner County
Group Number: G0039089
IRS Tax ID Number: 82-6000285
Plan Name: Medical HSA

Effective 10/01/2022, the Plan Document is amended as follows, all other language and sections remains the same:

The Out-of-network Preventive Care section of the Voyager HSA 2800_20+Rx Benefit Summary have been amended to read as follows:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No Deductible, 0%	~~After~~ No Deductible, 40%
Preventive physicals	No Deductible, 0%	~~After~~ No Deductible, 40%
Well woman visits	No Deductible, 0%	~~After~~ No Deductible, 40%
Preventive mammograms	No Deductible, 0%	~~After~~ No Deductible, 40%
Immunizations	No Deductible, 0%	~~After~~ No Deductible, 40%
Preventive colonoscopy	No Deductible, 0%	~~After~~ No Deductible, 40%
Prostate cancer screening	No Deductible, 0%	~~After~~ No Deductible, 40%

The Out-of-network benefits for Chiropractic manipulation/spinal manipulation and Acupuncture under the Professional Services section of the Voyager HSA 2800_20+Rx Benefit Summary have been amended to read as follows:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Professional Services		
Chiropractic manipulation/Spinal manipulation (20 visits per Benefit Year)	After Deductible, 20%	After Deductible, ~~40~~20%
Acupuncture (20 visits per Benefit Year)	After Deductible, 20%	After Deductible, ~~40~~20%

By:_____

Print:_____

Title:_____

Date:_____

Bonner County

Group No.: G0039089
Plan Name: Voyager 1500+30-45_20
Effective: October 1, 2023

With Third Party Administrative Services Provided By:

PacificSource
HEALTH PLANS

Retention of Fiduciary Duties

The Plan Sponsor has retained all fiduciary duties under the Plan, including all interpretations of the Plan and the benefits and exclusions it contains. This means that the Plan Sponsor is solely responsible for all final decisions regarding what benefits are or will be covered, both now and in the future. The Plan Sponsor is solely responsible for the design of this Plan. Plan Sponsor is solely responsible for setting any and all criteria used to determine enrollment and eligibility.

Governing Law

This Plan must comply with both state and federal law, including required changes occurring after the Plan's effective date. Therefore, coverage is subject to change as required by law.

Additional Information

Representations not warranties: In the absence of fraud, all statements made by the Plan Sponsor will be considered representations and not warranties. No statement made for the purpose of effecting coverage will void the coverage or reduce benefits unless it is contained in a written document signed by the Plan Sponsor and provided to a Member.

Questions?

PacificSource's Customer Service team is available to answer questions or concerns regarding the Plan. Phone lines are open from 8 a.m. to 5 p.m. Monday through Friday (excluding holidays). PacificSource's Customer Service team is not authorized to interpret or change the terms of the Plan.

For enrollment or eligibility questions, please contact the Plan Sponsor.

PacificSource Customer Service
Phone 888-246-1370
Email cs@pacificsource.com

Para asistencia en español, por favor llame al número 866-281-1464.

PacificSource Headquarters
555 International Way, Springfield, OR 97477
PO Box 7068, Springfield, OR 97475-0068
Phone 541-686-1242 or 800-624-6052

PacificSource Regional Office
408 E. Parkcenter Blvd., Suite 100, Boise, ID 83706
Phone 208-342-3709 or 888-492-2875

PacificSource Website
PacificSource.com

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Naturopath office visits	No Deductible, $30	After Deductible, 40%
Specialist office and home visits	No Deductible, $45	After Deductible, 40%
Telehealth visits	No Deductible, 0%	After Deductible, 40%
Office procedures and supplies	After Deductible, 20%	After Deductible, 40%
Surgery	After Deductible, 20%	After Deductible, 40%
Outpatient Habilitation Services (combined 30 visits per Benefit Year for Physical, Occupational, and Speech Therapy)	After Deductible, 20%	After Deductible, 40%
Outpatient Rehabilitation Services (combined 30 visits per Benefit Year for Physical, Occupational, and Speech Therapy)	After Deductible, 20%	After Deductible, 40%
Chiropractic manipulation/Spinal manipulation (20 visits per Benefit Year)	No Deductible, 20%	No Deductible, 20%
Acupuncture (20 visits per Benefit Year)	No Deductible, 20%	No Deductible, 20%
Hospital Services		
Inpatient room and board	After Deductible, 20%	After Deductible, 40%
Inpatient Habilitation Services	After Deductible, 20%	After Deductible, 40%
Inpatient Rehabilitation Services	After Deductible, 20%	After Deductible, 40%
Skilled nursing facility care (60 days per Benefit Year)	After Deductible, 20%	After Deductible, 40%
Outpatient Services		
Outpatient surgery/services	After Deductible, 20%	After Deductible, 40%
Outpatient at Ambulatory Surgical Center	After Deductible, 10%	After Deductible, 40%
Diagnostic imaging – advanced	After Deductible, 20%	After Deductible, 40%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	After Deductible, 20%	After Deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	No Deductible, $30 plus 20%	After Deductible, 40%
Emergency room visits – medical emergency	No Deductible, $100 plus 20%^	No Deductible, $100 plus 20%^
Emergency room visits – non-emergency	No Deductible, $100 plus 20%^	No Deductible, $100 plus 20%^
Ambulance, ground	After Deductible, 20%	After Deductible, 20%
Ambulance, air	After Deductible, 20%	After Deductible, 20%
Maternity Services		
Physician/Provider services (Global Charge)	After Deductible, 20%	After Deductible, 40%

Payments to Providers

Payment to Providers is based on the prevailing or Allowable Fee for Covered Services. In-network Providers accept the Allowable Fee as payment in full. Services of Out-of-network Providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior Authorization

Coverage of certain medical services and Surgical Procedures requires a Benefit Determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and Out-of-network Providers. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business)

Discrimination is against the law

Both the Plan Sponsor and PacificSource Health Plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan Sponsor and PacificSource do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Service/Supply	Incentive Drugs:	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
Compound Drugs**				
Up to a 90 day supply:		Same as retail Tier 3		
Out-of-network Pharmacy				
Up to a 30 day supply:	No Deductible, 0%	No Deductible, $15	After Deductible, $30	After Deductible, $45
31 – 60 day supply:	No Deductible, 0%	No Deductible, $30	After Deductible, $60	After Deductible, $90
61 – 90 day supply:	No Deductible, 0%	No Deductible, $45	After Deductible, $90	After Deductible, $135
Specialty Drugs – In-network Specialty Pharmacy				
Up to a 30 day supply:		After Deductible, $200		
Specialty Drugs – Out-of-network Specialty Pharmacy				
Up to a 30 day maximum fill, no more than three fills allowed per Benefit Year:		After Deductible, $200		

**Compounded medications are subject to a prior authorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medications are on the applicable formulary.

Specialty Medications – After Deductible, Coinsurance of 30% for medications that are on the PrudentRx drug list filled at CVS Specialty or our provider partner pharmacies; No Deductible, $0 when enrolled in the PrudentRx Program. If a Member's specialty medication is not on the PrudentRx drug list, the cost share will be the standard Copayment benefit. (Not the 30%)

MAC A - Regardless of the reason or Medical Necessity, if you receive a brand name drug or if your Provider prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's Copayment and/or Coinsurance plus the difference in cost between the brand name and Generic Drug after the Prescription Drug Deductible is met. The cost difference between the brand name and Generic Drug does not apply toward the medical or Prescription Drug Deductible or out of pocket limit.

If your Provider prescribes a brand name contraceptive due to Medical Necessity it may be subject to prior authorization for coverage at no charge.

See the Plan Document for important information about your Prescription Drug benefit, including which drugs are covered, limitations, and more.

OUT-OF-POCKET LIMIT

This Plan has an out-of-pocket limit provision. The Benefit Summaries show this Plan's annual out-of-pocket limits. If you incur Covered Services over those amounts, this Plan will pay 100 percent of the Allowable Fee for the remainder of the Benefit Year.

The allowed amounts Members pay for Covered Services will accrue toward the annual out-of-pocket limit except for the following, which will continue to be your responsibility:

- Coinsurance for out-of-network chiropractic manipulations/spinal manipulations and acupuncture treatments.
- Charges for non-Covered Services.
- Incurred charges that exceed amounts allowed under this Plan.
- Charges for the difference in cost between brand name medication and generic equivalent as explained in the Prescription Drugs section.

ESSENTIAL HEALTH BENEFITS

Except for pediatric dental which is not included in this Plan, this Plan covers the Essential Health Benefits as defined by the Secretary of the U.S. Department of Health and Human Services. Annual and Lifetime Maximum dollar limits will not be applied for any service that is an Essential Health Benefit.

UNDERSTANDING MEDICAL NECESSITY

In order for a service or supply to be covered, it must be both a Covered Service *and* Medically Necessary.

Be careful – just because a treatment is prescribed or recommended by a Provider does not mean it is Medically Necessary under the terms of this Plan. This Plan provides coverage only when such care is necessary to treat an Illness or Injury or the service qualifies as preventive care. All treatment is subject to review for Medical Necessity. Review of treatment may involve prior authorization, concurrent review of the continuation of treatment, post-treatment review, or any combination of these. A second opinion (at no cost to you when requested by PacificSource or the Plan Sponsor) may be required for a Medical Necessity determination.

Some Medically Necessary services are not Covered Services. Medically Necessary services and supplies that are specifically excluded from coverage under this Plan can be found in the Benefit Exclusions section.

If you ever have a question about your benefits, contact the PacificSource Customer Service team.

UNDERSTANDING EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN SERVICES

This Plan does not cover services or treatments that are Experimental, Investigational, or Unproven.

To ensure you receive the highest quality care at the lowest possible cost, PacificSource, on behalf of the Plan Sponsor, reviews new and emerging technologies and medications on a regular basis. PacificSource's internal committees make decisions about coverage of these methods and

Colorectal Cancer Screening

This Plan covers colorectal cancer screening as required under ACA. Screening coverage includes a follow up colonoscopy performed after a positive non-invasive stool based screening or direct visualization. For colorectal cancer screenings not required to be covered as preventive under ACA, see the Diagnostic and Therapeutic Radiology/Laboratory and Dialysis – (non-advanced) section.

Immunizations

This Plan covers age-appropriate childhood and adult immunizations for primary prevention of infectious diseases as recommended and adopted by the USPSTF, CDC, or similar standard-setting body. This benefit does not include immunizations that are determined to be elective or Experimental, Investigational, or Unproven.

Preventive Physicals

This Plan covers appropriate screening radiology and laboratory tests and other screening procedures. Screening exams and laboratory tests may include, but not limited to, depression screening for all adults including pregnant and postpartum women, blood pressure checks, weight checks, occult blood tests, urinalysis, complete blood count, prostate exams, cholesterol exams, stool guaiac screening, EKG screens, blood sugar tests, and tuberculosis skin tests. Only laboratory tests and other routine screening procedures related to the preventive physical are covered by this benefit. Diagnostic radiology and laboratory services outside the scope of the preventive physical will be subject to the standard cost sharing.

- Benefits are limited as follows: Age 22 and older once per Benefit Year.

Prostate Cancer Screening

This Plan covers appropriate screening that includes, but not limited to, a digital rectal exam and a prostate-specific antigen test.

Tobacco Cessation Program Services

This Plan covers Tobacco Cessation Program services.

Well Baby/Well Child Care

This Plan covers well baby/well child examinations. Only laboratory tests and other routine screening procedures related to the well baby/well child exam are covered by this benefit. Diagnostic radiology and laboratory services outside the scope of the preventive physical will be subject to the standard cost sharing.

- Benefits are limited as follows:
  - At birth: One standard in-Hospital exam
  - Ages 0-2: 12 additional exams during the first 36 months of life
  - Ages 3-21: One exam per Benefit Year

appropriate for the Member, or the Member provides medical or scientific information establishing that the trial would be appropriate. If an In-network Provider is participating in an Approved Clinical Trial, the Member may be required to participate in the trial through that In-network Provider if the Provider will accept the Member as a participant.

Cosmetic or Reconstructive Surgery

This Plan provides cosmetic or reconstructive services in the following situations:

- When necessary to correct a functional disorder or Congenital Anomaly;
- When necessary because of an Accidental Injury or Illness, or to correct a scar or defect that resulted from treatment of an Accidental Injury or Illness; or
- When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery.

Some cosmetic or reconstructive surgeries require prior authorization. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Cosmetic or reconstructive surgery must take place within 18 months after the Injury, surgery, scar, or defect first occurred unless the area needing treatment is a result of a Congenital Anomaly.

Dietary or Nutritional Counseling

This Plan covers services for diabetic education, management of inborn errors of metabolism, and management of anorexia nervosa or bulimia nervosa if provided by a qualified Provider or as required under ACA for obesity. Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults, and comprehensive, intensive behavioral interventions to promote improvement in weight status for children are also covered.

Foot Care

This Plan covers routine foot care for Members with diabetes mellitus.

Genetic Counseling

This Plan covers services of a board-certified or board-eligible genetic counselor for evaluation of genetic disease.

Inborn Errors of Metabolism

This Plan covers treatment for inborn errors of metabolism involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes expenses for diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including, but not limited to, clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Telehealth

This Plan covers Medically Necessary Telehealth services when provided by a Provider.

Traumatic Brain Injury

This Plan covers Medically Necessary therapy and services for the treatment of traumatic brain Injury.

AMBULANCE SERVICES

This Plan covers services of a state certified ground or air ambulance to the nearest facility capable of treating the condition, when other forms of transportation will endanger your health. There is no coverage for services that are for personal or convenience purposes. Air ambulance service is only covered when ground transportation is medically or physically inappropriate. Non-emergency ground or air ambulance between facilities requires prior authorization.

BLOOD TRANSFUSIONS

This Plan covers blood, blood products, and blood storage, including services and supplies of a blood bank.

BREAST PROSTHESES

This Plan covers removal, repair, and/or replacement of breast prostheses due to a contracture or rupture, but only when the original prosthesis was for a Medically Necessary Mastectomy. Prior authorization by PacificSource is required, and eligibility for benefits is subject to the following criteria:

- The contracture or rupture must be clinically evident by a Provider's physical examination, imaging studies, or findings at surgery;
- Removal, repair, and/or replacement of the prosthesis is not covered when recommended due to an autoimmune disease, connective tissue disease, arthritis, allergenic syndrome, psychiatric syndrome, fatigue, or other systemic signs or symptoms.

COCHLEAR IMPLANTS

This Plan covers single or bilateral cochlear implants when Medically Necessary, including programming and reprogramming.

CONTRACEPTIVES AND CONTRACEPTIVE DEVICES/FAMILY PLANNING

This Plan covers IUD, diaphragm, and cervical cap contraceptives and contraceptive devices along with their insertion or removal, as well as hormonal contraceptives including injections, formulary oral, patches, and rings prescribed by your Provider. Contraceptive drugs, devices, and other products approved by the Food and Drug Administration (FDA) and on the formulary are covered by this Plan when prescribed.

Over-the-counter contraceptive drugs approved by the FDA, purchased without a prescription, are reimbursable by this Plan.

In accordance with federal and state laws, there is an initial period where this Plan will be primary to Medicare. Once that period of time has elapsed the Plan will pay up to the amount it would have paid in the secondary position.

DIAGNOSTIC IMAGING – ADVANCED

This Plan covers Medically Necessary advanced diagnostic imaging for the diagnosis of Illness or Injury. For the purposes of this benefit, advanced diagnostic imaging includes CT scans, MRIs, PET scans, CATH labs, and nuclear cardiology studies. Some diagnostic imaging requires prior authorization. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business).

DURABLE MEDICAL EQUIPMENT

This Plan covers services and applicable sales tax for Durable Medical Equipment. Durable Medical Equipment must be prescribed.

This Plan covers Prosthetic Devices and Orthotic Devices to restore or maintain the ability to complete activities of daily living or essential job-related activities and are not for comfort or convenience. Repair or replacement of a Prosthetic Device and Orthotic Device is covered when needed due to normal use. This Plan covers maxillofacial prostheses to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing.

- Benefits are limited as follows:
  - Some Durable Medical Equipment requires a prior authorization. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business). Benefits will be paid toward either the purchase or the rental of the equipment for the period needed, whichever is less. Repair or replacement of equipment is also covered when necessary, subject to all conditions and limitations of this Plan.
  - Only expenses for Durable Medical Equipment, or Prosthetic and Orthotic Devices that are provided by a PacificSource contracted Provider or a Provider that satisfies the criteria of the Medicare fee schedule for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services are eligible for reimbursement.
  - Medically Necessary treatment for sleep apnea and other sleeping disorders (including snoring) is covered. Prior authorization is required. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a Provider specializing in evaluation and treatment of sleep disorders.
  - Hearing Aids: Hearing Aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, for Dependent Children with a Congenital Anomaly or acquired hearing loss which may result in cognitive or speech development deficits without intervention. The Durable Medical Equipment benefit covers one device per hearing impaired ear every 36 months and up to 45 speech therapy visits during the 12 months after delivery of the covered device.
  - Wheelchairs: Purchase, rental, repair, lease, or replacement of a power-assisted wheelchair (including batteries and other accessories) requires prior authorization and is payable only in lieu of benefits for a manual wheelchair.

Emergency Medical Screening Exams and Emergency Services, including any diagnostic tests necessary for emergency care (including radiology, laboratory work, CT scans and MRIs) are subject to the Deductibles, Copayment, and/or Coinsurance stated in your Medical Benefit Summary for either Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced or Diagnostic imaging - advanced, depending on the specific service provided.

If you need immediate assistance for a medical emergency, call 911, or go to the nearest emergency room or appropriate facility.

HEALTH EDUCATION BENEFITS

This Plan covers health education benefits. Health education topics usually include matters such as maternity, fitness and education, newborn care and parenting skills, nutrition and healthy heart exercises or CPR skills. Covered services include health-related classes and printed materials required for the class.

- Benefits are limited as follows: Up to $150 per Benefit Year.

After you have completed the class, please provide PacificSource with proof of payment and a completed Reimbursement Request Form for PacificSource to review for benefit payment consideration based on the Plan Sponsor's criteria. You may obtain the Reimbursement Request Form from the Plan Sponsor, or PacificSource's Customer Service team.

HOME HEALTHCARE SERVICES

This Plan covers Home Healthcare services, including home infusion services that cannot be self-administered, when provided by a licensed home health agency.

- Benefits are limited as follows: Up to 130 visits per Benefit Year. Private duty nursing is not covered.

HOSPICE CARE SERVICES

This Plan covers Hospice Care services intended to meet the physical, emotional, and spiritual needs of the Member and family during the final stages of Illness and dying, while maintaining the Member in the home setting. Services are to supplement the efforts of an unpaid caregiver and include pastoral care and bereavement services.

This Plan covers respite care provided in a nursing facility to provide relief for the primary caregiver.

- Benefits are limited as follows:
  - Hospice Care: This Plan does not cover services of a primary caregiver such as a relative, friend, or private duty nurse. Care is provided for a terminally ill Member subject to review for Medical Necessity.
  - Respite care: Care is subject to a maximum of five consecutive days and to a Lifetime Maximum benefit of 30 days. The Member must be enrolled in a hospice program to be eligible for respite care benefits.

This Plan covers routine nursery care of a newborn child born to a Member while the mother is hospitalized and eligible for pregnancy-related benefits under this Plan if the newborn is also eligible and enrolled in this Plan.

Please contact the PacificSource Customer Service team as soon as you learn of your pregnancy. Their team will explain this Plan's maternity benefits and help you enroll in a prenatal care program.

- Benefits are limited as follows: Unless the services are Medically Necessary due to a complication, this Plan does not cover any maternity services for Dependent Children.

OUTPATIENT SERVICES

Applied Behavioral Analysis (ABA) for Autism, Asperger's or Pervasive Development Disorder

This Plan covers ABA according to PacificSource's guidelines for Medical Necessity. Prior authorization and a treatment plan are required.

Mental Health and Substance Use Disorder Services – Outpatient

This Plan complies with all federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008. Treatment of Substance Use Disorder and related disorders is subject to placement criteria established by the American Society of Addiction Medicine, Third Edition.

This Plan covers crisis intervention, diagnosis, and treatment of Mental Health Conditions and Substance Use Disorders including chemical dependency detoxification by a Mental Health and/or Substance Use Disorder Healthcare Provider or Mental Health and/or Substance Use Disorder Healthcare Program, except as otherwise excluded in this Plan.

Outpatient Habilitation

This Plan covers Physical/Occupational Therapy, and speech therapy services to help a person keep, learn, or improve skills and functioning for daily living. These services must be part of a written treatment program that includes site, modality, duration, and frequency of treatment.

- Benefits are limited as follows: Up to a combined maximum of 30 visits per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual/supplemental benefits are met.

Outpatient Rehabilitation

This Plan covers outpatient Rehabilitation Services to help a person keep, restore, or improve skills and function for daily living that have been lost or impaired due to Illness, Injury, or disability and do not include maintenance services. Services must be part of a written treatment program that includes site, modality, duration, and frequency of treatment.

- Benefits are limited as follows: Up to a combined maximum of 30 visits per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual/supplemental benefits are met.

Services for speech therapy are only covered to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or Injury. Speech and/or cognitive therapy for acute Illnesses and Injuries are covered with reasonable expectation that the services will

Mail Order Pharmacy

This Plan includes mail order service for Prescription Drugs. Questions about mail order may be directed to the PacificSource Customer Service team. More information is available on the website, PacificSource.com/members/prescription-drug-information/resources.

Specialty Drugs

Specialty Drugs are designated with SP on the Drug List available on the PacificSource website. Specialty Drugs often require special handling, storage, and instructions. PacificSource contracts with Specialty Pharmacies for these high-cost medications (oral and injectable). A pharmacist-led care team provides individual follow-up care and support to covered Members with prescriptions for Specialty Drugs by providing them strong clinical support, as well as the best overall value for these specific medications. The care team also provides comprehensive disease education and counseling, assesses Member health status, and offers a supportive environment for Member inquiries.

Fills of Specialty Drugs are limited to a 30 day supply and must be filled through the PacificSource exclusive network Specialty Pharmacies. Specialty Drugs are not available through the in-network retail pharmacy network, mail order service, or non-exclusive Specialty Pharmacies without prior authorization. For more information, including prior authorization requirements, see the website PacificSource.com/members/prescription-drug-information/resources.

No Duplication of Services

Medications and supplies covered under your prescription benefit are in place of, not in addition to, those same covered supplies under the medical portion of this Plan.

Diabetic Supplies

Refer to your Drug List, available on the PacificSource website, to see which diabetic supplies are covered under your prescription benefit. Some diabetic supplies, such as glucose monitoring devices, may only be covered under your medical benefit. Diabetic testing supplies are subject to Plan quantity limits. For more information, see the Diabetic Equipment, Supplies, and Training section.

Contraceptives

Contraceptives approved by the FDA are covered as recommended by the USPSTF, HRSA, and CDC. Any Deductibles, Copayments, and/or Coinsurance amounts are waived if a generic is filled. When no generic exists, brand name contraceptives may be covered at no cost. If your Provider prescribes a non-formulary contraceptive due to Medical Necessity, it may be subject to prior authorization for coverage at no charge.

Anticancer Medications

Orally administered and self-administered anticancer medications used to kill or slow the growth of cancerous cells are available when prescribed. All orally administered cancer medications will be covered on the same basis and at no greater cost sharing than imposed for IV or injected cancer medication. See the Prescription Drug Benefit Summary for cost sharing information.

Formulary Changes

Any removal of a medication from your Drug List will be posted on the PacificSource website 60 days prior to the effective date of the change, unless the change is done on an emergency basis or an

and the days' supply entered by the pharmacy. Early refills will generally not be approved, except under the following circumstances:

- The request is for ophthalmic solutions or gels, refillable after 70 percent of the previous supply has been taken.
- The Member will be on vacation in a location that does not allow for reasonable access to a network pharmacy for subsequent refills.

All early refills are subject to standard cost share and are reviewed on a case-by-case basis.

Formulary Exception and Coverage Determination Process

Requests for formulary exceptions can be made by the Member or Provider by contacting the PacificSource Pharmacy Services team. Determinations on standard exception requests will be made no later than 72 hours, expedited requests are determined within 24 hours following receipt of the request. Formulary exceptions and coverage determinations must be based on Medical Necessity, and information must be submitted to support the Medical Necessity including all of the following:

- Documented intolerance or failure to the formulary alternatives for the submitted diagnosis;
- Formulary drugs were tried with an adequate dose and duration of therapy;
- Formulary drugs were not tolerated or were not effective;
- Formulary or preferred drugs would reasonably be expected to cause harm or not produce equivalent results as the requested drug;
- The requested drug therapy is evidence-based and generally accepted medical practice; and
- Special circumstances and individual needs, including the availability of service Providers in the Member's region.

For the complete Formulary Exception Criteria, please refer to the PacificSource website.

TEMPOROMANDIBULAR JOINT SERVICES

This Plan covers treatment of temporomandibular joint syndrome (TMJ) for medical reasons only. All TMJ-related services, including but not limited to, diagnostic and Surgical Procedures, must be provided by Providers practicing within the scope of their licenses and, if necessary, prior authorized. Services are only covered when Medically Necessary due to a history of advanced pathologic process (arthritic degeneration) or in the case of severe acute trauma.

- Benefits are limited as follows: Up to $1,000 per Benefit Year up to a Lifetime Maximum benefit of $5,000.

TRANSPLANT SERVICES

This Plan covers the following Medically Necessary organ and tissue transplants including supplies, treatment and facility fees for both donors and recipients: bone marrow, peripheral blood stem cell and high-dose Chemotherapy; corneal transplants; heart; heart – lungs; intestine; kidney; kidney – pancreas; liver; lungs; and pancreas whole organ transplantation. Expenses for the acquisition of organs or tissues for transplantation are only covered when the transplantation itself is covered under

WOMEN'S HEALTH AND CANCER RIGHTS

Breast Reconstruction

This Plan covers breast reconstruction in connection with a Medically Necessary Mastectomy, as required by the Women's Health and Cancer Rights Act of 1998. Coverage is provided in a manner determined in consultation with the attending Provider and for:

- All stages of reconstruction of the breast on which the Mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the Mastectomy, including lymphedema.

Benefits for breast reconstruction are subject to all terms and provisions of this Plan, including Deductibles, Copayments, and/or Coinsurance.

Post-Mastectomy Care

This Plan covers post-Mastectomy care for a period of time as determined by the attending Provider and, in consultation with the Member, determined to be Medically Necessary following a Mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

BENEFIT EXCLUSIONS

This Plan does not cover the following:

- Abdominoplasty for any indication.
- Academic skills training.
- Acute care, rehabilitative, diagnostic testing, except as specified as a Covered Service in this Plan.
- Biofeedback (other than as specifically noted under the Covered Services section).
- Charges for missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims unless otherwise contracted.
- Charges that are the responsibility of a third party who may have caused the Illness or Injury, or other insurers covering the incident (such as workers' compensation insurers and automobile insurers, and general liability insurers).
- Chelation therapy including associated infusions of vitamins and/or minerals, except as Medically Necessary for the treatment of selected medical conditions and medically significant heavy metal toxicities.
- Computer or electronic equipment for monitoring asthmatic, similar medical conditions, or related data.
- Cosmetic/reconstructive services and supplies - Services and supplies, including drugs, rendered primarily for cosmetic/reconstructive purposes and any complications as a result of non-covered

- Foot care (routine) – Services and supplies for corns and calluses of the feet, conditions of the toenails other than infection, hypertrophy, or hyperplasia of the skin of the feet, and other routine foot care, except in the case of Members being treated for diabetes mellitus.
- Gender affirmation – Procedures, services, or supplies related to gender affirmation.
- Hearing Aids including the fitting, provision, or replacement of Hearing Aids, except as specified as a Covered Service in the Durable Medical Equipment section.
- Homeopathic medicines or homeopathic supplies.
- Hypnotherapy except in the treatment of Mental Health Conditions.
- Immunizations when recommended for, or in anticipation of, exposure through travel or work.
- Infertility – This Plan does not cover Infertility diagnostic or treatment services.
- Inpatient or outpatient Custodial Care; or inpatient or outpatient services consisting mainly of educational therapy, behavioral modification, self-care or self-help training, except as specified as a Covered Service in this Plan.
- Instructional or educational programs, except diabetes self-management programs when Medically Necessary.
- Jaw – Procedures, services, and supplies for developmental or degenerative abnormalities of the head and face that can be replaced with living tissue; services and supplies that do not control or eliminate pain or infection or that do not restore functions such as speech, swallowing, or chewing; cosmetic procedures and procedures to improve on the normal range of functions; dentures; and artificial larynx. (This does not include services for Congenital Anomalies as defined in the Definitions section.)
- Jaw surgery – Treatment for malocclusion of the jaw, anterior and internal dislocations, derangements and myofascial pain syndrome, orthodontics or related appliances, or improving the placement of dentures and dental implants. (This does not include services for Congenital Anomalies as defined in the Definitions section.)
- Learning disorders.
- Maintenance supplies and equipment not unique to medical care.
- Massage or massage therapy, even as part of a Physical Therapy program.
- Mattresses and mattress pads unless Medically Necessary to heal pressure sores.
- Mental health treatments for conditions defined in the current edition of Diagnostic and Statistical Manual of Mental Disorders, that are not attributable to a Mental Health Condition or disease.
  - Mental Illness does not include – relationship problems (for example, parent-child, partner, sibling, or other relationship issues), except the treatment of children five years of age or younger for parent-child relational problems, physical abuse of a child, sexual abuse, neglect of a child, or bereavement.
  - Unless Medically Necessary, the following are excluded: court-mandated diversion and/or Substance Use Disorder education classes; court-mandated psychological evaluations for child custody determinations; voluntary mutual support groups such as Alcoholics Anonymous;

- Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present.
- Recreation therapy – outpatient.
- Rehabilitation – Functional capacity evaluations, work hardening programs, vocational rehabilitation, community reintegration services, and driving evaluations and driving training programs, except as Medically Necessary.
- Replacement costs for worn or damaged Durable Medical Equipment that would otherwise be replaceable without charges under warranty or other agreement.
- Scheduled and/or non-emergent care outside of the United States.
- Screening tests – Services and supplies, including imaging and screening exams performed for the sole purpose of screening and not associated with specific diagnoses and/or signs and symptoms of disease or of abnormalities on prior testing (including, but not limited to, total body CT imaging, CT colonography, and bone density testing). This does not include preventive care screenings listed in the Preventive Care Services section.
- Self-help health or instruction or training programs.
- Sensory integration training.
- Services for which no charge is normally made in the absence of insurance.
- Services or supplies covered under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law.
- Services or supplies not listed as a Covered Service, unless required under federal or state law.
- Services or supplies with no charge, or for which your Employer or the Plan Sponsor has paid, or for which the Member is not legally required to pay, or for which a Provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This exclusion includes any service provided by the Member, or any licensed professional that is directly related to the Member by blood or marriage.
- Services required by state law as a condition of maintaining a valid driver license or commercial driver license.
- Services, supplies, and equipment not involved in diagnosis or treatment but provided primarily for the comfort, convenience, alteration of the physical environment, or education of a Member. This includes appliances like adjustable power beds sold as furniture, air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows.
- Sexual disorders – Services or supplies for the treatment of sexual dysfunction or inadequacy. For related provisions, see Infertility and mental health in this section.
- Social skills training.
- Support groups.

Prior authorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements.

Your Provider can request prior authorization from the PacificSource Health Services team. If your Provider will not request prior authorization for you, you may contact PacificSource yourself. In some cases, they may ask for more information or require a second opinion before authorizing coverage.

Because of the changing nature of care, PacificSource, on behalf of the Plan Sponsor, continually reviews new technologies and standards. Therefore, procedures and services requiring prior authorization is subject to change. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business). The prior authorization search tool is not intended to suggest that all items listed are covered by the benefits in this Plan.

When services are received from an In-network Provider, the Provider is responsible for contacting PacificSource to obtain prior authorization.

If your treatment does not receive prior authorization, you can still seek treatment, but if the review determines the expenses were either not covered by this Plan or were not Medically Necessary, you will be held responsible for the expense. Remember, any time you are unsure if an expense will be covered, contact the PacificSource Customer Service team.

Notification of the Benefit Determination will be communicated by letter, fax, or electronic transmission to the Hospital, the Provider, and you. If time is a factor, notification will be made by telephone and followed up in writing. For more information regarding the timelines for review of Pre-service Claims and Post-service Claims, see Claim Handling Procedures in the Claims Payment section.

In a medical emergency, services and supplies necessary to determine the nature and extent of an Emergency Medical Condition and to Stabilize the Member are covered without prior authorization requirements. A Hospital or other healthcare facility must notify PacificSource of an emergency admission within two business days.

PacificSource reserves the right to contract with a third party to perform prior authorization procedures on its behalf and such third parties may impose independently developed, evidence-based criteria for making prior authorization determinations. If you have questions about any third party criteria, please contact the PacificSource Customer Service team.

If your Provider's prior authorization request is denied as not Medically Necessary or as Experimental, Investigational, or Unproven, your Provider may Appeal the Benefit Determination. You retain the right to Appeal the Benefit Determination independent from your Provider.

CASE MANAGEMENT

Case management is a service provided by Registered Nurses who are Certified Case Managers and Licensed Behavioral Health Clinicians with specialized skills to respond to the complexity of a Member's healthcare needs. Case management services may be initiated by PacificSource when there is a high utilization of health services or multiple Providers, or for health problems such as, but not limited to, transplantation, high risk obstetric or neonatal care, spinal cord Injury, trauma or traumatic Injury, or any acute or chronic condition that may necessitate specialized treatment or care coordination.

It is not safe to assume that when you are treated at an in-network facility that all services are performed by In-network Providers. Whenever possible, you should arrange for professional services, such as surgery and anesthesiology, to be provided by an In-network Provider. Doing so may help you maximize your benefits and limit your out-of-pocket expenses.

Risk-sharing Arrangements

By agreement, an In-network Provider may not bill you for any amount in excess of the Allowable Fee. However, the agreement does not prohibit the Provider from collecting Deductibles, Copayments, Coinsurance, and amounts for non-Covered Services.

FINDING AN IN-NETWORK PROVIDER

You can find up-to-date In-network Provider information:

- On the PacificSource website, PacificSource.com, go to Find a Doctor to easily look up In-network Providers, specialists, behavioral health Providers, and Hospitals. You can also print your own customized directory.
- Contact the PacificSource Customer Service team. They can answer your questions about specific Providers.

OUT-OF-NETWORK PROVIDERS

When you receive services or supplies from an Out-of-network Provider, your out-of-pocket expense is likely to be higher than if you had used an In-network Provider. If the same services or supplies are available from an In-network Provider, you may be responsible for more than the applicable Deductibles, Copayments, and/or Coinsurance amounts.

Allowable Fee for Out-of-network Providers

PacificSource, as your Third Party Administrator, bases payment to Out-of-network Providers on the Allowable Fee, which may be derived from several sources, depending on the service or supply and the Service Area where it is provided. To calculate the payment to Out-of-network Providers, PacificSource determines the Allowable Fee, then subtracts the Out-of-network Provider benefits.

Your Rights and Protections Against Surprise Medical Bills and Balance Billing No Surprises Act

When you get emergency care or get treated by an Out-of-network Provider at an in-network Hospital or Ambulatory Surgical Center, you are protected from surprise Balance Billing. In these cases, you shouldn't be charged more than your Plan's Copayments, Coinsurance and/or Deductible.

What is Balance Billing (sometimes called 'surprise billing')?

When you see a doctor or other healthcare Provider, you may owe certain out-of-pocket costs, like a Copayment, Coinsurance, or Deductible. You may have additional costs or have to pay the entire bill if you see a Provider or visit a healthcare facility that isn't in this Plan's network.

Out-of-network means Providers and facilities that haven't signed a contract with this Plan to provide services. Out-of-network Providers may be allowed to bill you for the difference between what this Plan pays and the full amount charged for a service. This is called 'Balance Billing'. This amount is likely more than in-network costs for the same service and might not count toward this Plan's

Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.

Example of Provider Payment

The following provides an example of how a payment could be made for In-network or Out-of-network Providers. This is only an example; this Plan's benefits may be different.

PacificSource will pay 80 percent of the Allowable Fee for In-network Providers and 60 percent of the Allowable Fee for Out-of-network Providers. The benefits would appear as follows:

In-network Provider	Out-of-network Provider
Payment: After Deductible, Member pays 20% of the Allowable Fee.	Payment: After Deductible, Member pays 40% of the Allowable Fee and the balance of billed charges unless the service qualifies for Balance Billing protection (see Your Rights and Protections Against Surprise Medical Bills and Balance Billing No Surprises Act).

In this example, the Provider's charge for a service is $5,000 and the Allowable Fee for an In-network Provider is $4,000. This example assumes that a Member has met the Deductible during the Benefit Year, but has not yet met the out-of-pocket limit for the Benefit Year:

In-network Provider:

This Plan would pay 80 percent of the Allowable Fee and the Member would pay 20 percent of the Allowable Fee, as follows:

Amount the In-Network Provider must discount (Allowable Fee):	$1,000
Amount this Plan pays (80% of the $4,000 Allowable Fee):	$3,200
Amount the Member pays (20% of the $4,000 Allowable Fee):	**$800**
Total:	$5,000

Out-of-network Provider:

This Plan would pay 60 percent of the Allowable Fee. (For this example, $4,000 is also the charge upon which the Out-of-Network Provider's Allowable Fee is established.) Because the Out-of-Network Provider does not accept the Allowable Fee and may charge more, the Member would pay 40 percent of the Allowable Fee, plus the $1,000 difference between the Out-of-Network Provider's billed charges and the Allowable Fee, as follows:

Amount this Plan pays (60% of the $4,000 Allowable Fee):	$2,400
Amount the Member pays (40% of the $4,000 Allowable Fee and the $1,000 difference between the billed charges and the Allowable Fee):	**$2,600**
Total:	$5,000

This Plan's actual benefits may vary, so please review the Benefit Summaries and Covered Services section to determine how your benefits are paid. Please remember that the Allowable Fee may vary for a Covered Service depending upon the selected Provider.

the Provider no longer holds an active license, or the Provider is otherwise unavailable to continue the care. Contact the PacificSource Customer Service team for additional information.

If you do not qualify for continuation of care, the Provider becomes an Out-of-network Provider on the date the contract with PacificSource terminates. Any services you receive from them will be paid at the percentage shown in the out-of-network column of the Benefit Summaries. To avoid unexpected costs, be sure to verify each time you see your Provider that they are still in-network.

CLAIMS PAYMENT

How to File a Claim

When an In-network Provider treats you, your claims are automatically sent to PacificSource and processed. All you need to do is show your PacificSource Member ID card to the Provider.

If you receive care from an Out-of-network Provider, the Provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to them for processing. Your claim must include a copy of your Provider's itemized bill, including the Provider name and address, the Provider tax identification number and National Provider Identifier (NPI), procedure codes, and diagnosis codes. It must also include your name, PacificSource Member ID number, group name, group number, and the Member's name. If you were treated for an Accidental Injury, please include the date, time, place, and circumstances of the Accident.

All claims for benefits should be turned in to PacificSource within 90 days of the date of service. If you are unable to submit a claim within 90 days, present the claim with an explanation for consideration for coverage. This Plan will never pay a claim that was submitted more than a year after the date of service.

Claims Payment Practices

Unless additional information is needed to process your claim, PacificSource, on behalf of the Plan Sponsor, will make every effort to pay or deny your claim within 30 days of receipt. If a claim cannot be paid within 30 days of receipt because additional information is needed, PacificSource will acknowledge receipt of the claim and explain why payment is delayed.

Claim Handling Procedures

Claim Determination – PacificSource, on behalf of the Plan Sponsor, will make a claim determination within the time period noted in the chart below for the specific type of claim, unless additional information is necessary to process the claim. In that event, PacificSource will send you notice that the claim was received and explain what additional information is necessary to process the claim. If PacificSource does not receive the necessary information within the allowed time, they will deny the claim.

Type of Notice	Concurrent Care Claim	Urgent Care Claim	Pre-service Claim	Post-service Claim
Initial determination by PacificSource	24 hours	48 hours	2 business days	30 calendar days
If PacificSource requires additional information, PacificSource will make request within	24 hours	48 hours	2 business days	30 calendar days

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a Member has healthcare 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 in accordance with its plan 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 percent of the total allowable expense.

Definitions

For the purpose of this section only, the following definitions apply:

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 Members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- Plan includes: group and non-group health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

- Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; Accident only coverage; specified disease or specified Accident coverage; limited benefit health coverage, as defined by state law; school Accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage described above 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.

This plan means, in a COB provision, the part of the plan providing the healthcare 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 healthcare 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.

Order of Benefit Determination Rules. The rules that determine whether this Plan is a primary plan or secondary plan, when the Member has healthcare 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 may reduce the benefits it pays so that all plan benefits do not exceed 100 percent of the total allowable expense.

Allowable Expense. A healthcare expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any plan covering the Member. When a plan provides benefits in the

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

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.

Each plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent. The plan that covers the Member 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 Member as a Dependent is the secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Member as a Dependent; and primary to the plan covering the Member as other than a Dependent (for example, a retired Employee; then the order of benefits between the two plans is reversed so that the plan covering the Member as an Employee, Member, policyholder, Subscriber, or retiree is the secondary plan and the other plan is the primary plan.

Dependent Children. 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. The following is known as the birthday rule:

- 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.
- For a Dependent Child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
  - If a court decree states that one of the parents is responsible for the Dependent Child's healthcare expenses or healthcare coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
  - If a court decree states that both parents are responsible for the Dependent Child's healthcare expenses or healthcare coverage, the provisions above shall determine the order of benefits;
  - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the Dependent Child, the provisions above shall determine the order of benefits; or
  - If there is no court decree allocating responsibility for the Dependent Child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
    - The plan covering the custodial parent;
    - The plan covering the Spouse of the custodial parent;

Sponsor, 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 Member claiming benefits. The Plan Sponsor and PacificSource need not tell, or get the consent of, any Member to do this. Each Member claiming benefits under this Plan must give the Plan Sponsor and PacificSource any facts needed to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

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

Coordination with Medicare

- *Employers with 20 or more Employees:* If you are Medicare entitled due to age, this Plan is usually the primary payer and Medicare is secondary. This rule applies to you and your Dependents only if you are an active Employee.
- *Employers with 19 or fewer Employees:* If you are Medicare entitled due to age, and are enrolled in Medicare Parts A and B, this Plan only pays the portion of covered charges that would not be paid by Medicare Parts A and B. In other words, this Plan pays secondary for anyone eligible for and enrolled in Medicare Parts A and B.
- *Medicare disabled and end-stage renal disease (ESRD) Members*: The rules above may not apply to disabled people under 65 and ESRD Members enrolled in Medicare; see the Medicare website, Medicare.gov, for more information. For information on coordination of benefits in those situations, please contact PacificSource.

THIRD PARTY LIABILITY

If you use this Plan's benefit for an Illness or Injury you think may involve another party, you must contact PacificSource right away.

Third party liability means claims that are the responsibility of someone other than the Plan Sponsor. The liable party may be a person, firm, or corporation. Auto Accidents and slip-and-fall property Accidents are examples of common third party liability cases.

A third party includes liability and casualty insurance, and any other form of insurance that may pay money to, or on behalf of, a Member, including, but not limited to, uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, Personal Injury Protection (PIP) coverage, homeowner's insurance, and workers' compensation insurance.

Right of Recovery

In addition to its subrogation rights, the Plan Sponsor may, at its sole discretion and option, ask that the Member, and their attorney, if any, protect the Plan Sponsor's reimbursement rights. If the Plan Sponsor elects to proceed under this subsection, the following rules apply:

- The Member holds any right of recovery against the other party in trust for the Plan Sponsor, but only for the amount of benefits this Plan pays for that Illness or Injury.
- The Plan Sponsor is entitled to receive the amount of benefits it has paid for that Illness or Injury out of any settlement or judgment which results from exercising the right of recovery against the other party. This is regardless of whether the third party admits liability or asserts that the Member is also at fault. In addition, the Plan Sponsor is entitled to receive the amount of benefits it has paid whether the expenses are itemized or expressly excluded in the third party recovery.
- The Plan Sponsor holds the option to subtract from the money to be paid back to the Plan Sponsor a proportionate share representing the Member's reasonable attorney fees for collecting amounts paid by the Plan to a third party.
- In addition, and as an alternative, if requested by the Plan Sponsor, the Member will take such action as may be necessary or appropriate to recover such benefits furnished as damages from the responsible third party. Such action will be taken in the name of the Member. If requested by the Plan Sponsor, such action will be prosecuted by a representative designated by the Plan Sponsor who does not have a conflict of interest with the Member. In the event of a recovery, the Plan Sponsor will be reimbursed out of such recovery for the Member's share of the expenses, costs, and attorney fees incurred by the Plan Sponsor in connection with the recovery.

Right of Recovery – Time Limit for Reimbursements

PacificSource regularly engages in activities to identify and recover claims payments which should not have been paid or applied to Deductible amounts (for example, claims which are duplicate claims, errors, or fraudulent claims). If PacificSource, on behalf of the Plan Sponsor, makes a payment to you that you are not entitled to, or pays a person who is not eligible for payment, they may recover the payment. They must request reimbursement within 12 months of the claim payment except under the following circumstance:

- In the case where PacificSource and/or the Plan Sponsor becomes aware of an incorrect payment that was made due to an error, misstatement, misrepresentation, omission, or concealment other than insurance fraud by the Provider or another person, the 12 month time limit begins on the date PacificSource and/or the Plan Sponsor has actual knowledge of the invalid claim, claim overpayment, or other incorrect payment. Regardless of the date upon which PacificSource and/or the Plan Sponsor obtains actual knowledge of an invalid claim, claim overpayment, or other incorrect payment, PacificSource, on behalf of the Plan Sponsor, may not request reimbursement more than 24 months after the payment.

Member Responsibility for Future Expenses

If the Member incurs expenses for treatment of the Illness or Injury after receiving a recovery from, or on behalf of, a third party, this Plan will exclude benefits for otherwise Covered Services until the total amount of expenses incurred before and after the recovery exceeds the amount of the total recovery from all third parties and insurers, less reasonable attorney fees incurred in connection with the recovery.

- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a healthcare item or service is Experimental, Investigational, or Unproven, not Medically Necessary, effective, or appropriate; or
- Determination that a course or plan or treatment you are undergoing is an active course of treatment for the purpose of continuity of care.

Any staff involved in the initial Adverse Benefit Determination will not be involved in the Internal Appeal.

You or your Authorized Representative may submit additional comments, documents, records, and other materials relating to the Adverse Benefit Determination that is the subject of the Appeal. If an Authorized Representative is filing on your behalf, PacificSource will not consider your Appeal to be filed until such time as they have received the Authorization to Use or Disclose PHI and the Designation of Authorized Representative forms.

If you request review of an Adverse Benefit Determination, this Plan will continue to provide coverage for the disputed benefit, pending outcome of the review, if you are currently receiving services or supplies under the disputed benefit. If this Plan prevails in the Appeal, you may be responsible for the cost of coverage received during the review period. The decision at the External Review level is binding unless other remedies are available under state or federal law.

Second Internal Appeal: If you are not satisfied with the first Internal Appeal decision, you may request an additional review. Your Appeal and any additional information not presented with your first Internal Appeal must be forwarded to PacificSource within 60 days of the first Appeal response.

Request for Expedited Response: If there is a clinical urgency to do so, you or your Authorized Representative may request in writing or orally, an expedited response to an internal or External Review of an Adverse Benefit Determination. To qualify for an expedited response, your attending Provider must attest to the fact that the time period for making a non-urgent Benefit Determination could seriously jeopardize your life, health, your ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the healthcare care service or treatment that is the subject of the request. If your Appeal qualifies for an expedited review and would also qualify for External Review (see Independent External Review), you may request that the internal and External Reviews be performed at the same time.

Timelines for Responding to Appeals

You will be afforded two levels of Internal Appeal and, if applicable to your case, an External Review. PacificSource will acknowledge receipt of an Appeal no later than seven days after receipt. A written decision in response to the Appeal will be made within 30 days after receiving your request to Appeal.

The above time frames do not apply if the period is too long to accommodate the clinical urgency of a situation, or if you do not reasonably cooperate, or if circumstances beyond your or our control prevent either party from complying with the time frame. In the case of a delay, the party unable to comply must give notice of delay, including the specific circumstances, to the other party.

Information Available with Regard to an Adverse Benefit Determination

The final Adverse Benefit Determination will include:

- A reference to the specific internal rule or guideline used in the Adverse Benefit Determination;

reach a decision on the External Review, including any judicial review of the External Review decision pursuant to ERISA, if applicable. The department will not act on an External Review request without your completed authorization form. If your request qualifies for External Review, the final Adverse Benefit Determination will be reviewed by an independent review organization selected by the department. The Plan will pay the costs of the review.

Standard External Review Request: You must file your written External Review request with the department within six months after the date we issue a final notice of denial.

- Within seven days after the department receives your request, the department will send a copy to us.
- Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may Appeal that determination to the department.
- If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
- Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
- The independent review organization must provide written notice of its decision to you, to us, and to the department within 42 days after receipt of an External Review request.

Expedited External Review Request: You may file a written urgent care request with the department for an expedited External Review of a pre-service or concurrent service denial. You may file for an internal urgent Appeal with us and for an expedited External Review with the department at the same time.

Urgent care request means a claim relating to an admission, availability of care, continued stay or service for which the Member received Emergency Services but has not been discharged from a facility, or any Pre-service or Concurrent Care Claim for medical care or treatment for which application of the time periods for making a regular External Review determination:

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

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may Appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review

BECOMING COVERED

Who Pays for Your Benefits

The Plan Sponsor shares the cost of providing benefits for Eligible Employees and their Dependents. From time to time, the Plan Sponsor may adjust the amount of contributions required for coverage. In addition, the Deductibles, Copayments, and/or Coinsurance may also change periodically. You will be notified by your Plan Sponsor of any changes in the cost of this Plan's coverage before they take effect.

ELIGIBILITY

Employees

Your status as an Employee is determined by the employment records maintained by the Plan Sponsor. Workers classified by the Plan Sponsor as independent contractors are not eligible for coverage under this Plan under any circumstances. You become eligible to enroll in coverage on this Plan when you have met the Plan Sponsor's eligibility requirements, which may include a Waiting Period or require you to work a certain minimum number of hours.

Dependents

This Plan does not cover Domestic Partners. Disregard any reference to Domestic Partner.

While you are covered under this Plan, the following Dependents are also eligible for coverage:

- Your legal Spouse.
- Your or your Spouse's Dependent Children under age 26 regardless of the child's place of residence, marital status, or financial dependence on you.
- Your or your Spouse's unmarried Dependent Children of any age who are medically certified as incapable of self-sustaining employment by reason of intellectual disability or physical disability. The Plan Sponsor requires documentation of the disability from the Dependent Child's Provider within 31 days in which the Dependent Child turns 26, and will review the case before determining eligibility for coverage.

No family or household members other than those listed above are eligible to enroll under your coverage. No person can be covered both as an Employee and as a Dependent, or as a Dependent of more than one Employee.

Special Rules for Eligibility

At any time the Plan Administrator may require proof that a Member qualifies, or continues to qualify, as a Dependent as defined by this Plan.

ENROLLING DURING THE INITIAL ENROLLMENT PERIOD

Once you satisfy the Plan Sponsor's Waiting Period, and meet the hours required for eligibility, you and your eligible Dependents become eligible for this plan. Starting on the date you become eligible, you and your Dependents have 31 days to enroll, called the Initial Enrollment Period. To enroll, you must submit the enrollment information to the Plan Sponsor. The Plan Sponsor will send the information to PacificSource.

submit a waiver of coverage to the Plan Sponsor.

You and/or your Dependents may enroll in this Plan later if you qualify under the Special Enrollment Rules below. To do so, you must submit an enrollment change within 60 days of the qualifying event. For more information, see the Enrolling New Dependents section.

All special enrollment provisions assume that the Employee has satisfied any Waiting Periods required and each individual is eligible as stated in the Plan.

- Special Enrollment Rule #1

  If you declined enrollment for yourself or your Dependents because of other coverage, you or your Dependents may enroll in the Plan later if the other coverage ends involuntarily. Coverage will begin on the day after the other coverage ends.

- Special Enrollment Rule #2

  If you acquire new Dependents due to a qualifying event, you may be able to enroll yourself and/or your eligible Dependents at that time.

- Special Enrollment Rule #3

  If you or your Dependents become eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance Program (CHIP), you may be able to enroll yourself and/or your Dependents at that time. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Late Enrollment

If you did not enroll during your Initial Enrollment Period or enrolled and later discontinued coverage, and you do not qualify for a special enrollment period, your enrollment will be delayed until the Plan's next designated open enrollment period.

Returning to Work after a Layoff

If you are laid off and then rehired by the Plan Sponsor within 12 months, you will not have to satisfy another Waiting Period.

Your coverage will resume the first day of the month after you return to work and again meet the Plan Sponsor's minimum hour requirement. If your Dependents were covered before your layoff, they can resume coverage at that time as well. You must re-enroll you and/or your Dependents by submitting an enrollment change within the 31 day enrollment period following your return to work.

Returning to Work after a Leave of Absence

If you return to work after a Plan Sponsor-approved Leave of Absence of 12 months or less, you will not have to satisfy another Waiting Period.

Your coverage will resume the first day of the month you return to work and again meet the Plan Sponsor's minimum hour requirement. If your Dependents were covered before your leave, they can resume coverage at that time as well. You must re-enroll you and/or your Dependents by submitting an enrollment change within the 31 day enrollment period following your return to work.

Please refer to the Bonner County policy regarding Non-FMLA Health and Personal Leave of Absence.

USERRA CONTINUATION

If you take a Leave of Absence from your job due to military service, you have continuation rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA).

Members may continue this Plan's coverage if you, the Employee, no longer qualify for coverage under the Plan because of military service. Continuation coverage under USERRA is available for up to 24 months while you are on military leave. If your military service ends and you do not return to work, your eligibility for USERRA continuation coverage will end. Premium for continuation coverage is your responsibility.

The following requirements apply to USERRA continuation:

- Only Dependents who were enrolled in the Plan can take continuation. The only exceptions are newborn babies and newly acquired eligible Dependents not covered by another group health plan.
- To apply for continuation, you must submit a completed Continuation Election form to the Plan Sponsor within 60 days after the last day of coverage under the Plan.
- You must pay continuation premium to the Plan Sponsor by the first of each month. PacificSource cannot accept the premium directly from you.
- The Plan Sponsor must still be self-insured. If the Plan Sponsor discontinues this Plan, you will no longer qualify for continuation.

COBRA CONTINUATION

This Plan is probably subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. To find out if you have continuation rights under COBRA, ask the Plan Sponsor.

If COBRA is available to you and certain circumstances (a qualifying event) occur that cause you to lose coverage, you may have the right to continue coverage for a period of time.

COBRA Eligibility and Length of Continuation

When the following qualifying events cause you to lose coverage, you may continue coverage for the lengths of time shown in the table:

Qualifying Event	Continuation Period
Employee's termination of employment or reduction in hours	Employee, Spouse, and children may continue for up to 18 months[1]
Employee's divorce or legal separation	Spouse and children may continue for up to 36 months[2]
Employee's entitlement to Medicare benefits if it causes a loss of coverage	Spouse and children may continue for up to 36 months[2]
Employee's death	Spouse and children may continue for up to 36 months[2]
Child no longer qualifies as a Dependent	Child may continue for up to 36 months[2]

[1] If the Employee or Dependent is determined disabled by the Social Security Administration prior to or within the first 60 days of COBRA coverage, all qualified beneficiaries may continue coverage for up to 29 months.

If you fail to provide the Plan Sponsor with the Continuation Election form in the required timeframe, then the Plan Sponsor's obligation to provide you with COBRA coverage will end. PacificSource does not accept any liability for any failure, on your part or the part of the Plan Sponsor, to provide required notices for coverage.

Continuation Premium

Members are responsible for the full cost of continuation coverage. The Plan Sponsor uses the services of a third-party COBRA administrator to collect premium for continuation coverage. Please see the Plan Sponsor for more information about the Plan's COBRA administrator. The monthly premium must be paid to the Plan Sponsor's COBRA administrator. You may make your first premium payment any time within 45 days after you return your Continuation Election form to the Plan Sponsor's COBRA administrator. After the first premium payment, each monthly payment must reach the Plan Sponsor's COBRA administrator within 30 days of your premium due date. If the COBRA administrator does not receive your continuation premium on time, continuation coverage will end. If your coverage is canceled due to a missed payment, it will not be reinstated for any reason. It is solely your responsibility to ensure that the COBRA administrator receives the premium on time. Premium rates are established annually and may be adjusted if the Plan's benefits or costs change.

RESOURCES FOR INFORMATION AND ASSISTANCE

Assistance

Members who do not speak English, have literacy difficulties, or have physical or mental disabilities may contact the PacificSource Customer Service team for assistance.

Information Available from PacificSource

The Plan makes the following disclosure information available to you free of charge. You may contact the PacificSource Customer Service team to request a copy or by visiting the website, PacificSource.com. Available disclosure information includes, but not limited to, the following:

- A directory of Providers under this Plan;
- Information about the Drug List (also known as a formulary);
- A description (consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services) of any risk-sharing arrangements the Plan or PacificSource has with Providers;
- A description of the Plan Sponsor's and/or PacificSource's efforts to monitor and improve the quality of health services;
- Information about how PacificSource checks the credentials of its network Providers and how you can obtain the names and qualifications of your Providers;
- Information about our prior authorization and utilization review procedures; and
- Information about any healthcare plan offered by PacificSource.

RIGHTS AND RESPONSIBILITIES

The Plan Sponsor and PacificSource are committed to providing you with the highest level of service

- You are responsible for being on time for appointments, and contacting your Provider ahead of time if you need to cancel.
- You are responsible for any fees the Provider charges for late cancellations or no shows.
- You are responsible for contacting the Plan Sponsor or PacificSource if you believe you are not receiving adequate care.
- You are responsible for supplying information to the extent possible that the Plan Sponsor or PacificSource needs in order to administer your benefits or your Providers need in order to provide care.
- You are responsible for following plans and instructions for care that you have agreed to with your Providers.
- You are responsible for understanding your health problems and participating in developing mutually agreed upon goals, to the degree possible.

PRIVACY AND CONFIDENTIALITY

The Plan Sponsor and PacificSource have strict policies in place to protect the confidentiality of your personal information, including medical records. Detailed information is available at PacificSource.com/privacy-policy.

Your personal information is only available to staff members who need that information to do their jobs. Disclosure outside the Plan Sponsor and PacificSource is allowed only when necessary to provide your coverage, or when otherwise allowed by law. Except when certain statutory exceptions apply, the law requires written authorization from you (or your Authorized Representative) before disclosing your personal information outside the Plan Sponsor or PacificSource. An example of one exception is that we do not need written authorization to disclose information to a designee performing utilization management, quality assurance, or peer review on our behalf.

PLAN ADMINISTRATION

Name of Plan:

The Bonner County Group Health Plan (the "Plan").

Name and Address of the Plan Sponsor:

Bonner County
1500 Hwy 2, Suite 337
Sandpoint, ID 83864
Phone: 208-255-3630
Fax: 208-265-1457

Plan Sponsor's Employer Identification / Tax Identification Number:

82-6000285

— The institution/organization is not a Provider; and

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

If payment is from a financially interested third party, the payment will be excluded from the accumulation towards the Deductible and out-of-pocket limit.

Upon rejecting or otherwise refusing to treat a third party payment as a payment from the Member, carriers must inform the Member in writing of the reason for doing so and of the Member's right to file a Complaint.

Funding Method and Contributions:

This Plan is self-insured, meaning that benefits are paid from the general assets and/or trust funds of the Plan Sponsor and are not guaranteed under an insurance policy or contract. The cost of the Plan is paid with contributions by the Plan Sponsor and participating Employees. The Plan Sponsor determines the amount of contributions to the Plan, based on estimates of claims and administration costs. The Plan Sponsor may purchase insurance coverage to guard against excess loss incurred by allowed claims under the Plan, but such coverage is not included as part of the Plan.

Plan Changes

The terms, conditions, and benefits of this Plan may be changed from time to time. The following people have the authority to accept or approve changes or terminate this Plan:

- The Plan Sponsor's board of directors or other governing body;
- The owner or partners of the Plan Sponsor; or
- Anyone authorized by the above people to take such action.

The Plan Administrator is authorized to make Plan changes on behalf of the Plan Sponsor.

If this Plan terminates and the Plan Sponsor does not replace the coverage with another group Plan, the Plan Sponsor is required by law to advise you in writing of the termination.

DEFINITIONS

Wherever used in this Plan, the following definitions apply to the masculine and feminine, and singular and plural forms of the terms. Other terms are defined where they are first used in the text.

Accident means an unforeseen or unexpected event causing Injury that requires medical attention.

Adverse Benefit Determination means this Plan's denial, reduction, or termination of, or this Plan's failure to provide or make a payment in whole or in part, for a benefit that is based on this Plan's:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of your coverage;

- Supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs;
- Conducted as an investigational new drug application, an investigational device exemption or a biologics license application subject to approval by the FDA; or
- Exempt by federal law from the requirement to submit an investigational new drug application to the FDA.

Authorized Representative is an individual who by law or by the consent of a Member may act on behalf of the Member. An Authorized Representative *must* have the Member complete and execute an Authorization to Use or Disclose PHI form and a Designation of Authorized Representative form, both of which are available at PacificSource.com, and which will be supplied to you upon request. These completed forms must be submitted to PacificSource before PacificSource can recognize the Authorized Representative as acting on behalf of the Member.

Balance Billing means the difference between the Allowable Fee and the Provider's billed charge. Out-of-network Providers may bill the Member this amount, unless the service qualifies for protection rights under federal law. For more information, see the Your Rights and Protections Against Surprise Medical Bills and Balance Billing No Surprises Act section.

Benefit Determination means the activity taken to determine or fulfill the Plan Sponsor's responsibility for provisions under this Plan and provide reimbursement for healthcare in accordance with those provisions. Such activity may include:

- Eligibility and coverage determinations (including coordination of benefits), and adjudication or subrogation of claims;
- Review of healthcare services with respect to Medical Necessity (including underlying criteria), coverage under this Plan, appropriateness of care, Experimental, Investigational, or Unproven treatment, justification of charges; and
- Utilization review activities, including precertification and prior authorization of services and concurrent and post-service review of services.

Benefit Year refers to the period of time during which benefits accumulate toward Plan maximums and is on a contract year basis, beginning on the Plan's date of issuance or date of renewal through the last day of that contract year.

Cardiac Rehabilitation refers to a comprehensive program that generally involves medical evaluation, prescribed exercise, and cardiac risk factor modification. Education, counseling, and behavioral interventions are sometimes used as well. Phase I refers to inpatient services that typically occur during hospitalization for heart attack or heart surgery. Phase II refers to a short-term outpatient program, usually involving ECG-monitored exercise. Phase III refers to a long-term program, usually at home or in a community-based facility, with little or no ECG monitoring.

Chemotherapy means the use of drugs approved for use in humans by the FDA and ordered by the Provider for the treatment of disease.

Coinsurance means a defined percentage of the Allowable Fee for certain Covered Services and supplies the Member receives. It is the percentage the Member is responsible for, not including Copayments and Deductibles.

canes, walkers, nebulizers, commodes, suction machines, traction equipment, respirators, and TENS units.

Durable Medical Equipment Supplier means a PacificSource In-network Provider or a Provider that satisfies the criteria in the Medicare Quality Standards for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and other items and services.

Elective Abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

Eligible Employee means an Employee or former Employee who is eligible for coverage under this Plan. Eligible Employees may be covered under this Plan only if they meet the eligibility requirements according to the terms of this Plan.

Emergency Medical Condition means a medical, Mental Health, or Substance Use Disorder condition:

- Manifesting itself by acute symptoms of sufficient severity, including severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition:
  - Placing the health of the Member, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to affect a safe transfer to another Hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Medical Screening Exam means the medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Emergency Services means those healthcare 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:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Employee means any individual employed by the Plan Sponsor.

Employer generally means the Plan Sponsor unless otherwise noted.

Essential Health Benefits are services defined as such by the Secretary of the U.S. Department of Health and Human Services. Essential Health Benefits fall into the following categories:

- Whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes;
- Whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;
- Whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects; and
- Whether any improved health outcomes from the services are attainable outside an investigational setting.

PacificSource may delegate the determination whether a service is Experimental, Investigational, or Unproven to a third party for services received outside Idaho, Montana, Oregon, and Washington. Such determinations shall be based upon evidence-based criteria and may vary from PacificSource's determinations within Idaho, Montana, Oregon, and Washington.

External Review means the request by an appellant for a determination by an independent review organization at the conclusion of an Internal Appeal.

Generic Drugs are drugs that, under federal law, require a prescription by a Provider, and are not a brand name medication. By law, Generic Drugs must have the same active ingredients as the brand name medication and are subject to the same standards of their brand name counterpart. Generic Drugs must be approved by the FDA through an Abbreviated New Drug Application and generally cannot be limited to a single manufacturer.

Global Charge means a lump sum charge for maternity care that includes prenatal care, labor and delivery, and post-delivery care. Ante partum services such as amniocentesis, cordocentesis, chorionic villus sampling, fetal stress test, fetal non-stress test, lab, radiology, maternal, and fetal echography are not considered part of global maternity services and are reimbursed separately.

Grievance means a written Complaint submitted by or on behalf of a Member regarding service delivery issues other than denial of payment for healthcare services or non-provision of healthcare services, including dissatisfaction with healthcare, waiting time for services, Provider or staff attitude or demeanor, or dissatisfaction with service provided by the carrier.

Habilitation Services and Devices are healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living. These services and devices may include Physical/Occupational Therapy, speech-language pathology, and other services and devices for people with disabilities in a variety of inpatient and/or outpatient settings.

Hearing Aid means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments, or accessory for the instrument or device, except batteries and cords. Hearing Aids include any amplifying device that does not produce as its output an electrical signal that directly stimulates the auditory nerve. For the purpose of this definition, such amplifying devices include air conduction and bone conduction devices, as well as those that provide vibratory input to the middle ear.

Home Healthcare means services provided by a licensed home health agency in the Member's place of residence that is prescribed by the Member's attending Provider as part of a written plan of care. Services provided by Home Healthcare include:

- Home health aide services;

Examples include: acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. It does not include false labor, occasional spotting, Provider prescribed bed rest during pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy, but which are not distinct from the pregnancy itself.

Leave of Absence is a period of time off work granted to an Employee by the Plan Sponsor at the Employee's request and during which the Employee is still considered to be employed and is carried on the employment records of the Plan Sponsor. A leave can be granted for any reason acceptable to the Plan Sponsor, including disability and pregnancy.

Lifetime Maximum means the maximum benefit that will be provided toward the expenses incurred by any one Member while the Member is covered by this Plan or any other Plan offered by the Plan Sponsor. If any Covered Service is deemed to be an Essential Health Benefit as determined by the Secretary of the U.S. Department of Health and Human Services, Lifetime Maximum dollar limits will not apply to that Covered Service in accordance with the standards established by the Secretary.

Mastectomy is the surgical removal of all or part of a breast or a breast tumor suspected to be malignant.

Medical Supplies means items of a disposable nature that may be essential to effectively carry out the care a Provider has ordered for the treatment or diagnosis of an Illness or Injury. Examples of Medical Supplies include, but not limited to, syringes and needles, splints and slings, ostomy supplies, sterile dressings, elastic stockings, enteral foods, drugs or biologicals that must be put directly into the equipment in order to achieve the therapeutic benefit of the Durable Medical Equipment or to assure the proper functioning of this equipment.

Medically Necessary or Medical Necessity means those services and supplies that are required for diagnosis or treatment of Illness or Injury and that are:

- Consistent with the symptoms or diagnosis and treatment of the condition;
- Consistent with generally accepted standards of good medical practice in this Plan's state of issuance, or expert consensus Provider opinion published in peer-reviewed medical literature, or the results of clinical outcome trials published in peer-reviewed medical literature;
- As likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any other service or supply, both as to the Illness or Injury involved and the Member's overall health condition;
- Not for the convenience of the Member or a Provider of services or supplies; and
- The least costly of the alternative services or supplies that can be safely provided. When specifically applied to a Hospital inpatient, it further means that the services or supplies cannot be safely provided in other than a Hospital inpatient setting without adversely affecting the Member's condition or the quality of medical care rendered.

PacificSource may delegate determinations of Medical Necessity to third parties for services outside Idaho, Montana, Oregon, and Washington, and such third parties may utilize evidence-based criteria for determining Medical Necessity consistent with the above. Services and supplies intended to diagnose or screen for a medical condition in the absence of signs or symptoms, or of abnormalities on prior testing, including exposure to infectious or toxic materials or family history of genetic disease, are not considered Medically Necessary under this definition. For more information, see screening tests in the Benefit Exclusions section.

Physical/Occupational Therapy is comprised of the services provided by (or under the direction and supervision of) a licensed physical or occupational therapist. Physical/Occupational Therapy includes emphasis on examination, evaluation, and intervention to alleviate impairment and functional limitation and to prevent further impairment or disability.

Plan Amendment is a written attachment that amends, alters, or supersedes any of the terms or conditions set forth in this Plan Document.

Post-service Claim means a request for benefits that involves services you have already received.

Pre-service Claim means a request for benefits that requires approval by PacificSource, on behalf of the Plan Sponsor, in advance (prior authorization) in order for a benefit to be paid.

Prescription Drugs are drugs that, under federal law, require a prescription by Providers practicing within the scope of their licenses.

Prosthetic Devices (excluding dental) means artificial limb devices or appliances designed to replace, in whole or in part, an arm or a leg. It includes devices that replace all or part of an internal or external body organ, or replace all or part of the function of a permanently inoperative or malfunctioning internal or external organ. Examples of Prosthetic Devices include, but not limited to, artificial limbs, cardiac pacemakers, prosthetic lenses, breast prosthesis (including Mastectomy bras), and maxillofacial devices.

Provider means a healthcare professional, Hospital/other institution or medical supplier that is state licensed or state certified to provide a Covered Service or supply. Healthcare professionals eligible to provide care include, but not limited to: chiropractors, dental Providers, massage therapists, mental health counselors, nurses, nurse midwives, nurse practitioners, pharmacists, physical therapists, physicians, podiatrists and psychologists.

Radiation Therapy is the treatment of disease using x-rays or similar forms of radiation.

Rehabilitation Services are those Medically Necessary services and devices that help a person keep, restore, or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt, or disabled.

Rescission means to retroactively cancel or discontinue coverage under this Plan for reasons other than failure to timely pay required premiums or required contributions. This Plan may not rescind coverage unless the Member or person seeking coverage on behalf of the Member, performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, as prohibited by the terms of the Plan or coverage and a 30 day prior written notice is provided.

Routine Costs of Care mean costs for Medically Necessary services or supplies covered by this Plan in the absence of a clinical trial. Routine Costs of Care do not include:

- The drug, device, or service being tested in the clinical trial unless the drug, device, or service would be covered for that indication by the Plan if provided outside of a clinical trial;
- Items or services required for the provisions of the drug, device, or service being tested in the clinical trial;
- Items or services required for the clinically appropriate monitoring of the drug, device, or service being tested in the clinical trial;
- Items or services required for the prevention, diagnosis, or treatment of complications arising from the provision of the drug, device, or service being tested in the clinical trial;

Substance Use Disorder Treatment Facility means a treatment facility that provides a program for the treatment of Substance Use Disorders pursuant to a written treatment plan approved and monitored by a Provider or addiction counselor licensed by the state; is licensed or approved as a treatment center by the department of public health and human services, and is licensed by the state where the facility is located.

Surgical Procedure means any of the following listed operative procedures:

- Procedures accomplished by cutting or incision;
- Suturing of wounds;
- Treatment of fractures, dislocations, and burns;
- Manipulations under general anesthesia;
- Visual examination of the hollow organs of the body including biopsy, or removal of tumors or foreign body;
- Procedures accomplished by the use of cannulas, needling, or endoscopic instruments; or
- Destruction of tissue by thermal, chemical, electrical, laser, or ultrasound means.

Telehealth means the use of audio, video, or other telecommunications technology or media, including audio-only communication, that is used by a Provider or facility to deliver services, and delivered over a secure connection that complies with state and federal privacy laws.

Third Party Administrator means an organization that processes claims and performs administrative functions on behalf of the Plan Sponsor pursuant to the terms of a contract or agreement. In the case of this Plan, the term Third Party Administrator refers solely to PacificSource.

Tobacco Cessation Program means a program recommended by a Provider that follows the United States Public Health Services guidelines for tobacco cessation. Tobacco Cessation Program includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

Tobacco Use means use of tobacco on average four or more times per week within the past six months. This includes all tobacco products. Tobacco Use does not include religious or ceremonial use of tobacco by American Indians and/or Alaska Natives.

Urgent Care means services for an unforeseen Illness or Injury that requires treatment within 24 hours to prevent serious deterioration of a Member's health. Urgent conditions are normally less severe than medical emergencies. Examples of conditions that could need Urgent Care are sprains and strains, vomiting, cuts, and headaches.

Urgent Care Claim means a request for medical care or treatment with respect to which the time periods for making a non-urgent determination could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Urgent Care Treatment Facility means a healthcare facility whose primary purpose is the provision of immediate, short-term medical care for minor, but urgent, medical conditions.

Waiting Period means the period that must pass with respect to the Employee before the Employee

SIGNATURE PAGE

The effective date of the Plan: Voyager 1500+30-45_20 is October 1, 2023.

It is agreed by Bonner County that the provisions of this document are correct and will be the basis for the administration of the Plan: Voyager 1500+30-45_20.

Dated this _____ day of _____, _____
(Date) (Month) (Year)

By_____

Title_____

Bonner County

Group No.: G0039089
Plan Name: Voyager 1500+30-45_20
Effective: October 1, ~~2022~~2023

With Third Party Administrative Services Provided By:

PacificSource
HEALTH PLANS

Retention of Fiduciary Duties

The Plan Sponsor has retained all fiduciary duties under the Plan, including all interpretations of the Plan and the benefits and exclusions it contains. This means that the Plan Sponsor is solely responsible for all final decisions regarding what benefits are or will be covered, both now and in the future. The Plan Sponsor is solely responsible for the design of this Plan. Plan Sponsor is solely responsible for setting any and all criteria used to determine enrollment and eligibility.

Governing Law

This Plan must comply with both state and federal law, including required changes occurring after the Plan's effective date. Therefore, coverage is subject to change as required by law.

Additional Information

Representations not warranties: In the absence of fraud, all statements made by the Plan Sponsor will be considered representations and not warranties. No statement made for the purpose of effecting coverage will void the coverage or reduce benefits unless it is contained in a written document signed by the Plan Sponsor and provided to a Member.

Questions?

PacificSource's Customer Service team is available to answer questions or concerns regarding the Plan. Phone lines are open from 8 a.m. to 5 p.m. Monday through Friday (excluding holidays). PacificSource's Customer Service team is not authorized to interpret or change the terms of the Plan.

For enrollment or eligibility questions, please contact the Plan Sponsor.

PacificSource Customer Service
Phone 888-246-1370
Email cs@pacificsource.com

Para asistencia en español, por favor llame al número 866-281-1464.

PacificSource Headquarters
555 International Way, Springfield, OR 97477
PO Box 7068, Springfield, OR 97475-0068
Phone 541-686-1242 or 800-624-6052

PacificSource Regional Office
408 E. Parkcenter Blvd., Suite 100, Boise, ID 83706
Phone 208-342-3709 or 888-492-2875

PacificSource Website
PacificSource.com

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Professional Services		
Office and home visits	No Deductible, $30	After Deductible, 40%
Naturopath office visits	No Deductible, $30	After Deductible, 40%
Specialist office and home visits	No Deductible, $45	After Deductible, 40%
Telehealth visits	No Deductible, 0%	After Deductible, 40%
Office procedures and supplies	After Deductible, 20%	After Deductible, 40%
Surgery	After Deductible, 20%	After Deductible, 40%
Outpatient Habilitation Services (combined 30 visits per Benefit Year for Physical, Occupational, and Speech Therapy)	After Deductible, 20%	After Deductible, 40%
Outpatient Rehabilitation Services (combined 30 visits per Benefit Year for Physical, Occupational, and Speech Therapy)	After Deductible, 20%	After Deductible, 40%
Chiropractic manipulation/Spinal manipulation (20 visits per Benefit Year)	No Deductible, 20%	No Deductible, 20%
Acupuncture (20 visits per Benefit Year)	No Deductible, 20%	No Deductible, 20%
Hospital Services		
Inpatient room and board	After Deductible, 20%	After Deductible, 40%
Inpatient Habilitation Services	After Deductible, 20%	After Deductible, 40%
Inpatient Rehabilitation Services	After Deductible, 20%	After Deductible, 40%
Skilled nursing facility care (60 days per Benefit Year)	After Deductible, 20%	After Deductible, 40%
Outpatient Services		
Outpatient surgery/services	After Deductible, 20%	After Deductible, 40%
Outpatient at Ambulatory Surgical Center	After Deductible, 10%	After Deductible, 40%
Diagnostic imaging – advanced	After Deductible, 20%	After Deductible, 40%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	After Deductible, 20%	After Deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	No Deductible, $30 plus 20%	After Deductible, 40%
Emergency room visits – medical emergency	No Deductible, $100 plus 20%^	No Deductible, $100 plus 20%^
Emergency room visits – non-emergency	No Deductible, $100 plus 20%^	No Deductible, $100 plus 20%^
Ambulance, ground	After Deductible, 20%	After Deductible, 20%

In-network expense and out-of-network expense apply together toward your out-of-pocket limit.

Payments to Providers

Payment to Providers is based on the prevailing or Allowable Fee for Covered Services. In-network Providers accept the Allowable Fee as payment in full. Services of Out-of-network Providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior Authorization

Coverage of certain medical services and Surgical Procedures requires a Benefit Determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and Out-of-network Providers. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business)

Discrimination is against the law

Both the Plan Sponsor and PacificSource Health Plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan Sponsor and PacificSource do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Service/Supply	Incentive Drugs:	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
Compound Drugs**				
Up to a 90 day supply:		Same as retail Tier 3		
Up to a 30 day supply:	No Deductible, 0%	No Deductible, $15~~No Deductible, 0%~~	After Deductible, $30~~No Deductible, 0%~~	After Deductible, $45~~No Deductible, 0%~~
31 – 60 day supply:	No Deductible, 0%	No Deductible, $30~~No Deductible, 0%~~	After Deductible, $60~~No Deductible, 0%~~	After Deductible, $90~~No Deductible, 0%~~
61 – 90 day supply:	No Deductible, 0%	No Deductible, $45~~No Deductible, 0%~~	After Deductible, $90~~No Deductible, 0%~~	After Deductible, $135~~No Deductible, 0%~~
Specialty Drugs – In-network Specialty Pharmacy				
Up to a 30 day supply:		After Deductible, $200		
Specialty Drugs – Out-of-network Specialty Pharmacy				
Up to a 30 day maximum ~~supply~~fill, no more than three fills allowed per Benefit Year:		After Deductible, $200		

Commented [AS2]: Correction to the Plan Document, not a change to the administration of out-of-network benefits for the 2022 Benefit Year.

Commented [AS3]: Clarification, not a change to the administration of benefits.

**Compounded medications are subject to a prior authorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medications are on the applicable formulary.

Specialty Medications – After Deductible, Coinsurance of 30% for medications that are on the PrudentRx drug list filled at CVS Specialty or our provider partner pharmacies; No Deductible, $0 when enrolled in the PrudentRx Program. If a Member's specialty medication is not on the PrudentRx drug list, the cost share will be the standard Copayment benefit. (Not the 30%)

MAC A - Regardless of the reason or Medical Necessity, if you receive a brand name drug or if your Provider prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's Copayment and/or Coinsurance plus the difference in cost between the brand name and Generic Drug after the Prescription Drug Deductible is met. The cost difference between the brand name and Generic Drug does not apply toward the medical or Prescription Drug Deductible or out of pocket limit.

If your Provider prescribes a brand name contraceptive due to Medical Necessity it may be subject to prior authorization for coverage at no charge.

See the Plan Document for important information about your Prescription Drug benefit, including which drugs are covered, limitations, and more.

OUT-OF-POCKET LIMIT

This Plan has an out-of-pocket limit provision. The Benefit Summaries show this Plan's annual out-of-pocket limits. If you incur Covered Services over those amounts, this Plan will pay 100 percent of the Allowable Fee for the remainder of the Benefit Year.

The allowed amounts Members pay for Covered Services will accrue toward the annual out-of-pocket limit except for the following, which will continue to be your responsibility:

- Coinsurance for out-of-network chiropractic manipulations/spinal manipulations and acupuncture treatments.
- Charges for non-Covered Services.
- Incurred charges that exceed amounts allowed under this Plan.
- Charges for the difference in cost between brand name medication and generic equivalent as explained in the Prescription Drugs section.

ESSENTIAL HEALTH BENEFITS

Except for pediatric dental which is not included in this Plan, this Plan covers the Essential Health Benefits as defined by the Secretary of the U.S. Department of Health and Human Services. Annual and Lifetime Maximum dollar limits will not be applied for any service that is an Essential Health Benefit.

UNDERSTANDING MEDICAL NECESSITY

In order for a service or supply to be covered, it must be both a Covered Service *and* Medically Necessary.

Be careful – just because a treatment is prescribed or recommended by a Provider does not mean it is Medically Necessary under the terms of this Plan. This Plan provides coverage only when such care is necessary to treat an Illness or Injury or the service qualifies as preventive care. All treatment is subject to review for Medical Necessity. Review of treatment may involve prior authorization, concurrent review of the continuation of treatment, post-treatment review, or any combination of these. A second opinion (at no cost to you when requested by PacificSource or the Plan Sponsor) may be required for a Medical Necessity determination.

Some Medically Necessary services are not Covered Services. Medically Necessary services and supplies that are specifically excluded from coverage under this Plan can be found in the Benefit Exclusions section.

If you ever have a question about your benefits, contact the PacificSource Customer Service team.

UNDERSTANDING EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN SERVICES

This Plan does not cover services or treatments that are Experimental, Investigational, or Unproven.

To ensure you receive the highest quality care at the lowest possible cost, PacificSource, on behalf of the Plan Sponsor, reviews new and emerging technologies and medications on a regular basis.

Colorectal Cancer Screening

This Plan covers colorectal cancer screening as required under ACA. Screening coverage includes a follow up colonoscopy performed after a positive non-invasive stool based screening or direct visualization. For colorectal cancer screenings not required to be covered as preventive under ACA, see the Diagnostic and Therapeutic Radiology/Laboratory and Dialysis – (non-advanced) section.

Commented [SS5]: 2023 NOC

Immunizations

This Plan covers age-appropriate childhood and adult immunizations for primary prevention of infectious diseases as recommended and adopted by the USPSTF, CDC, or similar standard-setting body. This benefit does not include immunizations that are determined to be elective or Experimental, Investigational, or Unproven.

Preventive Physicals

This Plan covers appropriate screening radiology and laboratory tests and other screening procedures. Screening exams and laboratory tests may include, but not limited to, depression screening for all adults including pregnant and postpartum women, blood pressure checks, weight checks, occult blood tests, urinalysis, complete blood count, prostate exams, cholesterol exams, stool guaiac screening, EKG screens, blood sugar tests, and tuberculosis skin tests. Only laboratory tests and other routine screening procedures related to the preventive physical are covered by this benefit. Diagnostic radiology and laboratory services outside the scope of the preventive physical will be subject to the standard cost sharing.

- Benefits are limited as follows: Age 22 and older once per Benefit Year.

Prostate Cancer Screening

This Plan covers appropriate screening that includes, but not limited to, a digital rectal exam and a prostate-specific antigen test.

Tobacco Cessation Program Services

This Plan covers Tobacco Cessation Program services.

Well Baby/Well Child Care

This Plan covers well baby/well child examinations. Only laboratory tests and other routine screening procedures related to the well baby/well child exam are covered by this benefit. Diagnostic radiology and laboratory services outside the scope of the preventive physical will be subject to the standard cost sharing.

- Benefits are limited as follows:
  - At birth: One standard in-Hospital exam
  - Ages 0-2: 12 additional exams during the first 36 months of life
  - Ages 3-21: One exam per Benefit Year

appropriate for the Member, or the Member provides medical or scientific information establishing that the trial would be appropriate. If an In-network Provider is participating in an Approved Clinical Trial, the Member may be required to participate in the trial through that In-network Provider if the Provider will accept the Member as a participant.

Cosmetic or Reconstructive Surgery

This Plan provides cosmetic or reconstructive services in the following situations:

- When necessary to correct a functional disorder or Congenital Anomaly;
- When necessary because of an Accidental Injury or Illness, or to correct a scar or defect that resulted from treatment of an Accidental Injury or Illness; or
- When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery.

Some cosmetic or reconstructive surgeries require prior authorization. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Cosmetic or reconstructive surgery must take place within 18 months after the Injury, surgery, scar, or defect first occurred unless the area needing treatment is a result of a Congenital Anomaly.

Dietary or Nutritional Counseling

This Plan covers services for diabetic education, management of inborn errors of metabolism, and management of anorexia nervosa or bulimia nervosa if provided by a qualified Provider or as required under ACA for obesity. Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults, and comprehensive, intensive behavioral interventions to promote improvement in weight status for children are also covered.

Foot Care

This Plan covers routine foot care for Members with diabetes mellitus.

Genetic Counseling

This Plan covers services of a board-certified or board-eligible genetic counselor for evaluation of genetic disease.

Inborn Errors of Metabolism

This Plan covers treatment for inborn errors of metabolism involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes expenses for diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including, but not limited to, clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Telehealth

This Plan covers Medically Necessary Telehealth services when provided by a Provider.

Traumatic Brain Injury

This Plan covers Medically Necessary therapy and services for the treatment of traumatic brain Injury.

AMBULANCE SERVICES

This Plan covers services of a state certified ground or air ambulance to the nearest facility capable of treating the condition, when other forms of transportation will endanger your health. There is no coverage for services that are for personal or convenience purposes. Air ambulance service is only covered when ground transportation is medically or physically inappropriate. Non-emergency ground or air ambulance between facilities requires prior authorization.

BLOOD TRANSFUSIONS

This Plan covers blood, blood products, and blood storage, including services and supplies of a blood bank.

BREAST PROSTHESES

This Plan covers removal, repair, and/or replacement of breast prostheses due to a contracture or rupture, but only when the original prosthesis was for a Medically Necessary Mastectomy. Prior authorization by PacificSource is required, and eligibility for benefits is subject to the following criteria:

- The contracture or rupture must be clinically evident by a Provider's physical examination, imaging studies, or findings at surgery;
- Removal, repair, and/or replacement of the prosthesis is not covered when recommended due to an autoimmune disease, connective tissue disease, arthritis, allergenic syndrome, psychiatric syndrome, fatigue, or other systemic signs or symptoms.

COCHLEAR IMPLANTS

This Plan covers single or bilateral cochlear implants when Medically Necessary, including programming and reprogramming.

CONTRACEPTIVES AND CONTRACEPTIVE DEVICES/FAMILY PLANNING

This Plan covers IUD, diaphragm, and cervical cap contraceptives and contraceptive devices along with their insertion or removal, as well as hormonal contraceptives including injections, formulary oral, patches, and rings prescribed by your Provider. Contraceptive drugs, devices, and other products approved by the Food and Drug Administration (FDA) and on the formulary are covered by this Plan when prescribed.

percent of the current Medicare allowable amount for in-network and out-of-network ESRD service Providers.

In accordance with federal and state laws, there is an initial period where this Plan will be primary to Medicare. Once that period of time has elapsed the Plan will pay up to the amount it would have paid in the secondary position.

DIAGNOSTIC IMAGING – ADVANCED

This Plan covers Medically Necessary advanced diagnostic imaging for the diagnosis of Illness or Injury. For the purposes of this benefit, advanced diagnostic imaging includes CT scans, MRIs, PET scans, CATH labs, and nuclear cardiology studies. Some diagnostic imaging requires prior authorization. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business).

DURABLE MEDICAL EQUIPMENT

This Plan covers services and applicable sales tax for Durable Medical Equipment. Durable Medical Equipment must be prescribed.

This Plan covers Prosthetic Devices and Orthotic Devices to restore or maintain the ability to complete activities of daily living or essential job-related activities and are not for comfort or convenience. Repair or replacement of a Prosthetic Device and Orthotic Device is covered when needed due to normal use. This Plan covers maxillofacial prostheses to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing.

- Benefits are limited as follows:
  - Some Durable Medical Equipment requires a prior authorization. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business). Benefits will be paid toward either the purchase or the rental of the equipment for the period needed, whichever is less. Repair or replacement of equipment is also covered when necessary, subject to all conditions and limitations of this Plan. ~~If the cost of the purchase, rental, repair, or replacement is over $1,000, prior authorization is required.~~
  - Only expenses for Durable Medical Equipment, or Prosthetic and Orthotic Devices that are provided by a PacificSource contracted Provider or a Provider that satisfies the criteria of the Medicare fee schedule for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services are eligible for reimbursement.
  - Medically Necessary treatment for sleep apnea and other sleeping disorders (including snoring) is covered. Prior authorization is required. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a Provider specializing in evaluation and treatment of ~~obstructive sleep apnea, and the condition must meet criteria for obstructive~~ sleep ~~apnea~~disorders.
  - Hearing Aids: Hearing Aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, for Dependent Children with a Congenital Anomaly or acquired hearing loss which may result in cognitive or speech development deficits without intervention. The Durable Medical Equipment benefit covers one device per hearing

Commented [SS7]: Core Language Update

Commented [SS8]: Core Language Update

EMERGENCY ROOM – PROVIDER AND FACILITY

This Plan covers an Emergency Medical Screening Exam and Emergency Services to evaluate and treat an Emergency Medical Condition. Any referred services or treatment after discharge from the emergency room will be covered under the applicable benefit for such services and treatment. For Emergency Medical Conditions, Out-of-network Providers are paid at the In-network Provider level. If you are admitted to an out-of-network Hospital, PacificSource will coordinate your transfer to an in-network facility if necessary.

Emergency Medical Screening Exams and Emergency Services, including any diagnostic tests necessary for emergency care (including radiology, laboratory work, CT scans and MRIs) are subject to the Deductibles, Copayment, and/or Coinsurance stated in your Medical Benefit Summary for either Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced or Diagnostic imaging - advanced, depending on the specific service provided.

If you need immediate assistance for a medical emergency, call 911, or go to the nearest emergency room or appropriate facility.

HEALTH EDUCATION BENEFITS

This Plan covers health education benefits. Health education topics usually include matters such as maternity, fitness and education, newborn care and parenting skills, nutrition and healthy heart exercises or CPR skills. Covered services include health-related classes and printed materials required for the class.

- Benefits are limited as follows: Up to $150 per Benefit Year.

After you have completed the class, please provide PacificSource with proof of payment and a completed Reimbursement Request Form for PacificSource to review for benefit payment consideration based on the Plan Sponsor's criteria. You may obtain the Reimbursement Request Form from the Plan Sponsor, or PacificSource's Customer Service team.

HOME HEALTHCARE SERVICES

This Plan covers Home Healthcare services, including home infusion services that cannot be self-administered, when provided by a licensed home health agency.

- Benefits are limited as follows: Up to 130 visits per Benefit Year. Private duty nursing is not covered.

HOSPICE CARE SERVICES

This Plan covers Hospice Care services intended to meet the physical, emotional, and spiritual needs of the Member and family during the final stages of Illness and dying, while maintaining the Member in the home setting. Services are to supplement the efforts of an unpaid caregiver and include pastoral care and bereavement services.

This Plan covers respite care provided in a nursing facility to provide relief for the primary caregiver.

- Benefits are limited as follows:

- Benefits are limited as follows: Up to 60 days per Benefit Year. Confinement for Custodial Care is not covered.

MATERNITY SERVICES

This Plan covers services of Providers practicing within the scope of their license, for prenatal and postnatal (provided within six weeks of delivery) maternity, childbirth, and Involuntary Complications of Pregnancy. A Hospital stay of at least 48 hours (vaginal) or 96 hours (cesarean) is covered.

This Plan covers routine nursery care of a newborn child born to a Member while the mother is hospitalized and eligible for pregnancy-related benefits under this Plan if the newborn is also eligible and enrolled in this Plan.

Please contact the PacificSource Customer Service team as soon as you learn of your pregnancy. Their team will explain this Plan's maternity benefits and help you enroll in a prenatal care program.

- Benefits are limited as follows: Unless the services are Medically Necessary due to a complication, this Plan does not cover any maternity services for Dependent Children.

OUTPATIENT SERVICES

Applied Behavioral Analysis (ABA) for Autism, Asperger's or Pervasive Development Disorder

This Plan covers ABA according to PacificSource's guidelines for Medical Necessity. Prior authorization and a treatment plan are required.

Mental Health and Substance Use Disorder Services – Outpatient

This Plan complies with all federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008. Treatment of Substance Use Disorder and related disorders is subject to placement criteria established by the American Society of Addiction Medicine, Third Edition.

This Plan covers crisis intervention, diagnosis, and treatment of Mental Health Conditions and Substance Use Disorders including chemical dependency detoxification by a Mental Health and/or Substance Use Disorder Healthcare Provider or Mental Health and/or Substance Use Disorder Healthcare Program, except as otherwise excluded in this Plan.

Outpatient Habilitation

This Plan covers Physical/Occupational Therapy, and speech therapy services to help a person keep, learn, or improve skills and functioning for daily living. These services must be part of a written treatment program that includes site, modality, duration, and frequency of treatment.

- Benefits are limited as follows: Up to a combined maximum of 30 visits per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual/supplemental benefits are met.

Outpatient Rehabilitation

This Plan covers outpatient Rehabilitation Services to help a person keep, restore, or improve skills and function for daily living that have been lost or impaired due to Illness, Injury, or disability and do

- Medications listed as SP on the Drug List may have additional restrictions or costs associated with them.

See the Prescription Drug Benefit Summary for cost sharing information.

Drug Discount Programs

Some medications may qualify for third party Copayment assistance programs that could lower your out-of-pocket costs for those products. For any such medication where third party Copayment assistance is used, the Member may not receive credit toward their Deductible or out-of-pocket limit for any Copayment or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Mail Order Pharmacy

This Plan includes mail order service for Prescription Drugs. Questions about mail order may be directed to the PacificSource Customer Service team. More information is available on the website, PacificSource.com/members/prescription-drug-information/resources.

Commented [AS11]: Core Language Update - hyperlink has been updated.

Specialty Drugs

Specialty Drugs are designated with SP on the Drug List available on the PacificSource website. Specialty Drugs often require special handling, storage, and instructions. PacificSource contracts with Specialty Pharmacies for these high-cost medications (oral and injectable). A pharmacist-led care team provides individual follow-up care and support to covered Members with prescriptions for Specialty Drugs by providing them strong clinical support, as well as the best overall value for these specific medications. The care team also provides comprehensive disease education and counseling, assesses Member health status, and offers a supportive environment for Member inquiries.

Fills of Specialty Drugs are limited to a 30 day supply and must be filled through the PacificSource exclusive network Specialty Pharmacies. Specialty Drugs are not available through the in-network retail pharmacy network, mail order service, or non-exclusive Specialty Pharmacies without prior authorization. For more information, including prior authorization requirements, see the website PacificSource.com/members/prescription-drug-information/resources.

No Duplication of Services

Medications and supplies covered under your prescription benefit are in place of, not in addition to, those same covered supplies under the medical portion of this Plan.

Diabetic Supplies

Refer to your Drug List, available on the PacificSource website, to see which diabetic supplies are covered under your prescription benefit. Some diabetic supplies, such as glucose monitoring devices, may only be covered under your medical benefit. Diabetic testing supplies are subject to Plan quantity limits. For more information, see the Diabetic Equipment, Supplies, and Training section.

Contraceptives

Contraceptives approved by the FDA are covered as recommended by the USPSTF, HRSA, and CDC. Any Deductibles, Copayments, and/or Coinsurance amounts are waived if a generic is filled. When no generic exists, brand name contraceptives may be covered at no cost. If your Provider prescribes a non-formulary contraceptive due to Medical Necessity, it may be subject to prior authorization for coverage at no charge.

- Certain drugs require prior authorization (PA). An up-to-date list of drugs requiring prior authorization along with all of our requirements is available on the PacificSource website.
- Certain drugs are subject to Step Therapy (ST) protocols, which means you may be required to try a pre-requisite drug before this Plan will pay for the requested drug. An up-to-date list of drugs requiring Step Therapy along with all of the requirements is available on the PacificSource website.
- Certain drugs have quantity limits (QL), which means the Plan will generally not pay for quantities above posted limits. An up-to-date list of drugs requiring quantity limit exceptions along with all of the requirements is available on the PacificSource website.
- For most prescriptions, you may refill your prescription only after 75 percent of the previous supply has been taken. This is calculated by the number of days that have elapsed since the previous fill and the days' supply entered by the pharmacy. Early refills will generally not be approved, except under the following circumstances:
  - The request is for ophthalmic solutions or gels, refillable after 70 percent of the previous supply has been taken.
  - The Member will be on vacation in a location that does not allow for reasonable access to a network pharmacy for subsequent refills.

  All early refills are subject to standard cost share and are reviewed on a case-by-case basis.

Formulary Exception and Coverage Determination Process

Requests for formulary exceptions can be made by the Member or Provider by contacting the PacificSource Pharmacy Services team. Determinations on standard exception requests will be made no later than 72 hours, expedited requests are determined within 24 hours following receipt of the request. Formulary exceptions and coverage determinations must be based on Medical Necessity, and information must be submitted to support the Medical Necessity including all of the following:

- Documented intolerance or failure to the formulary alternatives for the submitted diagnosis;
- Formulary drugs were tried with an adequate dose and duration of therapy;
- Formulary drugs were not tolerated or were not effective;
- Formulary or preferred drugs would reasonably be expected to cause harm or not produce equivalent results as the requested drug;
- The requested drug therapy is evidence-based and generally accepted medical practice; and
- Special circumstances and individual needs, including the availability of service Providers in the Member's region.

For the complete Formulary Exception Criteria, please refer to the PacificSource website.

TEMPOROMANDIBULAR JOINT SERVICES

This Plan covers treatment of temporomandibular joint syndrome (TMJ) for medical reasons only. All TMJ-related services, including but not limited to, diagnostic and Surgical Procedures, must be

Payment of Transplant Benefits

If a transplant is performed at an in-network Center of Excellence transplantation facility, covered charges of the facility are subject to this Plan's in-network transplant benefit. If the contract with the facility includes the services of the medical professionals performing the transplant, those charges are also subject to this Plan's in-network transplant benefit. If the professional fees are not included in the contract with the facility, then those benefits are provided according to the Medical Benefit Summary.

Transplant services that are not received at an in-network Center of Excellence and/or services of out-of-network medical professionals are paid at the out-of-network percentages stated in the Medical Benefit Summary. The maximum benefit payment for transplant services of Out-of-network Providers is 125 percent of the Medicare allowance.

WOMEN'S HEALTH AND CANCER RIGHTS

Breast Reconstruction

This Plan covers breast reconstruction in connection with a Medically Necessary Mastectomy, as required by the Women's Health and Cancer Rights Act of 1998. Coverage is provided in a manner determined in consultation with the attending Provider and for:

- All stages of reconstruction of the breast on which the Mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the Mastectomy, including lymphedema.

Benefits for breast reconstruction are subject to all terms and provisions of this Plan, including Deductibles, Copayments, and/or Coinsurance.

Post-Mastectomy Care

This Plan covers post-Mastectomy care for a period of time as determined by the attending Provider and, in consultation with the Member, determined to be Medically Necessary following a Mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

BENEFIT EXCLUSIONS

This Plan does not cover the following:

- Abdominoplasty for any indication.
- Academic skills training.
- Acute care, rehabilitative, diagnostic testing, except as specified as a Covered Service in this Plan.
- Biofeedback (other than as specifically noted under the Covered Services section).
- Charges for missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims unless otherwise contracted.

medical review of your case against the criteria established by the Plan Sponsor, and notify you of whether or not the proposed treatment will be covered.

- Eye examinations (preventive).
- Eye exercises and eye refraction, therapy, and procedures – Orthoptics, vision therapy, and procedures intended to correct refractive errors.
- Eye glasses/Contact lenses – The fitting, provision, or replacement of eye glasses, lenses, frames, contact lenses, or subnormal vision aids intended to correct refractive error.
- Fitness or exercise programs and health or fitness club memberships.
- Foot care (routine) – Services and supplies for corns and calluses of the feet, conditions of the toenails other than infection, hypertrophy, or hyperplasia of the skin of the feet, and other routine foot care, except in the case of Members being treated for diabetes mellitus.
- Gender affirmation – Procedures, services, or supplies related to gender affirmation.
- Hearing Aids including the fitting, provision, or replacement of Hearing Aids, except as specified as a Covered Service in the Durable Medical Equipment section.
- Homeopathic medicines or homeopathic supplies.
- Hypnotherapy except in the treatment of Mental Health Conditions.
- Immunizations when recommended for, or in anticipation of, exposure through travel or work.
- Infertility – This Plan does not cover Infertility diagnostic or treatment services.
- Inpatient or outpatient Custodial Care; or inpatient or outpatient services consisting mainly of educational therapy, behavioral modification, self-care or self-help training, except as specified as a Covered Service in this Plan.
- Instructional or educational programs, except diabetes self-management programs when Medically Necessary.
- Jaw – Procedures, services, and supplies for developmental or degenerative abnormalities of the head and face that can be replaced with living tissue; services and supplies that do not control or eliminate pain or infection or that do not restore functions such as speech, swallowing, or chewing; cosmetic procedures and procedures to improve on the normal range of functions; dentures; and artificial larynx. (This does not include services for Congenital Anomalies as defined in the Definitions section.)
- Jaw surgery – Treatment for malocclusion of the jaw, anterior and internal dislocations, derangements and myofascial pain syndrome, orthodontics or related appliances, or improving the placement of dentures and dental implants. (This does not include services for Congenital Anomalies as defined in the Definitions section.)
- Learning disorders.
- Maintenance supplies and equipment not unique to medical care.
- Massage or massage therapy, even as part of a Physical Therapy program.

- Paraphilias.
- Personal items such as telephones, televisions, and guest meals during a stay at a Hospital or other inpatient facility.
- Physical or eye examinations required for administrative purposes such as participation in athletics, admission to school, or by an employer.
- Private nursing service.
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition, except for diabetic education benefit.
- Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present.
- Recreation therapy – outpatient.
- Rehabilitation – Functional capacity evaluations, work hardening programs, vocational rehabilitation, community reintegration services, and driving evaluations and driving training programs, except as Medically Necessary.
- Replacement costs for worn or damaged Durable Medical Equipment that would otherwise be replaceable without charges under warranty or other agreement.
- Scheduled and/or non-emergent care outside of the United States.
- Screening tests – Services and supplies, including imaging and screening exams performed for the sole purpose of screening and not associated with specific diagnoses and/or signs and symptoms of disease or of abnormalities on prior testing (including, but not limited to, total body CT imaging, CT colonography, and bone density testing). This does not include preventive care screenings listed in the Preventive Care Services section.
- Self-help health or instruction or training programs.
- Sensory integration training.
- Services for which no charge is normally made in the absence of insurance.
- Services or supplies covered under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law.
- Services or supplies not listed as a Covered Service, unless required under federal or state law.
- Services or supplies with no charge, or for which your Employer or the Plan Sponsor has paid, or for which the Member is not legally required to pay, or for which a Provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This exclusion includes any service provided by the Member, or any licensed professional that is directly related to the Member by blood or marriage.
- Services required by state law as a condition of maintaining a valid driver license or commercial driver license.

Necessity, possible Experimental, Investigational, or Unproven services, appropriate setting, and appropriate treatment are forwarded to the PacificSource Medical Director for review and Benefit Determination based on the criteria established by the Plan Sponsor, where applicable.

Commented [SS13]: Updated 6.1.2023 via Plan Amendment for new National Network.

If you would like information on how PacificSource reached a particular utilization review Benefit Determination, please contact the PacificSource Health Services team by phone at 888-691-8209, or by email at healthservices@pacificsource.com.

PRIOR AUTHORIZATION

Coverage of certain services requires a Benefit Determination by PacificSource, on behalf of the Plan Sponsor, before the services are performed. This process is called prior authorization. PacificSource will utilize the criteria adopted by the Plan Sponsor and, where necessary, will coordinate review with the Plan Sponsor, to render a determination based on the Plan.

Prior authorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements.

Your Provider can request prior authorization from the PacificSource Health Services team. If your Provider will not request prior authorization for you, you may contact PacificSource yourself. In some cases, they may ask for more information or require a second opinion before authorizing coverage.

Because of the changing nature of care, PacificSource, on behalf of the Plan Sponsor, continually reviews new technologies and standards. Therefore, procedures and services requiring prior authorization is subject to change. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business). The prior authorization search tool is not intended to suggest that all items listed are covered by the benefits in this Plan.

When services are received from an In-network Provider, the Provider is responsible for contacting PacificSource to obtain prior authorization.

If your treatment does not receive prior authorization, you can still seek treatment, but if the review determines the expenses were either not covered by this Plan or were not Medically Necessary, you will be held responsible for the expense. Remember, any time you are unsure if an expense will be covered, contact the PacificSource Customer Service team.

Notification of the Benefit Determination will be communicated by letter, fax, or electronic transmission to the Hospital, the Provider, and you. If time is a factor, notification will be made by telephone and followed up in writing. For more information regarding the timelines for review of Pre-service Claims and Post-service Claims, see Claim Handling Procedures in the Claims Payment section.

In a medical emergency, services and supplies necessary to determine the nature and extent of an Emergency Medical Condition and to Stabilize the Member are covered without prior authorization requirements. A Hospital or other healthcare facility must notify PacificSource of an emergency admission within two business days.

PacificSource reserves the right to ~~employ~~ contract with a third party to perform prior authorization procedures on its behalf and such third parties may impose independently developed, evidence-based criteria for making prior authorization determinations. If you have questions about any third party criteria, please contact the PacificSource Customer Service team.

Commented [SS14]: Updated 6.1.2023 via Plan Amendment for new National Network.

Nothing in this Plan is designed to restrict Members from contracting to obtain any healthcare services outside the Plan on any terms Members choose.

IN-NETWORK PROVIDERS

In-network Providers contract with PacificSource to provide services and supplies for an Allowable Fee. In-network Providers bill PacificSource directly, and are paid directly by this Plan. When you receive Covered Services or supplies from an In-network Provider, you are only responsible for any applicable Deductibles, Copayments, and/or Coinsurance amounts. To ensure the highest level of benefits, access care from an In-network Provider including specialists and Hospitals.

PacificSource contracts directly and/or indirectly with In-network Providers throughout our networks' Service Area. They also have agreements with nationwide Provider networks. These Providers outside ~~our Service Area~~Idaho, Montana, Oregon, and Washington are also considered In-network Providers under your Plan.

Commented [SS15]: Updated 6.1.2023 via Plan Amendment for new National Network.

It is not safe to assume that when you are treated at an in-network facility that all services are performed by In-network Providers. Whenever possible, you should arrange for professional services, such as surgery and anesthesiology, to be provided by an In-network Provider. Doing so may help you maximize your benefits and limit your out-of-pocket expenses.

Risk-sharing Arrangements

By agreement, an In-network Provider may not bill you for any amount in excess of the Allowable Fee. However, the agreement does not prohibit the Provider from collecting Deductibles, Copayments, Coinsurance, and amounts for non-Covered Services.

FINDING AN IN-NETWORK PROVIDER

You can find up-to-date In-network Provider information:

- On the PacificSource website, PacificSource.com, go to Find a Doctor to easily look up In-network Providers, specialists, behavioral health Providers, and Hospitals. You can also print your own customized directory.
- Contact the PacificSource Customer Service team. They can answer your questions about specific Providers.

OUT-OF-NETWORK PROVIDERS

When you receive services or supplies from an Out-of-network Provider, your out-of-pocket expense is likely to be higher than if you had used an In-network Provider. If the same services or supplies are available from an In-network Provider, you may be responsible for more than the applicable Deductibles, Copayments, and/or Coinsurance amounts.

Allowable Fee for Out-of-network Providers

PacificSource, as your Third Party Administrator, bases payment to Out-of-network Providers on the Allowable Fee, which may be derived from several sources, depending on the service or supply and the Service Area where it is provided. To calculate the payment to Out-of-network Providers, PacificSource determines the Allowable Fee, then subtracts the Out-of-network Provider benefits.

additional costs to Out-of-network Providers and facilities directly.

Generally, ~~T~~this Plan ~~generally~~ must:

- Cover Emergency Services without requiring you to get approval for services in advance (also known as 'prior authorization');
- Cover Emergency Services by Out-of-network Providers;
- Base what you owe the Provider or facility (cost-sharing) on what it would pay an In-network Provider or facility and show that amount in your explanation of benefits; and
- Count any amount you pay for Emergency Services or out-of-network services toward your in-network Deductible and out-of-pocket limit.

If you ~~believe~~ think you've been wrongly billed, contact Idaho Department of Insurance at ~~you may file a Complaint with the Idaho Department of Insurance at~~ doi.idaho.gov/nosurprises or by calling the Consumer Affairs section at **208-334-4250** or **800-721-3272**.

Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.

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Example of Provider Payment

The following provides an example of how a payment could be made for In-network or Out-of-network Providers. This is only an example; this Plan's benefits may be different.

PacificSource will pay 80 percent of the Allowable Fee for In-network Providers and 60 percent of the Allowable Fee for Out-of-network Providers. The benefits would appear as follows:

In-network Provider	Out-of-network Provider
Payment: After Deductible, Member pays 20% of the Allowable Fee.	Payment: After Deductible, Member pays 40% of the Allowable Fee and the balance of billed charges unless the service qualifies for Balance Billing protection (see Your Rights and Protections Against Surprise Medical Bills and Balance Billing No Surprises Act).

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In this example, the Provider's charge for a service is $5,000 and the Allowable Fee for an In-network Provider is $4,000. This example assumes that a Member has met the Deductible during the Benefit Year, but has not yet met the out-of-pocket limit for the Benefit Year:

In-network Provider:

This Plan would pay 80 percent of the Allowable Fee and the Member would pay 20 percent of the Allowable Fee, as follows:

Amount the In-Network Provider must discount (Allowable Fee):	$1,000
Amount this Plan pays (80% of the $4,000 Allowable Fee):	$3,200
Amount the Member pays (20% of the $4,000 Allowable Fee):	**$800**
Total:	$5,000

Out-of-network Provider:

TERMINATION OF PROVIDER CONTRACTS

PacificSource, on behalf of the Plan Sponsor, will attempt to notify you within 30 days of learning about the termination of a Provider contractual relationship if you have received services in the previous six months from such a Provider when:

- A Provider terminates a contractual relationship with PacificSource in accordance with the terms and conditions of the agreement;
- A Provider terminates a contractual relationship with an organization under contract with PacificSource; or
- PacificSource terminates a contractual relationship with an individual Provider or the organization with which the Provider is contracted in accordance with the terms and conditions of the agreement.

You may be entitled to continue care with an individual Provider, whose contract was terminated without cause, for a limited period of time at the in-network cost share. Continuation of care will not be available if you are no longer covered under this Plan, the Provider will not accept the Allowable Fee, the Provider no longer holds an active license, or the Provider is otherwise unavailable to continue the care. Contact the PacificSource Customer Service team for additional information.

If you do not qualify for continuation of care, the Provider becomes an Out-of-network Provider on the date the contract with PacificSource terminates. Any services you receive from them will be paid at the percentage shown in the out-of-network column of the Benefit Summaries. To avoid unexpected costs, be sure to verify each time you see your Provider that they are still in-network.

CLAIMS PAYMENT

How to File a Claim

When an In-network Provider treats you, your claims are automatically sent to PacificSource and processed. All you need to do is show your PacificSource Member ID card to the Provider.

If you receive care from an Out-of-network Provider, the Provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to them for processing. Your claim must include a copy of your Provider's itemized bill, including the Provider name and address, the Provider tax identification number and National Provider Identifier (NPI), procedure codes, and diagnosis codes. It must also include your name, PacificSource Member ID number, group name, group number, and the Member's name. If you were treated for an Accidental Injury, please include the date, time, place, and circumstances of the Accident.

All claims for benefits should be turned in to PacificSource within 90 days of the date of service. If you are unable to submit a claim within 90 days, present the claim with an explanation for consideration for coverage. This Plan will never pay a claim that was submitted more than a year after the date of service.

Claims Payment Practices

Unless additional information is needed to process your claim, PacificSource, on behalf of the Plan Sponsor, will make every effort to pay or deny your claim within 30 days of receipt. If a claim cannot

Benefits Paid in Error

If the Plan makes a payment to you that you are not entitled to, or pays a person who is not eligible for payment, it may recover the payment. It may also deduct the amount paid in error from your future benefits.

In the same manner, if the Plan applies expenses to the Deductible that would not otherwise be reimbursable under the terms of this Plan, it may deduct a like amount from the accumulated Deductible amounts and/or recover payment of expenses that would have otherwise been applied to the Deductible.

Legal Procedures

You may not take legal action against the Plan Sponsor or PacificSource to enforce any provision of this Plan until 60 days after your claim is submitted. Also, you must exhaust this Plan's claims procedures before filing benefits litigation. No such action shall be brought against the Plan Sponsor or PacificSource after the expiration of any applicable statutes of limitations.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a Member has healthcare 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 in accordance with its plan 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 percent of the total allowable expense.

Definitions

For the purpose of this section only, the following definitions apply:

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 Members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- Plan includes: group and non-group health insurance contracts ~~and Subscriber contracts~~, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

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- Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; Accident only coverage; specified disease or specified Accident coverage; limited benefit health coverage, as defined by state law; school Accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage described above 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.

services through a panel of Providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial Parent. 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.

Order of Benefit Determination Rules

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

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

Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with this regulation 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 shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

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.

Each plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent. The plan that covers the Member 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 Member as a Dependent is the secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Member as a Dependent; and primary to the plan covering the Member as other than a Dependent (for example, a retired Employee; then the order of benefits between the two plans is reversed so that the plan covering the Member as an Employee, Member, policyholder, Subscriber, or retiree is the secondary plan and the other plan is the primary plan.

Dependent Children. 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. The following is known as the birthday rule:

- 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.
- For a Dependent Child whose parents are divorced, separated, or not living together, whether or

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 plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the 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 do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other healthcare coverage.

If a Member is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. PacificSource, on behalf of the Plan Sponsor, 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 Member claiming benefits. The Plan Sponsor and PacificSource need not tell, or get the consent of, any Member to do this. Each Member claiming benefits under this Plan must give the Plan Sponsor and PacificSource any facts needed to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

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

Coordination with Medicare

- *Employers with 20 or more Employees:* If you are Medicare entitled due to age, this Plan is usually the primary payer and Medicare is secondary. This rule applies to you and your Dependents only if you are an active Employee.
- *Employers with 19 or fewer Employees:* If you are Medicare entitled due to age, and are enrolled in Medicare Parts A and B, this Plan only pays the portion of covered charges that would not be

Illness giving rise to the Plan Sponsor's right of reimbursement or subrogation, until that right is satisfied or released.

- If any of these conditions are not met, then PacificSource, on behalf of the Plan Sponsor, may recover any such benefits paid or advanced for any Illness or Injury through legal action, as well as reasonable attorney fees incurred by the Plan Sponsor.
- Unless Federal Law is found to apply.
- The Plan Sponsor's right to reimbursement overrides the made whole doctrine and this Plan disclaims the application of the made whole doctrine to the extent permitted by law.

Subrogation

Upon payment under this Plan, PacificSource, on behalf of the Plan Sponsor, shall be subrogated to all of the Member's rights of recovery therefore, and the Member shall do whatever is necessary to secure such rights and do nothing to prejudice them.

Under this subsection, PacificSource, on behalf of the Plan Sponsor, may pursue the third party in its own name, or in the name of the Member. PacificSource, on behalf of the Plan Sponsor, is entitled to all subrogation rights and remedies under the common and statutory law, as well as under this Plan.

Right of Recovery

In addition to its subrogation rights, the Plan Sponsor may, at its sole discretion and option, ask that the Member, and their attorney, if any, protect the Plan Sponsor's reimbursement rights. If the Plan Sponsor elects to proceed under this subsection, the following rules apply:

- The Member holds any right of recovery against the other party in trust for the Plan Sponsor, but only for the amount of benefits this Plan pays for that Illness or Injury.
- The Plan Sponsor is entitled to receive the amount of benefits it has paid for that Illness or Injury out of any settlement or judgment which results from exercising the right of recovery against the other party. This is regardless of whether the third party admits liability or asserts that the Member is also at fault. In addition, the Plan Sponsor is entitled to receive the amount of benefits it has paid whether the expenses are itemized or expressly excluded in the third party recovery.
- The Plan Sponsor holds the option to subtract from the money to be paid back to the Plan Sponsor a proportionate share representing the Member's reasonable attorney fees for collecting amounts paid by the Plan to a third party.
- In addition, and as an alternative, if requested by the Plan Sponsor, the Member will take such action as may be necessary or appropriate to recover such benefits furnished as damages from the responsible third party. Such action will be taken in the name of the Member. If requested by the Plan Sponsor, such action will be prosecuted by a representative designated by the Plan Sponsor who does not have a conflict of interest with the Member. In the event of a recovery, the Plan Sponsor will be reimbursed out of such recovery for the Member's share of the expenses, costs, and attorney fees incurred by the Plan Sponsor in connection with the recovery.

Right of Recovery – Time Limit for Reimbursements

PacificSource regularly engages in activities to identify and recover claims payments which should not have been paid or applied to Deductible amounts (for example, claims which are duplicate claims,

GRIEVANCE PROCEDURES

If you or your Authorized Representative are dissatisfied with the availability, delivery, or the quality of healthcare services; or claims payment, handling, or reimbursement for healthcare services; you may file a Grievance in writing. Grievances are not Adverse Benefit Determinations and do not establish a right to internal or External Review for a resolution to a Grievance.

PacificSource, on behalf of the Plan Sponsor, will attempt to address your Grievance, generally within 30 days of receipt. For more information, see the How to Submit Grievances or Appeals section.

APPEAL PROCEDURES

First Internal Appeal: If you believe this Plan has improperly reduced or terminated a healthcare item or service, or failed or refused to provide or make a payment in whole or in part for a healthcare item or service that is based on any of the reasons listed below, you or your Authorized Representative may Appeal the decision. The request for Appeal must be made in writing and within 180 days of your receipt of the Adverse Benefit Determination. For more information, see the How to Submit Grievances or Appeals section. You may Appeal if there is an Adverse Benefit Determination based on a:

- Denial of eligibility for or termination of enrollment in a plan;
- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a healthcare item or service is Experimental, Investigational, or Unproven, not Medically Necessary, effective, or appropriate; or
- Determination that a course or plan or treatment you are undergoing is an active course of treatment for the purpose of continuity of care.

Any staff involved in the initial Adverse Benefit Determination will not be involved in the Internal Appeal.

You or your Authorized Representative may submit additional comments, documents, records, and other materials relating to the Adverse Benefit Determination that is the subject of the Appeal. If an Authorized Representative is filing on your behalf, PacificSource will not consider your Appeal to be filed until such time as they have received the Authorization to Use or Disclose PHI and the Designation of Authorized Representative forms.

If you request review of an Adverse Benefit Determination, this Plan will continue to provide coverage for the disputed benefit, pending outcome of the review, if you are currently receiving services or supplies under the disputed benefit. If this Plan prevails in the Appeal, you may be responsible for the cost of coverage received during the review period. The decision at the External Review level is binding unless other remedies are available under state or federal law.

Second Internal Appeal: If you are not satisfied with the first Internal Appeal decision, you may request an additional review. Your Appeal and any additional information not presented with your first Internal Appeal must be forwarded to PacificSource within 60 days of the first Appeal response.

Request for Expedited Response: If there is a clinical urgency to do so, you or your Authorized Representative may request in writing or orally, an expedited response to an internal or External Review of an Adverse Benefit Determination. To qualify for an expedited response, your attending

days of the date you filed your Appeal. The Plan may also agree to waive the exhaustion requirement for an External Review request. You may file for an internal urgent Appeal with us and for an expedited External Review with the Idaho Department of Insurance at the same time if your request qualifies as an urgent care request defined below.

You may submit a written request for an External Review to:

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

For more information and for an External Review request form:

Call 208-334-4250 or 800-721-3272

Website doi.idaho.gov

You may represent yourself in your request or you may name another person, including your treating Provider, to act as your Authorized Representative for your request. If you want someone else to represent you, you must include a signed Designation of Authorized Representative form with your request.

Your written External Review request to the Department of Insurance must include a completed form authorizing the release of any of your records the independent review organization may require to reach a decision on the External Review, including any judicial review of the External Review decision pursuant to ERISA, if applicable. The department will not act on an External Review request without your completed authorization form. If your request qualifies for External Review, the final Adverse Benefit Determination will be reviewed by an independent review organization selected by the department. The Plan will pay the costs of the review.

Standard External Review Request: You must file your written External Review request with the department within six months after the date we issue a final notice of denial.

- Within seven days after the department receives your request, the department will send a copy to us.
- Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may Appeal that determination to the department.
- If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
- Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
- The independent review organization must provide written notice of its decision to you, to us, and to the department within 42 days after receipt of an External Review request.

Expedited External Review Request: You may file a written urgent care request with the

Service team with your concerns. Issues can often be resolved at this level. Otherwise, you may file a Grievance or Appeal by contacting:

PacificSource Health Plans
Attn: Grievance and Appeals
PO Box 7068
Springfield, OR 97475-0068

Email cs@pacificsource.com, with Grievance or Appeal as the subject

Fax 541-225-3628

Assistance Outside PacificSource

You have the right to file a Complaint or seek other assistance from the Idaho Department of Insurance. Assistance is available by contacting:

Idaho Department of Insurance
Consumer Affairs
700 W State St, 3rd Floor
PO Box 83720
Boise, ID 83720-0043

Call 208-334-4250 or 800-721-3272

Website doi.idaho.gov

BECOMING COVERED

Who Pays for Your Benefits

The Plan Sponsor shares the cost of providing benefits for Eligible Employees and their Dependents. From time to time, the Plan Sponsor may adjust the amount of contributions required for coverage. In addition, the Deductibles, Copayments, and/or Coinsurance may also change periodically. You will be notified by your Plan Sponsor of any changes in the cost of this Plan's coverage before they take effect.

ELIGIBILITY

Employees

Your status as an Employee is determined by the employment records maintained by the Plan Sponsor. Workers classified by the Plan Sponsor as independent contractors are not eligible for coverage under this Plan under any circumstances. You become eligible to enroll in coverage on this Plan when you have met the Plan Sponsor's eligibility requirements, which may include a Waiting Period or require you to work a certain minimum number of hours.

Dependents

This Plan does not cover Domestic Partners. Disregard any reference to Domestic Partner.

While you are covered under this Plan, the following Dependents are also eligible for coverage:

- Placement of an adopted or foster child. Placement means physical placement in the care of the adoptive Member, or in those circumstances in which such physical placement is prevented due to medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive Member signs an agreement assuming financial responsibility for such child.

Coverage for newly eligible Dependents due to the following events will begin on the first day of the month after the event:

- Marriage;
- Guardianship; or
- Qualified medical child support order (QMCSO).

This Plan complies with a QMCSO issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including approval of a settlement agreement, which provides for benefit coverage for the child of a Member.

Open Enrollment Periods

If Eligible Employees and/or eligible Dependents are not enrolled during the Initial Enrollment Period, they must wait until the next open enrollment period to enroll unless they qualify for a special enrollment period as described below.

Special Enrollment Periods

You and/or your Dependents may decline coverage during your Initial Enrollment Period. To find out if this Plan allows Employees to decline coverage, ask the Plan Sponsor. If you wish to do so, you must submit a waiver of coverage to the Plan Sponsor.

You and/or your Dependents may enroll in this Plan later if you qualify under the Special Enrollment Rules below. To do so, you must submit an enrollment change within 60 days of the qualifying event. For more information, see the Enrolling New Dependents section.

All special enrollment provisions assume that the Employee has satisfied any Waiting Periods required and each individual is eligible as stated in the Plan.

- Special Enrollment Rule #1

  If you declined enrollment for yourself or your Dependents because of other coverage, you or your Dependents may enroll in the Plan later if the other coverage ends involuntarily. Coverage will begin on the day after the other coverage ends.

- Special Enrollment Rule #2

  If you acquire new Dependents due to a qualifying event, you may be able to enroll yourself and/or your eligible Dependents at that time.

- Special Enrollment Rule #3

  If you or your Dependents become eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance Program (CHIP), you may be able to enroll yourself and/or your Dependents at that time. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Plan option becomes effective on this Plan's anniversary date or date required for a qualifying event.

You may also choose another plan option upon eligibility for Medicare. You may select a different Plan option, if available, by submitting an enrollment change. Coverage under the new Plan option becomes effective on the date you become eligible for Medicare.

WHEN COVERAGE ENDS

If you leave your job for any reason or your work hours are reduced below the Plan Sponsor's minimum requirement, coverage for Members will end. Coverage ends on the last day of the month in which you worked the required minimum hours for coverage. You may be eligible to continue coverage for a limited time. For more information, see the Continuation of Coverage section.

Dependent Children

When your enrolled child no longer qualifies as a Dependent, their coverage will end on the last day of that month.

Divorced Spouses

If you divorce, coverage for your Spouse will end on the last day of the month in which the divorce decree or legal separation is final. You must notify the Plan Sponsor of the divorce or separation, and continuation coverage may be available for your Spouse. If there are special child custody circumstances, please contact the Plan Sponsor.

CONTINUATION OF COVERAGE

The following sections describe your rights to continuation under federal law, and the requirements you must meet to enroll in continuation coverage.

USERRA CONTINUATION

If you take a Leave of Absence from your job due to military service, you have continuation rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA).

Members may continue this Plan's coverage if you, the Employee, no longer qualify for coverage under the Plan because of military service. Continuation coverage under USERRA is available for up to 24 months while you are on military leave. If your military service ends and you do not return to work, your eligibility for USERRA continuation coverage will end. Premium for continuation coverage is your responsibility.

The following requirements apply to USERRA continuation:

- Only Dependents who were enrolled in the Plan can take continuation. The only exceptions are newborn babies and newly acquired eligible Dependents not covered by another group health plan.
- To apply for continuation, you must submit a completed Continuation Election form to the Plan Sponsor within 60 days after the last day of coverage under the Plan.
- You must pay continuation premium to the Plan Sponsor by the first of each month. PacificSource cannot accept the premium directly from you.

- The Plan Sponsor discontinues this Plan and no longer offers a group health plan to any of its Employees;
- Member who qualified for a disability extension is determined by the Social Security Administration to no longer be disabled;
- Member is terminated for cause (for example, submission of fraudulent claims).

Type of Coverage

Under COBRA, you may continue any coverage you had before the qualifying event. If the Plan Sponsor provides both medical and dental coverage and you were enrolled in both, you may continue both medical and dental. If the Plan Sponsor provides only one type of coverage, or if you were enrolled in only one type of coverage, you may continue only that coverage.

COBRA continuation benefits are always the same as the Plan Sponsor's current benefits. The Plan Sponsor has the right to change the benefits of this Plan or eliminate this Plan entirely. If that happens, any changes to this Plan will also apply to everyone enrolled in continuation coverage.

Your Responsibilities and Deadlines

You must notify the Plan Sponsor within 60 days if you divorce or if your child no longer qualifies as a Dependent. That will allow the Plan Sponsor to notify you or your Dependents of your continuation rights.

When the Plan Sponsor learns of your eligibility for continuation, the Plan Sponsor will notify you of your continuation rights and provide a Continuation Election form. You then have 60 days from that date or 60 days from the date coverage would otherwise end, whichever is later, to enroll in continuation coverage by submitting a completed Continuation Election form to the Plan Sponsor. If continuation coverage is not elected during that 60 day period, coverage will end on the last day of the last month you were an active Employee, or when your Dependent lost eligibility.

If you fail to provide the Plan Sponsor with the Continuation Election form in the required timeframe, then the Plan Sponsor's obligation to provide you with COBRA coverage will end. PacificSource does not accept any liability for any failure, on your part or the part of the Plan Sponsor, to provide required notices for coverage.

Continuation Premium

Members are responsible for the full cost of continuation coverage. The Plan Sponsor uses the services of a third-party COBRA administrator to collect premium for continuation coverage. Please see the Plan Sponsor for more information about the Plan's COBRA administrator. The monthly premium must be paid to the Plan Sponsor's COBRA administrator. You may make your first premium payment any time within 45 days after you return your Continuation Election form to the Plan Sponsor's COBRA administrator. After the first premium payment, each monthly payment must reach the Plan Sponsor's COBRA administrator within 30 days of your premium due date. If the COBRA administrator does not receive your continuation premium on time, continuation coverage will end. If your coverage is canceled due to a missed payment, it will not be reinstated for any reason. It is solely your responsibility to ensure that the COBRA administrator receives the premium on time. Premium rates are established annually and may be adjusted if the Plan's benefits or costs change.

- You have a right to the confidential protection of your records and personal information.
- You have a right to voice Complaints about this Plan, PacificSource, or the care you receive, and to Appeal decisions you believe are wrong.
- You have a right to participate with your Provider in decision-making regarding your care.
- You have a right to know why any tests, procedures, or treatments are performed and any risks involved.
- You have a right to refuse treatment and be informed of any possible medical consequences.
- You have a right to refuse to sign any consent form you do not fully understand, or cross out any part you do not want applied to your care.
- You have a right to change your mind about treatment you previously agreed to.

Your Responsibilities as a Member

- You are responsible for reading this Plan Document and all other communications from the Plan Sponsor and PacificSource, and for understanding this Plan's benefits. You are responsible for contacting the Plan Sponsor or PacificSource's Customer Service team if anything is unclear to you.
- You are responsible for making sure your Provider obtains prior authorization for any services that require it before you are treated.
- You are responsible for providing the Plan Sponsor and PacificSource with all the information required to provide benefits under this Plan.
- You are responsible for giving your Provider complete information to help accurately diagnose and treat you.
- You are responsible for telling your Providers you are covered by this Plan and showing your PacificSource Member ID card when you receive care.
- You are responsible for being on time for appointments, and contacting your Provider ahead of time if you need to cancel.
- You are responsible for any fees the Provider charges for late cancellations or no shows.
- You are responsible for contacting the Plan Sponsor or PacificSource if you believe you are not receiving adequate care.
- You are responsible for supplying information to the extent possible that the Plan Sponsor or PacificSource needs in order to administer your benefits or your Providers need in order to provide care.
- You are responsible for following plans and instructions for care that you have agreed to with your Providers.
- You are responsible for understanding your health problems and participating in developing mutually agreed upon goals, to the degree possible.

Name and Address of Third Party Administrator:

PacificSource Health Plans
P.O. Box 7068
Springfield, OR 97475-0068
Phone: (888) 977-9299
Fax: (541) 684-5264

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

Bonner County
Attn: Alissa Clark~~Cindy Binkerd~~
1500 Hwy 2, Suite 337
Sandpoint, ID 83864
Phone: 208-~~265~~255-~~1456~~3630 ext. 1237
Fax: 208-265-1457

Third Party Payments

PacificSource, on behalf of the Plan Sponsor, will accept third party payments of contributions and cost sharing as if the Member made the payment from the following:

- Family and friends;
- A Ryan White HIV/AIDS program;
- An Indian tribe, tribal organization, or urban Indian organization;
- Government programs, including grantees directed by a government program to make payments on its behalf; and
- Religious institutions and other not-for-profit organizations when each of the following criteria is met:
  - The assistance is provided on the basis of the Member's financial need;
  - The institution/organization is not a Provider; and
  - The institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of insurance claims.

If payment is from a financially interested third party, the payment will be excluded from the accumulation towards the Deductible and out-of-pocket limit.

Upon rejecting or otherwise refusing to treat a third party payment as a payment from the Member, carriers must inform the Member in writing of the reason for doing so and of the Member's right to file a Complaint.

given service or supply through direct or indirect contract.

- **Out-of-network Allowable Fee** is the dollar amount established for reimbursement of charges for specific services or supplies provided by Out-of-network Providers. PacificSource, on behalf of the Plan Sponsor, uses several sources to determine the Out-of-network Allowable Fee. Depending on the service or supply and the Service Area in which it is provided, the Out-of-network Allowable Fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), contracted vendors, other nationally recognized databases, or PacificSource, as documented in PacificSource's payment policy and adopted by the Plan Sponsor.

  An Out-of-network Provider may charge more than the limits established by the Out-of-network Allowable Fee. Charges that are eligible for reimbursement, but exceed the Out-of-network Allowable Fee, are the Member's responsibility. For more information, see the Out-of-network Providers section.

Ambulatory Surgical Center means a facility licensed by the appropriate state or federal agency to perform Surgical Procedures on an outpatient basis.

Appeal means a written or verbal request from a Member or, if authorized by the Member, the Member's Authorized Representative, to change a previous decision made under this Plan concerning:

- Access to healthcare benefits, including an Adverse Benefit Determination made pursuant to utilization management;
- Claims payment, handling, or reimbursement for healthcare services;
- Rescission of the Member's benefit coverage by the Plan Sponsor; and
- Other matters as specifically required by law.

Approved Clinical Trials are Phase I, II, III, or IV clinical trials for the prevention, detection, or treatment of cancer or another life threatening condition or disease. Life threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The trial must be:

- Funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs;
- Supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs;
- Conducted as an investigational new drug application, an investigational device exemption or a biologics license application subject to approval by the FDA; or
- Exempt by federal law from the requirement to submit an investigational new drug application to the FDA.

Authorized Representative is an individual who by law or by the consent of a Member may act on behalf of the Member. An Authorized Representative *must* have the Member complete and execute

disease. The term significant deviation is defined to be a deviation which impairs the function of the body and includes, but not limited to, the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism, and other conditions that are medically diagnosed to be Congenital Anomalies.

Copayment (also referred to as Copay) is a fixed, up-front dollar amount the Member is required to pay for certain Covered Services.

Covered Service means a service or supply for which benefits are payable under this Plan subject to applicable Deductibles, Copayments, Coinsurance, out-of-pocket limit, or other specific limitations.

Custodial Care means care that is for the purpose of watching and protecting a Member. Custodial Care includes care that helps the Member conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily for the purpose of separating the Member from others or preventing self-harm.

Deductible means the portion of the expense for a Covered Service that must be paid by the Member before the benefits of this Plan are applied. A Plan may include more than one Deductible.

Dependent means the Employee's legal Spouse, and Dependent Children who qualify for coverage under the Employee's Plan. For more information, see the Eligibility section.

Dependent Children means the following:

- Biological children;
- Step children;
- Adopted children; a child will be considered a Dependent upon assumption of a legal obligation for total or partial support in anticipation of adoption; and
- Foster children or children for whom you or your Spouse are under a current court order to act as legal custodian or guardian.

Drug List (also known as a formulary) is a list of covered medications used to treat various medical conditions. Please refer to PacificSource.com/find-a-drug to determine which Drug List applies to your coverage. The Drug Lists are developed and maintained by a committee of regional Providers, including doctors, who are not employed by the Plan Sponsor or PacificSource.

Durable Medical Equipment means equipment that can withstand repeated use; is primarily and customarily used to serve a medical purpose rather than convenience or comfort; is generally not useful to a Member in the absence of an Illness or Injury; is appropriate for use in the home; and is prescribed by a Provider. Examples include, but not limited to, Hospital beds, wheelchairs, crutches, canes, walkers, nebulizers, commodes, suction machines, traction equipment, respirators, and TENS units.

Durable Medical Equipment Supplier means a PacificSource In-network Provider or a Provider that satisfies the criteria in the Medicare Quality Standards for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and other items and services.

Elective Abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

Eligible Employee means an Employee or former Employee who is eligible for coverage under this

- Mental health and Substance Use Disorder services, including behavioral health treatment;
- Pediatric services, including oral and vision care;
- Prescription Drugs;
- Preventive and wellness services and chronic disease management; and
- Rehabilitation and Habilitation Services and Devices.

Experimental, Investigational, or Unproven means services, supplies, protocols, procedures, devices, Chemotherapy, drugs or medicines, or the use thereof, that are Experimental, Investigational, or Unproven for the diagnosis and treatment of Illness or Injury.

- Experimental, Investigational, or Unproven services and supplies include, but not limited to, services, supplies, procedures, devices, Chemotherapy, drugs or medicines, or the use thereof, which at the time they are rendered and for the purpose and in the manner they are being used:
  - Have not yet received full U.S. government agency required approval (for example, FDA) for other than Experimental, Investigational, or Unproven, or clinical testing;
  - Are not of generally accepted medical practice in this Plan's state of issue or as determined by medical advisors, medical associations, and/or technology resources;
  - Are not approved for reimbursement by the Centers for Medicare and Medicaid Services;
  - Are furnished in connection with medical or other research; or
  - Are considered by any governmental agency or subdivision to be Experimental, Investigational, or Unproven, not considered reasonable and necessary, or any similar finding.
- When making decisions about whether treatments are Experimental, Investigational, or Unproven, the Plan Sponsor relies on the above resources as well as:
  - Expert opinions of specialists and other medical authorities;
  - Published articles in peer-reviewed medical literature;
  - External agencies whose role is the evaluation of new technologies and drugs; and
  - External Review by an independent review organization.
- The following will be considered in making the determination whether the service is in an Experimental, Investigational, or Unproven status:
  - Whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes;
  - Whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;
  - Whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects; and

- Physical therapy; and
- Speech therapy.

Hospice Care means care designed to give supportive care to a Member in the final phase of a terminal Illness and focuses on comfort and quality of life, rather than curing a disease. A Member's Provider must certify that the Member is terminally ill with a life expectancy of less than six months, and the Member must not be undergoing treatment of the terminal Illness other than for direct control of adverse symptoms.

Hospital means it is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the Hospital on a prearranged basis and under the supervision of a staff of Providers, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured person's on an inpatient basis for which a charge is made; and provide 24 hour nursing service by or under the supervision of registered nurses.

Illness means a sickness, disease, ailment, bodily disorder, and pregnancy.

In-network Provider means a Provider that directly or indirectly holds a Provider contract or agreement with PacificSource.

Infertility means:

- Male: Low sperm counts or the inability to fertilize an egg; or
- Female: The inability to conceive or carry a pregnancy to 12 weeks.

Initial Enrollment Period means a period of days set by the Plan Sponsor that determines when an Employee is first eligible to enroll.

Injury means bodily trauma or damage that is independent of disease or infirmity. The damage must be caused through external and Accidental means.

Inquiry means a written request for information or clarification about any subject matter related to this Plan.

Internal Appeal means a review of an Adverse Benefit Determination.

Involuntary Complications of Pregnancy include, but are not limited to:

- Cesarean section delivery, ectopic pregnancy that is terminated, spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia, and toxemia; and
- Conditions requiring inpatient confinement (when the pregnancy is not terminated), the diagnoses of which are distinct from pregnancy, but are adversely affected or caused by pregnancy. Examples include: acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. It does not include false labor, occasional spotting, Provider prescribed bed rest during pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy, but which are not distinct from the pregnancy itself.

Leave of Absence is a period of time off work granted to an Employee by the Plan Sponsor at the Employee's request and during which the Employee is still considered to be employed and is carried

Commission or the Commission on Accreditation of Rehabilitation Facilities for the level of care which the facility provides.

Mental Health and/or Substance Use Disorder Healthcare Program means a particular type or level of service that is organizationally distinct within a Mental Health and/or Substance Use Disorder Healthcare Facility.

Mental Health and/or Substance Use Disorder Healthcare Provider means a person that has met the applicable credentialing requirements, is otherwise eligible to receive reimbursement under this Plan and is:

- A Mental Health and/or Substance Use Disorder Healthcare Facility;
- A residential Mental Health and/or Substance Use Disorder Healthcare Program or Facility;
- A day or partial hospitalization program;
- An outpatient service; or
- An individual behavioral health or medical professional duly licensed and authorized for reimbursement under state law.

Mental Health Condition means all disorders defined in the current edition of Diagnostic and Statistical Manual of Mental Disorders, except for neurodevelopmental disorders including:

- Intellectual Developmental Disorder, Global Developmental Delay, and Unspecified Intellectual Disability;
- Learning Disorders related to difficulties in learning and using academic skills which include impairment in reading, written expression, and mathematics;
- Paraphilias which include criminal offenses and are generally treated in correctional settings; and
- Mental health treatments for conditions defined in the current edition of Diagnostic and Statistical Manual of Mental Disorders, that are not attributable to a mental health disorder or disease, except the treatment of children five years of age or younger for parent-child relational problems, physical abuse of a child, sexual abuse, neglect of a child, or bereavement.

Orthotic Devices means rigid or semi rigid devices supporting a weak or deformed leg, foot, arm, hand, back, or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back, or neck. It includes orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. Orthotic Devices are usually customized for an individual's use and are not appropriate for anyone else. Examples of Orthotic Devices include, but not limited to, Ankle Foot Orthosis (AFO), Knee Ankle Foot Orthosis (KAFO), Lumbosacral Orthosis (LSO), and foot orthotics.

Out-of-network Provider means a Provider that does not directly or indirectly hold a Provider contract or agreement with PacificSource.

Physical/Occupational Therapy is comprised of the services provided by (or under the direction and supervision of) a licensed physical or occupational therapist. Physical/Occupational Therapy includes emphasis on examination, evaluation, and intervention to alleviate impairment and functional limitation and to prevent further impairment or disability.

- Items or services provided by a clinical trial sponsor free of charge to a Member participating in the clinical trial; or
- Items or services that are not covered by this Plan if provided outside of the clinical trial.

Service Area is Oregon, Idaho, Montana, and Washington.

Skilled Nursing Facility or Convalescent Home means an institution that provides skilled nursing care under the supervision of a Provider, provides 24 hour nursing service by or under the supervision of a registered nurse (RN), and maintains a daily record of each patient. Skilled Nursing Facilities must be licensed by an appropriate state agency and approved for payment of Medicare benefits to be eligible for reimbursement.

Specialized Treatment Facility means a facility that provides specialized short-term or long-term care. The term Specialized Treatment Facility includes Ambulatory Surgical Centers, birthing centers, hospice facilities, inpatient rehabilitation facilities, Mental Health and/or Substance Use Disorder Healthcare Facilities, organ transplant facilities, psychiatric day treatment facilities, residential treatment facilities, Skilled Nursing Facilities, Substance Use Disorder day treatment facilities, Substance Use Disorder Treatment Facilities, and Urgent Care Treatment Facilities.

Specialty Drugs are high dollar oral, injectable, infused, or inhaled biotech medications prescribed for the treatment of chronic and/or genetic disorders with complex care issues that have to be managed. The major conditions these drugs treat include, but not limited to: cancer, HIV/AIDS, hemophilia, hepatitis C, multiple sclerosis, Crohn's disease, rheumatoid arthritis, and growth hormone deficiency.

Specialty Pharmacies specialize in the distribution of Specialty Drugs and providing pharmacy care management services designed to assist Members in effectively managing their condition.

Spouse means any individual who is legally married under current state law.

Stabilize means to provide medical treatment as necessary to ensure that, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during or to result from the transfer of the Member from a facility; and with respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

Step Therapy means a program that requires the Member to try lower-cost alternative medications (Step 1 drugs) before using more expensive medications (Step 2 or 3 drugs). The program will not cover a brand name, or second-line medication, until less expensive, first-line/generic medications have been tried first.

Subscriber means an Employee or former Employee covered under this Plan. When a family that does not include an Employee or former Employee is covered under this Plan, the oldest Dependent is referred to as the Subscriber.

Substance Use Disorder means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the Member's social, psychological, or physical adjustment to common problems on a recurring basis. Substance Use Disorder does not include addiction to, or dependency on, tobacco products or foods.

Substance Use Disorder Treatment Facility means a treatment facility that provides a program for the treatment of Substance Use Disorders pursuant to a written treatment plan approved and monitored by a Provider or addiction counselor licensed by the state; is licensed or approved as a

Women's Healthcare Provider means an obstetrician, gynecologist, physician assistant, naturopathic physician, nurse practitioner specializing in women's health, physician, or other Provider practicing within the scope of their license.

Women's Healthcare Services means organized services to provide healthcare to women, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The services include, but not limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. Women's Healthcare Services also include any appropriate healthcare service for other health problems, discovered and treated during the course of a visit to a Women's Healthcare Provider for a Women's Healthcare Service, which is within the Provider's scope of practice. For purposes of determining a woman's right to directly access health services covered by this Plan, maternity care, reproductive health, and preventive services include: Contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breastfeeding, and complications of pregnancy.

Bonner County

Group No.: G0039089
Plan Name: Medical HSA
Effective: October 1, ~~2022~~2023

With Third Party Administrative Services Provided By:

Retention of Fiduciary Duties

The Plan Sponsor has retained all fiduciary duties under the Plan, including all interpretations of the Plan and the benefits and exclusions it contains. This means that the Plan Sponsor is solely responsible for all final decisions regarding what benefits are or will be covered, both now and in the future. The Plan Sponsor is solely responsible for the design of this Plan. Plan Sponsor is solely responsible for setting any and all criteria used to determine enrollment and eligibility.

Governing Law

This Plan must comply with both state and federal law, including required changes occurring after the Plan's effective date. Therefore, coverage is subject to change as required by law.

Additional Information

Representations not warranties: In the absence of fraud, all statements made by the Plan Sponsor will be considered representations and not warranties. No statement made for the purpose of effecting coverage will void the coverage or reduce benefits unless it is contained in a written document signed by the Plan Sponsor and provided to a Member.

Questions?

PacificSource's Customer Service team is available to answer questions or concerns regarding the Plan. Phone lines are open from 8 a.m. to 5 p.m. Monday through Friday (excluding holidays). PacificSource's Customer Service team is not authorized to interpret or change the terms of the Plan.

For enrollment or eligibility questions, please contact the Plan Sponsor.

PacificSource Customer Service
Phone 888-246-1370
Email cs@pacificsource.com

Para asistencia en español, por favor llame al número 866-281-1464.

PacificSource Headquarters
555 International Way, Springfield, OR 97477
PO Box 7068, Springfield, OR 97475-0068
Phone 541-686-1242 or 800-624-6052

PacificSource Regional Office
408 E. Parkcenter Blvd., Suite 100, Boise, ID 83706
Phone 208-342-3709 or 888-492-2875

PacificSource Website
PacificSource.com

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Well baby/Well child care	No Deductible, 0%	~~After~~ No Deductible, 40%
Preventive physicals	No Deductible, 0%	~~After~~ No Deductible, 40%
Well woman visits	No Deductible, 0%	~~After~~ No Deductible, 40%
Preventive mammograms	No Deductible, 0%	~~After~~ No Deductible, 40%
Immunizations	No Deductible, 0%	~~After~~ No Deductible, 40%
Preventive colonoscopy	No Deductible, 0%	~~After~~ No Deductible, 40%
Prostate cancer screening	No Deductible, 0%	~~After~~ No Deductible, 40%
Professional Services		
Office and home visits	After Deductible, 20%	After Deductible, 40%
Naturopath office visits	After Deductible, 20%	After Deductible, 40%
Specialist office and home visits	After Deductible, 20%	After Deductible, 40%
Telehealth visits	After Deductible, 20%	After Deductible, 40%
Office procedures and supplies	After Deductible, 20%	After Deductible, 40%
Surgery	After Deductible, 20%	After Deductible, 40%
Outpatient Habilitation Services (combined 30 visits per Benefit Year for Physical, Occupational, and Speech Therapy)	After Deductible, 20%	After Deductible, 40%
Outpatient Rehabilitation Services (combined 30 visits per Benefit Year for Physical, Occupational, and Speech Therapy)	After Deductible, 20%	After Deductible, 40%
Chiropractic manipulation/Spinal manipulation (20 visits per Benefit Year)	After Deductible, 20%	After Deductible, ~~40~~20%
Acupuncture (20 visits per Benefit Year)	After Deductible, 20%	After Deductible, ~~40~~20%
Hospital Services		
Inpatient room and board	After Deductible, 20%	After Deductible, 40%
Inpatient Habilitation Services	After Deductible, 20%	After Deductible, 40%
Inpatient Rehabilitation Services	After Deductible, 20%	After Deductible, 40%
Skilled nursing facility care (60 days per Benefit Year)	After Deductible, 20%	After Deductible, 40%

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more Dependents enroll, the individual Deductible applies for each Member only until the family Deductible has been met.

In-network expense and out-of-network expense apply together toward your Deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for Covered Services during the Benefit Year. Once the out-of-pocket limit has been met, this Plan will pay 100 percent of allowed amounts for Covered Services for the rest of that Benefit Year. The individual out-of-pocket limit applies only if you enroll without Dependents. If you and one or more Dependents enroll, the individual out-of-pocket limit applies for each Member only until the family out-of-pocket limit has been met. Be sure to check the Plan Document, as there are some charges, such as non-Essential Health Benefits, penalties, and Balance Billed amounts that do not count toward the out-of-pocket limit.

In-network expense and out-of-network expense apply together toward your out-of-pocket limit.

Payments to Providers

Payment to Providers is based on the prevailing or Allowable Fee for Covered Services. In-network Providers accept the Allowable Fee as payment in full. Services of Out-of-network Providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior Authorization

Coverage of certain medical services and Surgical Procedures requires a Benefit Determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and Out-of-network Providers. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business)

Discrimination is against the law

Both the Plan Sponsor and PacificSource Health Plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan Sponsor and PacificSource do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Well baby/Well child care	No Deductible, 0%	~~After~~ No Deductible, 40%
Preventive physicals	No Deductible, 0%	~~After~~ No Deductible, 40%
Well woman visits	No Deductible, 0%	~~After~~ No Deductible, 40%
Preventive mammograms	No Deductible, 0%	~~After~~ No Deductible, 40%
Immunizations	No Deductible, 0%	~~After~~ No Deductible, 40%
Preventive colonoscopy	No Deductible, 0%	~~After~~ No Deductible, 40%
Prostate cancer screening	No Deductible, 0%	~~After~~ No Deductible, 40%
Professional Services		
Office and home visits	After Deductible, 20%	After Deductible, 40%
Naturopath office visits	After Deductible, 20%	After Deductible, 40%
Specialist office and home visits	After Deductible, 20%	After Deductible, 40%
Telehealth visits	After Deductible, 20%	After Deductible, 40%
Office procedures and supplies	After Deductible, 20%	After Deductible, 40%
Surgery	After Deductible, 20%	After Deductible, 40%
Outpatient Habilitation Services (combined 30 visits per Benefit Year for Physical, Occupational, and Speech Therapy)	After Deductible, 20%	After Deductible, 40%
Outpatient Rehabilitation Services (combined 30 visits per Benefit Year for Physical, Occupational, and Speech Therapy)	After Deductible, 20%	After Deductible, 40%
Chiropractic manipulation/Spinal manipulation (20 visits per Benefit Year)	After Deductible, 20%	After Deductible, ~~40~~20%
Acupuncture (20 visits per Benefit Year)	After Deductible, 20%	After Deductible, ~~40~~20%
Hospital Services		
Inpatient room and board	After Deductible, 20%	After Deductible, 40%
Inpatient Habilitation Services	After Deductible, 20%	After Deductible, 40%
Inpatient Rehabilitation Services	After Deductible, 20%	After Deductible, 40%
Skilled nursing facility care (60 days per Benefit Year)	After Deductible, 20%	After Deductible, 40%

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In-network expense and out-of-network expense apply together toward your Deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for Covered Services during the Benefit Year. Once the out-of-pocket limit has been met, this Plan will pay 100 percent of allowed amounts for Covered Services for the rest of that Benefit Year. The individual out-of-pocket limit applies only if you enroll without Dependents. Be sure to check the Plan Document, as there are some charges, such as non-Essential Health Benefits, penalties, and Balance Billed amounts that do not count toward the out-of-pocket limit.

In-network expense and out-of-network expense apply together toward your out-of-pocket limit.

Payments to Providers

Payment to Providers is based on the prevailing or Allowable Fee for Covered Services. In-network Providers accept the Allowable Fee as payment in full. Services of Out-of-network Providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior Authorization

Coverage of certain medical services and Surgical Procedures requires a Benefit Determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and Out-of-network Providers. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business)

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Service/Supply	Incentive Drugs:	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
Specialty Drugs – Out-of-network Specialty Pharmacy				
Up to a 30 day maximum ~~supply~~fill, no more than three fills allowed per Benefit Year:			After Deductible, $200	

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**Compounded medications are subject to a prior authorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medications are on the applicable formulary.

MAC A - Regardless of the reason or Medical Necessity, if you receive a brand name drug or if your Provider prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's Copayment and/or Coinsurance plus the difference in cost between the brand name and Generic Drug after the medical Deductible is met. The cost difference between the brand name and Generic Drug does not apply toward the medical Deductible or out of pocket limit.

If your Provider prescribes a brand name contraceptive due to Medical Necessity it may be subject to prior authorization for coverage at no charge.

See the Plan Document for important information about your Prescription Drug benefit, including which drugs are covered, limitations, and more.

OUT-OF-POCKET LIMIT

This Plan has an out-of-pocket limit provision. The Benefit Summaries show this Plan's annual out-of-pocket limits. If you incur Covered Services over those amounts, this Plan will pay 100 percent of the Allowable Fee for the remainder of the Benefit Year.

The allowed amounts Members pay for Covered Services will accrue toward the annual out-of-pocket limit except for the following, which will continue to be your responsibility:

- Coinsurance for out-of-network chiropractic manipulations/spinal manipulations and acupuncture treatments.
- Charges for non-Covered Services.
- Incurred charges that exceed amounts allowed under this Plan.
- Charges for the difference in cost between brand name medication and generic equivalent as explained in the Prescription Drugs section.

ESSENTIAL HEALTH BENEFITS

Except for pediatric dental which is not included in this Plan, this Plan covers the Essential Health Benefits as defined by the Secretary of the U.S. Department of Health and Human Services. Annual and Lifetime Maximum dollar limits will not be applied for any service that is an Essential Health Benefit.

UNDERSTANDING MEDICAL NECESSITY

In order for a service or supply to be covered, it must be both a Covered Service *and* Medically Necessary.

Be careful – just because a treatment is prescribed or recommended by a Provider does not mean it is Medically Necessary under the terms of this Plan. This Plan provides coverage only when such care is necessary to treat an Illness or Injury or the service qualifies as preventive care. All treatment is subject to review for Medical Necessity. Review of treatment may involve prior authorization, concurrent review of the continuation of treatment, post-treatment review, or any combination of these. A second opinion (at no cost to you when requested by PacificSource or the Plan Sponsor) may be required for a Medical Necessity determination.

Some Medically Necessary services are not Covered Services. Medically Necessary services and supplies that are specifically excluded from coverage under this Plan can be found in the Benefit Exclusions section.

If you ever have a question about your benefits, contact the PacificSource Customer Service team.

UNDERSTANDING EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN SERVICES

This Plan does not cover services or treatments that are Experimental, Investigational, or Unproven.

To ensure you receive the highest quality care at the lowest possible cost, PacificSource, on behalf of the Plan Sponsor, reviews new and emerging technologies and medications on a regular basis.

Colorectal Cancer Screening

This Plan covers colorectal cancer screening as required under ACA. Screening coverage includes a follow up colonoscopy performed after a positive non-invasive stool based screening or direct visualization. For colorectal cancer screenings not required to be covered as preventive under ACA, see the Diagnostic and Therapeutic Radiology/Laboratory and Dialysis – (non-advanced) section.

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Immunizations

This Plan covers age-appropriate childhood and adult immunizations for primary prevention of infectious diseases as recommended and adopted by the USPSTF, CDC, or similar standard-setting body. This benefit does not include immunizations that are determined to be elective or Experimental, Investigational, or Unproven.

Preventive Physicals

This Plan covers appropriate screening radiology and laboratory tests and other screening procedures. Screening exams and laboratory tests may include, but not limited to, depression screening for all adults including pregnant and postpartum women, blood pressure checks, weight checks, occult blood tests, urinalysis, complete blood count, prostate exams, cholesterol exams, stool guaiac screening, EKG screens, blood sugar tests, and tuberculosis skin tests. Only laboratory tests and other routine screening procedures related to the preventive physical are covered by this benefit. Diagnostic radiology and laboratory services outside the scope of the preventive physical will be subject to the standard cost sharing.

- Benefits are limited as follows: Age 22 and older once per Benefit Year.

Prostate Cancer Screening

This Plan covers appropriate screening that includes, but not limited to, a digital rectal exam and a prostate-specific antigen test.

Tobacco Cessation Program Services

This Plan covers Tobacco Cessation Program services.

Well Baby/Well Child Care

This Plan covers well baby/well child examinations. Only laboratory tests and other routine screening procedures related to the well baby/well child exam are covered by this benefit. Diagnostic radiology and laboratory services outside the scope of the preventive physical will be subject to the standard cost sharing.

- Benefits are limited as follows:
  - At birth: One standard in-Hospital exam
  - Ages 0-2: 12 additional exams during the first 36 months of life
  - Ages 3-21: One exam per Benefit Year

appropriate for the Member, or the Member provides medical or scientific information establishing that the trial would be appropriate. If an In-network Provider is participating in an Approved Clinical Trial, the Member may be required to participate in the trial through that In-network Provider if the Provider will accept the Member as a participant.

Cosmetic or Reconstructive Surgery

This Plan provides cosmetic or reconstructive services in the following situations:

- When necessary to correct a functional disorder or Congenital Anomaly;
- When necessary because of an Accidental Injury or Illness, or to correct a scar or defect that resulted from treatment of an Accidental Injury or Illness; or
- When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery.

Some cosmetic or reconstructive surgeries require prior authorization. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Cosmetic or reconstructive surgery must take place within 18 months after the Injury, surgery, scar, or defect first occurred unless the area needing treatment is a result of a Congenital Anomaly.

Dietary or Nutritional Counseling

This Plan covers services for diabetic education, management of inborn errors of metabolism, and management of anorexia nervosa or bulimia nervosa if provided by a qualified Provider or as required under ACA for obesity. Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults, and comprehensive, intensive behavioral interventions to promote improvement in weight status for children are also covered.

Foot Care

This Plan covers routine foot care for Members with diabetes mellitus.

Genetic Counseling

This Plan covers services of a board-certified or board-eligible genetic counselor for evaluation of genetic disease.

Inborn Errors of Metabolism

This Plan covers treatment for inborn errors of metabolism involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes expenses for diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including, but not limited to, clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Telehealth

This Plan covers Medically Necessary Telehealth services when provided by a Provider.

Traumatic Brain Injury

This Plan covers Medically Necessary therapy and services for the treatment of traumatic brain Injury.

AMBULANCE SERVICES

This Plan covers services of a state certified ground or air ambulance to the nearest facility capable of treating the condition, when other forms of transportation will endanger your health. There is no coverage for services that are for personal or convenience purposes. Air ambulance service is only covered when ground transportation is medically or physically inappropriate. Non-emergency ground or air ambulance between facilities requires prior authorization.

BLOOD TRANSFUSIONS

This Plan covers blood, blood products, and blood storage, including services and supplies of a blood bank.

BREAST PROSTHESES

This Plan covers removal, repair, and/or replacement of breast prostheses due to a contracture or rupture, but only when the original prosthesis was for a Medically Necessary Mastectomy. Prior authorization by PacificSource is required, and eligibility for benefits is subject to the following criteria:

- The contracture or rupture must be clinically evident by a Provider's physical examination, imaging studies, or findings at surgery;
- Removal, repair, and/or replacement of the prosthesis is not covered when recommended due to an autoimmune disease, connective tissue disease, arthritis, allergenic syndrome, psychiatric syndrome, fatigue, or other systemic signs or symptoms.

COCHLEAR IMPLANTS

This Plan covers single or bilateral cochlear implants when Medically Necessary, including programming and reprogramming.

CONTRACEPTIVES AND CONTRACEPTIVE DEVICES/FAMILY PLANNING

This Plan covers IUD, diaphragm, and cervical cap contraceptives and contraceptive devices along with their insertion or removal, as well as hormonal contraceptives including injections, formulary oral, patches, and rings prescribed by your Provider. Contraceptive drugs, devices, and other products approved by the Food and Drug Administration (FDA) and on the formulary are covered by this Plan when prescribed.

percent of the current Medicare allowable amount for in-network and out-of-network ESRD service Providers.

In accordance with federal and state laws, there is an initial period where this Plan will be primary to Medicare. Once that period of time has elapsed the Plan will pay up to the amount it would have paid in the secondary position.

DIAGNOSTIC IMAGING – ADVANCED

This Plan covers Medically Necessary advanced diagnostic imaging for the diagnosis of Illness or Injury. For the purposes of this benefit, advanced diagnostic imaging includes CT scans, MRIs, PET scans, CATH labs, and nuclear cardiology studies. Some diagnostic imaging requires prior authorization. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business).

DURABLE MEDICAL EQUIPMENT

This Plan covers services and applicable sales tax for Durable Medical Equipment. Durable Medical Equipment must be prescribed.

This Plan covers Prosthetic Devices and Orthotic Devices to restore or maintain the ability to complete activities of daily living or essential job-related activities and are not for comfort or convenience. Repair or replacement of a Prosthetic Device and Orthotic Device is covered when needed due to normal use. This Plan covers maxillofacial prostheses to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing.

- Benefits are limited as follows:
  - Some Durable Medical Equipment requires a prior authorization. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business). Benefits will be paid toward either the purchase or the rental of the equipment for the period needed, whichever is less. Repair or replacement of equipment is also covered when necessary, subject to all conditions and limitations of this Plan. ~~If the cost of the purchase, rental, repair, or replacement is over $1,000, prior authorization is required.~~
  - Only expenses for Durable Medical Equipment, or Prosthetic and Orthotic Devices that are provided by a PacificSource contracted Provider or a Provider that satisfies the criteria of the Medicare fee schedule for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services are eligible for reimbursement.
  - Medically Necessary treatment for sleep apnea and other sleeping disorders (including snoring) is covered. Prior authorization is required. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a Provider specializing in evaluation and treatment of ~~obstructive sleep apnea, and the condition must meet criteria for obstructive~~ sleep ~~apnea~~disorders.
  - Hearing Aids: Hearing Aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, for Dependent Children with a Congenital Anomaly or acquired hearing loss which may result in cognitive or speech development deficits without intervention. The Durable Medical Equipment benefit covers one device per hearing

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EMERGENCY ROOM – PROVIDER AND FACILITY

This Plan covers an Emergency Medical Screening Exam and Emergency Services to evaluate and treat an Emergency Medical Condition. Any referred services or treatment after discharge from the emergency room will be covered under the applicable benefit for such services and treatment. For Emergency Medical Conditions, Out-of-network Providers are paid at the In-network Provider level. If you are admitted to an out-of-network Hospital, PacificSource will coordinate your transfer to an in-network facility if necessary.

Emergency Medical Screening Exams and Emergency Services, including any diagnostic tests necessary for emergency care (including radiology, laboratory work, CT scans and MRIs) are subject to the Deductibles, Copayment, and/or Coinsurance stated in your Medical Benefit Summary for either Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced or Diagnostic imaging - advanced, depending on the specific service provided.

If you need immediate assistance for a medical emergency, call 911, or go to the nearest emergency room or appropriate facility.

HEALTH EDUCATION BENEFITS

This Plan covers health education benefits. Health education topics usually include matters such as maternity, fitness and education, newborn care and parenting skills, nutrition and healthy heart exercises or CPR skills. Covered services include health-related classes and printed materials required for the class.

- Benefits are limited as follows: Up to $150 per Benefit Year.

After you have completed the class, please provide PacificSource with proof of payment and a completed Reimbursement Request Form for PacificSource to review for benefit payment consideration based on the Plan Sponsor's criteria. You may obtain the Reimbursement Request Form from the Plan Sponsor, or PacificSource's Customer Service team.

HOME HEALTHCARE SERVICES

This Plan covers Home Healthcare services, including home infusion services that cannot be self-administered, when provided by a licensed home health agency.

- Benefits are limited as follows: Up to 130 visits per Benefit Year. Private duty nursing is not covered.

HOSPICE CARE SERVICES

This Plan covers Hospice Care services intended to meet the physical, emotional, and spiritual needs of the Member and family during the final stages of Illness and dying, while maintaining the Member in the home setting. Services are to supplement the efforts of an unpaid caregiver and include pastoral care and bereavement services.

This Plan covers respite care provided in a nursing facility to provide relief for the primary caregiver.

- Benefits are limited as follows:

- Benefits are limited as follows: Up to 60 days per Benefit Year. Confinement for Custodial Care is not covered.

MATERNITY SERVICES

This Plan covers services of Providers practicing within the scope of their license, for prenatal and postnatal (provided within six weeks of delivery) maternity, childbirth, and Involuntary Complications of Pregnancy. A Hospital stay of at least 48 hours (vaginal) or 96 hours (cesarean) is covered.

This Plan covers routine nursery care of a newborn child born to a Member while the mother is hospitalized and eligible for pregnancy-related benefits under this Plan if the newborn is also eligible and enrolled in this Plan.

Please contact the PacificSource Customer Service team as soon as you learn of your pregnancy. Their team will explain this Plan's maternity benefits and help you enroll in a prenatal care program.

- Benefits are limited as follows: Unless the services are Medically Necessary due to a complication, this Plan does not cover any maternity services for Dependent Children.

OUTPATIENT SERVICES

Applied Behavioral Analysis (ABA) for Autism, Asperger's or Pervasive Development Disorder

This Plan covers ABA according to PacificSource's guidelines for Medical Necessity. Prior authorization and a treatment plan are required.

Mental Health and Substance Use Disorder Services – Outpatient

This Plan complies with all federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008. Treatment of Substance Use Disorder and related disorders is subject to placement criteria established by the American Society of Addiction Medicine, Third Edition.

This Plan covers crisis intervention, diagnosis, and treatment of Mental Health Conditions and Substance Use Disorders including chemical dependency detoxification by a Mental Health and/or Substance Use Disorder Healthcare Provider or Mental Health and/or Substance Use Disorder Healthcare Program, except as otherwise excluded in this Plan.

Outpatient Habilitation

This Plan covers Physical/Occupational Therapy, and speech therapy services to help a person keep, learn, or improve skills and functioning for daily living. These services must be part of a written treatment program that includes site, modality, duration, and frequency of treatment.

- Benefits are limited as follows: Up to a combined maximum of 30 visits per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual/supplemental benefits are met.

Outpatient Rehabilitation

This Plan covers outpatient Rehabilitation Services to help a person keep, restore, or improve skills and function for daily living that have been lost or impaired due to Illness, Injury, or disability and do

- Medications listed as SP on the Drug List may have additional restrictions or costs associated with them.

See the Prescription Drug Benefit Summary for cost sharing information.

Drug Discount Programs

Some medications may qualify for third party Copayment assistance programs that could lower your out-of-pocket costs for those products. For any such medication where third party Copayment assistance is used, the Member may not receive credit toward their Deductible or out-of-pocket limit for any Copayment or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Mail Order Pharmacy

This Plan includes mail order service for Prescription Drugs. Questions about mail order may be directed to the PacificSource Customer Service team. More information is available on the website, PacificSource.com/members/prescription-drug-information/resources.

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Specialty Drugs

Specialty Drugs are designated with SP on the Drug List available on the PacificSource website. Specialty Drugs often require special handling, storage, and instructions. PacificSource contracts with Specialty Pharmacies for these high-cost medications (oral and injectable). A pharmacist-led care team provides individual follow-up care and support to covered Members with prescriptions for Specialty Drugs by providing them strong clinical support, as well as the best overall value for these specific medications. The care team also provides comprehensive disease education and counseling, assesses Member health status, and offers a supportive environment for Member inquiries.

Fills of Specialty Drugs are limited to a 30 day supply and must be filled through the PacificSource exclusive network Specialty Pharmacies. Specialty Drugs are not available through the in-network retail pharmacy network, mail order service, or non-exclusive Specialty Pharmacies without prior authorization. For more information, including prior authorization requirements, see the website PacificSource.com/members/prescription-drug-information/resources.

No Duplication of Services

Medications and supplies covered under your prescription benefit are in place of, not in addition to, those same covered supplies under the medical portion of this Plan.

Diabetic Supplies

Refer to your Drug List, available on the PacificSource website, to see which diabetic supplies are covered under your prescription benefit. Some diabetic supplies, such as glucose monitoring devices, may only be covered under your medical benefit. Diabetic testing supplies are subject to Plan quantity limits. For more information, see the Diabetic Equipment, Supplies, and Training section.

Contraceptives

Contraceptives approved by the FDA are covered as recommended by the USPSTF, HRSA, and CDC. Any Deductibles, Copayments, and/or Coinsurance amounts are waived if a generic is filled. When no generic exists, brand name contraceptives may be covered at no cost. If your Provider prescribes a non-formulary contraceptive due to Medical Necessity, it may be subject to prior authorization for coverage at no charge.

- Certain drugs require prior authorization (PA). An up-to-date list of drugs requiring prior authorization along with all of our requirements is available on the PacificSource website.
- Certain drugs are subject to Step Therapy (ST) protocols, which means you may be required to try a pre-requisite drug before this Plan will pay for the requested drug. An up-to-date list of drugs requiring Step Therapy along with all of the requirements is available on the PacificSource website.
- Certain drugs have quantity limits (QL), which means the Plan will generally not pay for quantities above posted limits. An up-to-date list of drugs requiring quantity limit exceptions along with all of the requirements is available on the PacificSource website.
- For most prescriptions, you may refill your prescription only after 75 percent of the previous supply has been taken. This is calculated by the number of days that have elapsed since the previous fill and the days' supply entered by the pharmacy. Early refills will generally not be approved, except under the following circumstances:
  - The request is for ophthalmic solutions or gels, refillable after 70 percent of the previous supply has been taken.
  - The Member will be on vacation in a location that does not allow for reasonable access to a network pharmacy for subsequent refills.

  All early refills are subject to standard cost share and are reviewed on a case-by-case basis.

Formulary Exception and Coverage Determination Process

Requests for formulary exceptions can be made by the Member or Provider by contacting the PacificSource Pharmacy Services team. Determinations on standard exception requests will be made no later than 72 hours, expedited requests are determined within 24 hours following receipt of the request. Formulary exceptions and coverage determinations must be based on Medical Necessity, and information must be submitted to support the Medical Necessity including all of the following:

- Documented intolerance or failure to the formulary alternatives for the submitted diagnosis;
- Formulary drugs were tried with an adequate dose and duration of therapy;
- Formulary drugs were not tolerated or were not effective;
- Formulary or preferred drugs would reasonably be expected to cause harm or not produce equivalent results as the requested drug;
- The requested drug therapy is evidence-based and generally accepted medical practice; and
- Special circumstances and individual needs, including the availability of service Providers in the Member's region.

For the complete Formulary Exception Criteria, please refer to the PacificSource website.

TEMPOROMANDIBULAR JOINT SERVICES

This Plan covers treatment of temporomandibular joint syndrome (TMJ) for medical reasons only. All TMJ-related services, including but not limited to, diagnostic and Surgical Procedures, must be

Payment of Transplant Benefits

If a transplant is performed at an in-network Center of Excellence transplantation facility, covered charges of the facility are subject to this Plan's in-network transplant benefit. If the contract with the facility includes the services of the medical professionals performing the transplant, those charges are also subject to this Plan's in-network transplant benefit. If the professional fees are not included in the contract with the facility, then those benefits are provided according to the Medical Benefit Summary.

Transplant services that are not received at an in-network Center of Excellence and/or services of out-of-network medical professionals are paid at the out-of-network percentages stated in the Medical Benefit Summary. The maximum benefit payment for transplant services of Out-of-network Providers is 125 percent of the Medicare allowance.

WOMEN'S HEALTH AND CANCER RIGHTS

Breast Reconstruction

This Plan covers breast reconstruction in connection with a Medically Necessary Mastectomy, as required by the Women's Health and Cancer Rights Act of 1998. Coverage is provided in a manner determined in consultation with the attending Provider and for:

- All stages of reconstruction of the breast on which the Mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the Mastectomy, including lymphedema.

Benefits for breast reconstruction are subject to all terms and provisions of this Plan, including Deductibles, Copayments, and/or Coinsurance.

Post-Mastectomy Care

This Plan covers post-Mastectomy care for a period of time as determined by the attending Provider and, in consultation with the Member, determined to be Medically Necessary following a Mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

BENEFIT EXCLUSIONS

This Plan does not cover the following:

- Abdominoplasty for any indication.
- Academic skills training.
- Acute care, rehabilitative, diagnostic testing, except as specified as a Covered Service in this Plan.
- Biofeedback (other than as specifically noted under the Covered Services section).
- Charges for missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims unless otherwise contracted.

medical review of your case against the criteria established by the Plan Sponsor, and notify you of whether or not the proposed treatment will be covered.

- Eye examinations (preventive).
- Eye exercises and eye refraction, therapy, and procedures – Orthoptics, vision therapy, and procedures intended to correct refractive errors.
- Eye glasses/Contact lenses – The fitting, provision, or replacement of eye glasses, lenses, frames, contact lenses, or subnormal vision aids intended to correct refractive error.
- Fitness or exercise programs and health or fitness club memberships.
- Foot care (routine) – Services and supplies for corns and calluses of the feet, conditions of the toenails other than infection, hypertrophy, or hyperplasia of the skin of the feet, and other routine foot care, except in the case of Members being treated for diabetes mellitus.
- Gender affirmation – Procedures, services, or supplies related to gender affirmation.
- Hearing Aids including the fitting, provision, or replacement of Hearing Aids, except as specified as a Covered Service in the Durable Medical Equipment section.
- Homeopathic medicines or homeopathic supplies.
- Hypnotherapy except in the treatment of Mental Health Conditions.
- Immunizations when recommended for, or in anticipation of, exposure through travel or work.
- Infertility – This Plan does not cover Infertility diagnostic or treatment services.
- Inpatient or outpatient Custodial Care; or inpatient or outpatient services consisting mainly of educational therapy, behavioral modification, self-care or self-help training, except as specified as a Covered Service in this Plan.
- Instructional or educational programs, except diabetes self-management programs when Medically Necessary.
- Jaw – Procedures, services, and supplies for developmental or degenerative abnormalities of the head and face that can be replaced with living tissue; services and supplies that do not control or eliminate pain or infection or that do not restore functions such as speech, swallowing, or chewing; cosmetic procedures and procedures to improve on the normal range of functions; dentures; and artificial larynx. (This does not include services for Congenital Anomalies as defined in the Definitions section.)
- Jaw surgery – Treatment for malocclusion of the jaw, anterior and internal dislocations, derangements and myofascial pain syndrome, orthodontics or related appliances, or improving the placement of dentures and dental implants. (This does not include services for Congenital Anomalies as defined in the Definitions section.)
- Learning disorders.
- Maintenance supplies and equipment not unique to medical care.
- Massage or massage therapy, even as part of a Physical Therapy program.

- Paraphilias.
- Personal items such as telephones, televisions, and guest meals during a stay at a Hospital or other inpatient facility.
- Physical or eye examinations required for administrative purposes such as participation in athletics, admission to school, or by an employer.
- Private nursing service.
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition, except for diabetic education benefit.
- Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present.
- Recreation therapy – outpatient.
- Rehabilitation – Functional capacity evaluations, work hardening programs, vocational rehabilitation, community reintegration services, and driving evaluations and driving training programs, except as Medically Necessary.
- Replacement costs for worn or damaged Durable Medical Equipment that would otherwise be replaceable without charges under warranty or other agreement.
- Scheduled and/or non-emergent care outside of the United States.
- Screening tests – Services and supplies, including imaging and screening exams performed for the sole purpose of screening and not associated with specific diagnoses and/or signs and symptoms of disease or of abnormalities on prior testing (including, but not limited to, total body CT imaging, CT colonography, and bone density testing). This does not include preventive care screenings listed in the Preventive Care Services section.
- Self-help health or instruction or training programs.
- Sensory integration training.
- Services for which no charge is normally made in the absence of insurance.
- Services or supplies covered under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law.
- Services or supplies not listed as a Covered Service, unless required under federal or state law.
- Services or supplies with no charge, or for which your Employer or the Plan Sponsor has paid, or for which the Member is not legally required to pay, or for which a Provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This exclusion includes any service provided by the Member, or any licensed professional that is directly related to the Member by blood or marriage.
- Services required by state law as a condition of maintaining a valid driver license or commercial driver license.

Necessity, possible Experimental, Investigational, or Unproven services, appropriate setting, and appropriate treatment are forwarded to the PacificSource Medical Director for review and Benefit Determination based on the criteria established by the Plan Sponsor, where applicable.

Commented [SS20]: Updated 6.1.2023 via Plan Amendment for new National Network.

If you would like information on how PacificSource reached a particular utilization review Benefit Determination, please contact the PacificSource Health Services team by phone at 888-691-8209, or by email at healthservices@pacificsource.com.

PRIOR AUTHORIZATION

Coverage of certain services requires a Benefit Determination by PacificSource, on behalf of the Plan Sponsor, before the services are performed. This process is called prior authorization. PacificSource will utilize the criteria adopted by the Plan Sponsor and, where necessary, will coordinate review with the Plan Sponsor, to render a determination based on the Plan.

Prior authorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements.

Your Provider can request prior authorization from the PacificSource Health Services team. If your Provider will not request prior authorization for you, you may contact PacificSource yourself. In some cases, they may ask for more information or require a second opinion before authorizing coverage.

Because of the changing nature of care, PacificSource, on behalf of the Plan Sponsor, continually reviews new technologies and standards. Therefore, procedures and services requiring prior authorization is subject to change. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business). The prior authorization search tool is not intended to suggest that all items listed are covered by the benefits in this Plan.

When services are received from an In-network Provider, the Provider is responsible for contacting PacificSource to obtain prior authorization.

If your treatment does not receive prior authorization, you can still seek treatment, but if the review determines the expenses were either not covered by this Plan or were not Medically Necessary, you will be held responsible for the expense. Remember, any time you are unsure if an expense will be covered, contact the PacificSource Customer Service team.

Notification of the Benefit Determination will be communicated by letter, fax, or electronic transmission to the Hospital, the Provider, and you. If time is a factor, notification will be made by telephone and followed up in writing. For more information regarding the timelines for review of Pre-service Claims and Post-service Claims, see Claim Handling Procedures in the Claims Payment section.

In a medical emergency, services and supplies necessary to determine the nature and extent of an Emergency Medical Condition and to Stabilize the Member are covered without prior authorization requirements. A Hospital or other healthcare facility must notify PacificSource of an emergency admission within two business days.

PacificSource reserves the right to contract with~~employ~~ a third party to perform prior authorization procedures on its behalf and such third parties may impose independently developed, evidence-based criteria for making prior authorization determinations. If you have questions about any third party criteria, please contact the PacificSource Customer Service team.

Commented [SS21]: Updated 6.1.2023 via Plan Amendment for new National Network.

Nothing in this Plan is designed to restrict Members from contracting to obtain any healthcare services outside the Plan on any terms Members choose.

IN-NETWORK PROVIDERS

In-network Providers contract with PacificSource to provide services and supplies for an Allowable Fee. In-network Providers bill PacificSource directly, and are paid directly by this Plan. When you receive Covered Services or supplies from an In-network Provider, you are only responsible for any applicable Deductibles, Copayments, and/or Coinsurance amounts. To ensure the highest level of benefits, access care from an In-network Provider including specialists and Hospitals.

PacificSource contracts directly and/or indirectly with In-network Providers throughout our networks' Service Area. They also have agreements with nationwide Provider networks. These Providers outside Idaho, Montana, Oregon, and Washington ~~our Service Area~~ are also considered In-network Providers under your Plan.

Commented [SS22]: Updated 6.1.2023 via Plan Amendment for new National Network.

It is not safe to assume that when you are treated at an in-network facility that all services are performed by In-network Providers. Whenever possible, you should arrange for professional services, such as surgery and anesthesiology, to be provided by an In-network Provider. Doing so may help you maximize your benefits and limit your out-of-pocket expenses.

Risk-sharing Arrangements

By agreement, an In-network Provider may not bill you for any amount in excess of the Allowable Fee. However, the agreement does not prohibit the Provider from collecting Deductibles, Copayments, Coinsurance, and amounts for non-Covered Services.

FINDING AN IN-NETWORK PROVIDER

You can find up-to-date In-network Provider information:

- On the PacificSource website, PacificSource.com, go to Find a Doctor to easily look up In-network Providers, specialists, behavioral health Providers, and Hospitals. You can also print your own customized directory.
- Contact the PacificSource Customer Service team. They can answer your questions about specific Providers.

OUT-OF-NETWORK PROVIDERS

When you receive services or supplies from an Out-of-network Provider, your out-of-pocket expense is likely to be higher than if you had used an In-network Provider. If the same services or supplies are available from an In-network Provider, you may be responsible for more than the applicable Deductibles, Copayments, and/or Coinsurance amounts.

Allowable Fee for Out-of-network Providers

PacificSource, as your Third Party Administrator, bases payment to Out-of-network Providers on the Allowable Fee, which may be derived from several sources, depending on the service or supply and the Service Area where it is provided. To calculate the payment to Out-of-network Providers, PacificSource determines the Allowable Fee, then subtracts the Out-of-network Provider benefits.

additional costs to Out-of-network Providers and facilities directly.

Generally, ~~T~~this Plan ~~generally~~ must:

- Cover Emergency Services without requiring you to get approval for services in advance (also known as 'prior authorization');
- Cover Emergency Services by Out-of-network Providers;
- Base what you owe the Provider or facility (cost-sharing) on what it would pay an In-network Provider or facility and show that amount in your explanation of benefits; and
- Count any amount you pay for Emergency Services or out-of-network services toward your in-network Deductible and out-of-pocket limit.

If you ~~believe~~ think you've been wrongly billed, contact Idaho Department of Insurance at ~~you may file a Complaint with the Idaho Department of Insurance at~~ doi.idaho.gov/nosurprises or by calling the Consumer Affairs section at 208-334-4250 or 800-721-3272.

Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.

Example of Provider Payment

The following provides an example of how a payment could be made for In-network or Out-of-network Providers. This is only an example; this Plan's benefits may be different.

PacificSource will pay 80 percent of the Allowable Fee for In-network Providers and 60 percent of the Allowable Fee for Out-of-network Providers. The benefits would appear as follows:

In-network Provider	Out-of-network Provider
Payment: After Deductible, Member pays 20% of the Allowable Fee.	Payment: After Deductible, Member pays 40% of the Allowable Fee and the balance of billed charges unless the service qualifies for Balance Billing protection (see Your Rights and Protections Against Surprise Medical Bills and Balance Billing No Surprises Act).

In this example, the Provider's charge for a service is $5,000 and the Allowable Fee for an In-network Provider is $4,000. This example assumes that a Member has met the Deductible during the Benefit Year, but has not yet met the out-of-pocket limit for the Benefit Year:

In-network Provider:

This Plan would pay 80 percent of the Allowable Fee and the Member would pay 20 percent of the Allowable Fee, as follows:

Amount the In-Network Provider must discount (Allowable Fee):	$1,000
Amount this Plan pays (80% of the $4,000 Allowable Fee):	$3,200
Amount the Member pays (20% of the $4,000 Allowable Fee):	**$800**
Total:	$5,000

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TERMINATION OF PROVIDER CONTRACTS

PacificSource, on behalf of the Plan Sponsor, will attempt to notify you within 30 days of learning about the termination of a Provider contractual relationship if you have received services in the previous six months from such a Provider when:

- A Provider terminates a contractual relationship with PacificSource in accordance with the terms and conditions of the agreement;
- A Provider terminates a contractual relationship with an organization under contract with PacificSource; or
- PacificSource terminates a contractual relationship with an individual Provider or the organization with which the Provider is contracted in accordance with the terms and conditions of the agreement.

You may be entitled to continue care with an individual Provider, whose contract was terminated without cause, for a limited period of time at the in-network cost share. Continuation of care will not be available if you are no longer covered under this Plan, the Provider will not accept the Allowable Fee, the Provider no longer holds an active license, or the Provider is otherwise unavailable to continue the care. Contact the PacificSource Customer Service team for additional information.

If you do not qualify for continuation of care, the Provider becomes an Out-of-network Provider on the date the contract with PacificSource terminates. Any services you receive from them will be paid at the percentage shown in the out-of-network column of the Benefit Summaries. To avoid unexpected costs, be sure to verify each time you see your Provider that they are still in-network.

CLAIMS PAYMENT

How to File a Claim

When an In-network Provider treats you, your claims are automatically sent to PacificSource and processed. All you need to do is show your PacificSource Member ID card to the Provider.

If you receive care from an Out-of-network Provider, the Provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to them for processing. Your claim must include a copy of your Provider's itemized bill, including the Provider name and address, the Provider tax identification number and National Provider Identifier (NPI), procedure codes, and diagnosis codes. It must also include your name, PacificSource Member ID number, group name, group number, and the Member's name. If you were treated for an Accidental Injury, please include the date, time, place, and circumstances of the Accident.

All claims for benefits should be turned in to PacificSource within 90 days of the date of service. If you are unable to submit a claim within 90 days, present the claim with an explanation for consideration for coverage. This Plan will never pay a claim that was submitted more than a year after the date of service.

Claims Payment Practices

Unless additional information is needed to process your claim, PacificSource, on behalf of the Plan Sponsor, will make every effort to pay or deny your claim within 30 days of receipt. If a claim cannot

Benefits Paid in Error

If the Plan makes a payment to you that you are not entitled to, or pays a person who is not eligible for payment, it may recover the payment. It may also deduct the amount paid in error from your future benefits.

In the same manner, if the Plan applies expenses to the Deductible that would not otherwise be reimbursable under the terms of this Plan, it may deduct a like amount from the accumulated Deductible amounts and/or recover payment of expenses that would have otherwise been applied to the Deductible.

Legal Procedures

You may not take legal action against the Plan Sponsor or PacificSource to enforce any provision of this Plan until 60 days after your claim is submitted. Also, you must exhaust this Plan's claims procedures before filing benefits litigation. No such action shall be brought against the Plan Sponsor or PacificSource after the expiration of any applicable statutes of limitations.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a Member has healthcare 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 in accordance with its plan 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 percent of the total allowable expense.

Definitions

For the purpose of this section only, the following definitions apply:

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 Members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- Plan includes: group and non-group health insurance contracts ~~and Subscriber contracts~~, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

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- Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; Accident only coverage; specified disease or specified Accident coverage; limited benefit health coverage, as defined by state law; school Accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage described above 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.

services through a panel of Providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial Parent. 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.

Order of Benefit Determination Rules

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

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

Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with this regulation 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 shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

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.

Each plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent. The plan that covers the Member 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 Member as a Dependent is the secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Member as a Dependent; and primary to the plan covering the Member as other than a Dependent (for example, a retired Employee; then the order of benefits between the two plans is reversed so that the plan covering the Member as an Employee, Member, policyholder, Subscriber, or retiree is the secondary plan and the other plan is the primary plan.

Dependent Children. 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. The following is known as the birthday rule:

- 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.
- For a Dependent Child whose parents are divorced, separated, or not living together, whether or

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 plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the 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 do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other healthcare coverage.

If a Member is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. PacificSource, on behalf of the Plan Sponsor, 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 Member claiming benefits. The Plan Sponsor and PacificSource need not tell, or get the consent of, any Member to do this. Each Member claiming benefits under this Plan must give the Plan Sponsor and PacificSource any facts needed to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

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

Coordination with Medicare

- *Employers with 20 or more Employees:* If you are Medicare entitled due to age, this Plan is usually the primary payer and Medicare is secondary. This rule applies to you and your Dependents only if you are an active Employee.
- *Employers with 19 or fewer Employees:* If you are Medicare entitled due to age, and are enrolled in Medicare Parts A and B, this Plan only pays the portion of covered charges that would not be

Illness giving rise to the Plan Sponsor's right of reimbursement or subrogation, until that right is satisfied or released.

- If any of these conditions are not met, then PacificSource, on behalf of the Plan Sponsor, may recover any such benefits paid or advanced for any Illness or Injury through legal action, as well as reasonable attorney fees incurred by the Plan Sponsor.
- Unless Federal Law is found to apply.
- The Plan Sponsor's right to reimbursement overrides the made whole doctrine and this Plan disclaims the application of the made whole doctrine to the extent permitted by law.

Subrogation

Upon payment under this Plan, PacificSource, on behalf of the Plan Sponsor, shall be subrogated to all of the Member's rights of recovery therefore, and the Member shall do whatever is necessary to secure such rights and do nothing to prejudice them.

Under this subsection, PacificSource, on behalf of the Plan Sponsor, may pursue the third party in its own name, or in the name of the Member. PacificSource, on behalf of the Plan Sponsor, is entitled to all subrogation rights and remedies under the common and statutory law, as well as under this Plan.

Right of Recovery

In addition to its subrogation rights, the Plan Sponsor may, at its sole discretion and option, ask that the Member, and their attorney, if any, protect the Plan Sponsor's reimbursement rights. If the Plan Sponsor elects to proceed under this subsection, the following rules apply:

- The Member holds any right of recovery against the other party in trust for the Plan Sponsor, but only for the amount of benefits this Plan pays for that Illness or Injury.
- The Plan Sponsor is entitled to receive the amount of benefits it has paid for that Illness or Injury out of any settlement or judgment which results from exercising the right of recovery against the other party. This is regardless of whether the third party admits liability or asserts that the Member is also at fault. In addition, the Plan Sponsor is entitled to receive the amount of benefits it has paid whether the expenses are itemized or expressly excluded in the third party recovery.
- The Plan Sponsor holds the option to subtract from the money to be paid back to the Plan Sponsor a proportionate share representing the Member's reasonable attorney fees for collecting amounts paid by the Plan to a third party.
- In addition, and as an alternative, if requested by the Plan Sponsor, the Member will take such action as may be necessary or appropriate to recover such benefits furnished as damages from the responsible third party. Such action will be taken in the name of the Member. If requested by the Plan Sponsor, such action will be prosecuted by a representative designated by the Plan Sponsor who does not have a conflict of interest with the Member. In the event of a recovery, the Plan Sponsor will be reimbursed out of such recovery for the Member's share of the expenses, costs, and attorney fees incurred by the Plan Sponsor in connection with the recovery.

Right of Recovery – Time Limit for Reimbursements

PacificSource regularly engages in activities to identify and recover claims payments which should not have been paid or applied to Deductible amounts (for example, claims which are duplicate claims,

GRIEVANCE PROCEDURES

If you or your Authorized Representative are dissatisfied with the availability, delivery, or the quality of healthcare services; or claims payment, handling, or reimbursement for healthcare services; you may file a Grievance in writing. Grievances are not Adverse Benefit Determinations and do not establish a right to internal or External Review for a resolution to a Grievance.

PacificSource, on behalf of the Plan Sponsor, will attempt to address your Grievance, generally within 30 days of receipt. For more information, see the How to Submit Grievances or Appeals section.

APPEAL PROCEDURES

First Internal Appeal: If you believe this Plan has improperly reduced or terminated a healthcare item or service, or failed or refused to provide or make a payment in whole or in part for a healthcare item or service that is based on any of the reasons listed below, you or your Authorized Representative may Appeal the decision. The request for Appeal must be made in writing and within 180 days of your receipt of the Adverse Benefit Determination. For more information, see the How to Submit Grievances or Appeals section. You may Appeal if there is an Adverse Benefit Determination based on a:

- Denial of eligibility for or termination of enrollment in a plan;
- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a healthcare item or service is Experimental, Investigational, or Unproven, not Medically Necessary, effective, or appropriate; or
- Determination that a course or plan or treatment you are undergoing is an active course of treatment for the purpose of continuity of care.

Any staff involved in the initial Adverse Benefit Determination will not be involved in the Internal Appeal.

You or your Authorized Representative may submit additional comments, documents, records, and other materials relating to the Adverse Benefit Determination that is the subject of the Appeal. If an Authorized Representative is filing on your behalf, PacificSource will not consider your Appeal to be filed until such time as they have received the Authorization to Use or Disclose PHI and the Designation of Authorized Representative forms.

If you request review of an Adverse Benefit Determination, this Plan will continue to provide coverage for the disputed benefit, pending outcome of the review, if you are currently receiving services or supplies under the disputed benefit. If this Plan prevails in the Appeal, you may be responsible for the cost of coverage received during the review period. The decision at the External Review level is binding unless other remedies are available under state or federal law.

Second Internal Appeal: If you are not satisfied with the first Internal Appeal decision, you may request an additional review. Your Appeal and any additional information not presented with your first Internal Appeal must be forwarded to PacificSource within 60 days of the first Appeal response.

Request for Expedited Response: If there is a clinical urgency to do so, you or your Authorized Representative may request in writing or orally, an expedited response to an internal or External Review of an Adverse Benefit Determination. To qualify for an expedited response, your attending

days of the date you filed your Appeal. The Plan may also agree to waive the exhaustion requirement for an External Review request. You may file for an internal urgent Appeal with us and for an expedited External Review with the Idaho Department of Insurance at the same time if your request qualifies as an urgent care request defined below.

You may submit a written request for an External Review to:

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

For more information and for an External Review request form:

Call 208-334-4250 or 800-721-3272

Website doi.idaho.gov

You may represent yourself in your request or you may name another person, including your treating Provider, to act as your Authorized Representative for your request. If you want someone else to represent you, you must include a signed Designation of Authorized Representative form with your request.

Your written External Review request to the Department of Insurance must include a completed form authorizing the release of any of your records the independent review organization may require to reach a decision on the External Review, including any judicial review of the External Review decision pursuant to ERISA, if applicable. The department will not act on an External Review request without your completed authorization form. If your request qualifies for External Review, the final Adverse Benefit Determination will be reviewed by an independent review organization selected by the department. The Plan will pay the costs of the review.

Standard External Review Request: You must file your written External Review request with the department within six months after the date we issue a final notice of denial.

- Within seven days after the department receives your request, the department will send a copy to us.
- Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may Appeal that determination to the department.
- If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
- Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
- The independent review organization must provide written notice of its decision to you, to us, and to the department within 42 days after receipt of an External Review request.

Expedited External Review Request: You may file a written urgent care request with the

Service team with your concerns. Issues can often be resolved at this level. Otherwise, you may file a Grievance or Appeal by contacting:

PacificSource Health Plans
Attn: Grievance and Appeals
PO Box 7068
Springfield, OR 97475-0068

Email cs@pacificsource.com, with Grievance or Appeal as the subject

Fax 541-225-3628

Assistance Outside PacificSource

You have the right to file a Complaint or seek other assistance from the Idaho Department of Insurance. Assistance is available by contacting:

Idaho Department of Insurance
Consumer Affairs
700 W State St, 3rd Floor
PO Box 83720
Boise, ID 83720-0043

Call 208-334-4250 or 800-721-3272

Website doi.idaho.gov

BECOMING COVERED

Who Pays for Your Benefits

The Plan Sponsor shares the cost of providing benefits for Eligible Employees and their Dependents. From time to time, the Plan Sponsor may adjust the amount of contributions required for coverage. In addition, the Deductibles, Copayments, and/or Coinsurance may also change periodically. You will be notified by your Plan Sponsor of any changes in the cost of this Plan's coverage before they take effect.

ELIGIBILITY

Employees

Your status as an Employee is determined by the employment records maintained by the Plan Sponsor. Workers classified by the Plan Sponsor as independent contractors are not eligible for coverage under this Plan under any circumstances. You become eligible to enroll in coverage on this Plan when you have met the Plan Sponsor's eligibility requirements, which may include a Waiting Period or require you to work a certain minimum number of hours.

Dependents

This Plan does not cover Domestic Partners. Disregard any reference to Domestic Partner.

While you are covered under this Plan, the following Dependents are also eligible for coverage:

- Placement of an adopted or foster child. Placement means physical placement in the care of the adoptive Member, or in those circumstances in which such physical placement is prevented due to medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive Member signs an agreement assuming financial responsibility for such child.

Coverage for newly eligible Dependents due to the following events will begin on the first day of the month after the event:

- Marriage;
- Guardianship; or
- Qualified medical child support order (QMCSO).

This Plan complies with a QMCSO issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including approval of a settlement agreement, which provides for benefit coverage for the child of a Member.

Open Enrollment Periods

If Eligible Employees and/or eligible Dependents are not enrolled during the Initial Enrollment Period, they must wait until the next open enrollment period to enroll unless they qualify for a special enrollment period as described below.

Special Enrollment Periods

You and/or your Dependents may decline coverage during your Initial Enrollment Period. To find out if this Plan allows Employees to decline coverage, ask the Plan Sponsor. If you wish to do so, you must submit a waiver of coverage to the Plan Sponsor.

You and/or your Dependents may enroll in this Plan later if you qualify under the Special Enrollment Rules below. To do so, you must submit an enrollment change within 60 days of the qualifying event. For more information, see the Enrolling New Dependents section.

All special enrollment provisions assume that the Employee has satisfied any Waiting Periods required and each individual is eligible as stated in the Plan.

- Special Enrollment Rule #1

  If you declined enrollment for yourself or your Dependents because of other coverage, you or your Dependents may enroll in the Plan later if the other coverage ends involuntarily. Coverage will begin on the day after the other coverage ends.

- Special Enrollment Rule #2

  If you acquire new Dependents due to a qualifying event, you may be able to enroll yourself and/or your eligible Dependents at that time.

- Special Enrollment Rule #3

  If you or your Dependents become eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance Program (CHIP), you may be able to enroll yourself and/or your Dependents at that time. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Plan option becomes effective on this Plan's anniversary date or date required for a qualifying event.

You may also choose another plan option upon eligibility for Medicare. You may select a different Plan option, if available, by submitting an enrollment change. Coverage under the new Plan option becomes effective on the date you become eligible for Medicare.

WHEN COVERAGE ENDS

If you leave your job for any reason or your work hours are reduced below the Plan Sponsor's minimum requirement, coverage for Members will end. Coverage ends on the last day of the month in which you worked the required minimum hours for coverage. You may be eligible to continue coverage for a limited time. For more information, see the Continuation of Coverage section.

Dependent Children

When your enrolled child no longer qualifies as a Dependent, their coverage will end on the last day of that month.

Divorced Spouses

If you divorce, coverage for your Spouse will end on the last day of the month in which the divorce decree or legal separation is final. You must notify the Plan Sponsor of the divorce or separation, and continuation coverage may be available for your Spouse. If there are special child custody circumstances, please contact the Plan Sponsor.

CONTINUATION OF COVERAGE

The following sections describe your rights to continuation under federal law, and the requirements you must meet to enroll in continuation coverage.

USERRA CONTINUATION

If you take a Leave of Absence from your job due to military service, you have continuation rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA).

Members may continue this Plan's coverage if you, the Employee, no longer qualify for coverage under the Plan because of military service. Continuation coverage under USERRA is available for up to 24 months while you are on military leave. If your military service ends and you do not return to work, your eligibility for USERRA continuation coverage will end. Premium for continuation coverage is your responsibility.

The following requirements apply to USERRA continuation:

- Only Dependents who were enrolled in the Plan can take continuation. The only exceptions are newborn babies and newly acquired eligible Dependents not covered by another group health plan.
- To apply for continuation, you must submit a completed Continuation Election form to the Plan Sponsor within 60 days after the last day of coverage under the Plan.
- You must pay continuation premium to the Plan Sponsor by the first of each month. PacificSource cannot accept the premium directly from you.

- The Plan Sponsor discontinues this Plan and no longer offers a group health plan to any of its Employees;
- Member who qualified for a disability extension is determined by the Social Security Administration to no longer be disabled;
- Member is terminated for cause (for example, submission of fraudulent claims).

Type of Coverage

Under COBRA, you may continue any coverage you had before the qualifying event. If the Plan Sponsor provides both medical and dental coverage and you were enrolled in both, you may continue both medical and dental. If the Plan Sponsor provides only one type of coverage, or if you were enrolled in only one type of coverage, you may continue only that coverage.

COBRA continuation benefits are always the same as the Plan Sponsor's current benefits. The Plan Sponsor has the right to change the benefits of this Plan or eliminate this Plan entirely. If that happens, any changes to this Plan will also apply to everyone enrolled in continuation coverage.

Your Responsibilities and Deadlines

You must notify the Plan Sponsor within 60 days if you divorce or if your child no longer qualifies as a Dependent. That will allow the Plan Sponsor to notify you or your Dependents of your continuation rights.

When the Plan Sponsor learns of your eligibility for continuation, the Plan Sponsor will notify you of your continuation rights and provide a Continuation Election form. You then have 60 days from that date or 60 days from the date coverage would otherwise end, whichever is later, to enroll in continuation coverage by submitting a completed Continuation Election form to the Plan Sponsor. If continuation coverage is not elected during that 60 day period, coverage will end on the last day of the last month you were an active Employee, or when your Dependent lost eligibility.

If you fail to provide the Plan Sponsor with the Continuation Election form in the required timeframe, then the Plan Sponsor's obligation to provide you with COBRA coverage will end. PacificSource does not accept any liability for any failure, on your part or the part of the Plan Sponsor, to provide required notices for coverage.

Continuation Premium

Members are responsible for the full cost of continuation coverage. The Plan Sponsor uses the services of a third-party COBRA administrator to collect premium for continuation coverage. Please see the Plan Sponsor for more information about the Plan's COBRA administrator. The monthly premium must be paid to the Plan Sponsor's COBRA administrator. You may make your first premium payment any time within 45 days after you return your Continuation Election form to the Plan Sponsor's COBRA administrator. After the first premium payment, each monthly payment must reach the Plan Sponsor's COBRA administrator within 30 days of your premium due date. If the COBRA administrator does not receive your continuation premium on time, continuation coverage will end. If your coverage is canceled due to a missed payment, it will not be reinstated for any reason. It is solely your responsibility to ensure that the COBRA administrator receives the premium on time. Premium rates are established annually and may be adjusted if the Plan's benefits or costs change.

- You have a right to the confidential protection of your records and personal information.
- You have a right to voice Complaints about this Plan, PacificSource, or the care you receive, and to Appeal decisions you believe are wrong.
- You have a right to participate with your Provider in decision-making regarding your care.
- You have a right to know why any tests, procedures, or treatments are performed and any risks involved.
- You have a right to refuse treatment and be informed of any possible medical consequences.
- You have a right to refuse to sign any consent form you do not fully understand, or cross out any part you do not want applied to your care.
- You have a right to change your mind about treatment you previously agreed to.

Your Responsibilities as a Member

- You are responsible for reading this Plan Document and all other communications from the Plan Sponsor and PacificSource, and for understanding this Plan's benefits. You are responsible for contacting the Plan Sponsor or PacificSource's Customer Service team if anything is unclear to you.
- You are responsible for making sure your Provider obtains prior authorization for any services that require it before you are treated.
- You are responsible for providing the Plan Sponsor and PacificSource with all the information required to provide benefits under this Plan.
- You are responsible for giving your Provider complete information to help accurately diagnose and treat you.
- You are responsible for telling your Providers you are covered by this Plan and showing your PacificSource Member ID card when you receive care.
- You are responsible for being on time for appointments, and contacting your Provider ahead of time if you need to cancel.
- You are responsible for any fees the Provider charges for late cancellations or no shows.
- You are responsible for contacting the Plan Sponsor or PacificSource if you believe you are not receiving adequate care.
- You are responsible for supplying information to the extent possible that the Plan Sponsor or PacificSource needs in order to administer your benefits or your Providers need in order to provide care.
- You are responsible for following plans and instructions for care that you have agreed to with your Providers.
- You are responsible for understanding your health problems and participating in developing mutually agreed upon goals, to the degree possible.

Name and Address of Third Party Administrator:

PacificSource Health Plans
P.O. Box 7068
Springfield, OR 97475-0068
Phone: (888) 977-9299
Fax: (541) 684-5264

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

Bonner County
Attn: Alissa Clark~~Cindy Binkerd~~
1500 Hwy 2, Suite 337
Sandpoint, ID 83864
Phone: 208-~~265~~255-~~1456~~3630 ext. 1237
Fax: 208-265-1457

Third Party Payments

PacificSource, on behalf of the Plan Sponsor, will accept third party payments of contributions and cost sharing as if the Member made the payment from the following:

- Family and friends;
- A Ryan White HIV/AIDS program;
- An Indian tribe, tribal organization, or urban Indian organization;
- Government programs, including grantees directed by a government program to make payments on its behalf; and
- Religious institutions and other not-for-profit organizations when each of the following criteria is met:
  - The assistance is provided on the basis of the Member's financial need;
  - The institution/organization is not a Provider; and
  - The institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of insurance claims.

If payment is from a financially interested third party, the payment will be excluded from the accumulation towards the Deductible and out-of-pocket limit.

Upon rejecting or otherwise refusing to treat a third party payment as a payment from the Member, carriers must inform the Member in writing of the reason for doing so and of the Member's right to file a Complaint.

given service or supply through direct or indirect contract.

- **Out-of-network Allowable Fee** is the dollar amount established for reimbursement of charges for specific services or supplies provided by Out-of-network Providers. PacificSource, on behalf of the Plan Sponsor, uses several sources to determine the Out-of-network Allowable Fee. Depending on the service or supply and the Service Area in which it is provided, the Out-of-network Allowable Fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), contracted vendors, other nationally recognized databases, or PacificSource, as documented in PacificSource's payment policy and adopted by the Plan Sponsor.

  An Out-of-network Provider may charge more than the limits established by the Out-of-network Allowable Fee. Charges that are eligible for reimbursement, but exceed the Out-of-network Allowable Fee, are the Member's responsibility. For more information, see the Out-of-network Providers section.

Ambulatory Surgical Center means a facility licensed by the appropriate state or federal agency to perform Surgical Procedures on an outpatient basis.

Appeal means a written or verbal request from a Member or, if authorized by the Member, the Member's Authorized Representative, to change a previous decision made under this Plan concerning:

- Access to healthcare benefits, including an Adverse Benefit Determination made pursuant to utilization management;
- Claims payment, handling, or reimbursement for healthcare services;
- Rescission of the Member's benefit coverage by the Plan Sponsor; and
- Other matters as specifically required by law.

Approved Clinical Trials are Phase I, II, III, or IV clinical trials for the prevention, detection, or treatment of cancer or another life threatening condition or disease. Life threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The trial must be:

- Funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs;
- Supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs;
- Conducted as an investigational new drug application, an investigational device exemption or a biologics license application subject to approval by the FDA; or
- Exempt by federal law from the requirement to submit an investigational new drug application to the FDA.

Authorized Representative is an individual who by law or by the consent of a Member may act on behalf of the Member. An Authorized Representative *must* have the Member complete and execute

disease. The term significant deviation is defined to be a deviation which impairs the function of the body and includes, but not limited to, the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism, and other conditions that are medically diagnosed to be Congenital Anomalies.

Copayment (also referred to as Copay) is a fixed, up-front dollar amount the Member is required to pay for certain Covered Services.

Covered Service means a service or supply for which benefits are payable under this Plan subject to applicable Deductibles, Copayments, Coinsurance, out-of-pocket limit, or other specific limitations.

Custodial Care means care that is for the purpose of watching and protecting a Member. Custodial Care includes care that helps the Member conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily for the purpose of separating the Member from others or preventing self-harm.

Deductible means the portion of the expense for a Covered Service that must be paid by the Member before the benefits of this Plan are applied. A Plan may include more than one Deductible.

Dependent means the Employee's legal Spouse, and Dependent Children who qualify for coverage under the Employee's Plan. For more information, see the Eligibility section.

Dependent Children means the following:

- Biological children;
- Step children;
- Adopted children; a child will be considered a Dependent upon assumption of a legal obligation for total or partial support in anticipation of adoption; and
- Foster children or children for whom you or your Spouse are under a current court order to act as legal custodian or guardian.

Drug List (also known as a formulary) is a list of covered medications used to treat various medical conditions. Please refer to PacificSource.com/find-a-drug to determine which Drug List applies to your coverage. The Drug Lists are developed and maintained by a committee of regional Providers, including doctors, who are not employed by the Plan Sponsor or PacificSource.

Durable Medical Equipment means equipment that can withstand repeated use; is primarily and customarily used to serve a medical purpose rather than convenience or comfort; is generally not useful to a Member in the absence of an Illness or Injury; is appropriate for use in the home; and is prescribed by a Provider. Examples include, but not limited to, Hospital beds, wheelchairs, crutches, canes, walkers, nebulizers, commodes, suction machines, traction equipment, respirators, and TENS units.

Durable Medical Equipment Supplier means a PacificSource In-network Provider or a Provider that satisfies the criteria in the Medicare Quality Standards for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and other items and services.

Elective Abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

Eligible Employee means an Employee or former Employee who is eligible for coverage under this

- Mental health and Substance Use Disorder services, including behavioral health treatment;
- Pediatric services, including oral and vision care;
- Prescription Drugs;
- Preventive and wellness services and chronic disease management; and
- Rehabilitation and Habilitation Services and Devices.

Experimental, Investigational, or Unproven means services, supplies, protocols, procedures, devices, Chemotherapy, drugs or medicines, or the use thereof, that are Experimental, Investigational, or Unproven for the diagnosis and treatment of Illness or Injury.

- Experimental, Investigational, or Unproven services and supplies include, but not limited to, services, supplies, procedures, devices, Chemotherapy, drugs or medicines, or the use thereof, which at the time they are rendered and for the purpose and in the manner they are being used:
  - Have not yet received full U.S. government agency required approval (for example, FDA) for other than Experimental, Investigational, or Unproven, or clinical testing;
  - Are not of generally accepted medical practice in this Plan's state of issue or as determined by medical advisors, medical associations, and/or technology resources;
  - Are not approved for reimbursement by the Centers for Medicare and Medicaid Services;
  - Are furnished in connection with medical or other research; or
  - Are considered by any governmental agency or subdivision to be Experimental, Investigational, or Unproven, not considered reasonable and necessary, or any similar finding.
- When making decisions about whether treatments are Experimental, Investigational, or Unproven, the Plan Sponsor relies on the above resources as well as:
  - Expert opinions of specialists and other medical authorities;
  - Published articles in peer-reviewed medical literature;
  - External agencies whose role is the evaluation of new technologies and drugs; and
  - External Review by an independent review organization.
- The following will be considered in making the determination whether the service is in an Experimental, Investigational, or Unproven status:
  - Whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes;
  - Whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;
  - Whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects; and

- Physical therapy; and
- Speech therapy.

Hospice Care means care designed to give supportive care to a Member in the final phase of a terminal Illness and focuses on comfort and quality of life, rather than curing a disease. A Member's Provider must certify that the Member is terminally ill with a life expectancy of less than six months, and the Member must not be undergoing treatment of the terminal Illness other than for direct control of adverse symptoms.

Hospital means it is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the Hospital on a prearranged basis and under the supervision of a staff of Providers, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured person's on an inpatient basis for which a charge is made; and provide 24 hour nursing service by or under the supervision of registered nurses.

Illness means a sickness, disease, ailment, bodily disorder, and pregnancy.

In-network Provider means a Provider that directly or indirectly holds a Provider contract or agreement with PacificSource.

Infertility means:

- Male: Low sperm counts or the inability to fertilize an egg; or
- Female: The inability to conceive or carry a pregnancy to 12 weeks.

Initial Enrollment Period means a period of days set by the Plan Sponsor that determines when an Employee is first eligible to enroll.

Injury means bodily trauma or damage that is independent of disease or infirmity. The damage must be caused through external and Accidental means.

Inquiry means a written request for information or clarification about any subject matter related to this Plan.

Internal Appeal means a review of an Adverse Benefit Determination.

Involuntary Complications of Pregnancy include, but are not limited to:

- Cesarean section delivery, ectopic pregnancy that is terminated, spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia, and toxemia; and
- Conditions requiring inpatient confinement (when the pregnancy is not terminated), the diagnoses of which are distinct from pregnancy, but are adversely affected or caused by pregnancy. Examples include: acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. It does not include false labor, occasional spotting, Provider prescribed bed rest during pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy, but which are not distinct from the pregnancy itself.

Leave of Absence is a period of time off work granted to an Employee by the Plan Sponsor at the Employee's request and during which the Employee is still considered to be employed and is carried

Commission or the Commission on Accreditation of Rehabilitation Facilities for the level of care which the facility provides.

Mental Health and/or Substance Use Disorder Healthcare Program means a particular type or level of service that is organizationally distinct within a Mental Health and/or Substance Use Disorder Healthcare Facility.

Mental Health and/or Substance Use Disorder Healthcare Provider means a person that has met the applicable credentialing requirements, is otherwise eligible to receive reimbursement under this Plan and is:

- A Mental Health and/or Substance Use Disorder Healthcare Facility;
- A residential Mental Health and/or Substance Use Disorder Healthcare Program or Facility;
- A day or partial hospitalization program;
- An outpatient service; or
- An individual behavioral health or medical professional duly licensed and authorized for reimbursement under state law.

Mental Health Condition means all disorders defined in the current edition of Diagnostic and Statistical Manual of Mental Disorders, except for neurodevelopmental disorders including:

- Intellectual Developmental Disorder, Global Developmental Delay, and Unspecified Intellectual Disability;
- Learning Disorders related to difficulties in learning and using academic skills which include impairment in reading, written expression, and mathematics;
- Paraphilias which include criminal offenses and are generally treated in correctional settings; and
- Mental health treatments for conditions defined in the current edition of Diagnostic and Statistical Manual of Mental Disorders, that are not attributable to a mental health disorder or disease, except the treatment of children five years of age or younger for parent-child relational problems, physical abuse of a child, sexual abuse, neglect of a child, or bereavement.

Orthotic Devices means rigid or semi rigid devices supporting a weak or deformed leg, foot, arm, hand, back, or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back, or neck. It includes orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. Orthotic Devices are usually customized for an individual's use and are not appropriate for anyone else. Examples of Orthotic Devices include, but not limited to, Ankle Foot Orthosis (AFO), Knee Ankle Foot Orthosis (KAFO), Lumbosacral Orthosis (LSO), and foot orthotics.

Out-of-network Provider means a Provider that does not directly or indirectly hold a Provider contract or agreement with PacificSource.

Physical/Occupational Therapy is comprised of the services provided by (or under the direction and supervision of) a licensed physical or occupational therapist. Physical/Occupational Therapy includes emphasis on examination, evaluation, and intervention to alleviate impairment and functional limitation and to prevent further impairment or disability.

- Items or services provided by a clinical trial sponsor free of charge to a Member participating in the clinical trial; or
- Items or services that are not covered by this Plan if provided outside of the clinical trial.

Service Area is Oregon, Idaho, Montana, and Washington.

Skilled Nursing Facility or Convalescent Home means an institution that provides skilled nursing care under the supervision of a Provider, provides 24 hour nursing service by or under the supervision of a registered nurse (RN), and maintains a daily record of each patient. Skilled Nursing Facilities must be licensed by an appropriate state agency and approved for payment of Medicare benefits to be eligible for reimbursement.

Specialized Treatment Facility means a facility that provides specialized short-term or long-term care. The term Specialized Treatment Facility includes Ambulatory Surgical Centers, birthing centers, hospice facilities, inpatient rehabilitation facilities, Mental Health and/or Substance Use Disorder Healthcare Facilities, organ transplant facilities, psychiatric day treatment facilities, residential treatment facilities, Skilled Nursing Facilities, Substance Use Disorder day treatment facilities, Substance Use Disorder Treatment Facilities, and Urgent Care Treatment Facilities.

Specialty Drugs are high dollar oral, injectable, infused, or inhaled biotech medications prescribed for the treatment of chronic and/or genetic disorders with complex care issues that have to be managed. The major conditions these drugs treat include, but not limited to: cancer, HIV/AIDS, hemophilia, hepatitis C, multiple sclerosis, Crohn's disease, rheumatoid arthritis, and growth hormone deficiency.

Specialty Pharmacies specialize in the distribution of Specialty Drugs and providing pharmacy care management services designed to assist Members in effectively managing their condition.

Spouse means any individual who is legally married under current state law.

Stabilize means to provide medical treatment as necessary to ensure that, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during or to result from the transfer of the Member from a facility; and with respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

Step Therapy means a program that requires the Member to try lower-cost alternative medications (Step 1 drugs) before using more expensive medications (Step 2 or 3 drugs). The program will not cover a brand name, or second-line medication, until less expensive, first-line/generic medications have been tried first.

Subscriber means an Employee or former Employee covered under this Plan. When a family that does not include an Employee or former Employee is covered under this Plan, the oldest Dependent is referred to as the Subscriber.

Substance Use Disorder means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the Member's social, psychological, or physical adjustment to common problems on a recurring basis. Substance Use Disorder does not include addiction to, or dependency on, tobacco products or foods.

Substance Use Disorder Treatment Facility means a treatment facility that provides a program for the treatment of Substance Use Disorders pursuant to a written treatment plan approved and monitored by a Provider or addiction counselor licensed by the state; is licensed or approved as a

Women's Healthcare Provider means an obstetrician, gynecologist, physician assistant, naturopathic physician, nurse practitioner specializing in women's health, physician, or other Provider practicing within the scope of their license.

Women's Healthcare Services means organized services to provide healthcare to women, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The services include, but not limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. Women's Healthcare Services also include any appropriate healthcare service for other health problems, discovered and treated during the course of a visit to a Women's Healthcare Provider for a Women's Healthcare Service, which is within the Provider's scope of practice. For purposes of determining a woman's right to directly access health services covered by this Plan, maternity care, reproductive health, and preventive services include: Contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breastfeeding, and complications of pregnancy.

Bonner County

Group No.: G0039089
Plan Name: Medical HSA
Effective: October 1, 2023

With Third Party Administrative Services Provided By:

PacificSource
HEALTH PLANS

Retention of Fiduciary Duties

The Plan Sponsor has retained all fiduciary duties under the Plan, including all interpretations of the Plan and the benefits and exclusions it contains. This means that the Plan Sponsor is solely responsible for all final decisions regarding what benefits are or will be covered, both now and in the future. The Plan Sponsor is solely responsible for the design of this Plan. Plan Sponsor is solely responsible for setting any and all criteria used to determine enrollment and eligibility.

Governing Law

This Plan must comply with both state and federal law, including required changes occurring after the Plan's effective date. Therefore, coverage is subject to change as required by law.

Additional Information

Representations not warranties: In the absence of fraud, all statements made by the Plan Sponsor will be considered representations and not warranties. No statement made for the purpose of effecting coverage will void the coverage or reduce benefits unless it is contained in a written document signed by the Plan Sponsor and provided to a Member.

Questions?

PacificSource's Customer Service team is available to answer questions or concerns regarding the Plan. Phone lines are open from 8 a.m. to 5 p.m. Monday through Friday (excluding holidays). PacificSource's Customer Service team is not authorized to interpret or change the terms of the Plan.

For enrollment or eligibility questions, please contact the Plan Sponsor.

PacificSource Customer Service
Phone 888-246-1370
Email cs@pacificsource.com

Para asistencia en español, por favor llame al número 866-281-1464.

PacificSource Headquarters
555 International Way, Springfield, OR 97477
PO Box 7068, Springfield, OR 97475-0068
Phone 541-686-1242 or 800-624-6052

PacificSource Regional Office
408 E. Parkcenter Blvd., Suite 100, Boise, ID 83706
Phone 208-342-3709 or 888-492-2875

PacificSource Website
PacificSource.com

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive physicals	No Deductible, 0%	No Deductible, 40%
Well woman visits	No Deductible, 0%	No Deductible, 40%
Preventive mammograms	No Deductible, 0%	No Deductible, 40%
Immunizations	No Deductible, 0%	No Deductible, 40%
Preventive colonoscopy	No Deductible, 0%	No Deductible, 40%
Prostate cancer screening	No Deductible, 0%	No Deductible, 40%
Professional Services		
Office and home visits	After Deductible, 20%	After Deductible, 40%
Naturopath office visits	After Deductible, 20%	After Deductible, 40%
Specialist office and home visits	After Deductible, 20%	After Deductible, 40%
Telehealth visits	After Deductible, 20%	After Deductible, 40%
Office procedures and supplies	After Deductible, 20%	After Deductible, 40%
Surgery	After Deductible, 20%	After Deductible, 40%
Outpatient Habilitation Services (combined 30 visits per Benefit Year for Physical, Occupational, and Speech Therapy)	After Deductible, 20%	After Deductible, 40%
Outpatient Rehabilitation Services (combined 30 visits per Benefit Year for Physical, Occupational, and Speech Therapy)	After Deductible, 20%	After Deductible, 40%
Chiropractic manipulation/Spinal manipulation (20 visits per Benefit Year)	After Deductible, 20%	After Deductible, 20%
Acupuncture (20 visits per Benefit Year)	After Deductible, 20%	After Deductible, 20%
Hospital Services		
Inpatient room and board	After Deductible, 20%	After Deductible, 40%
Inpatient Habilitation Services	After Deductible, 20%	After Deductible, 40%
Inpatient Rehabilitation Services	After Deductible, 20%	After Deductible, 40%
Skilled nursing facility care (60 days per Benefit Year)	After Deductible, 20%	After Deductible, 40%
Outpatient Services		
Outpatient surgery/services	After Deductible, 20%	After Deductible, 40%
Outpatient at Ambulatory Surgical Center	After Deductible, 10%	After Deductible, 40%
Diagnostic imaging – advanced	After Deductible, 20%	After Deductible, 40%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	After Deductible, 20%	After Deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	After Deductible, 20%	After Deductible, 40%

Payments to Providers

Payment to Providers is based on the prevailing or Allowable Fee for Covered Services. In-network Providers accept the Allowable Fee as payment in full. Services of Out-of-network Providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior Authorization

Coverage of certain medical services and Surgical Procedures requires a Benefit Determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and Out-of-network Providers. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business)

Discrimination is against the law

Both the Plan Sponsor and PacificSource Health Plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan Sponsor and PacificSource do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive physicals	No Deductible, 0%	No Deductible, 40%
Well woman visits	No Deductible, 0%	No Deductible, 40%
Preventive mammograms	No Deductible, 0%	No Deductible, 40%
Immunizations	No Deductible, 0%	No Deductible, 40%
Preventive colonoscopy	No Deductible, 0%	No Deductible, 40%
Prostate cancer screening	No Deductible, 0%	No Deductible, 40%
Professional Services		
Office and home visits	After Deductible, 20%	After Deductible, 40%
Naturopath office visits	After Deductible, 20%	After Deductible, 40%
Specialist office and home visits	After Deductible, 20%	After Deductible, 40%
Telehealth visits	After Deductible, 20%	After Deductible, 40%
Office procedures and supplies	After Deductible, 20%	After Deductible, 40%
Surgery	After Deductible, 20%	After Deductible, 40%
Outpatient Habilitation Services (combined 30 visits per Benefit Year for Physical, Occupational, and Speech Therapy)	After Deductible, 20%	After Deductible, 40%
Outpatient Rehabilitation Services (combined 30 visits per Benefit Year for Physical, Occupational, and Speech Therapy)	After Deductible, 20%	After Deductible, 40%
Chiropractic manipulation/Spinal manipulation (20 visits per Benefit Year)	After Deductible, 20%	After Deductible, 20%
Acupuncture (20 visits per Benefit Year)	After Deductible, 20%	After Deductible, 20%
Hospital Services		
Inpatient room and board	After Deductible, 20%	After Deductible, 40%
Inpatient Habilitation Services	After Deductible, 20%	After Deductible, 40%
Inpatient Rehabilitation Services	After Deductible, 20%	After Deductible, 40%
Skilled nursing facility care (60 days per Benefit Year)	After Deductible, 20%	After Deductible, 40%
Outpatient Services		
Outpatient surgery/services	After Deductible, 20%	After Deductible, 40%
Outpatient at Ambulatory Surgical Center	After Deductible, 10%	After Deductible, 40%
Diagnostic imaging – advanced	After Deductible, 20%	After Deductible, 40%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	After Deductible, 20%	After Deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	After Deductible, 20%	After Deductible, 40%

Payments to Providers

Payment to Providers is based on the prevailing or Allowable Fee for Covered Services. In-network Providers accept the Allowable Fee as payment in full. Services of Out-of-network Providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior Authorization

Coverage of certain medical services and Surgical Procedures requires a Benefit Determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and Out-of-network Providers. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business)

Discrimination is against the law

Both the Plan Sponsor and PacificSource Health Plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan Sponsor and PacificSource do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Service/Supply	Incentive Drugs:	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
Specialty Drugs – Out-of-network Specialty Pharmacy				
Up to a 30 day maximum fill, no more than three fills allowed per Benefit Year:		After Deductible, $200		

**Compounded medications are subject to a prior authorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medications are on the applicable formulary.

MAC A - Regardless of the reason or Medical Necessity, if you receive a brand name drug or if your Provider prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's Copayment and/or Coinsurance plus the difference in cost between the brand name and Generic Drug after the medical Deductible is met. The cost difference between the brand name and Generic Drug does not apply toward the medical Deductible or out of pocket limit.

If your Provider prescribes a brand name contraceptive due to Medical Necessity it may be subject to prior authorization for coverage at no charge.

See the Plan Document for important information about your Prescription Drug benefit, including which drugs are covered, limitations, and more.

OUT-OF-POCKET LIMIT

This Plan has an out-of-pocket limit provision. The Benefit Summaries show this Plan's annual out-of-pocket limits. If you incur Covered Services over those amounts, this Plan will pay 100 percent of the Allowable Fee for the remainder of the Benefit Year.

The allowed amounts Members pay for Covered Services will accrue toward the annual out-of-pocket limit except for the following, which will continue to be your responsibility:

- Coinsurance for out-of-network chiropractic manipulations/spinal manipulations and acupuncture treatments.
- Charges for non-Covered Services.
- Incurred charges that exceed amounts allowed under this Plan.
- Charges for the difference in cost between brand name medication and generic equivalent as explained in the Prescription Drugs section.

ESSENTIAL HEALTH BENEFITS

Except for pediatric dental which is not included in this Plan, this Plan covers the Essential Health Benefits as defined by the Secretary of the U.S. Department of Health and Human Services. Annual and Lifetime Maximum dollar limits will not be applied for any service that is an Essential Health Benefit.

UNDERSTANDING MEDICAL NECESSITY

In order for a service or supply to be covered, it must be both a Covered Service *and* Medically Necessary.

Be careful – just because a treatment is prescribed or recommended by a Provider does not mean it is Medically Necessary under the terms of this Plan. This Plan provides coverage only when such care is necessary to treat an Illness or Injury or the service qualifies as preventive care. All treatment is subject to review for Medical Necessity. Review of treatment may involve prior authorization, concurrent review of the continuation of treatment, post-treatment review, or any combination of these. A second opinion (at no cost to you when requested by PacificSource or the Plan Sponsor) may be required for a Medical Necessity determination.

Some Medically Necessary services are not Covered Services. Medically Necessary services and supplies that are specifically excluded from coverage under this Plan can be found in the Benefit Exclusions section.

If you ever have a question about your benefits, contact the PacificSource Customer Service team.

UNDERSTANDING EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN SERVICES

This Plan does not cover services or treatments that are Experimental, Investigational, or Unproven.

To ensure you receive the highest quality care at the lowest possible cost, PacificSource, on behalf of the Plan Sponsor, reviews new and emerging technologies and medications on a regular basis. PacificSource's internal committees make decisions about coverage of these methods and

Colorectal Cancer Screening

This Plan covers colorectal cancer screening as required under ACA. Screening coverage includes a follow up colonoscopy performed after a positive non-invasive stool based screening or direct visualization. For colorectal cancer screenings not required to be covered as preventive under ACA, see the Diagnostic and Therapeutic Radiology/Laboratory and Dialysis – (non-advanced) section.

Immunizations

This Plan covers age-appropriate childhood and adult immunizations for primary prevention of infectious diseases as recommended and adopted by the USPSTF, CDC, or similar standard-setting body. This benefit does not include immunizations that are determined to be elective or Experimental, Investigational, or Unproven.

Preventive Physicals

This Plan covers appropriate screening radiology and laboratory tests and other screening procedures. Screening exams and laboratory tests may include, but not limited to, depression screening for all adults including pregnant and postpartum women, blood pressure checks, weight checks, occult blood tests, urinalysis, complete blood count, prostate exams, cholesterol exams, stool guaiac screening, EKG screens, blood sugar tests, and tuberculosis skin tests. Only laboratory tests and other routine screening procedures related to the preventive physical are covered by this benefit. Diagnostic radiology and laboratory services outside the scope of the preventive physical will be subject to the standard cost sharing.

- Benefits are limited as follows: Age 22 and older once per Benefit Year.

Prostate Cancer Screening

This Plan covers appropriate screening that includes, but not limited to, a digital rectal exam and a prostate-specific antigen test.

Tobacco Cessation Program Services

This Plan covers Tobacco Cessation Program services.

Well Baby/Well Child Care

This Plan covers well baby/well child examinations. Only laboratory tests and other routine screening procedures related to the well baby/well child exam are covered by this benefit. Diagnostic radiology and laboratory services outside the scope of the preventive physical will be subject to the standard cost sharing.

- Benefits are limited as follows:
  - At birth: One standard in-Hospital exam
  - Ages 0-2: 12 additional exams during the first 36 months of life
  - Ages 3-21: One exam per Benefit Year

appropriate for the Member, or the Member provides medical or scientific information establishing that the trial would be appropriate. If an In-network Provider is participating in an Approved Clinical Trial, the Member may be required to participate in the trial through that In-network Provider if the Provider will accept the Member as a participant.

Cosmetic or Reconstructive Surgery

This Plan provides cosmetic or reconstructive services in the following situations:

- When necessary to correct a functional disorder or Congenital Anomaly;
- When necessary because of an Accidental Injury or Illness, or to correct a scar or defect that resulted from treatment of an Accidental Injury or Illness; or
- When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery.

Some cosmetic or reconstructive surgeries require prior authorization. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Cosmetic or reconstructive surgery must take place within 18 months after the Injury, surgery, scar, or defect first occurred unless the area needing treatment is a result of a Congenital Anomaly.

Dietary or Nutritional Counseling

This Plan covers services for diabetic education, management of inborn errors of metabolism, and management of anorexia nervosa or bulimia nervosa if provided by a qualified Provider or as required under ACA for obesity. Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults, and comprehensive, intensive behavioral interventions to promote improvement in weight status for children are also covered.

Foot Care

This Plan covers routine foot care for Members with diabetes mellitus.

Genetic Counseling

This Plan covers services of a board-certified or board-eligible genetic counselor for evaluation of genetic disease.

Inborn Errors of Metabolism

This Plan covers treatment for inborn errors of metabolism involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes expenses for diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including, but not limited to, clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Telehealth

This Plan covers Medically Necessary Telehealth services when provided by a Provider.

Traumatic Brain Injury

This Plan covers Medically Necessary therapy and services for the treatment of traumatic brain Injury.

AMBULANCE SERVICES

This Plan covers services of a state certified ground or air ambulance to the nearest facility capable of treating the condition, when other forms of transportation will endanger your health. There is no coverage for services that are for personal or convenience purposes. Air ambulance service is only covered when ground transportation is medically or physically inappropriate. Non-emergency ground or air ambulance between facilities requires prior authorization.

BLOOD TRANSFUSIONS

This Plan covers blood, blood products, and blood storage, including services and supplies of a blood bank.

BREAST PROSTHESES

This Plan covers removal, repair, and/or replacement of breast prostheses due to a contracture or rupture, but only when the original prosthesis was for a Medically Necessary Mastectomy. Prior authorization by PacificSource is required, and eligibility for benefits is subject to the following criteria:

- The contracture or rupture must be clinically evident by a Provider's physical examination, imaging studies, or findings at surgery;
- Removal, repair, and/or replacement of the prosthesis is not covered when recommended due to an autoimmune disease, connective tissue disease, arthritis, allergenic syndrome, psychiatric syndrome, fatigue, or other systemic signs or symptoms.

COCHLEAR IMPLANTS

This Plan covers single or bilateral cochlear implants when Medically Necessary, including programming and reprogramming.

CONTRACEPTIVES AND CONTRACEPTIVE DEVICES/FAMILY PLANNING

This Plan covers IUD, diaphragm, and cervical cap contraceptives and contraceptive devices along with their insertion or removal, as well as hormonal contraceptives including injections, formulary oral, patches, and rings prescribed by your Provider. Contraceptive drugs, devices, and other products approved by the Food and Drug Administration (FDA) and on the formulary are covered by this Plan when prescribed.

Over-the-counter contraceptive drugs approved by the FDA, purchased without a prescription, are reimbursable by this Plan.

In accordance with federal and state laws, there is an initial period where this Plan will be primary to Medicare. Once that period of time has elapsed the Plan will pay up to the amount it would have paid in the secondary position.

DIAGNOSTIC IMAGING – ADVANCED

This Plan covers Medically Necessary advanced diagnostic imaging for the diagnosis of Illness or Injury. For the purposes of this benefit, advanced diagnostic imaging includes CT scans, MRIs, PET scans, CATH labs, and nuclear cardiology studies. Some diagnostic imaging requires prior authorization. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business).

DURABLE MEDICAL EQUIPMENT

This Plan covers services and applicable sales tax for Durable Medical Equipment. Durable Medical Equipment must be prescribed.

This Plan covers Prosthetic Devices and Orthotic Devices to restore or maintain the ability to complete activities of daily living or essential job-related activities and are not for comfort or convenience. Repair or replacement of a Prosthetic Device and Orthotic Device is covered when needed due to normal use. This Plan covers maxillofacial prostheses to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing.

- Benefits are limited as follows:
  - Some Durable Medical Equipment requires a prior authorization. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business). Benefits will be paid toward either the purchase or the rental of the equipment for the period needed, whichever is less. Repair or replacement of equipment is also covered when necessary, subject to all conditions and limitations of this Plan.
  - Only expenses for Durable Medical Equipment, or Prosthetic and Orthotic Devices that are provided by a PacificSource contracted Provider or a Provider that satisfies the criteria of the Medicare fee schedule for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services are eligible for reimbursement.
  - Medically Necessary treatment for sleep apnea and other sleeping disorders (including snoring) is covered. Prior authorization is required. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a Provider specializing in evaluation and treatment of sleep disorders.
  - Hearing Aids: Hearing Aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, for Dependent Children with a Congenital Anomaly or acquired hearing loss which may result in cognitive or speech development deficits without intervention. The Durable Medical Equipment benefit covers one device per hearing impaired ear every 36 months and up to 45 speech therapy visits during the 12 months after delivery of the covered device.
  - Wheelchairs: Purchase, rental, repair, lease, or replacement of a power-assisted wheelchair (including batteries and other accessories) requires prior authorization and is payable only in lieu of benefits for a manual wheelchair.

Emergency Medical Screening Exams and Emergency Services, including any diagnostic tests necessary for emergency care (including radiology, laboratory work, CT scans and MRIs) are subject to the Deductibles, Copayment, and/or Coinsurance stated in your Medical Benefit Summary for either Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced or Diagnostic imaging - advanced, depending on the specific service provided.

If you need immediate assistance for a medical emergency, call 911, or go to the nearest emergency room or appropriate facility.

HEALTH EDUCATION BENEFITS

This Plan covers health education benefits. Health education topics usually include matters such as maternity, fitness and education, newborn care and parenting skills, nutrition and healthy heart exercises or CPR skills. Covered services include health-related classes and printed materials required for the class.

- Benefits are limited as follows: Up to $150 per Benefit Year.

After you have completed the class, please provide PacificSource with proof of payment and a completed Reimbursement Request Form for PacificSource to review for benefit payment consideration based on the Plan Sponsor's criteria. You may obtain the Reimbursement Request Form from the Plan Sponsor, or PacificSource's Customer Service team.

HOME HEALTHCARE SERVICES

This Plan covers Home Healthcare services, including home infusion services that cannot be self-administered, when provided by a licensed home health agency.

- Benefits are limited as follows: Up to 130 visits per Benefit Year. Private duty nursing is not covered.

HOSPICE CARE SERVICES

This Plan covers Hospice Care services intended to meet the physical, emotional, and spiritual needs of the Member and family during the final stages of Illness and dying, while maintaining the Member in the home setting. Services are to supplement the efforts of an unpaid caregiver and include pastoral care and bereavement services.

This Plan covers respite care provided in a nursing facility to provide relief for the primary caregiver.

- Benefits are limited as follows:
  - Hospice Care: This Plan does not cover services of a primary caregiver such as a relative, friend, or private duty nurse. Care is provided for a terminally ill Member subject to review for Medical Necessity.
  - Respite care: Care is subject to a maximum of five consecutive days and to a Lifetime Maximum benefit of 30 days. The Member must be enrolled in a hospice program to be eligible for respite care benefits.

This Plan covers routine nursery care of a newborn child born to a Member while the mother is hospitalized and eligible for pregnancy-related benefits under this Plan if the newborn is also eligible and enrolled in this Plan.

Please contact the PacificSource Customer Service team as soon as you learn of your pregnancy. Their team will explain this Plan's maternity benefits and help you enroll in a prenatal care program.

- Benefits are limited as follows: Unless the services are Medically Necessary due to a complication, this Plan does not cover any maternity services for Dependent Children.

OUTPATIENT SERVICES

Applied Behavioral Analysis (ABA) for Autism, Asperger's or Pervasive Development Disorder

This Plan covers ABA according to PacificSource's guidelines for Medical Necessity. Prior authorization and a treatment plan are required.

Mental Health and Substance Use Disorder Services – Outpatient

This Plan complies with all federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008. Treatment of Substance Use Disorder and related disorders is subject to placement criteria established by the American Society of Addiction Medicine, Third Edition.

This Plan covers crisis intervention, diagnosis, and treatment of Mental Health Conditions and Substance Use Disorders including chemical dependency detoxification by a Mental Health and/or Substance Use Disorder Healthcare Provider or Mental Health and/or Substance Use Disorder Healthcare Program, except as otherwise excluded in this Plan.

Outpatient Habilitation

This Plan covers Physical/Occupational Therapy, and speech therapy services to help a person keep, learn, or improve skills and functioning for daily living. These services must be part of a written treatment program that includes site, modality, duration, and frequency of treatment.

- Benefits are limited as follows: Up to a combined maximum of 30 visits per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual/supplemental benefits are met.

Outpatient Rehabilitation

This Plan covers outpatient Rehabilitation Services to help a person keep, restore, or improve skills and function for daily living that have been lost or impaired due to Illness, Injury, or disability and do not include maintenance services. Services must be part of a written treatment program that includes site, modality, duration, and frequency of treatment.

- Benefits are limited as follows: Up to a combined maximum of 30 visits per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual/supplemental benefits are met.

Services for speech therapy are only covered to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or Injury. Speech and/or cognitive therapy for acute Illnesses and Injuries are covered with reasonable expectation that the services will

Mail Order Pharmacy

This Plan includes mail order service for Prescription Drugs. Questions about mail order may be directed to the PacificSource Customer Service team. More information is available on the website, PacificSource.com/members/prescription-drug-information/resources.

Specialty Drugs

Specialty Drugs are designated with SP on the Drug List available on the PacificSource website. Specialty Drugs often require special handling, storage, and instructions. PacificSource contracts with Specialty Pharmacies for these high-cost medications (oral and injectable). A pharmacist-led care team provides individual follow-up care and support to covered Members with prescriptions for Specialty Drugs by providing them strong clinical support, as well as the best overall value for these specific medications. The care team also provides comprehensive disease education and counseling, assesses Member health status, and offers a supportive environment for Member inquiries.

Fills of Specialty Drugs are limited to a 30 day supply and must be filled through the PacificSource exclusive network Specialty Pharmacies. Specialty Drugs are not available through the in-network retail pharmacy network, mail order service, or non-exclusive Specialty Pharmacies without prior authorization. For more information, including prior authorization requirements, see the website PacificSource.com/members/prescription-drug-information/resources.

No Duplication of Services

Medications and supplies covered under your prescription benefit are in place of, not in addition to, those same covered supplies under the medical portion of this Plan.

Diabetic Supplies

Refer to your Drug List, available on the PacificSource website, to see which diabetic supplies are covered under your prescription benefit. Some diabetic supplies, such as glucose monitoring devices, may only be covered under your medical benefit. Diabetic testing supplies are subject to Plan quantity limits. For more information, see the Diabetic Equipment, Supplies, and Training section.

Contraceptives

Contraceptives approved by the FDA are covered as recommended by the USPSTF, HRSA, and CDC. Any Deductibles, Copayments, and/or Coinsurance amounts are waived if a generic is filled. When no generic exists, brand name contraceptives may be covered at no cost. If your Provider prescribes a non-formulary contraceptive due to Medical Necessity, it may be subject to prior authorization for coverage at no charge.

Anticancer Medications

Orally administered and self-administered anticancer medications used to kill or slow the growth of cancerous cells are available when prescribed. All orally administered cancer medications will be covered on the same basis and at no greater cost sharing than imposed for IV or injected cancer medication. See the Prescription Drug Benefit Summary for cost sharing information.

Formulary Changes

Any removal of a medication from your Drug List will be posted on the PacificSource website 60 days prior to the effective date of the change, unless the change is done on an emergency basis or an

and the days' supply entered by the pharmacy. Early refills will generally not be approved, except under the following circumstances:

- The request is for ophthalmic solutions or gels, refillable after 70 percent of the previous supply has been taken.
- The Member will be on vacation in a location that does not allow for reasonable access to a network pharmacy for subsequent refills.

All early refills are subject to standard cost share and are reviewed on a case-by-case basis.

Formulary Exception and Coverage Determination Process

Requests for formulary exceptions can be made by the Member or Provider by contacting the PacificSource Pharmacy Services team. Determinations on standard exception requests will be made no later than 72 hours, expedited requests are determined within 24 hours following receipt of the request. Formulary exceptions and coverage determinations must be based on Medical Necessity, and information must be submitted to support the Medical Necessity including all of the following:

- Documented intolerance or failure to the formulary alternatives for the submitted diagnosis;
- Formulary drugs were tried with an adequate dose and duration of therapy;
- Formulary drugs were not tolerated or were not effective;
- Formulary or preferred drugs would reasonably be expected to cause harm or not produce equivalent results as the requested drug;
- The requested drug therapy is evidence-based and generally accepted medical practice; and
- Special circumstances and individual needs, including the availability of service Providers in the Member's region.

For the complete Formulary Exception Criteria, please refer to the PacificSource website.

TEMPOROMANDIBULAR JOINT SERVICES

This Plan covers treatment of temporomandibular joint syndrome (TMJ) for medical reasons only. All TMJ-related services, including but not limited to, diagnostic and Surgical Procedures, must be provided by Providers practicing within the scope of their licenses and, if necessary, prior authorized. Services are only covered when Medically Necessary due to a history of advanced pathologic process (arthritic degeneration) or in the case of severe acute trauma.

- Benefits are limited as follows: Up to $1,000 per Benefit Year up to a Lifetime Maximum benefit of $5,000.

TRANSPLANT SERVICES

This Plan covers the following Medically Necessary organ and tissue transplants including supplies, treatment and facility fees for both donors and recipients: bone marrow, peripheral blood stem cell and high-dose Chemotherapy; corneal transplants; heart; heart – lungs; intestine; kidney; kidney – pancreas; liver; lungs; and pancreas whole organ transplantation. Expenses for the acquisition of organs or tissues for transplantation are only covered when the transplantation itself is covered under

WOMEN'S HEALTH AND CANCER RIGHTS

Breast Reconstruction

This Plan covers breast reconstruction in connection with a Medically Necessary Mastectomy, as required by the Women's Health and Cancer Rights Act of 1998. Coverage is provided in a manner determined in consultation with the attending Provider and for:

- All stages of reconstruction of the breast on which the Mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the Mastectomy, including lymphedema.

Benefits for breast reconstruction are subject to all terms and provisions of this Plan, including Deductibles, Copayments, and/or Coinsurance.

Post-Mastectomy Care

This Plan covers post-Mastectomy care for a period of time as determined by the attending Provider and, in consultation with the Member, determined to be Medically Necessary following a Mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

BENEFIT EXCLUSIONS

This Plan does not cover the following:

- Abdominoplasty for any indication.
- Academic skills training.
- Acute care, rehabilitative, diagnostic testing, except as specified as a Covered Service in this Plan.
- Biofeedback (other than as specifically noted under the Covered Services section).
- Charges for missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims unless otherwise contracted.
- Charges that are the responsibility of a third party who may have caused the Illness or Injury, or other insurers covering the incident (such as workers' compensation insurers and automobile insurers, and general liability insurers).
- Chelation therapy including associated infusions of vitamins and/or minerals, except as Medically Necessary for the treatment of selected medical conditions and medically significant heavy metal toxicities.
- Computer or electronic equipment for monitoring asthmatic, similar medical conditions, or related data.
- Cosmetic/reconstructive services and supplies - Services and supplies, including drugs, rendered primarily for cosmetic/reconstructive purposes and any complications as a result of non-covered

- Foot care (routine) – Services and supplies for corns and calluses of the feet, conditions of the toenails other than infection, hypertrophy, or hyperplasia of the skin of the feet, and other routine foot care, except in the case of Members being treated for diabetes mellitus.
- Gender affirmation – Procedures, services, or supplies related to gender affirmation.
- Hearing Aids including the fitting, provision, or replacement of Hearing Aids, except as specified as a Covered Service in the Durable Medical Equipment section.
- Homeopathic medicines or homeopathic supplies.
- Hypnotherapy except in the treatment of Mental Health Conditions.
- Immunizations when recommended for, or in anticipation of, exposure through travel or work.
- Infertility – This Plan does not cover Infertility diagnostic or treatment services.
- Inpatient or outpatient Custodial Care; or inpatient or outpatient services consisting mainly of educational therapy, behavioral modification, self-care or self-help training, except as specified as a Covered Service in this Plan.
- Instructional or educational programs, except diabetes self-management programs when Medically Necessary.
- Jaw – Procedures, services, and supplies for developmental or degenerative abnormalities of the head and face that can be replaced with living tissue; services and supplies that do not control or eliminate pain or infection or that do not restore functions such as speech, swallowing, or chewing; cosmetic procedures and procedures to improve on the normal range of functions; dentures; and artificial larynx. (This does not include services for Congenital Anomalies as defined in the Definitions section.)
- Jaw surgery – Treatment for malocclusion of the jaw, anterior and internal dislocations, derangements and myofascial pain syndrome, orthodontics or related appliances, or improving the placement of dentures and dental implants. (This does not include services for Congenital Anomalies as defined in the Definitions section.)
- Learning disorders.
- Maintenance supplies and equipment not unique to medical care.
- Massage or massage therapy, even as part of a Physical Therapy program.
- Mattresses and mattress pads unless Medically Necessary to heal pressure sores.
- Mental health treatments for conditions defined in the current edition of Diagnostic and Statistical Manual of Mental Disorders, that are not attributable to a Mental Health Condition or disease.
  - Mental Illness does not include – relationship problems (for example, parent-child, partner, sibling, or other relationship issues), except the treatment of children five years of age or younger for parent-child relational problems, physical abuse of a child, sexual abuse, neglect of a child, or bereavement.
  - Unless Medically Necessary, the following are excluded: court-mandated diversion and/or Substance Use Disorder education classes; court-mandated psychological evaluations for child custody determinations; voluntary mutual support groups such as Alcoholics Anonymous;

- Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present.
- Recreation therapy – outpatient.
- Rehabilitation – Functional capacity evaluations, work hardening programs, vocational rehabilitation, community reintegration services, and driving evaluations and driving training programs, except as Medically Necessary.
- Replacement costs for worn or damaged Durable Medical Equipment that would otherwise be replaceable without charges under warranty or other agreement.
- Scheduled and/or non-emergent care outside of the United States.
- Screening tests – Services and supplies, including imaging and screening exams performed for the sole purpose of screening and not associated with specific diagnoses and/or signs and symptoms of disease or of abnormalities on prior testing (including, but not limited to, total body CT imaging, CT colonography, and bone density testing). This does not include preventive care screenings listed in the Preventive Care Services section.
- Self-help health or instruction or training programs.
- Sensory integration training.
- Services for which no charge is normally made in the absence of insurance.
- Services or supplies covered under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law.
- Services or supplies not listed as a Covered Service, unless required under federal or state law.
- Services or supplies with no charge, or for which your Employer or the Plan Sponsor has paid, or for which the Member is not legally required to pay, or for which a Provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This exclusion includes any service provided by the Member, or any licensed professional that is directly related to the Member by blood or marriage.
- Services required by state law as a condition of maintaining a valid driver license or commercial driver license.
- Services, supplies, and equipment not involved in diagnosis or treatment but provided primarily for the comfort, convenience, alteration of the physical environment, or education of a Member. This includes appliances like adjustable power beds sold as furniture, air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows.
- Sexual disorders – Services or supplies for the treatment of sexual dysfunction or inadequacy. For related provisions, see Infertility and mental health in this section.
- Social skills training.
- Support groups.

Prior authorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements.

Your Provider can request prior authorization from the PacificSource Health Services team. If your Provider will not request prior authorization for you, you may contact PacificSource yourself. In some cases, they may ask for more information or require a second opinion before authorizing coverage.

Because of the changing nature of care, PacificSource, on behalf of the Plan Sponsor, continually reviews new technologies and standards. Therefore, procedures and services requiring prior authorization is subject to change. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business). The prior authorization search tool is not intended to suggest that all items listed are covered by the benefits in this Plan.

When services are received from an In-network Provider, the Provider is responsible for contacting PacificSource to obtain prior authorization.

If your treatment does not receive prior authorization, you can still seek treatment, but if the review determines the expenses were either not covered by this Plan or were not Medically Necessary, you will be held responsible for the expense. Remember, any time you are unsure if an expense will be covered, contact the PacificSource Customer Service team.

Notification of the Benefit Determination will be communicated by letter, fax, or electronic transmission to the Hospital, the Provider, and you. If time is a factor, notification will be made by telephone and followed up in writing. For more information regarding the timelines for review of Pre-service Claims and Post-service Claims, see Claim Handling Procedures in the Claims Payment section.

In a medical emergency, services and supplies necessary to determine the nature and extent of an Emergency Medical Condition and to Stabilize the Member are covered without prior authorization requirements. A Hospital or other healthcare facility must notify PacificSource of an emergency admission within two business days.

PacificSource reserves the right to contract with a third party to perform prior authorization procedures on its behalf and such third parties may impose independently developed, evidence-based criteria for making prior authorization determinations. If you have questions about any third party criteria, please contact the PacificSource Customer Service team.

If your Provider's prior authorization request is denied as not Medically Necessary or as Experimental, Investigational, or Unproven, your Provider may Appeal the Benefit Determination. You retain the right to Appeal the Benefit Determination independent from your Provider.

CASE MANAGEMENT

Case management is a service provided by Registered Nurses who are Certified Case Managers and Licensed Behavioral Health Clinicians with specialized skills to respond to the complexity of a Member's healthcare needs. Case management services may be initiated by PacificSource when there is a high utilization of health services or multiple Providers, or for health problems such as, but not limited to, transplantation, high risk obstetric or neonatal care, spinal cord Injury, trauma or traumatic Injury, or any acute or chronic condition that may necessitate specialized treatment or care coordination.

It is not safe to assume that when you are treated at an in-network facility that all services are performed by In-network Providers. Whenever possible, you should arrange for professional services, such as surgery and anesthesiology, to be provided by an In-network Provider. Doing so may help you maximize your benefits and limit your out-of-pocket expenses.

Risk-sharing Arrangements

By agreement, an In-network Provider may not bill you for any amount in excess of the Allowable Fee. However, the agreement does not prohibit the Provider from collecting Deductibles, Copayments, Coinsurance, and amounts for non-Covered Services.

FINDING AN IN-NETWORK PROVIDER

You can find up-to-date In-network Provider information:

- On the PacificSource website, PacificSource.com, go to Find a Doctor to easily look up In-network Providers, specialists, behavioral health Providers, and Hospitals. You can also print your own customized directory.
- Contact the PacificSource Customer Service team. They can answer your questions about specific Providers.

OUT-OF-NETWORK PROVIDERS

When you receive services or supplies from an Out-of-network Provider, your out-of-pocket expense is likely to be higher than if you had used an In-network Provider. If the same services or supplies are available from an In-network Provider, you may be responsible for more than the applicable Deductibles, Copayments, and/or Coinsurance amounts.

Allowable Fee for Out-of-network Providers

PacificSource, as your Third Party Administrator, bases payment to Out-of-network Providers on the Allowable Fee, which may be derived from several sources, depending on the service or supply and the Service Area where it is provided. To calculate the payment to Out-of-network Providers, PacificSource determines the Allowable Fee, then subtracts the Out-of-network Provider benefits.

Your Rights and Protections Against Surprise Medical Bills and Balance Billing No Surprises Act

When you get emergency care or get treated by an Out-of-network Provider at an in-network Hospital or Ambulatory Surgical Center, you are protected from surprise Balance Billing. In these cases, you shouldn't be charged more than your Plan's Copayments, Coinsurance and/or Deductible.

What is Balance Billing (sometimes called 'surprise billing')?

When you see a doctor or other healthcare Provider, you may owe certain out-of-pocket costs, like a Copayment, Coinsurance, or Deductible. You may have additional costs or have to pay the entire bill if you see a Provider or visit a healthcare facility that isn't in this Plan's network.

Out-of-network means Providers and facilities that haven't signed a contract with this Plan to provide services. Out-of-network Providers may be allowed to bill you for the difference between what this Plan pays and the full amount charged for a service. This is called 'Balance Billing'. This amount is likely more than in-network costs for the same service and might not count toward this Plan's

Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.

Example of Provider Payment

The following provides an example of how a payment could be made for In-network or Out-of-network Providers. This is only an example; this Plan's benefits may be different.

PacificSource will pay 80 percent of the Allowable Fee for In-network Providers and 60 percent of the Allowable Fee for Out-of-network Providers. The benefits would appear as follows:

In-network Provider	Out-of-network Provider
Payment: After Deductible, Member pays 20% of the Allowable Fee.	Payment: After Deductible, Member pays 40% of the Allowable Fee and the balance of billed charges unless the service qualifies for Balance Billing protection (see Your Rights and Protections Against Surprise Medical Bills and Balance Billing No Surprises Act).

In this example, the Provider's charge for a service is $5,000 and the Allowable Fee for an In-network Provider is $4,000. This example assumes that a Member has met the Deductible during the Benefit Year, but has not yet met the out-of-pocket limit for the Benefit Year:

In-network Provider:

This Plan would pay 80 percent of the Allowable Fee and the Member would pay 20 percent of the Allowable Fee, as follows:

Amount the In-Network Provider must discount (Allowable Fee):	$1,000
Amount this Plan pays (80% of the $4,000 Allowable Fee):	$3,200
Amount the Member pays (20% of the $4,000 Allowable Fee):	**$800**
Total:	$5,000

Out-of-network Provider:

This Plan would pay 60 percent of the Allowable Fee. (For this example, $4,000 is also the charge upon which the Out-of-Network Provider's Allowable Fee is established.) Because the Out-of-Network Provider does not accept the Allowable Fee and may charge more, the Member would pay 40 percent of the Allowable Fee, plus the $1,000 difference between the Out-of-Network Provider's billed charges and the Allowable Fee, as follows:

Amount this Plan pays (60% of the $4,000 Allowable Fee):	$2,400
Amount the Member pays (40% of the $4,000 Allowable Fee and the $1,000 difference between the billed charges and the Allowable Fee):	**$2,600**
Total:	$5,000

This Plan's actual benefits may vary, so please review the Benefit Summaries and Covered Services section to determine how your benefits are paid. Please remember that the Allowable Fee may vary for a Covered Service depending upon the selected Provider.

the Provider no longer holds an active license, or the Provider is otherwise unavailable to continue the care. Contact the PacificSource Customer Service team for additional information.

If you do not qualify for continuation of care, the Provider becomes an Out-of-network Provider on the date the contract with PacificSource terminates. Any services you receive from them will be paid at the percentage shown in the out-of-network column of the Benefit Summaries. To avoid unexpected costs, be sure to verify each time you see your Provider that they are still in-network.

CLAIMS PAYMENT

How to File a Claim

When an In-network Provider treats you, your claims are automatically sent to PacificSource and processed. All you need to do is show your PacificSource Member ID card to the Provider.

If you receive care from an Out-of-network Provider, the Provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to them for processing. Your claim must include a copy of your Provider's itemized bill, including the Provider name and address, the Provider tax identification number and National Provider Identifier (NPI), procedure codes, and diagnosis codes. It must also include your name, PacificSource Member ID number, group name, group number, and the Member's name. If you were treated for an Accidental Injury, please include the date, time, place, and circumstances of the Accident.

All claims for benefits should be turned in to PacificSource within 90 days of the date of service. If you are unable to submit a claim within 90 days, present the claim with an explanation for consideration for coverage. This Plan will never pay a claim that was submitted more than a year after the date of service.

Claims Payment Practices

Unless additional information is needed to process your claim, PacificSource, on behalf of the Plan Sponsor, will make every effort to pay or deny your claim within 30 days of receipt. If a claim cannot be paid within 30 days of receipt because additional information is needed, PacificSource will acknowledge receipt of the claim and explain why payment is delayed.

Claim Handling Procedures

Claim Determination – PacificSource, on behalf of the Plan Sponsor, will make a claim determination within the time period noted in the chart below for the specific type of claim, unless additional information is necessary to process the claim. In that event, PacificSource will send you notice that the claim was received and explain what additional information is necessary to process the claim. If PacificSource does not receive the necessary information within the allowed time, they will deny the claim.

Type of Notice	Concurrent Care Claim	Urgent Care Claim	Pre-service Claim	Post-service Claim
Initial determination by PacificSource	24 hours	48 hours	2 business days	30 calendar days
If PacificSource requires additional information, PacificSource will make request within	24 hours	48 hours	2 business days	30 calendar days

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a Member has healthcare 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 in accordance with its plan 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 percent of the total allowable expense.

Definitions

For the purpose of this section only, the following definitions apply:

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 Members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- Plan includes: group and non-group health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

- Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; Accident only coverage; specified disease or specified Accident coverage; limited benefit health coverage, as defined by state law; school Accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage described above 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.

This plan means, in a COB provision, the part of the plan providing the healthcare 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 healthcare 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.

Order of Benefit Determination Rules. The rules that determine whether this Plan is a primary plan or secondary plan, when the Member has healthcare 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 may reduce the benefits it pays so that all plan benefits do not exceed 100 percent of the total allowable expense.

Allowable Expense. A healthcare expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any plan covering the Member. When a plan provides benefits in the

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

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.

Each plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent. The plan that covers the Member 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 Member as a Dependent is the secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Member as a Dependent; and primary to the plan covering the Member as other than a Dependent (for example, a retired Employee; then the order of benefits between the two plans is reversed so that the plan covering the Member as an Employee, Member, policyholder, Subscriber, or retiree is the secondary plan and the other plan is the primary plan.

Dependent Children. 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. The following is known as the birthday rule:

- 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.
- For a Dependent Child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
  - If a court decree states that one of the parents is responsible for the Dependent Child's healthcare expenses or healthcare coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
  - If a court decree states that both parents are responsible for the Dependent Child's healthcare expenses or healthcare coverage, the provisions above shall determine the order of benefits;
  - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the Dependent Child, the provisions above shall determine the order of benefits; or
  - If there is no court decree allocating responsibility for the Dependent Child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
    - The plan covering the custodial parent;
    - The plan covering the Spouse of the custodial parent;

Sponsor, 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 Member claiming benefits. The Plan Sponsor and PacificSource need not tell, or get the consent of, any Member to do this. Each Member claiming benefits under this Plan must give the Plan Sponsor and PacificSource any facts needed to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

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

Coordination with Medicare

- *Employers with 20 or more Employees:* If you are Medicare entitled due to age, this Plan is usually the primary payer and Medicare is secondary. This rule applies to you and your Dependents only if you are an active Employee.
- *Employers with 19 or fewer Employees:* If you are Medicare entitled due to age, and are enrolled in Medicare Parts A and B, this Plan only pays the portion of covered charges that would not be paid by Medicare Parts A and B. In other words, this Plan pays secondary for anyone eligible for and enrolled in Medicare Parts A and B.
- *Medicare disabled and end-stage renal disease (ESRD) Members*: The rules above may not apply to disabled people under 65 and ESRD Members enrolled in Medicare; see the Medicare website, Medicare.gov, for more information. For information on coordination of benefits in those situations, please contact PacificSource.

THIRD PARTY LIABILITY

If you use this Plan's benefit for an Illness or Injury you think may involve another party, you must contact PacificSource right away.

Third party liability means claims that are the responsibility of someone other than the Plan Sponsor. The liable party may be a person, firm, or corporation. Auto Accidents and slip-and-fall property Accidents are examples of common third party liability cases.

A third party includes liability and casualty insurance, and any other form of insurance that may pay money to, or on behalf of, a Member, including, but not limited to, uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, Personal Injury Protection (PIP) coverage, homeowner's insurance, and workers' compensation insurance.

Right of Recovery

In addition to its subrogation rights, the Plan Sponsor may, at its sole discretion and option, ask that the Member, and their attorney, if any, protect the Plan Sponsor's reimbursement rights. If the Plan Sponsor elects to proceed under this subsection, the following rules apply:

- The Member holds any right of recovery against the other party in trust for the Plan Sponsor, but only for the amount of benefits this Plan pays for that Illness or Injury.
- The Plan Sponsor is entitled to receive the amount of benefits it has paid for that Illness or Injury out of any settlement or judgment which results from exercising the right of recovery against the other party. This is regardless of whether the third party admits liability or asserts that the Member is also at fault. In addition, the Plan Sponsor is entitled to receive the amount of benefits it has paid whether the expenses are itemized or expressly excluded in the third party recovery.
- The Plan Sponsor holds the option to subtract from the money to be paid back to the Plan Sponsor a proportionate share representing the Member's reasonable attorney fees for collecting amounts paid by the Plan to a third party.
- In addition, and as an alternative, if requested by the Plan Sponsor, the Member will take such action as may be necessary or appropriate to recover such benefits furnished as damages from the responsible third party. Such action will be taken in the name of the Member. If requested by the Plan Sponsor, such action will be prosecuted by a representative designated by the Plan Sponsor who does not have a conflict of interest with the Member. In the event of a recovery, the Plan Sponsor will be reimbursed out of such recovery for the Member's share of the expenses, costs, and attorney fees incurred by the Plan Sponsor in connection with the recovery.

Right of Recovery – Time Limit for Reimbursements

PacificSource regularly engages in activities to identify and recover claims payments which should not have been paid or applied to Deductible amounts (for example, claims which are duplicate claims, errors, or fraudulent claims). If PacificSource, on behalf of the Plan Sponsor, makes a payment to you that you are not entitled to, or pays a person who is not eligible for payment, they may recover the payment. They must request reimbursement within 12 months of the claim payment except under the following circumstance:

- In the case where PacificSource and/or the Plan Sponsor becomes aware of an incorrect payment that was made due to an error, misstatement, misrepresentation, omission, or concealment other than insurance fraud by the Provider or another person, the 12 month time limit begins on the date PacificSource and/or the Plan Sponsor has actual knowledge of the invalid claim, claim overpayment, or other incorrect payment. Regardless of the date upon which PacificSource and/or the Plan Sponsor obtains actual knowledge of an invalid claim, claim overpayment, or other incorrect payment, PacificSource, on behalf of the Plan Sponsor, may not request reimbursement more than 24 months after the payment.

Member Responsibility for Future Expenses

If the Member incurs expenses for treatment of the Illness or Injury after receiving a recovery from, or on behalf of, a third party, this Plan will exclude benefits for otherwise Covered Services until the total amount of expenses incurred before and after the recovery exceeds the amount of the total recovery from all third parties and insurers, less reasonable attorney fees incurred in connection with the recovery.

- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a healthcare item or service is Experimental, Investigational, or Unproven, not Medically Necessary, effective, or appropriate; or
- Determination that a course or plan or treatment you are undergoing is an active course of treatment for the purpose of continuity of care.

Any staff involved in the initial Adverse Benefit Determination will not be involved in the Internal Appeal.

You or your Authorized Representative may submit additional comments, documents, records, and other materials relating to the Adverse Benefit Determination that is the subject of the Appeal. If an Authorized Representative is filing on your behalf, PacificSource will not consider your Appeal to be filed until such time as they have received the Authorization to Use or Disclose PHI and the Designation of Authorized Representative forms.

If you request review of an Adverse Benefit Determination, this Plan will continue to provide coverage for the disputed benefit, pending outcome of the review, if you are currently receiving services or supplies under the disputed benefit. If this Plan prevails in the Appeal, you may be responsible for the cost of coverage received during the review period. The decision at the External Review level is binding unless other remedies are available under state or federal law.

Second Internal Appeal: If you are not satisfied with the first Internal Appeal decision, you may request an additional review. Your Appeal and any additional information not presented with your first Internal Appeal must be forwarded to PacificSource within 60 days of the first Appeal response.

Request for Expedited Response: If there is a clinical urgency to do so, you or your Authorized Representative may request in writing or orally, an expedited response to an internal or External Review of an Adverse Benefit Determination. To qualify for an expedited response, your attending Provider must attest to the fact that the time period for making a non-urgent Benefit Determination could seriously jeopardize your life, health, your ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the healthcare care service or treatment that is the subject of the request. If your Appeal qualifies for an expedited review and would also qualify for External Review (see Independent External Review), you may request that the internal and External Reviews be performed at the same time.

Timelines for Responding to Appeals

You will be afforded two levels of Internal Appeal and, if applicable to your case, an External Review. PacificSource will acknowledge receipt of an Appeal no later than seven days after receipt. A written decision in response to the Appeal will be made within 30 days after receiving your request to Appeal.

The above time frames do not apply if the period is too long to accommodate the clinical urgency of a situation, or if you do not reasonably cooperate, or if circumstances beyond your or our control prevent either party from complying with the time frame. In the case of a delay, the party unable to comply must give notice of delay, including the specific circumstances, to the other party.

Information Available with Regard to an Adverse Benefit Determination

The final Adverse Benefit Determination will include:

- A reference to the specific internal rule or guideline used in the Adverse Benefit Determination;

reach a decision on the External Review, including any judicial review of the External Review decision pursuant to ERISA, if applicable. The department will not act on an External Review request without your completed authorization form. If your request qualifies for External Review, the final Adverse Benefit Determination will be reviewed by an independent review organization selected by the department. The Plan will pay the costs of the review.

Standard External Review Request: You must file your written External Review request with the department within six months after the date we issue a final notice of denial.

- Within seven days after the department receives your request, the department will send a copy to us.
- Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may Appeal that determination to the department.
- If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
- Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
- The independent review organization must provide written notice of its decision to you, to us, and to the department within 42 days after receipt of an External Review request.

Expedited External Review Request: You may file a written urgent care request with the department for an expedited External Review of a pre-service or concurrent service denial. You may file for an internal urgent Appeal with us and for an expedited External Review with the department at the same time.

Urgent care request means a claim relating to an admission, availability of care, continued stay or service for which the Member received Emergency Services but has not been discharged from a facility, or any Pre-service or Concurrent Care Claim for medical care or treatment for which application of the time periods for making a regular External Review determination:

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

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may Appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review

BECOMING COVERED

Who Pays for Your Benefits

The Plan Sponsor shares the cost of providing benefits for Eligible Employees and their Dependents. From time to time, the Plan Sponsor may adjust the amount of contributions required for coverage. In addition, the Deductibles, Copayments, and/or Coinsurance may also change periodically. You will be notified by your Plan Sponsor of any changes in the cost of this Plan's coverage before they take effect.

ELIGIBILITY

Employees

Your status as an Employee is determined by the employment records maintained by the Plan Sponsor. Workers classified by the Plan Sponsor as independent contractors are not eligible for coverage under this Plan under any circumstances. You become eligible to enroll in coverage on this Plan when you have met the Plan Sponsor's eligibility requirements, which may include a Waiting Period or require you to work a certain minimum number of hours.

Dependents

This Plan does not cover Domestic Partners. Disregard any reference to Domestic Partner.

While you are covered under this Plan, the following Dependents are also eligible for coverage:

- Your legal Spouse.
- Your or your Spouse's Dependent Children under age 26 regardless of the child's place of residence, marital status, or financial dependence on you.
- Your or your Spouse's unmarried Dependent Children of any age who are medically certified as incapable of self-sustaining employment by reason of intellectual disability or physical disability. The Plan Sponsor requires documentation of the disability from the Dependent Child's Provider within 31 days in which the Dependent Child turns 26, and will review the case before determining eligibility for coverage.

No family or household members other than those listed above are eligible to enroll under your coverage. No person can be covered both as an Employee and as a Dependent, or as a Dependent of more than one Employee.

Special Rules for Eligibility

At any time the Plan Administrator may require proof that a Member qualifies, or continues to qualify, as a Dependent as defined by this Plan.

ENROLLING DURING THE INITIAL ENROLLMENT PERIOD

Once you satisfy the Plan Sponsor's Waiting Period, and meet the hours required for eligibility, you and your eligible Dependents become eligible for this plan. Starting on the date you become eligible, you and your Dependents have 31 days to enroll, called the Initial Enrollment Period. To enroll, you must submit the enrollment information to the Plan Sponsor. The Plan Sponsor will send the information to PacificSource.

submit a waiver of coverage to the Plan Sponsor.

You and/or your Dependents may enroll in this Plan later if you qualify under the Special Enrollment Rules below. To do so, you must submit an enrollment change within 60 days of the qualifying event. For more information, see the Enrolling New Dependents section.

All special enrollment provisions assume that the Employee has satisfied any Waiting Periods required and each individual is eligible as stated in the Plan.

- Special Enrollment Rule #1

  If you declined enrollment for yourself or your Dependents because of other coverage, you or your Dependents may enroll in the Plan later if the other coverage ends involuntarily. Coverage will begin on the day after the other coverage ends.

- Special Enrollment Rule #2

  If you acquire new Dependents due to a qualifying event, you may be able to enroll yourself and/or your eligible Dependents at that time.

- Special Enrollment Rule #3

  If you or your Dependents become eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance Program (CHIP), you may be able to enroll yourself and/or your Dependents at that time. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Late Enrollment

If you did not enroll during your Initial Enrollment Period or enrolled and later discontinued coverage, and you do not qualify for a special enrollment period, your enrollment will be delayed until the Plan's next designated open enrollment period.

Returning to Work after a Layoff

If you are laid off and then rehired by the Plan Sponsor within 12 months, you will not have to satisfy another Waiting Period.

Your coverage will resume the first day of the month after you return to work and again meet the Plan Sponsor's minimum hour requirement. If your Dependents were covered before your layoff, they can resume coverage at that time as well. You must re-enroll you and/or your Dependents by submitting an enrollment change within the 31 day enrollment period following your return to work.

Returning to Work after a Leave of Absence

If you return to work after a Plan Sponsor-approved Leave of Absence of 12 months or less, you will not have to satisfy another Waiting Period.

Your coverage will resume the first day of the month you return to work and again meet the Plan Sponsor's minimum hour requirement. If your Dependents were covered before your leave, they can resume coverage at that time as well. You must re-enroll you and/or your Dependents by submitting an enrollment change within the 31 day enrollment period following your return to work.

Please refer to the Bonner County policy regarding Non-FMLA Health and Personal Leave of Absence.

USERRA CONTINUATION

If you take a Leave of Absence from your job due to military service, you have continuation rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA).

Members may continue this Plan's coverage if you, the Employee, no longer qualify for coverage under the Plan because of military service. Continuation coverage under USERRA is available for up to 24 months while you are on military leave. If your military service ends and you do not return to work, your eligibility for USERRA continuation coverage will end. Premium for continuation coverage is your responsibility.

The following requirements apply to USERRA continuation:

- Only Dependents who were enrolled in the Plan can take continuation. The only exceptions are newborn babies and newly acquired eligible Dependents not covered by another group health plan.
- To apply for continuation, you must submit a completed Continuation Election form to the Plan Sponsor within 60 days after the last day of coverage under the Plan.
- You must pay continuation premium to the Plan Sponsor by the first of each month. PacificSource cannot accept the premium directly from you.
- The Plan Sponsor must still be self-insured. If the Plan Sponsor discontinues this Plan, you will no longer qualify for continuation.

COBRA CONTINUATION

This Plan is probably subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. To find out if you have continuation rights under COBRA, ask the Plan Sponsor.

If COBRA is available to you and certain circumstances (a qualifying event) occur that cause you to lose coverage, you may have the right to continue coverage for a period of time.

COBRA Eligibility and Length of Continuation

When the following qualifying events cause you to lose coverage, you may continue coverage for the lengths of time shown in the table:

Qualifying Event	Continuation Period
Employee's termination of employment or reduction in hours	Employee, Spouse, and children may continue for up to 18 months[1]
Employee's divorce or legal separation	Spouse and children may continue for up to 36 months[2]
Employee's entitlement to Medicare benefits if it causes a loss of coverage	Spouse and children may continue for up to 36 months[2]
Employee's death	Spouse and children may continue for up to 36 months[2]
Child no longer qualifies as a Dependent	Child may continue for up to 36 months[2]

[1] *If the Employee or Dependent is determined disabled by the Social Security Administration prior to or within the first 60 days of COBRA coverage, all qualified beneficiaries may continue coverage for up to 29 months.*

If you fail to provide the Plan Sponsor with the Continuation Election form in the required timeframe, then the Plan Sponsor's obligation to provide you with COBRA coverage will end. PacificSource does not accept any liability for any failure, on your part or the part of the Plan Sponsor, to provide required notices for coverage.

Continuation Premium

Members are responsible for the full cost of continuation coverage. The Plan Sponsor uses the services of a third-party COBRA administrator to collect premium for continuation coverage. Please see the Plan Sponsor for more information about the Plan's COBRA administrator. The monthly premium must be paid to the Plan Sponsor's COBRA administrator. You may make your first premium payment any time within 45 days after you return your Continuation Election form to the Plan Sponsor's COBRA administrator. After the first premium payment, each monthly payment must reach the Plan Sponsor's COBRA administrator within 30 days of your premium due date. If the COBRA administrator does not receive your continuation premium on time, continuation coverage will end. If your coverage is canceled due to a missed payment, it will not be reinstated for any reason. It is solely your responsibility to ensure that the COBRA administrator receives the premium on time. Premium rates are established annually and may be adjusted if the Plan's benefits or costs change.

RESOURCES FOR INFORMATION AND ASSISTANCE

Assistance

Members who do not speak English, have literacy difficulties, or have physical or mental disabilities may contact the PacificSource Customer Service team for assistance.

Information Available from PacificSource

The Plan makes the following disclosure information available to you free of charge. You may contact the PacificSource Customer Service team to request a copy or by visiting the website, PacificSource.com. Available disclosure information includes, but not limited to, the following:

- A directory of Providers under this Plan;
- Information about the Drug List (also known as a formulary);
- A description (consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services) of any risk-sharing arrangements the Plan or PacificSource has with Providers;
- A description of the Plan Sponsor's and/or PacificSource's efforts to monitor and improve the quality of health services;
- Information about how PacificSource checks the credentials of its network Providers and how you can obtain the names and qualifications of your Providers;
- Information about our prior authorization and utilization review procedures; and
- Information about any healthcare plan offered by PacificSource.

RIGHTS AND RESPONSIBILITIES

The Plan Sponsor and PacificSource are committed to providing you with the highest level of service

- You are responsible for being on time for appointments, and contacting your Provider ahead of time if you need to cancel.
- You are responsible for any fees the Provider charges for late cancellations or no shows.
- You are responsible for contacting the Plan Sponsor or PacificSource if you believe you are not receiving adequate care.
- You are responsible for supplying information to the extent possible that the Plan Sponsor or PacificSource needs in order to administer your benefits or your Providers need in order to provide care.
- You are responsible for following plans and instructions for care that you have agreed to with your Providers.
- You are responsible for understanding your health problems and participating in developing mutually agreed upon goals, to the degree possible.

PRIVACY AND CONFIDENTIALITY

The Plan Sponsor and PacificSource have strict policies in place to protect the confidentiality of your personal information, including medical records. Detailed information is available at PacificSource.com/privacy-policy.

Your personal information is only available to staff members who need that information to do their jobs. Disclosure outside the Plan Sponsor and PacificSource is allowed only when necessary to provide your coverage, or when otherwise allowed by law. Except when certain statutory exceptions apply, the law requires written authorization from you (or your Authorized Representative) before disclosing your personal information outside the Plan Sponsor or PacificSource. An example of one exception is that we do not need written authorization to disclose information to a designee performing utilization management, quality assurance, or peer review on our behalf.

PLAN ADMINISTRATION

Name of Plan:

The Bonner County Group Health Plan (the "Plan").

Name and Address of the Plan Sponsor:

Bonner County
1500 Hwy 2, Suite 337
Sandpoint, ID 83864
Phone: 208-255-3630
Fax: 208-265-1457

Plan Sponsor's Employer Identification / Tax Identification Number:

82-6000285

— The institution/organization is not a Provider; and

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

If payment is from a financially interested third party, the payment will be excluded from the accumulation towards the Deductible and out-of-pocket limit.

Upon rejecting or otherwise refusing to treat a third party payment as a payment from the Member, carriers must inform the Member in writing of the reason for doing so and of the Member's right to file a Complaint.

Funding Method and Contributions:

This Plan is self-insured, meaning that benefits are paid from the general assets and/or trust funds of the Plan Sponsor and are not guaranteed under an insurance policy or contract. The cost of the Plan is paid with contributions by the Plan Sponsor and participating Employees. The Plan Sponsor determines the amount of contributions to the Plan, based on estimates of claims and administration costs. The Plan Sponsor may purchase insurance coverage to guard against excess loss incurred by allowed claims under the Plan, but such coverage is not included as part of the Plan.

Plan Changes

The terms, conditions, and benefits of this Plan may be changed from time to time. The following people have the authority to accept or approve changes or terminate this Plan:

- The Plan Sponsor's board of directors or other governing body;
- The owner or partners of the Plan Sponsor; or
- Anyone authorized by the above people to take such action.

The Plan Administrator is authorized to make Plan changes on behalf of the Plan Sponsor.

If this Plan terminates and the Plan Sponsor does not replace the coverage with another group Plan, the Plan Sponsor is required by law to advise you in writing of the termination.

DEFINITIONS

Wherever used in this Plan, the following definitions apply to the masculine and feminine, and singular and plural forms of the terms. Other terms are defined where they are first used in the text.

Accident means an unforeseen or unexpected event causing Injury that requires medical attention.

Adverse Benefit Determination means this Plan's denial, reduction, or termination of, or this Plan's failure to provide or make a payment in whole or in part, for a benefit that is based on this Plan's:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of your coverage;

- Supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs;
- Conducted as an investigational new drug application, an investigational device exemption or a biologics license application subject to approval by the FDA; or
- Exempt by federal law from the requirement to submit an investigational new drug application to the FDA.

Authorized Representative is an individual who by law or by the consent of a Member may act on behalf of the Member. An Authorized Representative *must* have the Member complete and execute an Authorization to Use or Disclose PHI form and a Designation of Authorized Representative form, both of which are available at PacificSource.com, and which will be supplied to you upon request. These completed forms must be submitted to PacificSource before PacificSource can recognize the Authorized Representative as acting on behalf of the Member.

Balance Billing means the difference between the Allowable Fee and the Provider's billed charge. Out-of-network Providers may bill the Member this amount, unless the service qualifies for protection rights under federal law. For more information, see the Your Rights and Protections Against Surprise Medical Bills and Balance Billing No Surprises Act section.

Benefit Determination means the activity taken to determine or fulfill the Plan Sponsor's responsibility for provisions under this Plan and provide reimbursement for healthcare in accordance with those provisions. Such activity may include:

- Eligibility and coverage determinations (including coordination of benefits), and adjudication or subrogation of claims;
- Review of healthcare services with respect to Medical Necessity (including underlying criteria), coverage under this Plan, appropriateness of care, Experimental, Investigational, or Unproven treatment, justification of charges; and
- Utilization review activities, including precertification and prior authorization of services and concurrent and post-service review of services.

Benefit Year refers to the period of time during which benefits accumulate toward Plan maximums and is on a contract year basis, beginning on the Plan's date of issuance or date of renewal through the last day of that contract year.

Cardiac Rehabilitation refers to a comprehensive program that generally involves medical evaluation, prescribed exercise, and cardiac risk factor modification. Education, counseling, and behavioral interventions are sometimes used as well. Phase I refers to inpatient services that typically occur during hospitalization for heart attack or heart surgery. Phase II refers to a short-term outpatient program, usually involving ECG-monitored exercise. Phase III refers to a long-term program, usually at home or in a community-based facility, with little or no ECG monitoring.

Chemotherapy means the use of drugs approved for use in humans by the FDA and ordered by the Provider for the treatment of disease.

Coinsurance means a defined percentage of the Allowable Fee for certain Covered Services and supplies the Member receives. It is the percentage the Member is responsible for, not including Copayments and Deductibles.

canes, walkers, nebulizers, commodes, suction machines, traction equipment, respirators, and TENS units.

Durable Medical Equipment Supplier means a PacificSource In-network Provider or a Provider that satisfies the criteria in the Medicare Quality Standards for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and other items and services.

Elective Abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

Eligible Employee means an Employee or former Employee who is eligible for coverage under this Plan. Eligible Employees may be covered under this Plan only if they meet the eligibility requirements according to the terms of this Plan.

Emergency Medical Condition means a medical, Mental Health, or Substance Use Disorder condition:

- Manifesting itself by acute symptoms of sufficient severity, including severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition:
  - Placing the health of the Member, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to affect a safe transfer to another Hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Medical Screening Exam means the medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Emergency Services means those healthcare 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:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Employee means any individual employed by the Plan Sponsor.

Employer generally means the Plan Sponsor unless otherwise noted.

Essential Health Benefits are services defined as such by the Secretary of the U.S. Department of Health and Human Services. Essential Health Benefits fall into the following categories:

- Whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes;
- Whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;
- Whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects; and
- Whether any improved health outcomes from the services are attainable outside an investigational setting.

PacificSource may delegate the determination whether a service is Experimental, Investigational, or Unproven to a third party for services received outside Idaho, Montana, Oregon, and Washington. Such determinations shall be based upon evidence-based criteria and may vary from PacificSource's determinations within Idaho, Montana, Oregon, and Washington.

External Review means the request by an appellant for a determination by an independent review organization at the conclusion of an Internal Appeal.

Generic Drugs are drugs that, under federal law, require a prescription by a Provider, and are not a brand name medication. By law, Generic Drugs must have the same active ingredients as the brand name medication and are subject to the same standards of their brand name counterpart. Generic Drugs must be approved by the FDA through an Abbreviated New Drug Application and generally cannot be limited to a single manufacturer.

Global Charge means a lump sum charge for maternity care that includes prenatal care, labor and delivery, and post-delivery care. Ante partum services such as amniocentesis, cordocentesis, chorionic villus sampling, fetal stress test, fetal non-stress test, lab, radiology, maternal, and fetal echography are not considered part of global maternity services and are reimbursed separately.

Grievance means a written Complaint submitted by or on behalf of a Member regarding service delivery issues other than denial of payment for healthcare services or non-provision of healthcare services, including dissatisfaction with healthcare, waiting time for services, Provider or staff attitude or demeanor, or dissatisfaction with service provided by the carrier.

Habilitation Services and Devices are healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living. These services and devices may include Physical/Occupational Therapy, speech-language pathology, and other services and devices for people with disabilities in a variety of inpatient and/or outpatient settings.

Hearing Aid means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments, or accessory for the instrument or device, except batteries and cords. Hearing Aids include any amplifying device that does not produce as its output an electrical signal that directly stimulates the auditory nerve. For the purpose of this definition, such amplifying devices include air conduction and bone conduction devices, as well as those that provide vibratory input to the middle ear.

Home Healthcare means services provided by a licensed home health agency in the Member's place of residence that is prescribed by the Member's attending Provider as part of a written plan of care. Services provided by Home Healthcare include:

- Home health aide services;

Examples include: acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. It does not include false labor, occasional spotting, Provider prescribed bed rest during pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy, but which are not distinct from the pregnancy itself.

Leave of Absence is a period of time off work granted to an Employee by the Plan Sponsor at the Employee's request and during which the Employee is still considered to be employed and is carried on the employment records of the Plan Sponsor. A leave can be granted for any reason acceptable to the Plan Sponsor, including disability and pregnancy.

Lifetime Maximum means the maximum benefit that will be provided toward the expenses incurred by any one Member while the Member is covered by this Plan or any other Plan offered by the Plan Sponsor. If any Covered Service is deemed to be an Essential Health Benefit as determined by the Secretary of the U.S. Department of Health and Human Services, Lifetime Maximum dollar limits will not apply to that Covered Service in accordance with the standards established by the Secretary.

Mastectomy is the surgical removal of all or part of a breast or a breast tumor suspected to be malignant.

Medical Supplies means items of a disposable nature that may be essential to effectively carry out the care a Provider has ordered for the treatment or diagnosis of an Illness or Injury. Examples of Medical Supplies include, but not limited to, syringes and needles, splints and slings, ostomy supplies, sterile dressings, elastic stockings, enteral foods, drugs or biologicals that must be put directly into the equipment in order to achieve the therapeutic benefit of the Durable Medical Equipment or to assure the proper functioning of this equipment.

Medically Necessary or Medical Necessity means those services and supplies that are required for diagnosis or treatment of Illness or Injury and that are:

- Consistent with the symptoms or diagnosis and treatment of the condition;
- Consistent with generally accepted standards of good medical practice in this Plan's state of issuance, or expert consensus Provider opinion published in peer-reviewed medical literature, or the results of clinical outcome trials published in peer-reviewed medical literature;
- As likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any other service or supply, both as to the Illness or Injury involved and the Member's overall health condition;
- Not for the convenience of the Member or a Provider of services or supplies; and
- The least costly of the alternative services or supplies that can be safely provided. When specifically applied to a Hospital inpatient, it further means that the services or supplies cannot be safely provided in other than a Hospital inpatient setting without adversely affecting the Member's condition or the quality of medical care rendered.

PacificSource may delegate determinations of Medical Necessity to third parties for services outside Idaho, Montana, Oregon, and Washington, and such third parties may utilize evidence-based criteria for determining Medical Necessity consistent with the above. Services and supplies intended to diagnose or screen for a medical condition in the absence of signs or symptoms, or of abnormalities on prior testing, including exposure to infectious or toxic materials or family history of genetic disease, are not considered Medically Necessary under this definition. For more information, see screening tests in the Benefit Exclusions section.

Physical/Occupational Therapy is comprised of the services provided by (or under the direction and supervision of) a licensed physical or occupational therapist. Physical/Occupational Therapy includes emphasis on examination, evaluation, and intervention to alleviate impairment and functional limitation and to prevent further impairment or disability.

Plan Amendment is a written attachment that amends, alters, or supersedes any of the terms or conditions set forth in this Plan Document.

Post-service Claim means a request for benefits that involves services you have already received.

Pre-service Claim means a request for benefits that requires approval by PacificSource, on behalf of the Plan Sponsor, in advance (prior authorization) in order for a benefit to be paid.

Prescription Drugs are drugs that, under federal law, require a prescription by Providers practicing within the scope of their licenses.

Prosthetic Devices (excluding dental) means artificial limb devices or appliances designed to replace, in whole or in part, an arm or a leg. It includes devices that replace all or part of an internal or external body organ, or replace all or part of the function of a permanently inoperative or malfunctioning internal or external organ. Examples of Prosthetic Devices include, but not limited to, artificial limbs, cardiac pacemakers, prosthetic lenses, breast prosthesis (including Mastectomy bras), and maxillofacial devices.

Provider means a healthcare professional, Hospital/other institution or medical supplier that is state licensed or state certified to provide a Covered Service or supply. Healthcare professionals eligible to provide care include, but not limited to: chiropractors, dental Providers, massage therapists, mental health counselors, nurses, nurse midwives, nurse practitioners, pharmacists, physical therapists, physicians, podiatrists and psychologists.

Radiation Therapy is the treatment of disease using x-rays or similar forms of radiation.

Rehabilitation Services are those Medically Necessary services and devices that help a person keep, restore, or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt, or disabled.

Rescission means to retroactively cancel or discontinue coverage under this Plan for reasons other than failure to timely pay required premiums or required contributions. This Plan may not rescind coverage unless the Member or person seeking coverage on behalf of the Member, performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, as prohibited by the terms of the Plan or coverage and a 30 day prior written notice is provided.

Routine Costs of Care mean costs for Medically Necessary services or supplies covered by this Plan in the absence of a clinical trial. Routine Costs of Care do not include:

- The drug, device, or service being tested in the clinical trial unless the drug, device, or service would be covered for that indication by the Plan if provided outside of a clinical trial;
- Items or services required for the provisions of the drug, device, or service being tested in the clinical trial;
- Items or services required for the clinically appropriate monitoring of the drug, device, or service being tested in the clinical trial;
- Items or services required for the prevention, diagnosis, or treatment of complications arising from the provision of the drug, device, or service being tested in the clinical trial;

Substance Use Disorder Treatment Facility means a treatment facility that provides a program for the treatment of Substance Use Disorders pursuant to a written treatment plan approved and monitored by a Provider or addiction counselor licensed by the state; is licensed or approved as a treatment center by the department of public health and human services, and is licensed by the state where the facility is located.

Surgical Procedure means any of the following listed operative procedures:

- Procedures accomplished by cutting or incision;
- Suturing of wounds;
- Treatment of fractures, dislocations, and burns;
- Manipulations under general anesthesia;
- Visual examination of the hollow organs of the body including biopsy, or removal of tumors or foreign body;
- Procedures accomplished by the use of cannulas, needling, or endoscopic instruments; or
- Destruction of tissue by thermal, chemical, electrical, laser, or ultrasound means.

Telehealth means the use of audio, video, or other telecommunications technology or media, including audio-only communication, that is used by a Provider or facility to deliver services, and delivered over a secure connection that complies with state and federal privacy laws.

Third Party Administrator means an organization that processes claims and performs administrative functions on behalf of the Plan Sponsor pursuant to the terms of a contract or agreement. In the case of this Plan, the term Third Party Administrator refers solely to PacificSource.

Tobacco Cessation Program means a program recommended by a Provider that follows the United States Public Health Services guidelines for tobacco cessation. Tobacco Cessation Program includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

Tobacco Use means use of tobacco on average four or more times per week within the past six months. This includes all tobacco products. Tobacco Use does not include religious or ceremonial use of tobacco by American Indians and/or Alaska Natives.

Urgent Care means services for an unforeseen Illness or Injury that requires treatment within 24 hours to prevent serious deterioration of a Member's health. Urgent conditions are normally less severe than medical emergencies. Examples of conditions that could need Urgent Care are sprains and strains, vomiting, cuts, and headaches.

Urgent Care Claim means a request for medical care or treatment with respect to which the time periods for making a non-urgent determination could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Urgent Care Treatment Facility means a healthcare facility whose primary purpose is the provision of immediate, short-term medical care for minor, but urgent, medical conditions.

Waiting Period means the period that must pass with respect to the Employee before the Employee

SIGNATURE PAGE

The effective date of the Plan: Medical HSA is October 1, 2023.

It is agreed by Bonner County that the provisions of this document are correct and will be the basis for the administration of the Plan: Medical HSA.

Dated this _____ day of _____, _____
(Date) (Month) (Year)

By_____

Title_____

Bonner County EMS

521 N. Third Ave • Sandpoint, ID 83864 • Phone: (208) 255-2194

EMS Item #1

September 19, 2023

Memorandum

To: Bonner County Commissioners

From: Jeff Lindsey

Re: Medical Director Agreement

Description: Medical Director Agreement between Dr. Ronald Jenkins and Bonner County EMS for the 2024 fiscal year. This contract commences October 1, 2023 and will remain effective for one year. The cost of this contract is $45,360.00 which will be paid in monthly installments of $3,780.00.

Distribution:

1 Original Copy to be returned to EMS
1 Copy to the Auditor's Office
1 Copy to the Commissioner's Office

A suggested motion would be Mr. **Chairman, based on the information before us, I move to approve and sign the Medical Director Agreement between Dr. Ronald Jenkins and Bonner County EMS for the 2024 fiscal year. This contract commences October 1, 2023, and will remain effective for one year. The cost of this contract is $45,360.00 which will be paid in monthly installments of $3,780.00.**

Recommendation Acceptance: □ yes □ no _____ Date:_____
Commissioner Steve Bradshaw, Chairman

BONNER COUNTY EMERGENCY MEDICAL SERVICES SYSTEM
MEDICAL DIRECTOR AGREEMENT REQUIRED ELEMENTS

This Agreement is between Ronald D. Jenkins, MD hereinafter called the Medical Director and Bonner County Emergency Medical Services System, hereinafter called Bonner County EMS system. By entering into this Agreement, the parties agree to be bound and obligated by its specific terms and conditions as defined and described in this document. Any changes, amendments, addendums or attachments to this Agreement must be in writing and signed by both parties.

1. Term of Agreement
   This Agreement shall be effective on October 1, 2023 and shall remain effective for one year unless terminated for any reason by either party, subject to 90 days written notice. This Agreement may be renewed if parties so desire.
2. Title, Rank and status
   A. The Medical Director shall hold the official title and rank of "Medical Director" for the Bonner County EMS system.
   B. The Medical Director shall serve as an agent of the local medical community for the benefit of Bonner County customers and patients served by Bonner County EMS system. To accommodate these responsibilities, the Medical Director shall have a direct reporting relationship with the Bonner County Commissioners or Board of Bonner County EMS System Authority and shall possess authority to communicate directly with any person or persons that provide, supervise, manage or direct emergency medical care on behalf of the EMS System.
3. Operational Authority
   A. The Medical Director shall have authority to observe and monitor the availability and quality of emergency medical care provided by Bonner County EMS system and its agents, representatives, members and employees.
   B. The Medical Director shall have primary authority and responsibility for developing the Bonner County EMS system's training, treatment, and medical transportation policies, subject to budgetary limitations, state and federal regulatory requirements and constraints, and labor agreements between Bonner County EMS system and its employees and/or members.
   C. If, in the discretion of the Medical Director, an administering policy, procedure or practice of Bonner County EMS system requires altering or amending in order to assure the availability and quality of service, the Medical Director shall have immediate and unrestricted access to the Bonner County EMS Executive Director in order to report on the needed alteration(s) or amendment(s) and to recommend alternatives.
   D. The Medical Director shall be considered a member of the Bonner County EMS system representative to the Bonner County Medical community and the medical community's representative to the EMS System.
   E. The Medical Director shall be considered a member of the Bonner County EMS systems executive leadership staff and shall be included in all meetings and policy discussions relating to the availability and quality of emergency medical care provided by Bonner County EMS systems.

F. The operations authority of the Medical Director shall be articulated to every agent, representative, member and employee of Bonner County EMS system, and that authority.

4. Compensation
   A. For the services rendered under this Agreement by the Medical Director under this Agreement, the Bonner County EMS system shall pay to the Medical Director the annual amount of $45,360.00. This will be paid in monthly installments of $3,780.00.
5. Indemnification
   A. Bonner County EMS system agrees to indemnify and hold harmless Medical Director from any and all loss and expense, including but not limited to, legal fees and other costs incurred by the Medical Director in defense of any claims or suits related in any way to any alleged acts or omissions by Bonner County EMS system, its agents, representatives, members and employees during all periods covered by these agreements, and any period of time thereafter which may be covered by applicable statues of limitations.
6. Insurance
   A. The Medical Director shall maintain, at his own expense, medical malpractice liability insurance in the amount of One Million Dollars ($1,000,000.00) per occurrence, Three Million Dollars ($3,000,000.00) aggregate, which shall provide coverage for all of the clinical duties, responsibilities, and actions which he shall assume and undertake pursuant to this Agreement. The Medical Director must provide proof of current medical malpractice insurance that is adequate to cover the responsibilities of the Medical Director within ten (10) working days of signing this Agreement, and the Medical Director shall provide the proof within ten (10) days of the beginning of any renewal periods made under this Agreement.

Ronald D. Jenkins, Medical Director

9/13/2023
Date

Steve Bradshaw, Chairman Board of County Commissioners

Date

Attest, Deputy Clerk

Bonner County EMS

521 N. Third Ave • Sandpoint, ID 83864 • Phone: (208) 255-2194

EMS Item #2

September 19, 2023

Memorandum

To: Bonner County Commissioners

From: Jeff Lindsey, BCEMS

Re: Medical transport agreements

Description: Contracts for the medical transport with the below listed agencies and Bonner County for the 2024 fiscal year. These contracts are for the provision of emergency and non-emergency medical transport services in Bonner County commencing October 1, 2023. The cost of these contracts are listed below:
Clark Fork Valley Ambulance - $45,895.00 for the fiscal year to be paid in installments of $3,824.58.
Schweitzer Fire District - $38,725.00 for the fiscal year to be paid in installments of $3,227.09.
Priest Lake EMTS - $45,895.00 to be paid in installments of $3,824.58.
Kootenai County Emergency Medical Services Systems - $9,015.00 to be paid in installments of $751.25.

Distribution:

1 Original Copy to be returned to EMS
1 Copy to the Auditor's Office
1 Copy to the Commissioner's Office

Legal _____

A suggested motion would be: Mr. Chairman, based on the information before us. I move to approve and sign the contracts for the provision of emergency and non-emergency medical transport services in Bonner County with Schweitzer Fire District, Clark Fork Valley Ambulance, Priest Lake EMTS commencing October 1, 2023. The total cost of these contracts will be $139,530.00 for the fiscal year and will be paid in installments of $11.627.50.

Recommendation Acceptance: □ yes □ no _____ Date: _____
Commissioner Steve Bradshaw, Chairman

MASTER AGREEMENT

Bonner County and Clark Fork Valley Ambulance

AGREEMENT FOR THE PROVISION OF EMERGENCY AND NON- EMERGENCY MEDICAL TRANSPORT SERVICES IN BONNER COUNTY, IDAHO

THIS AGREEMENT is made by and between Bonner County, State of Idaho, (hereinafter referred to as "Bonner County"), and **Clark Fork Valley Ambulance**, Medical service Provider (hereinafter referred to as "SERVICE PROVIDER")

PURPOSE

WHEREAS, the parties hereto desire to combine and unify pre-hospital emergency medical services, including emergency and non-emergency medical services throughout Bonner County and to provide for certainty, consistency and economy in the management and delivery of those services, and;

WHEREAS, the partied to this Agreement agree to provide medical transport services to sick and/or injured persons.

NOW, THEREFORE, in consideration of the mutual covenants and promises herein set forth and for other good and valuable consideration, the parties mutually promise, covenant and agree as follows:

Bonner County, by the terms of this Agreement, hereby authorizes BCEMS, in conjunction with the Medical Director and with the agreement and assistance of the other medical transport SERVICE PROVIDERS who are party to this Agreement, to operate in Bonner County's medical services.

TERM

The term of this Agreement shall commence on October 1, 2023 for a period of one year. This Agreement shall renew automatically annually for an additional fiscal year (October 1 through September 30) under the same terms and conditions identified herein, except for the compensation to be paid by Bonner County. Compensation for the services provided herein shall be negotiated annually by the partied in good faith by no later than April 1st of the current contract year. If an Agreement has not been reached by May 1st of the contract year, the Agreement shall be automatically terminated on September 30th of the contract year.

AMENDMENTS AND NOTICE

a) This Agreement may be amended at any time by mutual agreement of the parties. Before any amendment is valid, it must first be reduced to writing and signed by both Bonner County and SERVICE PROVIDER.
b) All notices and other written communication between the parties shall be provided as follows:

Notices and communications to be given to SERVICE PROVIDER shall be addressed~~s~~ to and delivered to the following address:

Clark Fork Valley Ambulance
PO BOX 464
Clark Fork, ID 83811

Notice and communication as required to be given to Bonner County shall be addressed to and delivered at the following address:

Bonner County Emergency Medical Services
521 N. Third Ave
Sandpoint, ID 83864

COMPENSATION

SERVICE PROVIDER will be compensated commencing October 1, 2023 and in monthly installments based upon:

- $45,895.00 to be paid in 12 equal monthly installments of $3,824.58.

INDEPENDENT CONTRACTOR

It is agreed that the relationship created by this Agreement between Bonner County and SERVICE PROVIDER is one of an Independent Contractor and not that of employer/employee. Neither SERVICE PROVIDER nor any employees of SERVICE PROVIDER nor any other medical or other personnel cooperation with the assisting SERVICE PROVIDER and providing services consistent with the Agreement are employees of Bonner County. Bonner County is interested in only the results obtained pursuant to this Agreement.

None of the benefits provided by Bonner County to its employees including but not limited to compensation, insurance, and unemployment insurance are available from Bonner County to SERVICE PROVIDER and/or agents operation for and under arrangements with SERVICE PROVIDER. SERVICE PROVIDER is solely and entirely responsible for his acts and the acts of his agents, employees and servants during the performance of this Agreement. Bonner County shall have no liability for any error, omission, act of negligence in any medical service provided or not provided to patients by SERVICE PROVIDER or any of SERVICE PROVIDER'S agents, employees, and cooperating and assisting personnel.

SERVICE PROVIDER shall be responsible for all Federal and State taxes, Social Security, Medicare taxes, and Self-Employment related taxes and obligations including Federal and State income tax withholding, Social Security contributions, and similar obligations related to SERVICE PROVIDER Independent SERVICE PROVIDER Status and providing the services under this Agreement. SERVICE PROVIDER shall obtain Worker's Compensation insurance for SERVICE PROVIDER and any agents, employees and staff that SERVICE PROVIDER may employ, and provide to Bonner County proof of such coverage or proof that Worker's Compensation is not required by law. SERVICE PROVIDER shall indemnify Bonner County and hold Bonner County, its agents and departments harmless from any and all claims for these obligations

and taxes (including but not limited to Social Security taxes arising out of SERVICE PROVIDER'S failure to pay such fees, taxes, contributions and other obligations).

EMS STANDARDS AND PRACTICES

It is agreed by the parties hereto that they shall all abide by the applicable standards and requirements of the Idaho Department of Health and Welfare, EMS Bureau, as set forth in Idaho Code 56-1011 to 1018B; the Rules Governing Emergency Medical Services, IDAPA 16.02.03; Standards Manuals as developed and published by the EMS Bureau, as well as the Bonner County EMS Ordinance 456 and all other relevant statues, ordinances and administrative rules hereinafter adopted, identified and filed in the Office of the Clerk and provided to SERVICE PROVIDER by BCEMS.

SERVICE PROVIDER agrees that the sole medical director for their organization shall be the medical director appointed by the County Commissioners for the County's EMS System.

SERVICE PROVIDER further agrees to adhere to the orders, protocols, procedures and other lawful requirements of the system medical director as they pertain to the Medical Supervision Plan and the Medical Protocols.

SERVICE PROVIDER understands and agrees that each licensed member of their organization must be granted the right to practice by the county appointed medical director at a practice level determined by the medical director that may be below but cannot exceed the level at which the member is licensed by the State of Idaho.

SERVICE PROVIDER shall agree to maintain annual agency licensure through the Idaho EMS Bureau as required by statute or administrative rule at a licensure level appropriate to the level of service being provided.

SERVICE PROVIDER shall agree to operate as a county-wide resource, thus agreeing to respond to calls for service outside their primary area as defined in this agreement. This includes covering other areas by temporarily locating an ambulance at a designated location as well as responding to calls to aid persons sick and/or injured.

The parties hereto mutually covenant and agree to deal with each other, at all times with respect, in a good faith manner in performance of this Agreement. The parties agree to do all things, the extent reasonably practicable, to settle disputes amicably and quickly, and to forge a mutually beneficial and long lasting working relationship.

INSURANCE

The parties hereto mutually covenant and agree to indemnify and hold each other harmless from and against any and all suits, claims, losses, actions, damages or liability of every kind, nature and description, including costs, expenses and attorney fees that may be incurred, by reason of any act or omission, neglect or misconduct on the part of themselves, agent employees and representatives.

SRVICE PROVIDER shall maintain Commercial General Liability insurance with minimum limits of $500,000 Occurrence / $1,000,000 Aggregate, including coverage for premises and operations, contractual liability, personal injury liability, products/completed operations liability (if applicable) SERVICE PROVIDER agrees to provide and be financially responsible for their personnel, liability and

property insurance. It is further agreed that each party hereto shall provide BCEMS with proof of insurance consistent with the above provisions within ten (10) days following the signing of the Agreement.

Bonner County shall provide collision and liability insurance for all Bonner County – owned apparatus.

MALPRACTICE

Certificate of Medical Malpractice Liability Insurance in the amount of One Million Dollars ($500,000/$1,000,000 aggregate) shall be provided by SERVICE PROVIDER to Bonner County. For any additional provider that is added as a temporary or permanent provider, similar certificates of insurance will be provided to Bonner County.

All employees in the employ of SERVICE PROVIDER who provide services under this Agreement shall be covered under the terms of SERVICE PROVIDER'S Medical Malpractice Liability Certificates. SERVICE PROVIDER shall indemnify Bonner County and hold Bonner County harmless for any services provided in association with this Agreement. However, no services will be directly by SERVICE PROVIDERS except as allowed by SERVICE PROVIDER'S licensing and appropriate and approved Bonner County Medical Director's Protocol.

ADDITIONAL DUTIES AND RESPONSIBILITIES OF SERVICE PROVIDER

The essential services/responsibilities to be performs by the SERVICE PROVIDER on an as-needed basis are as follows:

1. SERVICE PROVIDER will provide BCEMS with sufficient qualified personnel to staff (1) ambulance pursuant to Idaho Statute 56-1016 (1) at the minimum ILS Level transport, available to respond to any location served by BCEMS.
2. This staffing will be in effect twenty-four (24) hours per day, seven (7) days per week.
3. SERVICE PROVIDER will provide a current staff roster to BCEMS every six (6) months.
4. SERVICE PROVIDER will follow all Bonner County 9-1-1 Standard Operating Procedures.
5. SERVICE PROVIDER will comply with any request for information made by BCEMS as the requested information relates to any provision of this agreement.
6. SERVICE PROVIDER will participate in the Quality Assurance, Quality Improvement process under the supervision of the BCEMS Deputy Chief as the County Medical Director's designee.
7. SERVICE PROVIDER will be responsible for all ambulance billing and collections and will retain all monies when SERVICE PROVIDER transports.
8. SERVICE PROVIDER will furnish BCEMS with a copy of annual financial statements.
9. SERVICE PROVIDER will be the primary transport unit in the following defined area:
    a. East on Highway 200 to the Montana State Line
    b. West on Highway 200 to MP 43
    c. North to the mountains
    d. South to Lake Pend Oreille

ADDITIONAL DUTIES AND RESPONSIBILITIES OF BONNER COUNTY EMS

- BCEMS will provide dispatch and administrative and medical protocols and procedures with Emergency Medical Dispatch, and provide any updates
- BCEMS agrees to provide SERVICE PROVIDER with medical supplies at BCEMS cost. Oxygen and Medical waste will be taken care of by SERVICE PROVIDER through approved vendors. All other consumable items will be replenished at the cost of the SERVICE PROVIDER.
- BCEMS may offer SERVICE PROVIDER continuing education.
- BCEMS will submit reports to the Idaho Department of Health and Welfare, EMS Bureau, at such times and in such manner as the EMS Bureau may require.

COMPLAINCE

Failure to comply with any provision of this Agreement by SERVICE PROVIDER shall entitle Bonner County to withhold any monies payable after notice of breach and failure to cure in accordance with this Agreement.

TERMINATION FOR CAUSE

Any party to this Agreement may terminate this Agreement in accordance with the provisions identified herein. A party seeking to terminate this Agreement shall give the other party at least thirty (30) days written notice before such withdrawal shall become effective. Upon termination, for cause , all property owned or provided by Bonner County shall be returned in good working condition to Bonner County at the time of termination. Further, any unearned payments received by SERVICE PROVIDER shall be reimbursed to Bonner County based on the prorated amount in accordance with the days of service rendered for the month.

INVALIDITY

If any portion of this Agreement is determined to be invalid or enforceable as a matter of law, such invalidity or lack of enforcement shall be limited to such portion and shall not affect any other portions or provisions which shall be given the fullest effect permitted by law. In the event that is should be determined by a tribunal having appropriate jurisdiction that this Agreement is illegal or unenforceable as a matter of law, this Agreement shall be deemed to be null and void and the parties hereto shall be relieved of any further performance under the terms of this Agreement. In the event that Bonner County should fail to fund BCEMS as set forth above, Bonner County and SERVICE PROVIDER hereto shall be relieved of any further performance under the terms of this Agreement.

The parties hereto further mutually covenant, agree and represent that the terms of this Agreement have been completely read by them and that the terms of this Agreement are fully understood, binding and voluntarily accepted by them.

ATTORNEY'S FEES

If any party is required to enforce a breach or termination of this Agreement. The party shall be entitled to recover its reasonable attorney fees and costs from the breaching party, whether with suit or without suit.

COMPLETE AGREEMENT

This Agreement constitutes the complete and final understanding of the parties with respect to the subject matter hereof and cannot be amended or modified except by a written agreement signed by SERVICE PROVIDER and Bonner County.

IN WITNESS WHEREOF, the parties have executed this Agreement this 25 day of August 2023.

Clark Fork Valley Ambulance

BOARD OF BONNER COUNTY COMMISSIONERS

Steven Bradshaw, Chairman

ATTEST:

Deputy Clerk

Asia Williams, Commissioner

Luke Omodt, Commissioner

MASTER AGREEMENT

Bonner County and the Kootenai County Emergency Medical Services System

AGREEMENT FOR THE PROVISION OF EMERGENCY AND NON-EMERGENCY MEDICAL TRANSPORT SERVICES IN BONNER COUNTY, IDAHO

THIS AGREEMENT is made by and between **Bonner County**, State of Idaho, (hereinafter referred to as "Bonner County"), and the **Kootenai County Emergency Medical Services System** (hereinafter referred to as "KCEMSS").

PURPOSE

WHEREAS, the parties hereto desire to combine and unify pre-hospital medical services, including both emergency and non-emergency medical services, in a defined area within Bonner County and to provide for certainty, consistency and economy in the management and delivery of those services, and;

WHEREAS, the parties to this Agreement agree to provide pre-hospital emergency and non-emergency medical services to sick and/or injured persons;

NOW, THEREFORE, in consideration of the mutual covenants and promises herein set forth and for other good and valuable consideration, the parties mutually promise, covenant and agree as follows:

Bonner County, by the terms of this Agreement, hereby authorizes KCEMSS, with the agreement and assistance of the KCEMSS Medical Director, to operate within the area of Bonner County described in **Attachment "A"** hereto, which is incorporated into this Agreement by reference herein.

TERM

The term of this Agreement shall commence on October 1, 2023 for a period of one year. This Agreement shall renew automatically annually for an additional fiscal year (October 1 through September 30) under the same terms and conditions identified herein, except for the compensation to be paid by Bonner County. Compensation for the services provided herein shall be negotiated annually by the parties in good faith by no later than April 1st of the current contract year. If an Agreement has not been reached by May 1st of the contract year, the Agreement shall be automatically terminated on September 30th of the contract year.

AMENDMENTS AND NOTICE

a) This Agreement may be amended at any time by mutual agreement of the parties. Before any amendment is valid, it must first be reduced to writing and signed by both Bonner County and KCEMSS.

b) All notices and other written communication between the parties shall be provided as follows:

Notices and communications to be given to KCEMSS shall be addresses to and delivered to the following address:

Kootenai County Emergency Medical Services System
4381 W. Seltice Way
Coeur d'Alene, ID 83814

Notice and communication as required to be given to Bonner County shall be addressed to and delivered at the following address:

Bonner County Emergency Medical Services
521 N. Third Ave
Sandpoint, ID 83864

COMPENSATION

During the initial term of this Agreement, SERVICE PROVIDER will be compensated a total amount of $9,015.00, to be paid in equal monthly installments of $751.25 commencing in October of 2023.

INDEPENDENT CONTRACTOR

It is agreed that the relationship created by this Agreement between Bonner County and KCEMSS is one of an Independent Contractor and not that of employer/employee. Neither KCEMSS nor any employees of KCEMSS nor any KCEMSS medical service provider which provides services consistent with the Agreement are employees of Bonner County. Bonner County is interested in only the results obtained pursuant to this Agreement.

None of the benefits provided by Bonner County to its employees, including but not limited to compensation, insurance, and unemployment insurance, are available from Bonner County to KCEMSS and/or its agents, employees, and cooperating or assisting personnel. KCEMSS is solely and entirely responsible for its acts and the acts of its agents, employees, and cooperating or assisting personnel during the performance of this Agreement. Bonner County shall have no liability for any error, omission, act of negligence in any medical service provided or not provided to patients by KCEMSS or any of KCEMSS' agents, employees, and cooperating or assisting personnel.

KCEMSS shall be responsible for all Federal and State taxes, Social Security, Medicare taxes, and Self-Employment related taxes and obligations, including Federal and State income tax withholding, Social Security contributions, and similar obligations. KCEMSS shall obtain Worker's Compensation insurance for KCEMSS and any agents, employees and staff that KCEMSS may employ, and provide to Bonner County proof of such coverage or proof that Worker's Compensation is not required by law. KCEMSS shall indemnify Bonner County and hold Bonner

County, its agents and departments harmless from any and all claims for these obligations and taxes (including but not limited to Social Security taxes arising out of KCEMSS' failure to pay such fees, taxes, contributions and other obligations).

Bonner County understands that KCEMSS does not provide any general liability, property, medical malpractice, or workers' compensation insurance covering its respective medical service providers, including, without limitation, Spirit Lake Fire Protection District, Northern Lakes Fire Protection District, Kootenai County Fire and Rescue, and the City of Coeur d'Alene, nor any of their employees; rather, each medical service provider is covered by its own insurance. KCEMSS agrees to make its best efforts to ensure that each such provider provides Bonner County with proof of insurance consistent with the provisions of this Agreement with ten (10) days following the signing of the Agreement.

EMS STANDARDS AND PRACTICES

It is agreed by the parties hereto that they shall all abide by the applicable standards and requirements of the Idaho Department of Health and Welfare, EMS Bureau, as set forth in Idaho Code §§ 56-1011 through 56-1018B; the Rules Governing Emergency Medical Services, IDAPA 16.02.03; Standards Manuals as developed and published by the EMS Bureau, and all other relevant statues and administrative rules pertaining to the provision of EMS services currently or subsequently adopted by the State of Idaho.

The parties agree that the KCEMSS medical director shall be the sole medical director for all KCEMSS responses and operations within Bonner County. The parties further agree that the KCEMSS policies and protocols shall govern all KCEMSS responses and operations within Bonner County.

KCEMSS understands and agrees that each licensed member of their organization must be granted the right to practice by its medical director at a practice level determined by the medical director that may be below but cannot exceed the level at which the member is licensed by the State of Idaho.

KCEMSS shall agree to maintain annual agency licensure through the Idaho EMS Bureau as required by statute or administrative rule at a licensure level appropriate to the level of service being provided.

The parties hereto mutually covenant and agree to deal with each other at all times with respect, in a good faith manner, in performance of this Agreement. The parties agree to do all things, to the extent reasonably practicable, to settle disputes amicably and quickly, and to forge a mutually beneficial and long lasting working relationship.

INSURANCE

To the extent allowed by law, the parties hereto mutually covenant and agree to indemnify and hold each other harmless from and against any and all suits, claims, losses, actions, damages or

liability of every kind, nature and description, including costs, expenses and attorney fees that may be incurred, by reason of any act or omission, neglect or misconduct on the part of themselves, agents, employees and representatives.

KCEMSS shall maintain Commercial General Liability insurance with minimum limits of $500,000 Occurrence / $1,000,000 Aggregate, including coverage for premises and operations, contractual liability, personal injury liability, and products/completed operations liability (if applicable). KCEMSS agrees to provide and be financially responsible for its own personnel, liability and property insurance. It is further agreed that each party hereto shall provide Bonner County with proof of insurance consistent with the above provisions with ten (10) days following the signing of the Agreement.

Bonner County shall provide collision and liability insurance for all Bonner County-owned apparatus.

MALPRACTICE

A certificate of medical malpractice liability insurance in the amount of One Million Dollars ($500,000/$1,000,000 aggregate) shall be provided by KCEMSS to Bonner County. All employees in the employ of KCEMSS who provide services under this Agreement shall be covered under the terms of KCEMSS'S Medical Malpractice Liability Certificates.

KCEMSS shall indemnify Bonner County and hold Bonner County harmless for any services provided by KCEMSS personnel in association with this Agreement. This provision shall not apply to services provided by a KCEMSS medical service provider or any other independent contractor of KCEMSS.

ADDITIONAL DUTIES AND RESPONSIBILITIES OF KCEMSS

The essential services/responsibilities to be performs by the KCEMSS on an as-needed basis are as follows:

1. KCEMSS will comply with any request for information made by Bonner County as the requested information relates to any provision of this agreement.

2. KCEMSS will be the primary BLS/ILS transport unit in the service area defined in **Attachment A.**

3. KCEMSS will be responsible for all ambulance billing and collections and will retain all monies when KCEMSS transports, except that billing and collection for ALS calls involving a Bonner County EMS (BCEMS) paramedic and a transport unit operated by Spirit Lake Fire (and owned by KCEMSS) shall be performed as set forth in **Attachment B**.

COMPLIANCE

Failure to comply with any provision of this Agreement by KCEMSS shall entitle Bonner County to withhold any monies payable after notice of breach and failure to cure in accordance with this Agreement.

TERMINATION FOR CONVENIENCE

Any party to this Agreement may terminate this Agreement in accordance with the provisions identified herein. A party seeking to terminate this Agreement shall give the other party at least thirty (30) days written notice before such withdrawal shall become effective. Any unearned payments received by KCEMSS shall be reimbursed to Bonner County based on the prorated amount in accordance with the days of service rendered for the month.

INVALIDITY

If any portion of this Agreement is determined to be invalid or enforceable as a matter of law, such invalidity or lack of enforcement shall be limited to such portion and shall not affect any other portions or provisions which shall be given the fullest effect permitted by law. In the event that is should be determined by a tribunal having appropriate jurisdiction that this Agreement is illegal or unenforceable as a matter of law, this Agreement shall be deemed to be null and void and the parties hereto shall be relieved of any further performance under the terms of this Agreement. In the event that Bonner County should fail to fund BCEMS as set forth above, Bonner County and KCEMSS hereto shall be relieved of any further performance under the terms of this Agreement.

The parties hereto further mutually covenant, agree and represent that the terms of this Agreement have been completely read by them and that the terms of this Agreement are fully understood, binding and voluntarily accepted by them.

ATTORNEY'S FEES

If any party is required to enforce a breach or termination of this Agreement, that party shall be entitled to recover its reasonable attorney fees and costs from the breaching party, whether with suit or without suit.

COMPLETE AGREEMENT

This Agreement constitutes the complete and final understanding of the parties with respect to the subject matter hereof and cannot be amended or modified except by a written agreement signed by KCEMSS and Bonner County.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the last date shown below.

ATTACHMENT A

ALS Transport Coverage Area

KCEMSS and BCEMS agree that those areas of Bonner County that are within Spirit Lake Fire Protection District will be covered by EMS transport service by Spirit Lake Fire Protection District or other units designated by the Kootenai County Emergency Medical Services System.

Advanced Life Support response shall be selected based upon the closest (based upon mileage from the assigned station to the call) available paramedic staffed unit including resources from Bonner County Priest River Station and Newport Ambulance Service (under contract with Bonner County EMS) and any Kootenai County paramedic staffed unit. The ALS coverage area to which this paragraph shall apply shall run along the southern border of Bonner County west of 4265 Kelso Lake to the Washington state line and north to mile marker 30.3 on Highway 41 (including Three Rocks Lane to the state line, Tower Mountain Road to the end).

Both parties further agree to act upon requests for EMS mutual aid whenever each respective county has units that are available within a reasonable response time to the incident. Neither party will expect compensation from the other regarding these responses. This agreement does not cover rescue services or other activities related to the duties and responsibilities of the respective fire protection districts.

ATTACHMENT B

ALS Transport Billing and Reimbursement Procedures

The billing and reimbursement procedure for all ALS Transport calls involving a BCEMS paramedic and a transport unit operated by Spirit Lake Fire (and owned by KCEMSS) shall be as follows:

1. BCEMS will submit all ALS transport reports and invoices for all calls involving a BCEMS paramedic and a transport unit operated by Spirit Lake Fire (and owned by KCEMSS). ALS reports and invoices covering the previous month must be delivered to the KCEMSS administrative office no later than the 15th of the month.

2. KCEMSS will reimburse BCEMS $65.00 for each report that is submitted and billed as an ALS call by System Design Billing.

3. KCEMSS will reimburse BCEMS once KCEMSS has received full payment for the transport.

4. KCEMSS will provide BCEMS with a quarterly update regarding all unpaid invoices.

DATED this 24 day of AUGUST, 2023.

KOOTENAI COUNTY EMERGENCY MEDICAL SERVICES SYSTEM

Woody McEvers

Woody McEvers, Chairman

ATTEST:

Tracy R. A

Tracy Abrahamson, Secretary

DATED this ____ day of _____, 2023.

BONNER COUNTY BOARD OF COMMISSIONERS

_____

Steven Bradshaw, Chairman

_____

Asia Williams, Commissioner

_____

Luke Omodt, Commissioner

ATTEST:
MICHAEL ROSEDALE, CLERK

By: _____
Deputy Clerk

MASTER AGREEMENT

Bonner County and Priest Lake EMTS, Inc.

AGREEMENT FOR THE PROVISION OF EMERGENCY AND NON- EMERGENCY MEDICAL TRANSPORT SERVICES IN BONNER COUNTY, IDAHO

THIS AGREEMENT is made by and between Bonner County, State of Idaho, (hereinafter referred to as "Bonner County"), and **Priest Lake EMTS**, Inc. Medical Service Provider (hereinafter referred to as "SERVICE PROVIDER")

PURPOSE

WHEREAS, the parties hereto desire to combine and unify pre-hospital emergency medical services, including emergency and non-emergency medical services throughout Bonner County and to provide for certainty, consistency and economy in the management and delivery of those services, and;

WHEREAS, the partied to this Agreement agree to provide medical transport services to sick and/or injured persons.

NOW, THEREFORE, in consideration of the mutual covenants and promises herein set forth and for other good and valuable consideration, the parties mutually promise, covenant and agree as follows:

Bonner County, by the terms of this Agreement, hereby authorizes BCEMS, in conjunction with the Medical Director and with the agreement and assistance of the other medical transport SERVICE PROVIDERS who are party to this Agreement, to operate in Bonner County's medical services.

TERM

The term of this Agreement shall commence on October 1, 2023 for a period of one year. This Agreement shall renew automatically annually for an additional fiscal year (October 1 through September 30) under the same terms and conditions identified herein, except for the compensation to be paid by Bonner County. Compensation for the services provided herein shall be negotiated annually by the partied in good faith by no later than April 1st of the current contract year. If an Agreement has not been reached by May 1st of the contract year, the Agreement shall be automatically terminated on September 30th of the contract year.

AMENDMENTS AND NOTICE

a) This Agreement may be amended at any time by mutual agreement of the parties. Before any amendment is valid, it must first be reduced to writing and signed by both Bonner County and SERVICE PROVIDER.
b) All notices and other written communication between the parties shall be provided as follows:

Notices and communications to be given to SERVICE PROVIDER shall be addresses to and delivered to the following address:

Priest Lake EMTS, Inc.
27929 Highway 57
Priest Lake, ID 83856

Notice and communication as required to be given to Bonner County shall be addressed to and delivered at the following address:

Bonner County Emergency Medical Services
521 N. Third Ave
Sandpoint, ID 83864

COMPENSATION

SERVICE PROVIDER will be compensated commencing October 1, 2023 and in monthly installments based upon:

- $45,895.00 to be paid in 12 equal monthly installments of $3,824.58.

INDEPENDANCT CONTRACTOR

It is agreed that the relationship created by this Agreement between Bonner County and SERVICE PROVIDER is one of an Independent Contractor and not that of employer/employee. Neither SERVICE PROVIDER nor any employees of SERVICE PROVIDER nor any other medical or other personnel cooperation with the assisting SERVICE PROVIDER and providing services consistent with the Agreement are employees of Bonner County. Bonner County is interested in only the results obtained pursuant to this Agreement.

None of the benefits provided by Bonner County to its employees including but not limited to compensation, insurance, and unemployment insurance are available from Bonner County to SERVICE PROVIDER and/or agents operation for and under arrangements with SERVICE PROVIDER. SERVICE PROVIDER is solely and entirely responsible for his acts and the acts of his agents, employees and servants during the performance of this Agreement. Bonner County shall have no liability for any error, omission, act of negligence in any medical service provided or not provided to patients by SERVICE PROVIDER or any of SERVICE PROVIDER'S agents, employees, and cooperating and assisting personnel.

SERVICE PROVIDER shall be responsible for all Federal and State taxes, Social Security, Medicare taxes, and Self-Employment related taxes and obligations including Federal and State income tax withholding, Social Security contributions, and similar obligations related to SERVICE PROVIDER Independent SERVICE PROVIDER Status and providing the services under this Agreement. SERVICE PROVIDER shall obtain Worker's Compensation insurance for SERVICE PROVIDER and any agents, employees and staff that SERVICE PROVIDER may employ, and provide to Bonner County proof of such coverage or proof that Worker's Compensation is not required by law. SERVICE PROVIDER shall indemnify Bonner County and hold Bonner County, its agents and departments harmless from any and all claims for these obligations and taxes (including but not limited to Social Security taxes arising out of SERVICE PROVIDER'S failure to pay such fees, taxes, contributions and other obligations).

EMS STANDARDS AND PRACTICES

It is agreed by the parties hereto that they shall all abide by the applicable standards and requirements of the Idaho Department of Health and Welfare, EMS Bureau, as set forth in Idaho Code 56-1011 to 1018B; the Rules Governing Emergency Medical Services, IDAPA 16.02.03; Standards Manuals as developed and published by the EMS Bureau, as well as the Bonner County EMS Ordinance 456 and all other relevant statues, ordinances and administrative rules hereinafter adopted, identified and filed in the Office of the Clerk and provided to SERVICE PROVIDER by BCEMS.

SERVICE PROVIDER agrees that the sole medical director for their organization shall be the medical director appointed by the County Commissioners for the County's EMS System.

SERVICE PROVIDER further agrees to adhere to the orders, protocols, procedures and other lawful requirements of the system medical director as they pertain to the Medical Supervision Plan and the Medical Protocols.

SERVICE PROVIDER understands and agrees that each licensed member of their organization must be granted the right to practice by the county appointed medical director at a practice level determined by the medical director that may be below but cannot exceed the level at which the member is licensed by the State of Idaho.

SERVICE PROVIDER shall agree to maintain annual agency licensure through the Idaho EMS Bureau as required by statute or administrative rule at a licensure level appropriate to the level of service being provided.

SERVICE PROVIDER shall agree to operate as a county-wide resource, thus agreeing to respond to calls for service outside their primary area as defined in this agreement. This includes covering other areas by temporarily locating an ambulance at a designated location as well as responding to calls to aid persons sick and/or injured.

The parties hereto mutually covenant and agree to deal with each other, at all times with respect, in a good faith manner in performance of this Agreement. The parties agree to do all things, the extent reasonably practicable, to settle disputes amicably and quickly, and to forge a mutually beneficial and long lasting working relationship.

INSURANCE

The parties hereto mutually covenant and agree to indemnify and hold each other harmless from and against any and all suits, claims, losses, actions, damages or liability of every kind, nature and description, including costs, expenses and attorney fees that may be incurred, by reason of any act or omission, neglect or misconduct on the part of themselves, agent employees and representatives.

SRVICE PROVIDER shall maintain Commercial General Liability insurance with minimum limits of $500,000 Occurrence / $1,000,000 Aggregate, including coverage for premises and operations, contractual liability, personal injury liability, products/completed operations liability (if applicable) SERVICE PROVIDER agrees to provide and be financially responsible for their personnel, liability and property insurance. It is further agreed that each party hereto shall provide BCEMS with proof of insurance consistent with the above provisions with ten (10) days following the signing of the Agreement.

Bonner County shall provide collision and liability insurance for all Bonner County – owned apparatus.

MALPRACTICE

Certificate of Medical Malpractice Liability Insurance in the amount of One Million Dollars ($500,000/$1,000,000 aggregate) shall be provided by SERVICE PROVIDER to Bonner County. For any additional provider that is added as a temporary or permanent provider, similar certificates of insurance will be provided to Bonner County.

All employees in the employ of SERVICE PROVIDER who provide services under this Agreement shall be covered under the terms of SERVICE PROVIDER'S Medical Malpractice Liability Certificates. SERVICE PROVIDER shall indemnify Bonner County and hold Bonner County harmless for any services provided in association with this Agreement. However, no services will be directly by SERVICE PROVIDERS except as allowed by SERVICE PROVIDER'S licensing and appropriate and approved Bonner County Medical Director's Protocol.

ADDITIONAL DUTIES AND RESPONSIBILITIES OF SERVICE PROVIDER

The essential services/responsibilities to be performs by the SERVICE PROVIDER on an as-needed basis are as follows:

1. SERVICE PROVIDER will provide BCEMS with sufficient qualified personnel to staff (1) ambulance pursuant to Idaho Statute 56-1016 (1) at the minimum BLS Level transport, available to respond to any location served by BCEMS.
2. This staffing will be in effect twenty-four (24) hours per day, seven (7) days per week.
3. SERVICE PROVIDER will current provide staff roster to BCEMS every six (6) months.
4. SERVICE PROVIDER will follow all Bonner County 9-1-1 Standard Operating Procedures.
5. SERVICE PROVIDER will comply with any request for information made by BCMES as the requested information relates to any provision of this agreement.
6. SERVICE PROVIDER will participate in the Quality Assurance, Quality Improvement process under the supervision of the BCEMS Captain of Clinical Practice as the County Medical Director's designee.
7. SERVICE PROVIDER will be responsible for all ambulance billing and collections and will retain all monies when SERVICE PROVIDER transports.
8. SERVICE PROVIDER will obtain approval from BCEMS for all continuing education or initial provider classes.
9. SERVICE PROVIDER will furnish BCEMS with a copy of annual financial statements.
10. SERVICE PROVIDER will be the primary transport unit in the following defined area:
    a. South on Highway 57 to MP 14
    b. North to Boundary County
    c. South on East River Road to Fox Creek
    d. West to Pend Oreille County, Washington

ADDITIONAL DUTIES AND RESPONSIBILITIES OF BONNER COUNTY EMS

1. BCEMS will provide dispatch and administrative and medical protocols and procedures with Emergency Medical Dispatch, and provide any updates
2. BCEMS agrees to provide SERVICE PROVIDER with medical supplies at BCEMS cost. Oxygen and Medical waste will be taken care of by SERVICE PROVIDER through

approved vendors. All other consumable items will be replenished at the cost of the SERVICE PROVIDER.

3. BCEMS will offer SERVICE PROVIDER continuing education. BCEMS will pay for Basic EMT training with prior written approval from the BCEMS Chief.
4. BCEMS will submit reports to the Idaho Department of Health and Welfare, EMS Bureau, at such times and in such manner as the EMS Bureau may require.

COMPLAINCE

Failure to comply with any provision of this Agreement by SERVICE PROVIDER shall entitle Bonner County to withhold any monies payable after notice of breach and failure to cure in accordance with this Agreement.

TERMINATION FOR CONVENIENCE

Any party to this Agreement may terminate this Agreement in accordance with the provisions identified herein. A party seeking to terminate this Agreement shall give the other party at least thirty (30) days written notice before such withdrawal shall become effective. Upon termination, either for cause or convenience, all property owned or provided by Bonner County shall be returned in good working condition to Bonner County at the time of termination. Further, any unearned payments received by SERVICE PROVIDER shall be reimbursed to Bonner County based on the prorated amount in accordance with the days of service rendered for the month.

INVALIDITY

If any portion of this Agreement is determined to be invalid or not enforceable as a matter of law, such invalidity or lack of enforcement shall be limited to such portion and shall not affect any other portions or provisions which shall be given the fullest effect permitted by law. In the event that it is determined by a tribunal having appropriate jurisdiction that this Agreement is illegal or unenforceable as a matter of law, this Agreement shall be deemed to be null and void and the parties hereto shall be relieved of any further performance under the terms of this Agreement. In the event that Bonner County should fail to fund BCEMS as set forth above, Bonner County and SERVICE PROVIDER hereto shall be relieved of any further performance under the terms of this Agreement.

The parties hereto further mutually covenant, agree and represent that the terms of this Agreement have been completely read by them and that the terms of this Agreement are fully understood, binding and voluntarily accepted by them.

ATTORNEY'S FEES

If any party is required to enforce a breach or termination of this Agreement. The party shall be entitled to recover its reasonable attorney fees and costs from the breaching party, whether with suit or without suit.

COMPLETE AGREEMENT

This Agreement constitutes the complete and final understanding of the parties with respect to the subject matter hereof and cannot be amended or modified except by a written agreement signed by SERVICE PROVIDER and Bonner County.

IN WITNESS WHEREOF, the parties have executed this Agreement this _____ day of _____ 2023.

Priest Lake EMTS, Inc.

BOARD OF BONNER COUNTY COMMISSIONERS

_____

Steven Bradshaw, Chairman

_____

Asia Williams, Commissioner

_____

Luke Omodt, Commissioner

ATTEST:

_____

Deputy Clerk

MASTER AGREEMENT

Bonner County and Schweitzer Fire District

AGREEMENT FOR THE PROVISION OF EMERGENCY AND NON-EMERGENCY MEDICAL TRANSPORT SERVICES IN BONNER COUNTY, IDAHO

THIS AGREEMENT is made by and between Bonner County, State of Idaho, (hereinafter referred to as "Bonner County"), and **Schweitzer Fire District,** Medical Service Provider (hereinafter referred to as "SERVICE PROVIDER")

PURPOSE

WHEREAS, the parties to this Agreement agree to provide medical transport serviced to sick and/or injured persons.

NOW, THEREFORE, in consideration of the mutual covenants and promises herein set forth and for other good and valuable consideration, the parties mutually promise, covenant and agree as follows:

Bonner County, by the terms of this Agreement, hereby authorizes BCEMS, in conjunction with the Medical Director and with the agreement and assistance of the other medical transport SERVICE PROVIDERS who are party to this Agreement, to operate in Bonner County's medical services.

TERM

The term of this Agreement shall commence on October 1, 2023 for a period of one year. This Agreement shall renew automatically annually for an additional fiscal year (October 1 through September 30) under the same terms and conditions identified herein, except for the compensation to be paid by Bonner County. Compensation for the services provided herein shall be negotiated annually by the parties in good faith by no later than April 1st of the current contract year. If an Agreement has not been reached by May 1st of the current contract year, the Agreement shall be automatically terminated on September 30th of the contract year.

AMENDMENTS AND NOTICE

a) This Agreement may be amended at any time by mutual agreement of the partied. Before any amendment is valid, it must first be reduced to writing and signed by both Bonner County and SERVICE PROVIDER.
b) All notices and other written communication between the parties shall be provided as follows:

Notices and communications to be given to SERVICE PROVIDER shall be addressed to and delivered to the following addresses:

Schweitzer Fire District
7904 Schweitzer Mountain Road
Sandpoint, ID 83864

Notice and communication as required to be given to Bonner County shall be addressed to and delivered at the following address:

Bonner County Emergency Medical Services
521 N. Third Ave
Sandpoint, ID 83864

COMPENSATION

SERVICE PROVIDER will be compensated commencing October 1, 2023 and in monthly installments based upon:

- $38,725.00 to be paid in equal monthly installments of $3,227.08.

INDEPENDENT CONTRACTOR

It is agreed that the relationship created by this Agreement between Bonner County and SERVICE PROVIDER is one of an Independent Contractor and not that of employer/employee. Neither SERVICE PROVIDER nor any employees of SERVICE PROVIDER nor any other medical or other personnel cooperation with the assisting SERVICE PROVIDER and providing services consistent with the Agreement are employees of Bonner County. Bonner County is interested in only the results obtained pursuant to this Agreement.

None of the benefits provided by Bonner County to its employees including but not limited to compensation, insurance, and unemployment insurance are available from Bonner County to SERVICE PROVIDER and/or agents operation for and under arrangements with SERVICE PROVIDER. SERVICE PROVIDER is solely and entirely responsible for his acts and the acts of his agents, employees and servants during the performance of this Agreement. Bonner County shall have no liability for any error, omission, act of negligence in any medical service provided or not provided to patients by SERVICE PROVIDER or any of SERVICE PROVIDER'S agents, employees, and cooperating and assisting personnel.

SERVICE PROVIDER shall be responsible for all Federal and State taxes, Social Security, Medicare taxes, and Self-Employment related taxes and obligations including Federal and State income tax withholding, Social Security contributions, and similar obligations related to SERVICE PROVIDER Independent SERVICE PROVIDER Status and providing the services under this Agreement. SERVICE PROVIDER shall obtain Worker's Compensation insurance for SERVICE PROVIDER and any agents, employees and staff that SERVICE PROVIDER may employ, and provide to Bonner County proof of such coverage or proof that Worker's Compensation is not required by law. SERVICE PROVIDER shall indemnify Bonner County and hold Bonner County, its agents and departments harmless from any and all claims for these obligations and taxes (including but not limited to Social Security taxes arising out of SERVICE PROVIDER'S failure to pay such fees, taxes, contributions and other obligations).

EMS STANDARDS AND PRACTICES

It is agreed by the parties hereto that they shall all abide by the applicable standards and requirements of the Idaho Department of Health and Welfare, EMS Bureau, as set forth in Idaho Code 56-1011 to 1018B; the Rules Governing Emergency Medical Services, IDAPA 16.02.03; Standards Manuals as developed and published by the EMS Bureau, as well as the Bonner County EMS Ordinance 456 and all other relevant

statutes, ordinances and administrative rules hereinafter adopted, identified and filed in the Office of the Clerk and provided to SERVICE PROVIDER by BCEMS.

SERVICE PROVIDER agrees that the sole medical director for their organization shall be the medical director appointed by the County Commissioners for the County's EMS System.

SERVICE PROVIDER further agrees to adhere to the orders, protocols, procedures and other lawful requirements of the system medical director as they pertain to the Medical Supervision Plan and the Medical Protocols.

SERVICE PROVIDER understands and agrees that each licensed member of their organization must be granted the right to practice by the county appointed medical director at a practice level determined by the medical director that may be below but cannot exceed the level at which the member is licensed by the State of Idaho.

SERVICE PROVIDER shall agree to maintain annual agency licensure through the Idaho EMS Bureau as required by statute or administrative rule at a licensure level appropriate to the level of service being provided.

SERVICE PROVIDER shall agree to operate as a county-wide resource, thus agreeing to respond to calls for service outside their primary area as defined in this agreement. This includes covering other areas by temporarily locating an ambulance at a designated location as well as responding to calls to aid persons sick and/or injured.

The parties hereto mutually covenant and agree to deal with each other, at all times with respect, in a good faith manner in performance of this Agreement. The parties agree to do all things, the extent reasonably practicable, to settle disputes amicably and quickly, and to forge a mutually beneficial and long lasting working relationship.

INSURANCE

The parties hereto mutually covenant and agree to indemnify and hold each other harmless from and against any and all suits, claims, losses, actions, damages or liability of every kind, nature and description, including costs, expenses and attorney fees that may be incurred, by reason of any act or omission, neglect or misconduct on the part of themselves, agent employees and representatives.

SRVICE PROVIDER shall maintain Commercial General Liability insurance with minimum limits of $500,000 Occurrence / $1,000,000 Aggregate, including coverage for premises and operations, contractual liability, personal injury liability, products/completed operations liability (if applicable) SERVICE PROVIDER agrees to provide and be financially responsible for their personnel, liability and property insurance. It is further agreed that each party hereto shall provide BCEMS with proof of insurance consistent with the above provisions with ten (10) days following the signing of the Agreement.

Bonner County shall provide collision and liability insurance for all Bonner County – owned apparatus.

MALPRACTICE

Certificate of Medical Malpractice Liability Insurance in the amount of One Million Dollars ($500,000/$1,000,000 aggregate) shall be provided by SERVICE PROVIDER to Bonner County. For any

additional provider that is added as a temporary or permanent provider, similar certificates of insurance will be provided to Bonner County.

All employees in the employ of SERVICE PROVIDER who provide services under this Agreement shall be covered under the terms of SERVICE PROVIDER'S Medical Malpractice Liability Certificates. SERVICE PROVIDER shall indemnify Bonner County and hold Bonner County harmless for any services provided in association with this Agreement. However, no services will be directly by SERVICE PROVIDERS except as allowed by SERVICE PROVIDER'S licensing and appropriate and approved Bonner County Medical Director's Protocol.

ADDITIONAL DUTIES AND RESPONSIBILITIES OF SERVICE PROVIDER

The essential services/responsibilities to be performs by the SERVICE PROVIDER on an as-needed basis are as follows:

1. SERVICE PROVIDER will provide BCEMS with sufficient qualified personnel to staff (1) ambulance pursuant to Idaho Statute 56-1016 (1) at the minimum BLS Level transport, available to respond to any location served by BCEMS.
2. This staffing will be in effect twenty-four (24) hours per day, seven (7) days per week.
3. SERVICE PROVIDER will provide staff roster to BCEMS every six (6) months.
4. SERVICE PROVIDER will follow all Bonner County 9-1-1 Standard Operating Procedures.
5. SERVICE PROVIDER will comply with any request for information made by BCEMS as the requested information relates to any provision of this agreement.
6. SERVICE PROVIDER will participate in the Quality Assurance, Quality Improvement process under the supervision of the BCEMS Deputy Chief as the County Medical Director's designee.
7. SERVICE PROVIDER will be responsible for all ambulance billing and collections and will retain all monies when SERVICE PROVIDER transports.
8. SERVICE PROVIDER will furnish BCEMS with a copy of annual financial statements.
9. SERVICE PROVIDER will be the primary transport unit within the ~~Schweitzer Fire District~~ - established boundaries of the states EMS licensure.

ADDITIONAL DUTIES AND RESPONSIBILITIES OF BONNER COUNTY EMS

- BCEMS will provide dispatch and administrative and medical protocols and procedures with Emergency Medical Dispatch, and provide any updates
- BCEMS agrees to provide SERVICE PROVIDER with medical supplies at BCEMS cost. Oxygen and Medical waste will be taken care of by SERVICE PROVIDER through approved vendors. All other consumable items will be replenished at the cost of the SERVICE PROVIDER.
- BCEMS may offer SERVICE PROVIDER continuing education.
- BCEMS will submit reports to the Idaho Department of Health and Welfare, EMS Bureau, at such times and in such manner as the EMS Bureau may require.

COMPLAINCE

Failure to comply with any provision of this Agreement by SERVICE PROVIDER shall entitle Bonner County to withhold any monies payable after notice of breach and failure to cure in accordance with this Agreement.

TERMINATION FOR CONVENIENCE

Any party to this Agreement may terminate this Agreement in accordance with the provisions identified herein. A party seeking to terminate this Agreement shall give the other party at least thirty (30) days written notice before such withdrawal shall become effective. Upon termination, either for cause or convenience, all property owned or provided by Bonner County shall be returned in good working condition to Bonner County at the time of termination. Further, any unearned payments received by SERVICE PROVIDER shall be reimbursed to Bonner County based on the prorated amount in accordance with the days of service rendered for the month.

INVALIDITY

If any portion of this Agreement is determined to be invalid or enforceable as a matter of law, such invalidity or lack of enforcement shall be limited to such portion and shall not affect any other portions or provisions which shall be given the fullest effect permitted by law. In the event that is should be determined by a tribunal having appropriate jurisdiction that this Agreement is illegal or unenforceable as a matter of law, this Agreement shall be deemed to be null and void and the parties hereto shall be relieved of any further performance under the terms of this Agreement. In the event that Bonner County should fail to fund BCEMS as set forth above, Bonner County and SERVICE PROVIDER hereto shall be relieved of any further performance under the terms of this Agreement.

The parties hereto further mutually covenant, agree and represent that the terms of this Agreement have been completely read by them and that the terms of this Agreement are fully understood, binding and voluntarily accepted by them.

ATTORNEY'S FEES

If any party is required to enforce a breach or termination of this Agreement. The party shall be entitled to recover its reasonable attorney fees and costs from the breaching party, whether with suit or without suit.

COMPLETE AGREEMENT

This Agreement constitutes the complete and final understanding of the parties with respect to the subject matter hereof and cannot be amended or modified except by a written agreement signed by SERVICE PROVIDER and Bonner County.

IN WITNESS WHEREOF, the parties have executed this Agreement this _____ day of _____2023.

9/14/23

Schweitzer Fire District

BOARD OF BONNER COUNTY COMMISSIONERS

_____

Steven Bradshaw, Chairman

_____

Asia Williams, Commissioner

_____

Luke Omodt, Commissioner

ATTEST:

_____

Deputy Clerk

Bonner County EMS

521 N. Third Ave • Sandpoint, ID 83864 • Phone: (208) 255-2194

EMS
Item #3

September 19, 2023

Memorandum

To: Bonner County Commissioners

From: Jeff Lindsey; BCEMS Chief

Re: Medical Director Consent and Dispatch Agreements

Description: The attached Medical Director Consent & Dispatch agreements are for all the fire protection districts who wish to be considered collaborative agencies with Bonner County during the fiscal year of 2024.

- Sagle Fire District
- Sandpoint Fire Department
- Westside Fire District
- West Pend Oreille Fire District
- Northside Fire District
- Sam Owen Fire District
- Schweitzer Fire District
- Priest Lake EMTs
- Clark Fork Valley Ambulance

Distribution:

__1__ Original Copy to be returned to EMS

__1__ Copy to the Commissioner's Office

A suggested motion would be: Mr. Chairman based on the information before us I move to approve the medical director consent and dispatch agreement for all the fire protection districts who wish to be considered collaborative agencies with Bonner County during the fiscal year of 2024.

Recommendation Acceptance: □ yes □ no _____ Date:_____
Commissioner Steve Bradshaw, Chairman

MEDICAL DIRECTOR CONSENT & DISPATCH AGREEMENT

Whereas, Bonner County has adopted Emergency Management Service (EMS) Ordinance # 456 codified as Bonner County Revised Code (BCRC) 4-2 (hereinafter referred to as the "EMS Ordinance"); and

Whereas, the EMS Ordinance provides that its rules and regulation shall include the certification/licensing, by the Bonner County Ambulance Board (Board) of all EMS providers within the county; and

Whereas, the EMS Ordinance provides that the Board has the authority to determine which entities shall have primary response authority and to determine the defined EMS geographic boundaries in which such authority shall be exercised; and

Whereas, the EMS Ordinance authorizes the Board to enter into a written agreement with a medical director licensed pursuant to the requirements of Idaho Code and IDAPA rules; and

Whereas, the Board has entered into such medical director agreement with Ronald D. Jenkins, MD, who serves as the Board's EMS medical director; and

Whereas, the Board's medical director has issued a letter dated 7/12/23 (Attachment 1) which provides that Ronald D. Jenkins, MD will only serve as a Medical Director for agencies that provide services in a collaborative arrangement with the County; and

Whereas, Sagle Fire District desires to be a collaborative agency with the County; Now therefore it is agreed as follows:

#1. For the period of October 1, 2023 through September 30, 2024 Bonner County shall recognize Sagle Fire District as a collaborative agency with the County. Additionally the County will provide Emergency medical dispatching to the collaborative agency; and

#2. Sagle Fire District stipulates to the validity of Bonner County Ordinance #456 and agrees to provide EMS services according to the Ordinance and to provide services pursuant to the medical supervision plan established by Ronald D. Jenkins, MD within the EMS geographic boundaries established by the Board;

_____ _____

Steve Bradshaw, Chairman Board of County Commissioners Date

_____

Attest, Deputy Clerk

_____ 7/14/23

Authorized Agent of Sagle Fire District; Date

MEDICAL DIRECTOR CONSENT & DISPATCH AGREEMENT

Whereas, Bonner County has adopted Emergency Management Service (EMS) Ordinance # 456 codified as Bonner County Revised Code (BCRC) 4-2 (hereinafter referred to as the "EMS Ordinance"); and

Whereas, the EMS Ordinance provides that its rules and regulation shall include the certification/licensing, by the Bonner County Ambulance Board (Board) of all EMS providers within the county; and

Whereas, the EMS Ordinance provides that the Board has the authority to determine which entities shall have primary response authority and to determine the defined EMS geographic boundaries in which such authority shall be exercised; and

Whereas, the EMS Ordinance authorizes the Board to enter into a written agreement with a medical director licensed pursuant to the requirements of Idaho Code and IDAPA rules; and

Whereas, the Board has entered into such medical director agreement with Ronald D. Jenkins, MD, who serves as the Board's EMS medical director; and

Whereas, the Board's medical director has issued a letter dated 7/12/23 (Attachment 1) which provides that Ronald D. Jenkins, MD will only serve as a Medical Director for agencies that provide services in a collaborative arrangement with the County; and

Whereas, City of Sandpoint desires to be a collaborative agency with the County;

Now therefore it is agreed as follows:

#1. For the period of October 1, 2023 through September 30, 2024 Bonner County shall recognize City of Sandpoint as a collaborative agency with the County. Additionally the County will provide Emergency medical dispatching to the collaborative agency; and

#2. City of Sandpoint stipulates to the validity of Bonner County Ordinance #456 and agrees to provide EMS services according to the Ordinance and to provide services pursuant to the medical supervision plan established by Ronald D. Jenkins, MD within the EMS geographic boundaries established by the Board;

_____ _____

Steve Bradshaw, Chairman Board of County Commissioners Date

_____

Attest, Deputy Clerk

_____ 7/17/23

Authorized Agent of City of Sandpoint Date

MEDICAL DIRECTOR CONSENT & DISPATCH AGREEMENT

Whereas, Bonner County has adopted Emergency Management Service (EMS) Ordinance # 456 codified as Bonner County Revised Code (BCRC) 4-2 (hereinafter referred to as the "EMS Ordinance"); and

Whereas, the EMS Ordinance provides that its rules and regulation shall include the certification/licensing, by the Bonner County Ambulance Board (Board) of all EMS providers within the county; and

Whereas, the EMS Ordinance provides that the Board has the authority to determine which entities shall have primary response authority and to determine the defined EMS geographic boundaries in which such authority shall be exercised; and

Whereas, the EMS Ordinance authorizes the Board to enter into a written agreement with a medical director licensed pursuant to the requirements of Idaho Code and IDAPA rules; and

Whereas, the Board has entered into such medical director agreement with Ronald D. Jenkins, MD, who serves as the Board's EMS medical director; and

Whereas, the Board's medical director has issued a letter dated 7/12/23 (Attachment 1) which provides that Ronald D. Jenkins, MD will only serve as a Medical Director for agencies that provide services in a collaborative arrangement with the County; and

Whereas, Westside Fire District desires to be a collaborative agency with the County; Now therefore it is agreed as follows:

#1. For the period of October 1, 2023 through September 30, 2024 Bonner County shall recognize Westside Fire District as a collaborative agency with the County. Additionally the County will provide Emergency medical dispatching to the collaborative agency; and

#2. Westside Fire District stipulates to the validity of Bonner County Ordinance #456 and agrees to provide EMS services according to the Ordinance and to provide services pursuant to the medical supervision plan established by Ronald D. Jenkins, MD within the EMS geographic boundaries established by the Board;

_____ _____

Steve Bradshaw, Chairman Board of County Commissioners Date

_____

Attest, Deputy Clerk

_____ 7/17/23

Authorized Agent of Westside Fire District; Date

MEDICAL DIRECTOR CONSENT & DISPATCH AGREEMENT

Whereas, Bonner County has adopted Emergency Management Service (EMS) Ordinance # 456 codified as Bonner County Revised Code (BCRC) 4-2 (hereinafter referred to as the "EMS Ordinance"); and

Whereas, the EMS Ordinance provides that its rules and regulation shall include the certification/licensing, by the Bonner County Ambulance Board (Board) of all EMS providers within the county; and

Whereas, the EMS Ordinance provides that the Board has the authority to determine which entities shall have primary response authority and to determine the defined EMS geographic boundaries in which such authority shall be exercised; and

Whereas, the EMS Ordinance authorizes the Board to enter into a written agreement with a medical director licensed pursuant to the requirements of Idaho Code and IDAPA rules; and

Whereas, the Board has entered into such medical director agreement with Ronald D. Jenkins, MD, who serves as the Board's EMS medical director; and

Whereas, the Board's medical director has issued a letter dated 7/12/23 (Attachment 1) which provides that Ronald D. Jenkins, MD will only serve as a Medical Director for agencies that provide services in a collaborative arrangement with the County; and

Whereas, West Pend Oreille Fire District desires to be a collaborative agency with the County; Now therefore it is agreed as follows:

#1. For the period of October 1, 2023 through September 30, 2024 Bonner County shall recognize West Pend Oreille Fire District as a collaborative agency with the County. Additionally the County will provide Emergency medical dispatching to the collaborative agency; and

#2. West Pend Oreille Fire District stipulates to the validity of Bonner County Ordinance #456 and agrees to provide EMS services according to the Ordinance and to provide services pursuant to the medical supervision plan established by Ronald D. Jenkins, MD within the EMS geographic boundaries established by the Board;

_____ _____

Steve Bradshaw, Chairman Board of County Commissioners Date

_____

Attest, Deputy Clerk

_____ 9/5/23

Authorized Agent of West Pend Oreille Fire District; Date

MEDICAL DIRECTOR CONSENT & DISPATCH AGREEMENT

Whereas, Bonner County has adopted Emergency Management Service (EMS) Ordinance # 456 codified as Bonner County Revised Code (BCRC) 4-2 (hereinafter referred to as the "EMS Ordinance"); and

Whereas, the EMS Ordinance provides that its rules and regulation shall include the certification/licensing, by the Bonner County Ambulance Board (Board) of all EMS providers within the county; and

Whereas, the EMS Ordinance provides that the Board has the authority to determine which entities shall have primary response authority and to determine the defined EMS geographic boundaries in which such authority shall be exercised; and

Whereas, the EMS Ordinance authorizes the Board to enter into a written agreement with a medical director licensed pursuant to the requirements of Idaho Code and IDAPA rules; and

Whereas, the Board has entered into such medical director agreement with Ronald D. Jenkins, MD, who serves as the Board's EMS medical director; and

Whereas, the Board's medical director has issued a letter dated 7/12/23 (Attachment 1) which provides that Ronald D. Jenkins, MD will only serve as a Medical Director for agencies that provide services in a collaborative arrangement with the County; and

Whereas, Northside Fire District desires to be a collaborative agency with the County; Now therefore it is agreed as follows:

#1. For the period of October 1, 2023 through September 30, 2024 Bonner County shall recognize Northside Fire District as a collaborative agency with the County. Additionally the County will provide Emergency medical dispatching to the collaborative agency; and

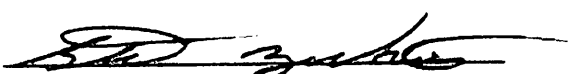
#2. Northside Fire District stipulates to the validity of Bonner County Ordinance #456 and agrees to provide EMS services according to the Ordinance and to provide services pursuant to the medical supervision plan established by Ronald D. Jenkins, MD within the EMS geographic boundaries established by the Board;

_____ _____

Steve Bradshaw, Chairman Board of County Commissioners Date

_____

Attest, Deputy Clerk



Authorized Agent of Northside Fire District; 9/27/2023 Date

MEDICAL DIRECTOR CONSENT & DISPATCH AGREEMENT

Whereas, Bonner County has adopted Emergency Management Service (EMS) Ordinance # 456 codified as Bonner County Revised Code (BCRC) 4-2 (hereinafter referred to as the "EMS Ordinance"); and

Whereas, the EMS Ordinance provides that its rules and regulation shall include the certification/licensing, by the Bonner County Ambulance Board (Board) of all EMS providers within the county; and

Whereas, the EMS Ordinance provides that the Board has the authority to determine which entities shall have primary response authority and to determine the defined EMS geographic boundaries in which such authority shall be exercised; and

Whereas, the EMS Ordinance authorizes the Board to enter into a written agreement with a medical director licensed pursuant to the requirements of Idaho Code and IDAPA rules; and

Whereas, the Board has entered into such medical director agreement with Ronald D. Jenkins, MD, who serves as the Board's EMS medical director; and

Whereas, the Board's medical director has issued a letter dated 7/12/23 (Attachment 1) which provides that Ronald D. Jenkins, MD will only serve as a Medical Director for agencies that provide services in a collaborative arrangement with the County; and

Whereas, Sam Owen Fire Department desires to be a collaborative agency with the County; Now therefore it is agreed as follows:

#1. For the period of October 1, 2023 through September 30, 2024 Bonner County shall recognize Sam Owen Fire department as a collaborative agency with the County. Additionally the County will provide Emergency medical dispatching to the collaborative agency; and

#2. Sam Owen Fire Department stipulates to the validity of Bonner County Ordinance #456 and agrees to provide EMS services according to the Ordinance and to provide services pursuant to the medical supervision plan established by Ronald D. Jenkins, MD within the EMS geographic boundaries established by the Board;

_____ _____

Steve Bradshaw, Chairman Board of County Commissioners Date

_____

Attest, Deputy Clerk

_____ 9.18.2023

Authorized Agent of Sam Owen Fire Department; Date

MEDICAL DIRECTOR CONSENT & DISPATCH AGREEMENT

Whereas, Bonner County has adopted Emergency Management Service (EMS) Ordinance # 456 codified as Bonner County Revised Code (BCRC) 4-2 (hereinafter referred to as the "EMS Ordinance"); and

Whereas, the EMS Ordinance provides that its rules and regulation shall include the certification/licensing, by the Bonner County Ambulance Board (Board) of all EMS providers within the county; and

Whereas, the EMS Ordinance provides that the Board has the authority to determine which entities shall have primary response authority and to determine the defined EMS geographic boundaries in which such authority shall be exercised; and

Whereas, the EMS Ordinance authorizes the Board to enter into a written agreement with a medical director licensed pursuant to the requirements of Idaho Code and IDAPA rules; and

Whereas, the Board has entered into such medical director agreement with Ronald D. Jenkins, MD, who serves as the Board's EMS medical director; and

Whereas, the Board's medical director has issued a letter dated 7/12/23 (Attachment 1) which provides that Ronald D. Jenkins, MD will only serve as a Medical Director for agencies that provide services in a collaborative arrangement with the County; and

Whereas, Schweitzer Fire District desires to be a collaborative agency with the County; Now therefore it is agreed as follows:

#1. For the period of October 1, 2023 through September 30, 2024 Bonner County shall recognize Schweitzer Fire District department as a collaborative agency with the County. Additionally the County will provide Emergency medical dispatching to the collaborative agency; and

#2. Schweitzer Fire District stipulates to the validity of Bonner County Ordinance #456 and agrees to provide EMS services according to the Ordinance and to provide services pursuant to the medical supervision plan established by Ronald D. Jenkins, MD within the EMS geographic boundaries established by the Board;

_____ _____

Steve Bradshaw, Chairman Board of County Commissioners Date

_____

Attest, Deputy Clerk

_____ 9/14/23

Authorized Agent of Schweitzer Fire District; Date

MEDICAL DIRECTOR CONSENT & DISPATCH AGREEMENT

Whereas, Bonner County has adopted Emergency Management Service (EMS) Ordinance # 456 codified as Bonner County Revised Code (BCRC) 4-2 (hereinafter referred to as the "EMS Ordinance"); and

Whereas, the EMS Ordinance provides that its rules and regulation shall include the certification/licensing, by the Bonner County Ambulance Board (Board) of all EMS providers within the county; and

Whereas, the EMS Ordinance provides that the Board has the authority to determine which entities shall have primary response authority and to determine the defined EMS geographic boundaries in which such authority shall be exercised; and

Whereas, the EMS Ordinance authorizes the Board to enter into a written agreement with a medical director licensed pursuant to the requirements of Idaho Code and IDAPA rules; and

Whereas, the Board has entered into such medical director agreement with Ronald D. Jenkins, MD, who serves as the Board's EMS medical director; and

Whereas, the Board's medical director has issued a letter dated 7/12/23 (Attachment 1) which provides that Ronald D. Jenkins, MD will only serve as a Medical Director for agencies that provide services in a collaborative arrangement with the County; and

Whereas, Priest Lake EMTs, Inc. desires to be a collaborative agency with the County; Now therefore it is agreed as follows:

#1. For the period of October 1, 2023 through September 30, 2024 Bonner County shall recognize Priest Lake EMTs, Inc. department as a collaborative agency with the County. Additionally the County will provide Emergency medical dispatching to the collaborative agency; and

#2. Priest Lake EMTs, Inc. stipulates to the validity of Bonner County Ordinance #456 and agrees to provide EMS services according to the Ordinance and to provide services pursuant to the medical supervision plan established by Ronald D. Jenkins, MD within the EMS geographic boundaries established by the Board;

_____ _____

Steve Bradshaw, Chairman Board of County Commissioners Date

_____

Attest, Deputy Clerk

_____ 8/31/23

Authorized Agent of Priest Lake EMTs, Inc.; Date

MEDICAL DIRECTOR CONSENT & DISPATCH AGREEMENT

Whereas, Bonner County has adopted Emergency Management Service (EMS) Ordinance # 456 codified as Bonner County Revised Code (BCRC) 4-2 (hereinafter referred to as the "EMS Ordinance"); and

Whereas, the EMS Ordinance provides that its rules and regulation shall include the certification/licensing, by the Bonner County Ambulance Board (Board) of all EMS providers within the county; and

Whereas, the EMS Ordinance provides that the Board has the authority to determine which entities shall have primary response authority and to determine the defined EMS geographic boundaries in which such authority shall be exercised; and

Whereas, the EMS Ordinance authorizes the Board to enter into a written agreement with a medical director licensed pursuant to the requirements of Idaho Code and IDAPA rules; and

Whereas, the Board has entered into such medical director agreement with Ronald D. Jenkins, MD, who serves as the Board's EMS medical director; and

Whereas, the Board's medical director has issued a letter dated 7/12/23 (Attachment 1) which provides that Ronald D. Jenkins, MD will only serve as a Medical Director for agencies that provide services in a collaborative arrangement with the County; and

Whereas, Clark Fork Valley Ambulance desires to be a collaborative agency with the County; Now therefore it is agreed as follows:

#1. For the period of October 1, 2023 through September 30, 2024 Bonner County shall recognize Clark Fork Valley Ambulance department as a collaborative agency with the County. Additionally, the County will provide Emergency medical dispatching to the collaborative agency; and

#2. Clark Fork Valley Ambulance stipulates to the validity of Bonner County Ordinance #456 and agrees to provide EMS services according to the Ordinance and to provide services pursuant to the medical supervision plan established by Ronald D. Jenkins, MD within the EMS geographic boundaries established by the Board;

_____ _____

Steve Bradshaw, Chairman Board of County Commissioners — Date

Nick Woodward 9/13/23

President of Clark Fork Valley Ambulance; — Date

S. Dunn 9/13/2023

Chief of Clark Fork Valley Ambulance — Date

_____

Attest, Deputy Clerk

Office of
BONNER COUNTY PUBLIC DEFENDER
123 S. First Avenue
Sandpoint, Idaho 83864
Telephone: (208) 255-7889 | Fax: (208) 255-7559

Luke Hagelberg, Attorney at Law
Catherine Enright, Attorney at Law
Donald Terry, Attorney at Law

Jay Northam, Attorney at Law
Jennifer Kohout, Attorney at Law
Peter Cook, Attorney at Law

Public Defender
Item #1

October 3, 2023

MEMORANDUM

To: Bonner County Board of Commissioners

From: Luke Hagelberg, Public Defender

Re: Dana Bowes – Conflict Public Defender (FY2024 Contract)

Description: Dana Bowes is the Conflict Public Defender for Bonner County. She is responsible for representing the clients that the Office of the Public Defender cannot represent (usually co-defendants). This contract retains her services for FY2024 under the current pay/terms.

Legal Review: Approved by _____

Distribution: Original to Public Defender's Office
Copy to BOCC Office
Copy to Auditor's Office

Based on the information before us, I move to approve… and sign the Conflict Public Defender Contract with attorney Dana Bowes for FY2024.

Recommendation Acceptance: ☐ Yes ☐ No _____ Date:_____
Commissioner Steven Bradshaw, Chairman

CONTRACT FOR SERVICES OF CONFLICT PUBLIC DEFENDER
FIRST LEVEL CONFLICTS
FY2024

This Contract is made and entered into by and between **Bonner County, Idaho**, a political subdivision of the State of Idaho, herein referred to as the "County," and **Dana Bowes**, Attorney at Law, herein referred to as "Attorney."

For valuable consideration, including the mutual promises hereinafter set forth, it is agreed between the County and the Attorney as follows:

1. **LEGAL SERVICES** – During the period of October 1, 2023, through September 30, 2024, the Attorney is retained by the County to provide legal services for coverage in the courts when there is a conflict with the Bonner County Public Defender's Office, which the law requires the County to provide to "needy persons" pursuant to Chapter 5, Title 20, Idaho Code, the Juvenile Protection Act and pursuant to Chapter 8, Title 19, Idaho Code, the Idaho Child Protective Act and such other court proceedings that may deprive an individual of liberty by incarceration. The legal services provided for herein include the defense of any crime wherein incarceration in the county jail or the state penal system is a possible punishment, youth rehabilitation and child protective proceedings, mental competency hearings, contempt proceeding for non-payment of child support and similar responsibilities when incarceration or detention through court proceedings is possible and when, and only when, the Bonner County Public Defender's Office has a conflict wherein they are unable to provide representation to the "needy persons." This Contract is for the First Level of conflicts which include felony and misdemeanor assignments, cases filed under the Post Conviction Relief Act, cases filed under the Juvenile Corrections Act, and cases filed under the Idaho Child Protective Act.

   Where an indigent person is represented by an Attorney under this Contract and such person receives additional charges during that period of representation, the same Attorney shall be assigned representation on the new charges.

   Attorney represents that he/she possesses and agrees to apply the necessary skills, knowledge, experience and training to provide legal representation in each case assigned to Attorney consistent with applicable professional standards, the PDC standards for Defending Attorneys, including the Idaho Rules of Professional Conduct.

   EXCEPTION – The Attorney shall not be obligated under the terms of this Contract to defend any person for which the Prosecuting Attorney has elected to seek the death penalty. Such matter shall be assigned to the appropriately

qualified capital defense attorney. Further, the Attorney shall not be required to provide legal services to the following categories of matters which are now covered by the State Appellate Public Defender's Office:

a) Appeals from criminal conviction in District Court; and
b) Appeals from District Court in Post-Conviction Relief Proceedings brought pursuant to the Uniform Post-Conviction Procedure Act, Chapter 49, Title 19, Idaho Code; and
c) Appeal from District Court in Habeus Corpus proceeding brought pursuant to Chapter 42, Title 19, Idaho Code; and
d) Post-Conviction Relief proceedings pursuant to Chapter 49, Title 19, Idaho Code in District Court from capital cases.

2. **CONFLICTS COVERAGE** – A conflict for which the attorney shall provide coverage as indicated is a situation wherein the Bonner County Public Defender's Office for whatever reason cannot ethically provide legal services to a "needy person." A conflict does not include a situation when the Bonner County Public Defender's Office is unable to attend a court hearing in a matter because the Bonner County Public Defender's Office is scheduled to appear at the same time between two (2) or more judges in cases for which the Bonner County Public Defender's Office was assigned. If coverage for conflict is required greater than the level of conflict provided under this Contract, thereafter the County will be required to fulfill its obligation required by law to any additional persons for counsel outside the terms of this Contract. The contractor will not provide representation to defendants when doing so would involve a conflict of interest.

3. **LICENSES** – Attorney warrants that he/she is an active member of the Idaho State Bar and in good standing and will maintain that status throughout the term of this Contract. Attorney agrees to maintain in full force and effect any other licenses, certificates or permits required by the federal, state, county or municipal governments in order to provide services under this contract.

4. **TRAINING REQUIREMENTS** – The contract shall require each defending attorney providing services pursuant to the contract to participate in regular training programs on criminal defense law, including a minimum of seven (7) hours of continuing legal education annually in areas relating to their public defense practice, as required by the most recent edition of "Standards for Defending Attorneys."

5. **COMPENSATION** – The Attorney shall be compensated at an hourly rate based upon the time spent by Attorney on each assigned matter for the period of October 1, 2023, through September 30, 2024. The hourly rate is $150.00 per hour.

Further, it is agreed that the Attorney is responsible for any ordinary office expense (office space, furniture, equipment, books), including secretarial time, and postage and any other supplies necessary in carrying out this Contract. The County, through the funds allocated to the Public Defender's Office, shall pay the following expenses: costs of service, necessary investigation, necessary expert fees, and reasonable copy and research expense. However, any said allowances for expenses may be increased for extraordinary services (including but not limited to investigators and/or experts) and expenses not recurring on a regular basis within the purview of Idaho Code §19-860(a)(1), if authorized by court order after notice to County and after a hearing to consider the same. Such extraordinary services and expenses will be paid in addition to the hourly contract amount and shall be determined on a case-by-case basis. The County reserves the right to deny any claim for expenses or other out of pocket expenses which are incurred by Attorney without prior authorization as required by this provision. In the event of any dispute as to the necessity for employment of such investigators, experts, or other out of pocket costs, the request shall be presented to the court, whose decision as to the appropriateness and amount of such expenses shall be final.

Any expense incurred in transportation, mileage expense for court appearance or for client and witness interview by the Attorney in Bonner County shall be the responsibility of the Attorney. If in performing services that are the responsibility of the Attorney under this Contract that requires out-of-Bonner-County travel, the Attorney shall be reimbursed for such travel, meals, and lodging in accordance with rates paid to Bonner County employees pursuant to county policy. The County reserves the right to deny reimbursement to Attorney for out of county travel or per diem expenses which are either in excess of the amount paid to County employees or which are incurred by Attorney without prior authorization.

The County shall pay to Attorney on a monthly basis all amounts owed to Attorney for services provided pursuant to this Contract. Attorney shall submit, on a monthly basis, a statement for services rendered and expenses incurred in the form provided by the County. The statement will contain the name of the assigned client, the court case number, the number of hours worked and the total fees for each matter. Any fractional amount may be billed in one-tenth of an hour increments. The statement will also include any pre-authorized costs or expenses incurred by the Attorney and include a copy of the court or Board authorization for such expenses. The statement shall also contain a certification by Attorney that the cases listed, amounts claimed and times reported are true and accurate. The statement for services shall be submitted to the Office of the Public Defender on a monthly basis for review and submission for payment. The County shall make payment to Attorney for all compensation and expenses due to Attorney under the Contract within 30 days of the County's receipt of such statement.

Attorney acknowledges that timely billing is critical for County budget management purposes. Attorney agrees that the County may impose a ten percent (10%) penalty for any billings for services that are not billed in the month immediately following the month in which the services are rendered unless good cause is shown for the delay in billing.

The Attorney shall be required to keep such records as are required by Idaho Code § 19-864 when representing indigent persons. The Attorney agrees to provide such records and reports to the County and to the District Court as required by statute upon request. The Attorney shall comply with and meet all standards as imposed by law upon court-appointed counsel and shall perform fully thereunder. The County shall have the right to notify the Attorney in writing of any concern or problem as determined by the Board of County Commissioners and require the Attorney to attend a conference to discuss and review the same, provided however, the duty of the Attorney to represent clients for whom the Attorney are appointed shall be required by law and no infringement thereof shall be made.

The Attorney shall be able to pursue both private civil and criminal practices in addition to the duties under this Contract. However, Attorney shall not take or pursue any new cases adverse to the County without a written waiver of conflict by the County. Also, Attorney shall not take or pursue any contract that creates an automatic conflict with the cases for which they are First Level Conflict Attorney. This provision applies directly to Attorney under this Contract and is not imputed to other Attorneys if Attorney is part of a law firm and not a solo practitioner.

If at the conclusion of the term of this Contract, the services of the Attorney are not renewed by a new contract, the Attorney shall continue representation of clients appointed prior to the termination date of this Contract until the 15th day of October, 2024, provided however, any appearance or representation necessary after September 30, 2024, shall be compensated by the County at the hourly rate established in this contract. Such representation after September 30, 2024, shall be provided by the Attorney herein only if a new contract has not been executed by that date. Further, this provision shall not relieve the parties of the duty to negotiate in good faith using their best efforts to determine the compensation rate for the next contract period, if applicable.

The County makes no guarantee or warranty of any nature as to the number of cases that will be assigned to Attorney. The County also makes no guarantee of any minimum amount of compensation that Attorney can expect to earn from this Contract.

6. **NOT AN OFFICE OF PUBLIC DEFENDER** – The Attorney shall not be deemed to serve in the office of the Public Defender of Bonner County, Idaho. This Contract for legal services shall be deemed to be an arrangement with the courts to assign attorneys on an equitable basis through a systematic coordinated plan under Idaho Code §19-859(a)(2) for conflicts coverage only.

7. **FACILITIES FOR EVALUATION** – As provided by Idaho Code §19-861(c), the Attorney is entitled to use the same state facilities for evaluation of evidence as are available to the Prosecuting Attorney of Bonner County. If the Attorney considers use of such facility impractical, the court concerned may authorize the use of private facilities to be provided pursuant to court order and in conjunction with notice and after hearing as identified herein.

8. **DIRECT EXPENSES** – As provided by Idaho Code §19-863(a), direct expenses, including the cost of a transcript that is necessarily incurred in representing a needy person, are a charge against the County and shall be paid by the County or reimbursed to the Attorney in the event Attorney has paid such direct expense. The term "direct expenses" refers to cost or expenses which are incurred for or arise from the representation of a specific client in a specific case, rather than for the general maintenance of a law office. The Attorney will endeavor to minimize such expenses to the best of the Attorney's ability while maintaining proper standards of representation of needy clients. On request by the County, the Attorney will provide to the County a copy of any bill or invoice which the Attorney has paid for such direct expense.

9. **WITHDRAWAL OF ATTORNEY** – The Attorney herein may withdraw from this Contract upon thirty (30) days notice to the County. In the event of the withdrawal of the Attorney or the death of the Attorney who would happen to be the sole principle in a law firm, neither said law firm nor estate of said Attorney, as the case may be, shall have any further right under this Contract except in the right to receive compensation earned for services provided and reimbursement for direct expenses incurred prior to such withdrawal or death.

10. **WITHDRAWAL OF COUNTY** – In the event the County chooses, the County may withdraw from this Contract by providing notice to the Attorney herein, not less than thirty (30) days prior notice of the County's intent to withdraw.

11. **RELATIONSHIP OF PARTIES** – In all matters related to this Agreement, the Attorney is acting as an independent contractor and shall not be entitled to any state, county or local employee benefits, statutory or otherwise. The County is interested only in the quality of the services provided and the final results to be achieved. It is understood and agreed that neither the Attorney nor any employees of the Attorney, if any, are employees of the County under the meaning or application of any federal or state unemployment, insurance or

workman's compensation laws, or otherwise. The Attorney assumes all liability for obligations imposed by one or more of these laws and will hold the County harmless therefrom. The Attorney shall have no authority to make representations that the Attorney is an agent, employee or serving in any other capacity other than that identified under this Agreement.

The Attorney shall be responsible for all federal and state taxes, social security and self-employment related taxes and obligations including federal and state income tax withholding, social security contributions and any other similar obligations related to the Attorney's independent contractor status and providing the services under this Agreement. The Attorney shall indemnify the County and hold the County and agents harmless from any and all claims for these obligations and taxes arising out of Attorney's failure to pay said obligations and/or taxes.

12. **ASSIGNMENT** – Neither this Agreement nor any duties or obligations under this Agreement may be assigned by the Attorney without prior written consent of the County.

13. **INDEMNIFICATION** – Attorney shall indemnify, defend, and hold harmless the County, its officers, agents, and employees from and against any liability, claims, damages, losses, expenses, actions, and suits whatsoever caused by or arising out of the Attorney's negligence or otherwise wrongful performance, act or omission of any duties required under this Agreement.

14. **WAIVER** – The failure of either party to require the other to strictly adhere to the terms of this Agreement shall not operate as a waiver of any rights or subsequent breaches of said rights. This Agreement shall be interpreted according to the laws of the State of Idaho. The courts of the State of Idaho, in and for the County of Bonner, shall be the forum and venue for any lawsuits arising from or incident to this Agreement.

15. **SEVERABILITY** – If any portion of this Contract shall be declared invalid by a court of competent jurisdiction, the remaining provisions of the Contract shall not be invalidated thereby and shall remain in full force and effect.

16. **MODIFICATION** – This Contract may be modified, by the mutual consent of the parties, but such modification must be in writing and executed with the same formalities as this Contract.

17. **ATTORNEY'S FEES** – In the event of a legal proceeding of any kind instituted under this Agreement or to obtain performance under this Agreement, the

prevailing party shall be awarded a reasonable amount as determined by the Court for attorney's fees as well as costs incurred in such proceedings.

18. **COMPLETE AGREEMENT** – This Agreement constitutes the entire understanding of the parties and is complete and final. This Agreement may not be amended or modified except by a written agreement signed by the Attorney and the County.

DATED this _____ day of September, 2023.

BOARD OF BONNER COUNTY COMMISSIONERS

_____
STEVE BRADSHAW, Chairman

_____
LUKE OMODT, Commissioner

_____
ASIA WILLIAMS, Commissioner

ATTEST:

_____

_____, Deputy Clerk

_____
Dana Bowes, Attorney

Date:_____

Office of
BONNER COUNTY PUBLIC DEFENDER
123 S. First Avenue
Sandpoint, Idaho 83864
Telephone: (208) 255-7889 | Fax: (208) 255-7559

Luke Hagelberg, Attorney at Law
Catherine Enright, Attorney at Law
Donald Terry, Attorney at Law

Jay Northam, Attorney at Law
Jennifer Kohout, Attorney at Law
Peter Cook, Attorney at Law

Public Defender
Item #2

October 3, 2023

MEMORANDUM

To: Bonner County Board of Commissioners

From: Luke Hagelberg, Public Defender

Re: Margaret Williams – CASA Attorney (FY2024 Contract)

Description: Margaret Williams represents CASA (Court Appointed Special Advocates) in all Bonner County child protection cases. This allows the Office of the Public Defender to focus on representing the parents/and or child(ren) of said cases. This contract retains her services for FY2024 under the same pay and terms as FY2023.

Legal Review: Approved by _____

Distribution: Original to Public Defender's Office
Copy to BOCC Office
Copy to Auditor's Office

Based on the information before us, I move to approve… and sign the CASA Attorney Contract with attorney Margaret Williams for FY2024.

Recommendation Acceptance: ☐ Yes ☐ No _____ Date:_____
Commissioner Steven Bradshaw, Chairman

CONTRACT FOR SERVICES OF
COURT-APPOINTED SPECIAL ADVOCATE ATTORNEY
FY2024

This Contract is made and entered into by and between Bonner County, a political subdivision of the State of Idaho, herein referred to as the "County", and Margaret Williams, Attorney at Law, herein referred to as the "Attorney".

For valuable consideration, including the mutual promises hereinafter set forth, it is agreed between the County and the Attorney in their individual capacities, as follows:

1. **LEGAL SERVICES -** During the period of October 1, 2023 through September 30, 2024, the Attorney is retained by the County to provide legal services in the courts of Bonner and Boundary Counties which require the courts of Bonner and Boundary County to appoint an attorney for Court Appointed Special Advocate hereinafter referred to as "CASA" and such other court proceedings associated with said appointment.

   Attorney represents that he/she possesses and agrees to apply the necessary skills, knowledge, experience and training to provide legal representation in each case assigned to Attorney consistent with applicable professional standards, the PDC standards for Defending Attorneys, including the Idaho Rules of Professional Conduct.

2. **LICENSES** – Attorney warrants that he/she is an active member of the Idaho State Bar and in good standing and will maintain that status throughout the term of this Contract. Attorney agrees to maintain in full force and effect any other licenses, certificates or permits required by the federal, state, county or municipal governments in order to provide services under this contract.

3. **TRAINING REQUIREMENTS** – The contract shall require each defending attorney providing services pursuant to the contract to participate in regular training programs on criminal defense law or child protection law, including a minimum of seven (7) hours of continuing legal education annually in areas relating to their public defense practice, as required by the most recent edition of "Standards for Defending Attorneys."

4. **COMPENSATION -** The Attorney shall be paid for legal services a total annual compensation of Forty-Two Thousand Dollars ($42,000) payable in twelve monthly payments of Three Thousand Five Hundred Dollars ($3,500) through the period ending September 30, 2024.

   It is agreed that the payment of the above-described compensation will include payment of the Attorney, secretarial allowance and the other allowances under Idaho Code §19-861(b)(2) for any expenses, including office space, furniture, equipment, books, postage, and supplies necessary in carrying out the duties

under this agreement. However, said allowances for expenses may be increased for extraordinary services and expenses not recurring on a regular basis if authorized by court order after notice to Bonner County and a hearing to consider the same. Such extraordinary services and expenses may be paid in addition to the contract amount. Any expense incurred in transportation, mileage expense for court appearance or client and witness interviews by the Attorney in either Bonner or Boundary County, shall be the responsibility of the Attorney. If in performing services that are the responsibility of the Attorney under this Agreement requires travel out of Bonner or Boundary County, the Attorney so incurring expenses shall be reimbursed for such travel, meals, and lodging in accordance with rates paid to Bonner County employees pursuant to Bonner County policy.

The undersigned Attorney further agrees to keep such records as are required by Idaho Code §19-864 in respect to representation of indigent persons. The Attorney agrees to provide such records and report to the board of county commissioners and to the district court as required by statute or upon request.

The Attorney shall comply with and meet all standards as imposed by law upon court-appointed counsel and shall perform fully thereunder. Bonner County shall have the right to notify any Attorney in writing of any concern or problem as determined by the Board of County Commissioners and require the Attorney to attend a conference to discuss and review the same; provided, however, the duty of the Attorney to represent those clients for whom the Attorney is appointed shall be required by law and no infringement thereof shall be made.

The undersigned Attorney shall be able to pursue private civil and criminal practices in addition to the duties under any such agreement or contract with Bonner County, Idaho. However, Attorney shall not take or pursue any new cases adverse to the County without a written waiver of conflict by the County.

If, at the conclusion of the term of this Agreement, the services of the Attorney are not renewed by a new contract, the Attorney shall continue representation of clients appointed prior to the termination date of this Agreement until the 15th day of October, 2024, provided however, that any appearance or representation necessary after September 30, 2024 shall be compensated by the County at the rate established by the district court for representation of indigent persons on an hourly basis. Such representation after September 30, 2024 shall be provided by the Attorney herein only if a new contract has not been executed by that date.

The Attorney serving hereunder is not deemed to be an office of the public defender under Idaho Code §19-861(a). This Agreement for legal services shall be deemed to be an arrangement with the courts by the County to assign an attorney on a systematic, coordinated plan in accordance with Title 19, Chapter 8 of Idaho Code.

4. **DIRECT EXPENSES** - Direct expenses as provided by Title 19, Chapter 8 of Idaho Code, including the cost of a transcript that is necessarily incurred in representing an appointed person, is a charge against the County and shall be paid by the County or reimbursed to the Attorney in the event that the Attorney has paid such direct expense. The term "direct expense" refers to costs or expenses which are incurred or arise from the representation of a specific client in a specific case rather than for the general maintenance of a law office. The Attorney will endeavor to minimize such expenses to the best of the Attorney's ability while maintaining proper standards of representation of appointed persons. On request of the County, the Attorney will provide to the County a copy of any bill or invoice which the Attorney has paid for such direct expense.

5. **RETENTION OF FILES** – The Attorney will safeguard and retain case files and records as necessary to protect assigned client, and at termination of their contract, transfer files to the successor contract Attorney; proper safeguards will be put in place to ensure no file is transferred to an attorney who may have a conflict.

6. **NOTIFICATION OF CHARGES** – The Attorney will notify the county and the lead institutional Defending Attorney if the Idaho State Bar or other licensing organization files formal charges against the Attorney or non-attorney staff.

7. **DISCLOSURE TO THE PDC** – The Attorney authorizes the disclosure of this contract to the PDC.

8. **WITHDRAWAL OF ATTORNEY** - The Attorney may withdraw from this Agreement upon ninety (90) days notice to the County. In the event of the withdrawal of the Attorney or the death of the Attorney, neither said Attorney nor the estate of said Attorney as the case may be, shall have any further right under this Agreement except the right to receive compensation earned for services provided and reimbursement for direct expenses incurred prior to such withdrawal or death. A replacement for said Attorney shall be approved by the County.

9. **WITHDRAWAL OF COUNTY** - In the event the County chooses, the County may withdraw from this Contract by providing notice to the Attorney identified herein with providing not less than ninety (90) days notice prior to withdrawal.

10. **RELATIONSHIP OF PARTIES** - In all matters related to this Agreement, the Attorney is acting as an independent contractor and shall not be entitled to any state, county or local employee benefits, statutory or otherwise. The County is interested only in the quality of the services provided and the final results to be achieved. It is understood and agreed that neither the Attorney nor any employees of the Attorney, if any, are employees of the County under the meaning or application of any federal or state unemployment, insurance or workman's compensation laws, or otherwise. The Attorney assumes all liability

for obligations imposed by one or more of these laws and will hold the County harmless therefrom. The Attorney shall have no authority to make representations that the Attorney is an agent, employee or serving in any other capacity other than that identified under this Agreement.

The Attorney shall be responsible for all federal and state taxes, social security and self-employment related taxes and obligations including federal and state income tax withholding, social security contributions and any other similar obligations related to the Attorney's independent contractor status and providing the services under this Agreement. The Attorney shall indemnify the County and hold the County and agents harmless from any and all claims for these obligations and taxes arising out of Attorney's failure to pay said obligations and/or taxes.

11. **ASSIGNMENT** - Neither this Agreement nor any duties or obligations under this Agreement may be assigned by the Attorney without prior written consent of the County.

12. **INDEMNIFICATION** - Attorney shall indemnify, defend, and hold harmless the County, its officers, agents, and employees from and against any liability, claims, damages, losses, expenses, actions, and suits whatsoever caused by or arising out of the Attorney's negligence or otherwise wrongful performance, act or omission of any duties required under this Agreement.

13. **WAIVER** - The failure of either party to require the other to strictly adhere to the terms of this Agreement shall not operate as a waiver of any rights or subsequent breaches of said rights. This Agreement shall be interpreted according to the laws of the State of Idaho. The courts of the State of Idaho, in and for the County of Bonner, shall be the forum and venue for any lawsuits arising from or incident to this Agreement.

14. **ATTORNEY'S FEES** - In the event of a legal proceeding of any kind instituted under this Agreement or to obtain performance under this Agreement, the prevailing party shall be awarded a reasonable amount as determined by the Court for attorney's fees as well as costs incurred in such proceedings.

15. **COMPLETE AGREEMENT** - This Agreement constitutes the entire understanding of the parties and is complete and final. This Agreement may not be amended or modified except by a written agreement signed by the Attorney and the County.

DATED this _____ day of October, 2023.

BONNER COUNTY BOARD OF COMMISSIONERS:

_____
STEVE BRADSHAW, Chairman

_____
LUKE OMODT, Commissioner

_____
ASIA WILLIAMS, Commissioner

Attest:

_____
_____, Deputy Clerk

_____
MARGARET WILLIAMS, Attorney

Date: 09/28/2023

Bonner County Treasurer's Office

Clorrisa Koster, Treasurer
1500 Hwy 2, Ste 304 – Sandpoint, ID 83864-1305
Telephone (208) 265-1433 - Fax (844) 565-7873

TREASURER ITEM #1

October 10, 2023

Memorandum

To: Bonner County Commissioners

From: Clorrisa Koster, Bonner County Treasurer

Re: **Approval to pay excess tax sale funds to Treeport Homeowner's Association and Ken Youmans per Idaho Code §31-808.**

Per Idaho Code 31-808 (c) the time has passed for accepting claims for overages from the tax sale. We received two claims for the tax sale overage of $177,488.04 on parcel RP005650020090. I am requesting that the Board of County Commissioners approve payment of the overage to Treeport Homeowner's Association in the amount of $1,451.19 and Ken Youmans in the amount of $176,036.85.

Legal has reviewed and approved.

A suggested motion would be: I move to approve payment of the excess tax sale funds in the amount of $177,488.04 on parcel RP005650020090. We received two claims and the time for recorded parties of interest and record owners to make a claim for the overage has passed. $1,451.19 will be paid to Treeport Homeowner's Association and $176,036.85 will be paid to Ken Youmans. This has been reviewed and approved by legal.

Recommendation Acceptance: □ yes □ no _____ Date: _____
Commissioner Steven Bradshaw, Chairman

Bonner County Treasurer's Office

Clorrisa Koster, Treasurer
1500 Hwy 2, Ste 304 – Sandpoint, ID 83864-1305
Telephone (208) 265-1433 - Fax (844) 565-7873

TREASURER ITEM #2

October 10, 2023

Memorandum

To: Bonner County Commissioners

From: Clorrisa Koster, Bonner County Treasurer

Re: **Approval to pay excess tax sale funds to State of Idaho, Department of Health & Welfare per Idaho Code §31-808.**

Per Idaho Code §31-808 (c) the time has passed for accepting claims for overages from the tax sale. We received one claim for the tax sale overage of $152,788.22 on parcel RP56N05W137801. I am requesting that the Board of County Commissioners approve payment for a portion of the overage to State of Idaho, Department of Health & Welfare for their claim amount of $6,310.45.

Legal has reviewed and approved.

A suggested motion would be: I move to approve payment for a portion of the excess tax sale funds in the amount of $152,788.22 on parcel RP56N05W137801. We received one claim and the time for recorded parties of interest and record owners to make a claim for the overage has passed. $6,310.45 will be paid to State of Idaho, Department of Health & Welfare which represents the amount of their claim. This has been reviewed and approved by legal.

Recommendation Acceptance: □ yes □ no _____ Date: _____
Commissioner Steven Bradshaw, Chairman

Bonner County Treasurer's Office

Clorrisa Koster, Treasurer
1500 Hwy 2, Ste 304 – Sandpoint, ID 83864-1305
Telephone (208) 265-1433 - Fax (844) 565-7873

TREASURER ITEM #3

October 10, 2023

Memorandum

To: Bonner County Commissioners

From: Clorrisa Koster, Bonner County Treasurer

Re: **Approval to pay excess tax sale funds to Clarence W Taylor and Nancy J Taylor per Idaho Code §31-808.**

Per Idaho Code §31-808 (c) the time has passed for accepting claims for overages from the tax sale. We received two claims for the tax sale overage of $6,612.48 on parcel RP57N03W179990. I am requesting that the Board of County Commissioners approve payment of the overage to Clarence W Taylor in the amount of $3,306.24 and Nancy J Taylor in the amount of $3,306.24.

Legal has reviewed and approved.

A suggested motion would be: I move to approve payment of the excess tax sale funds in the amount of $6,612.48 on parcel RP57N03W179990. We received two claims and the time for recorded parties of interest and record owners to make a claim for the overage has passed. $3,306.24 will be paid to Clarence W Taylor and $3,306.24 will be paid to Nancy J Taylor. This has been reviewed and approved by legal.

Recommendation Acceptance: □ yes □ no _____ Date: _____
Commissioner Steven Bradshaw, Chairman

Bonner County Treasurer's Office

Clorrisa Koster, Treasurer
1500 Hwy 2, Ste 304 – Sandpoint, ID 83864-1305
Telephone (208) 265-1433 - Fax (844) 565-7873

TREASURER ITEM #4

October 10, 2023

Memorandum

To: Bonner County Commissioners

From: Clorrisa Koster, Bonner County Treasurer

Re: **Resolution Authorizing Transfer of Excess Sale Proceeds to the State Treasurer per Idaho Code §31-808**

I am requesting that the Board of County Commissioners approve the attached Resolution authorizing the transfer of excess tax sale proceeds as shown in Exhibit A to the State Treasurer.

Per Idaho Code 31-808(2)(c) the time has passed for accepting claims for overages from the tax sale and Idaho Code 31-808(2)(d) states that with the consent of the state treasurer, the board of county commissioners may transfer funds to be paid to parties in interest or the owner(s) of records pursuant to paragraph (c) of this subsection to the state treasurer. Upon transfer, the board of county commissioners shall immediately notify by first-class mail all parties that submitted a claim on the proceeds and the owner(s) of record of the transfer. The board of county commissioners shall provide such information to the state treasurer concerning the claims and the proceeds as the state treasurer shall reasonably request. The state treasurer shall keep and distribute the proceeds in accordance with chapter 5, title 14, Idaho Code.

The County Treasurer's Office will notify all record owners and recorded parties of interest that the funds have been turned over to the State Treasurer on behalf of the County Commissioners and turn over all required documentation needed.

The State has additional resources to process claims and locate taxpayers.

Legal has reviewed the resolution.

A suggested motion would be: **I move to approve Resolution # 23-_____ to transfer the excess tax sale funds as shown in Exhibit A to the State Treasurer. The time for recorded parties of interest and record owners to make a claim for the overage has passed. The State has better resources to manage the funds and locate the owners. This Resolution has been approved by legal.**

Recommendation Acceptance: □ yes □ no _____ Date: _____
Commissioner Steven Bradshaw, Chairman

EXHIBIT A

TAX SALE OVERAGE TURNED OVER TO IDAHO STATE TREASURER

PARCEL NUMBER	TAX SALE OVERAGE AMOUNTS
RP56N04W340151 Aichele, Harvey R Sudetenstr 8 71083 Herrenberg - Gultstein, Germany	**$72,088.26**
RP56N05W137801 Rasmussen, Ervin H Trustee Rasmussen Trust 4031 Thousand Oaks Dr Apt 1405 San Antonio, TX 78217-1852	$152,788.22 Less Claim - $6,310.45 **$146,477.77**
RP59N02W114800 Green Forest Group 413 W Fourth Ave Spokane, WA 99204	**$13,703.66**

TOTAL OVERAGE $232,269.69

RESOLUTION #23-_____

TREASURER'S OFFICE

A RESOLUTION OF THE BOARD OF BONNER COUNTY COMMISSIONERS, STATE OF IDAHO, BONNER COUNTY, AUTHORIZING TRANSFER OF EXCESS SALE PROCEEDS TO THE STATE TREASURER PURSUANT TO IDAHO CODE §31-808

The following resolution and order were considered and adopted by the Bonner County, Idaho Board of Commissioners ("Board") on the _____ day of October 2023.

Upon the motion of Commissioner _____ and second by Commissioner _____, the Board resolves as follows:

WHEREAS, Idaho Code §31-801 grants the general powers and duties, subject to the restrictions of law, to the boards of county commissioners in their respective counties; and

WHEREAS, Idaho Code §31-828 grants the Board authority "to do and perform all other acts…which may be necessary to the full discharge of the duties of the chief executive authority of the county government"; and

WHEREAS, Idaho Code §31-807 authorizes the Board to manage county property subject to restrictions including, but not limited to, those described in Idaho Code §31-808; and

WHEREAS, Idaho Code §31-808 authorizes the Board to sell surplus properties acquired by tax deed; and

WHEREAS, Idaho Code §31-808 provides that proceeds from the sale of property acquired by tax deed, after payment of all delinquent taxes, late charges, interest and costs, (excess proceeds) be apportioned by the Board of parties in interest that make claims, and then to the owner(s) of record at the time the tax deed was issued on the property; and

WHEREAS, Idaho Code §31-808 was amended by 2016 Senate Bill 1347a to permit the County, after payment of party in interest claims, to transfer excess proceeds resulting from the sale of tax deeded properties to the State Treasurer to be claimed and distributed as unclaimed property; and

WHEREAS, The State Treasurer has indicated that she will accept transfer of unpaid excess proceeds in the possession of the County provided certain conditions are met and

WHEREAS, the County has certain unpaid excess proceeds on account as set forth in Exhibit A, and finds that transferring said proceeds to the State Treasurer will result in more efficient processing of such claims; and

WHEREAS, the board had determined that the County met the requirements for transferring said excess proceeds to the State Treasurer

NOW THEREFORE, THE BOARD OF COMMISSIONERS OF BONNER COUNTY, IDAHO HEREBY RESOLVES, that the excess proceeds, as described in Exhibit A, be transferred to the State Treasurer, pursuant to Idaho Code §31-808, together with a completed unclaimed property report as directed by the State Treasurer and such other information that the State Treasurer might reasonably request.

IT IS FURTHER RESOLVED BY THE BOARD, that notice of said transfer be sent as required by Idaho Code §31-808.

IT IS FURTHER RESOLVED BY THE BOARD, that this resolution shall be effective this _____ day of October 2023.

_____ Motion Carried Unanimously
_____ Motion Carried/Split Vote Below
_____ Motion Defeated/Split Vote Below

	Yes	No	Did Not Vote
_____ Steven Bradshaw, Chairman	____	____	____
_____ Asia Williams, Commissioner	____	____	____
_____ Luke Omodt, Commissioner	____	____	____

ATTESTED
By_____
Deputy Clerk

RESOLUTION AUTHORIZING
TRANSFER OF EXCESS SALE PROCEEDS
TO THE STATE TREASURER

RESOLUTION NO. _____

BONNER COUNTY
EMERGENCY MANAGEMENT

1500 Highway 2, Suite 101
Sandpoint, ID 83864

Phone: 208-255-5681
E-mail: em@bonnercountyid.gov

October 10th, 2023

Emergency Management Item #1

MEMORANDUM

To: Commissioners

From: Bob Howard
Director Emergency Management

Re: SPOTBUS MOU

Description: Bonner County had an MOU with SPOTBUS (SELKIRKS-PEND OREILLE TRANSIT) that recently expired. Bonner County Emergency Management and SPOTBUS have worked together to update the contents of the new MOU to renew the agreement inwhich SPOTBUS will provide transportation services for those who are providing emergency services to designated populations affected by an emergency, disaster, or public health emergency.

Legal Review: Approved by legal: B Wilson

Distribution: Original to BOCC
Copy to Bob Howard & Cameron La Combe

A suggested motion would be: **Based on the information provided, I make a motion to have Bonner County accept and sign the MOU with Spotbus for them provide transportation services in time of an emergency or natural disaster.**

Recommendation Acceptance: □ yes □ no _____ Date: _____
Commissioner Steve Bradshaw, Chairman

THIS MEMORANDUM OF UNDERSTANDING (MOU) is hereby entered into by and between **SELKIRKS-PEND OREILLE TRANSIT** ("the SPOT") and **BONNER COUNTY** ("the County").

THE PARTIES AGREE AS FOLLOWS:

I. PURPOSE.

The purpose of this MOU is to provide transportation services for the general public, special populations, and to volunteers and support personnel who are providing emergency services to designated populations affected by an emergency, disaster, or public health emergency.

II. STATEMENT OF BACKGROUND INFORMATION.

Continued growth in Bonner County has required contingency planning in the event of a public health emergency, natural disaster or terrorist event.

III. STATEMENT OF MUTUAL BENEFIT AND INTEREST.

Selkirks-Pend Oreille Transit and the County hereby agree to work together to provide transportation for displaced citizens and emergency personnel affected by a natural disaster or terrorist event as follows:

The County shall:

- Notify the SPOT emergency contact when use of its' transportation services are needed during an emergency. The County is aware that during certain times the facilities may be unavailable for use due to previously scheduled events.
- Request for usage of the SPOT will come from the Board of County Commissioners or the Bonner County Emergency Manager who will have the authority to implement emergency procedures.
- In the case of an emergency, provide the SPOT with forecasted numbers of persons to be transported during a disaster or emergency has been declared.
- Reimburse the SPOT for fuels, utilities, food, and any other materials used during emergency transportation operations.
- Reimburse the SPOT the amount of gross salary of its personnel employed during these emergency shelter operations gross salaries to include employer portion of FICA and FUTA.

The Selkirks-Pend Oreille Transit shall:

- Provide availability of the SPOT transportation services to be used by Bonner County as a temporary emergency during an emergency or disaster when appropriate.
- Provide Bonner County with contact information of the SPOT representatives to be called to make the space available for usage by Bonner County.
- Provide transportation services, qualified drivers, heavy equipment, and support functions as necessary, and as available, within 24 hours of notification from Bonner County.
- Be Solely responsible for the supervision of their employees, as well as the operations, maintenance, insurance liability of the requested transportation resources and heavy equipment.
- It is understood by all parties to this agreement that these services will be used only when the County makes a declaration that a disaster or emergency exists.
- Compensation to the above mentioned party will be in accordance with Title 46 Chapter 10 and Idaho Code. The County will assist the SPOT by coordinating all requests for compensation.

IV. PRINCIPAL CONTACTS- The principal contacts for this MOU are:

BONNER COUNTY	CONTACT #1	CONTACT #2	CONTACT #3
Bob Howard Director	Donna Griffin Executive Director		
Bonner County Emergency Management	SPOTBUS		
1500 Highway 2 STE 101 Sandpoint, ID 83864	31656 HWY 200 Box 8 Ponderary, ID 83852		
Phone: 208-265-8867 Cell: 208-255-6901	Phone: 208-263-3774 Cell: 208-946-7656		
bob.howard@ bonnercountyid.gov	dgriffin@spotbus.org		

V. COMMENCEMENT/EXPIRATION DATE This MOU shall be effective as of the date of last signature below and shall remain in full force and effective for three consecutive years, at which time it will expire unless extended by mutual written agreement of parties.

VI. EARLY TERMINATION Either party may terminate the MOU with thirty (30) days' written notice to the other party.

VII. MODIFICATION Modifications of this MOU shall be made by mutual consent of the parties by the issuance of a written addendum executed by each of the parties to this MOU. Any such modification shall be effective as of the date of the last signature on the addendum.

VIII. LIABILITY (NOTE: SPOT is referred to throughout this agreement as "the SPOT"):

Subject to the limits of the Idaho Tort Claims Act, Idaho constitution or any law, rule or regulation granting immunity to the County, the County shall be Solely responsible for any loss, costs, damages or injury caused to the third parties or property arising from the actions of the County, or its elected officials, employees, agents, or volunteers, and shall indemnify, hold harmless and defend the SPOT from any claims, litigation or liability arising from such actions taken pursuant to this MOU.

A. The COUNTY agrees to hold harmless, protect and indemnify the SPOT from and against any and all liabilities, losses, damages, expenses and charges, including but not limited to attorney's fees and expenses of litigation, which may be sustained or incurred by the SPOT or alleged as against the SPOT, arising directly or indirectly from the actions of the COUNTY, its employees and officers, from any claim, judgment, order, proceeding or process arising from or based upon or growing out of the use of SPOT Property or this Agreement. The COUNTY further agrees to maintain liability insurance in the minimum amount required under the Idaho Tort Claims Act, which is currently $500,000.00 per occurrence, or an aggregate of $500,000.00 per occurrence, and the COUNTY shall provide the SPOT with proof of coverage if requested.

B. The SPOT agrees to hold harmless, protect and indemnify the COUNTY from and against any andall liabilities, losses, damages, expenses and charges, including but not limited to attorney's fees and expenses of litigation, which may be sustained or incurred by the COUNTY or alleged as against the COUNTY, arising directly or indirectly from the actions of the SPOT, its employees and officers, from any claim, judgment, order, proceeding or process arising from or based upon or growing out of the use of SPOT Property or this Agreement. The SPOT further agrees to maintain liability insurance in the minimum amount required under the Idaho Tort Claims Act, which is currently $500,000.00 per occurrence, or an aggregate of $500,000.00 per occurrence, and the SPOT shall provide the COUNTY with proof of coverage if requested.

C. The covenants and agreement regarding liability as set forth in this section, particularly subparagraph (A) and (B), shall not apply, one party to the other, in the event of a wrongful act of a third party (i.e., passenger or guest), which wrongful action does not arise from a negligent or wrongful act of the COUNTY or the SPOT.

IX. PARTICIPATION IN SIMILAR ACTIVITES This instrument in no way restricts SPOT or the County from participating in similar activities with other public or private agencies, organizations, and individuals.

X. NON-FUND OBLIGATION DOCUMENT This instrument is neither a fiscal or obligating document. Any endeavor involving reimbursement, contribution of funds, or transfer of anything of value between the parties to this instrument will be handled in accordance with applicable laws, regulations, and procedures including those governing government procurement and printing. Such endeavors will be outlined in separate agreements that shall be made in writing by representatives to the parties and shall be independently authorized by appropriate statutory authority. This instrument does not provide such authority. Specifically, this instrument does not establish authority of non-competitive award to SPOT of any contract or other agreement. Any contact of training or other services must fully comply with all applicable requirements for competition.

The persons executing this MOU on behalf of their respective entities hereby represent and warrant that they have the right, power, and legal capacity, and appropriate authority to enter into this MOU on behalf of the entity for which they sign.

IN WITNESS WHEREOF, the parties hereto have executed the memorandum of understanding as of the last date written below

DATED this _____ day of _____, 2023

Selkirks-Pend Oreille Transit

_____
Nancy Lewis, Board Chair

DATED this _____ day of _____, 2023.

BONNER COUNTY
BOARD OF COMMISSIONERS

_____
Steve Bradshaw, Chairman

_____
Asia Williams, Commissioner

_____
Luke Omodt, Commissioner

ATTEST:

By: _____
Deputy Clerk

AIRPORTS

Dave Schuck
208-255-9179

AIRPORT ITEM #1

Meeting Date: October 10, 2023

MEMORANDUM

To: Commissioners

Re: Mutual Easement Acquisition between Bonner County and Big Toy Condos, LLC.

Description: Bonner County would like to acquire an avigation easement over a parcel of land adjacent to Sandpoint Airport owned by Big Toy Condos, LLC. Big Toy Condos would like to acquire an underground stormwater conveyance easement on airport property.

An agreement has been reached wherein Bonner County will grant the stormwater easement in exchange for the avigation easement over Big Toy Condos and approximately $15,000 in proceeds from the removal of trees on airport property as described in the attached appraisal, legal descriptions, and exhibits.

The proposed easement agreement is in the public interest in that it removes a hazard to navigation presented by the trees on airport property and ensures right-of-flight and safety of navigation over the adjacent private property.

I recommend approving this resolution and acquiring this easement.

Legal Review: ____X____
Auditing Review: _____

Distribution: Original to BOCC Office; email copy to Airports – Dave Schuck; copy to Auditing

A suggested motion would be: Mr. Chairman based on the information before us I make a motion to approve Resolution #2023-_____ approving the acquisition of this easement as presented.

Recommendation Acceptance: □ yes □ no _____ Date:_____
Commissioner Steven Bradshaw, Chairman

Resolution

WHEREAS, *Idaho Code* §31-807 vests the Board of County Commissioners with the power and authority to manage real and personal property for the benefit of the County; and

WHEREAS, *Idaho Code* §31-808(7) vests the Board of County Commissioners with the power and authority, at its discretion, when in the county's best interest, to exchange and do all things necessary to exchange any of the real property now or hereafter held and owned by the county for real property of equal value, public or private; and

WHEREAS, Big Toy Condos, LLC, desires to grant to Bonner County a Surface and Overhead Avigation Easement, as set forth in Exhibit "A", attached hereto and incorporated herein by reference; and

WHEREAS, Bonner County desires to grant to Big Toy Condos, LLC, a Stormwater Easement on the real property described in Exhibit "B", attached hereto and incorporated herein by reference; and

WHEREAS, the value of the easements identified hereinabove are of approximately equal value; and

NOW THEREFORE, BE IT HEREBY RESOLVED that the Bonner County Board of Commissioners finds that the exchange of the easements identified hereinabove is in the best interest of Bonner County.

BE IT FURTHER RESOLVED that the Bonner County Board of Commissioners hereby authorizes the exchange of the easements identified hereinabove pursuant to *Idaho Code* §31-808(7).

BE IT FURTHER RESOLVED that the Bonner County Board of Commissioners hereby authorizes the acceptance of the Surface and Overhead Avigation Easement and the execution and recording of a Stormwater Easement.

Upon a motion to adopt the text of the foregoing Resolution made by Commissioner _____, seconded by Commissioner _____, the following vote was recorded:

Commissioner Williams:
Commissioner Omodt:
Chairman Bradshaw:

Upon said roll call, the text of the foregoing was duly enacted as a Resolution of the Board of Commissioners of Bonner County, Idaho on the _____ day of _____, 2023.

Dated this _____ day of _____, 2023.

BONNER COUNTY
BOARD OF COMMISSIONERS

_____
Steven Bradshaw, Chairman

_____
Luke Omodt, Commissioner

_____
Asia Williams, Commissioner

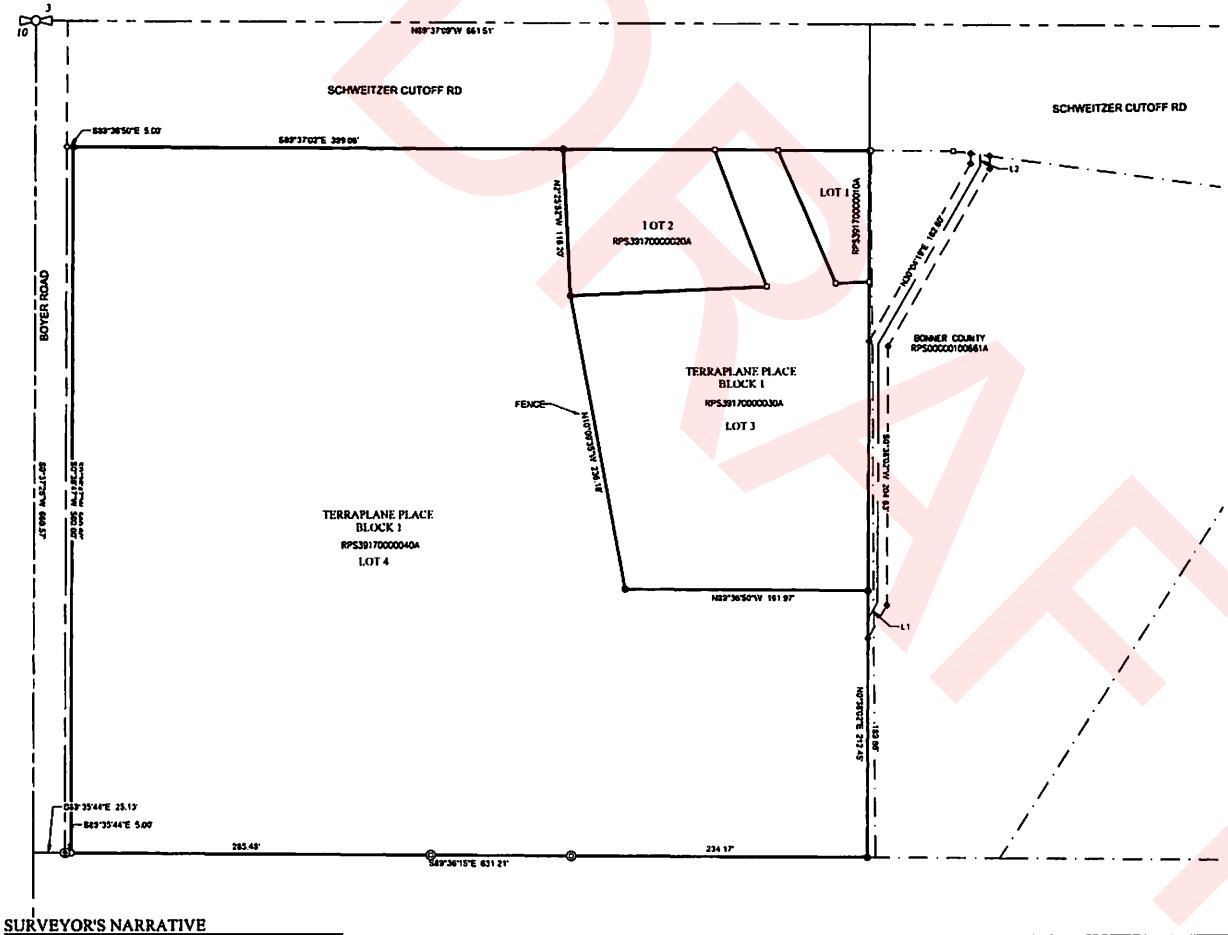
ATTEST:
MICHAEL W. ROSEDALE, CLERK

By:_____
Deputy Clerk

RECORD OF SURVEY

A PORTION OF THE NORTHEAST QUARTER OF SECTION 10, TOWNSHIP 57 N., RANGE 4 W., BOISE MERIDIAN, BONNER COUNTY, IDAHO

INST.#



N

H-Scale 1"= 60'

60' 30' 0 60' 120'

LEGEND

- FOUND 5/8" REBAR WITH YELLOW PLASTIC CAP, P.L.S. 974, OR AS NOTED
- FOUND MAG NAIL IN WASHER PLS 9905
- FOUND 5/8" REBAR WITH CAP, P.L.S. 6107
- DISTURBED BY CONSTRUCTION RE SET 5/8" x 24" REBAR WITH YELLOW PLASTIC CAP, P.L.S. 9367
- SET A 1/2" X 24" RECAR AND PLS 9367 CAP
- CALCULATED POSITION, NOTHING FOUND OR SET
- N-S 1/4 SECTION CORNER AS NOTED
- SECTION CORNER AS NOTED

CP&F CORNER PERPETUATION & FILING RECORD (WITH INSTRUMENT NO.)
T.P.O.B. TRUE POINT OF BEGINNING
R.O.W. RIGHT-OF-WAY

REFERENCES

IN RECORDS OF BONNER COUNTY, IDAHO

R-1 PLAT OF TERRAPLANE PLACE BY ALAN V. IGEBERT, RECORDED UNDER INSTRUMENT NO. 971472.

R-2 RECORD OF SURVEY BY LAWRENCE L. LEIMMEBER PLS 681, RECORDED UNDER INSTRUMENT NO. 458187

R-3 RECORD OF SURVEY BY MARK W. DUFFNER PLS 9905, RECORDED IN UNDER INSTRUMENT NO. 900456.

BASIS OF BEARING

AS SHOWN HEREON, BASIS OF BEARING FOR THIS SURVEY IS IDAHO STATE PLANE COORDINATE BYSTEM, WEST ZONE, (1103) - US SURVEY FEET. THE PROJECT COORDINATES WERE DERIVED FROM NGS OPUS SOLUTION USING A REFERENCE FRAME OF NAD83 (2011)(EPOCH: 2010.0000). BEARINGS SHOWN ARE GRID AND DISTANCES SHOWN ARE GROUND USING A COMBINED ADJUSTMENT FACTOR (CAF) OF 1.00012194. A CONVERGENCE ANGLE OF - 00°36'09" SHOULD BE USED TO CONVERT GRID BEARINGS TO GEODETIC.

RECORDER'S CERTIFICATE

I HEREBY CERTIFY THAT THIS PLAT WAS FILED FOR RECORD IN THE OFFICE OF THE RECORDER OF BONNER COUNTY, IDAHO THIS

___ DAY OF _____ 20___ AT _____ M.

INSTRUMENT NO. _____ AT THE REQUEST OF JOHNSON SURVEYING.

BY
BONNER COUNTY CLERK DEPUTY CLERK

FEE —

SURVEYOR'S CERTIFICATE

I, CHAD J. JOHNSON, PLS 9367, A PROFESSIONAL LAND SURVEYOR IN THE STATE OF IDAHO, DO HEREBY CERTIFY THAT THIS IS A TRUE SURVEY OF THE PLATTED LAND MADE BY ME, OR UNDER MY DIRECT SUPERVISION, AND THAT APPLICABLE CORNER RECORDS HAVE BEEN FILED, IN COMPLIANCE WITH THE LAWS OF THE STATE OF IDAHO.

_____
CHAD J. JOHNSON PLS 9367 DATE

SURVEYOR'S NARRATIVE

THE PURPOSE OF THIS SURVEY IS TO MONUMENT A STORM WATER EASEMENT OVER PARCEL NUMBER RP00000100681A, THE BOUNDARIES OF TERRAPLANE PLACE WERE DISTURBED BY CONSTRUCTION AND I RESULT THE PLAT BASED ON FOUND MONUMENTS ALONG THE EAST RIGHT OF WAY OF BOYER ROAD AND THE SOUTH LINE OF LOT 4 BLOCK 1 AND SECTION TIES ALONG TIES FROM THE ORIGINAL PLAT..

NOTES

1. THERE WAS NO ATTEMPT MADE TO SHOW PHYSICAL FEATURES OF THE PROPERTY, OR TO SHOW ANY NON-RECORDED EASEMENTS, EXCEPT FOR THOSE SHOWN HEREON.

LINE TABLE		
LINE	BEARING	LENGTH
L1	N30°04'19"E	15.34'
L2	N5°07'37"E	8.81'

PROFESSIONAL LAND SURVEYOR REGISTERED 9367 STATE OF IDAHO CHAD J. JOHNSON

RECORD OF SURVEY

SCHWEITAER CUTOFF ROAD
SECTION 10, TOWNSHIP 57 NORTH, RANGE 2 WEST,
BOISE MERIDIAN, BONNER COUNTY, IDAHO

Johnson Surveying

DATE SURVEYED JUNE, 2022	DRAFTED BY CJJ	PLOT DATE 07/21/2023	SHEET 1 / 1
FILE NAME 22-122 SURVEY	CHECKED BY CJJ	PROJECT No. 22-122	

P.O. Box 2544 Post Falls, ID 83877
208-660-2351
johnsonsurveyingpw.com

EXHIBIT "A"
EASEMENT DESCRIPTION

A STRIP OF LAND 15 FEET IN WIDTH OVER, UNDER AND ACROSS A PORTION OF THE PROPERTY DESCRIBED IN WARRANTY DEED RECORDED UNDER INSTRUMENT NUMBER 993658, RECORDS OF BONNER COUNTY, IDAHO, LYING IN THE NORTHEAST QUARTER OF SECTION 10, TOWNSHIP 57 NORTH, RANGE 2 WEST, BOISE MERIDIAN, CITY OF SANDPOINT, BONNER COUNTY, IDAHO, DESCRIBED AS FOLLOWS:

COMMENCING AT THE SOUTHEAST CORNER OF LOT 4 BLOCK 1 OF TERRAPLANE PLACE, UNDER INSTRUMENT NUMBER 971472, RECORDS OF BONNER COUNTY, IDAHO; THENCE ALONG THE EAST LINE OF SAID LOT 4, NORTH 00°38'02" EAST A DISTANCE OF 189.86 FEET TO THE CENTERLINE OF THE 15 FOOT STORM WATER EASEMENT, SAID POINT BEING THE **TRUE POINT OF BEGINNING**;

THENCE, LEAVING SAID EAST LINE OF LOT 4 BLOCK 1 OF TERRAPLANE PLACE ALONG THE CENTERLINE OF SAID 15 FOOT STORM WATER EASEMENT, NORTH 30°04'19" EAST A DISTANCE OF 15.34;

THENCE, NORTH 00°38'02" EAST PARALLEL TO THE EAST LINE OF TERRAPLANE PLACE A DISTANCE OF 204.63 FEET;

THENCE, NORTH 30°04'19" EAST A DISTANCE OF 162.60 FEET;

THENCE, NORTH 00°07'37" EAST A DISTANCE OF 8.91 FEET TO THE TERMINUS POINT ON THE SOUTH RIGHT OF WAY OF SCHWEITZER CUTOFF ROAD.

WITH THE SIDE LINES OF SAID 15 FOOT STRIP LENGTHENING OR SHORTENING TO INTERSECT THE EAST BOUNDARY OF LOT 4 BLOCK 1 TERRAPLANE PLACE AND THE SOUTH RIGHT OF WAY OF SCHWEITZER CUT ROAD.

SURFACE AND OVERHEAD AVIGATION EASEMENT

THIS INDENTURE is made this ___ day of _____, 2023 by and between Big Toy Condos, whose address is 425 Schweitzer Cutoff Road, Sandpoint, Idaho 83864 ("GRANTORS"), and Bonner County, Idaho, whose address is 1500 Highway 2, Suite 308, Sandpoint, Idaho 83864 ("GRANTEE"). The term GRANTORS as used herein includes GRANTORS' heirs, administrators, executors, successors and assigns regardless of whether explicitly mentioned.

WHEREAS, GRANTORS are the fee owners of the following specifically described parcel of land situated in Bonner County, Idaho, which is hereinafter called the "EASEMENT PROPERTY" and with the legal description(s), maps, and/or drawings attached hereto and made a part hereof as Exhibit A.

WHEREAS, the GRANTEE is the owner and operator of the Sandpoint Airport ("AIRPORT"), situated in Bonner County, Idaho, and in close proximity to the EASEMENT PROPERTY owned by the GRANTORS; and

WHEREAS, the GRANTEE desires to obtain and preserve for the use and benefit of the public a right of free and unobstructed flight for aircraft landing upon, taking off from, or maneuvering about the AIRPORT, and the GRANTORS desire to grant said right;

NOW THEREFORE, for and in consideration of the sum of $1.00 (dollars) and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, and intending to be legally bound, the GRANTORS, for themselves, their heirs, administrators, executors, successors, and assigns, do hereby grant the easement described herein over and across the EASEMENT PROPERTY to the GRANTEE, its successors and assigns, for the benefit of the general public at large:

1. An easement for (i) the free, unobstructed use and passage of all types of aircraft in and through the airspace at any height or altitude above the acquired surface as described and depicted on Exhibit A hereto, and as amended or revised by any applicable airport layout plan, hereinafter referred to as the ACQUIRED SURFACE; (ii) the free, unobstructed passage of aircraft landing upon, taking off from, or maneuvering about the AIRPORT, as legally permitted by state and federal statutes, rules and/or regulations governing aircraft operations on or near airports as they now exist or may be amended or revised in the future; and, (iii) any and all activities that are inherent in the operation of aircraft.

2. The right of said aircraft to cause noise, vibrations, fumes, deposits of dust, fuel

particles (incidental to the normal operation of aircraft); fear, interference with sleep or communication, and any other effects associated with the normal operation of aircraft taking off, landing or operating in the vicinity of the AIRPORT.

As used herein, the term "aircraft" shall mean any and all types of aircraft, whether now in existence or hereafter manufactured and developed, to include jet, propeller-driven, civil, military or commercial aircraft; helicopters, regardless of existing or future noise levels, for the purpose of transporting persons or property through the air, by whoever owned or operated.

This easement shall remain in full force and effect until such time that the AIRPORT shall be abandoned and shall cease to be used for public airport purposes, upon which event it shall terminate automatically with no further action by any party hereto.

The rights and benefits appurtenant to the easement hereby granted include the uses, rights and restrictions as follows:

1. GRANTEE shall at all times have the free, unrestricted:

   (a) right to keep the airspace above the ACQUIRED SURFACE, clear and free from any and all fences, crops, trees, poles, buildings, and other obstructions of any kind or nature which now extend, or which may at any time in the future extend, above the ACQUIRED SURFACE;

   (b) right to remove to ground level any or all natural growths which extend on the EASEMENT PROPERTY above the ACQUIRED SURFACE, to the extent such action is reasonably necessary, in the sole discretion of GRANTEE, in furtherance of the purpose of this easement. Examples include situations in which: (i) trimming is unsafe or not reasonably possible, (ii) the species of the tree or other natural growth is too fast growing, or (iii) trimming would have a reasonable probability of killing the tree or other natural growth or causing it to become susceptible to disease;

   (c) right to remove obstructions from the EASEMENT PROPERTY. Except in cases of imminent danger to health, safety or welfare, the GRANTEE shall provide the GRANTORS reasonable advance written notice of its intent to remove any obstruction;

   (d) right to mark and light, or cause to require to be marked or lighted, as obstructions to air navigation on the EASEMENT PROPERTY, any and all buildings, structures, or other improvements, and trees or other objects, which extend into or above the ACQUIRED SURFACE;

   (e) right of ingress to, passage within, and egress from the EASEMENT PROPERTY,

for the purposes described in subparagraphs (a) through (d) above, at reasonable times and after reasonable notice; and

2. In furtherance of this easement, the GRANTORS hereby covenant, both on their own behalf and on behalf of their successors and assigns, for and during the term of this easement, as follows:

(a) The GRANTORS shall not construct upon the EASEMENT PROPERTY any structure that extends above the ACQUIRED SURFACE.

(b) The GRANTORS shall not promote any activity on the EASEMENT PROPERTY that is incompatible with the purpose of this easement or the AIRPORT.

(c) The GRANTORS shall not cause to be located in the EASEMENT PROPERTY any structure or device that might create electrical interference with radio communication to or from any aircraft, create glare or make it difficult for aircraft pilots to distinguish between airport lights and other lights, impair visibility in the vicinity of the AIRPORT, or otherwise to endanger the landing, taking-off, maneuvering or flight of aircraft.

(d) The GRANTORS shall not use the EASEMENT PROPERTY for any use that would be incompatible with the operation of the AIRPORT including, but not limited to, the following: landfills, open dumps, waste disposal sites, storm water retention ponds, creation of new wetlands, planting of crops that would attract or sustain hazardous bird movements, or any use that would be incompatible with the operation of the AIRPORT.

As additional consideration for the sum paid by GRANTEE to GRANTORS, GRANTORS hereby knowingly and irrevocably waive all claims of any nature, whether sounding in law or equity, together with any associated damages or claims for damages, that GRANTORS may now have, or ever in the future have, as against GRANTEE, caused or alleged to be caused by any of the uses, rights or restrictions granted in or appurtenant to this easement document.

GRANTORS shall, on receipt of notice from GRANTEE, sign, or cause to be signed, all further documents, do, or cause to be done, all further acts, and provide all assurances as may reasonably be necessary or desirable to give effect to the terms of this easement. GRANTORS shall, where the EASEMENT PROPERTY is encumbered by a mortgage or mortgages, facilitate obtaining the consent of all mortgagees, in the form set forth on Exhibit B hereto.

TO HAVE AND TO HOLD said easement, and all rights appertaining thereto unto the GRANTEE, its successors, and assigns, until the AIRPORT shall be abandoned and shall cease to be used for public airport purposes. It is understood and agreed that all provisions herein shall run with the land and shall be binding upon the GRANTORS, their heirs, administrators, executors, successors, and assigns until such time that the easement is extinguished.

IN WITNESS WHERE OF, the GRANTORS have hereunto set their hands and seals this _____ day of _____, 2023.

GRANTORS PRINTED NAMES **SIGNATURE**

_____ _____

STATE OF IDAHO

COUNTY OF _____

On this _____ day of _____, 2023, before me, a Notary Public, in and for said

County, personally appeared _____ to me known to be the same person(s)

described in, and who executed the within instrument.

_____

Notary Public, _____ County, Idaho,

My Commission Expires: _____

When recorded please return to the following address (name and address):

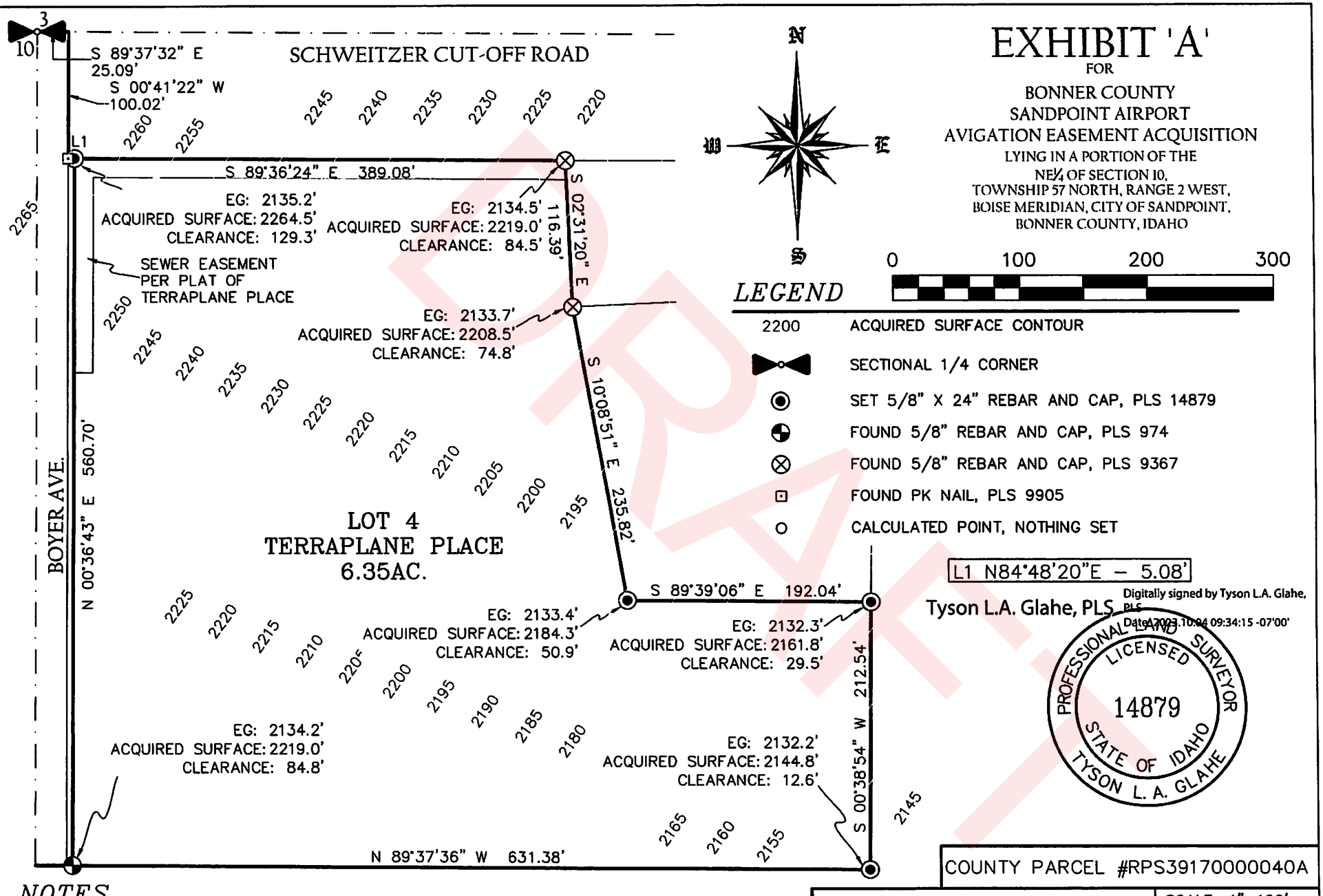


EXHIBIT 'A'

FOR

BONNER COUNTY
SANDPOINT AIRPORT
AVIGATION EASEMENT ACQUISITION

LYING IN A PORTION OF THE
NE¼ OF SECTION 10,
TOWNSHIP 57 NORTH, RANGE 2 WEST,
BOISE MERIDIAN, CITY OF SANDPOINT,
BONNER COUNTY, IDAHO

LEGEND

- 2200 — ACQUIRED SURFACE CONTOUR
- SECTIONAL 1/4 CORNER
- SET 5/8" X 24" REBAR AND CAP, PLS 14879
- FOUND 5/8" REBAR AND CAP, PLS 974
- FOUND 5/8" REBAR AND CAP, PLS 9367
- FOUND PK NAIL, PLS 9905
- CALCULATED POINT, NOTHING SET

L1 N84°48'20"E – 5.08'

Digitally signed by Tyson L.A. Glahe, PLS
Tyson L.A. Glahe, PLS Date: 2023.10.04 09:34:15 -07'00'

PROFESSIONAL LAND SURVEYOR
LICENSED
14879
STATE OF IDAHO
TYSON L. A. GLAHE

COUNTY PARCEL #RPS39170000040A

NOTES

1. THIS SURVEY MAKES NO REPRESENTATION OF OWNERSHIP, NOR ATTEMPTS TO SHOW ALL EASEMENTS OF RECORD OR IN VIEW, NOR PHYSICAL FEATURES AND IMPROVEMENTS OF THE PROPERTY.
2. ELEVATIONS SHOWN ARE BASED ON THE NORTH AMERICAN DATUM OF 1988 (NAVD88), COMPUTED USING GEOID18.

GLAHE & ASSOCIATES
PROFESSIONAL LAND SURVEYORS
P.O. Box 1863
Sandpoint, ID 83864
208–265–4474

SCALE:	1"=100'
DRAWN BY:	TLAG
DATE:	8/18/2023
DWG:	23–000A
SHEET	1 of 1

GLAHE & ASSOCIATES, Professional Land Surveyors

P.O. Box 1863
303 Church Street
Sandpoint, ID 83864

Phone: (208) 265-4474
Fax: (208) 265-0675
Website: glaheinc.com

LEGAL DESCRIPTION
LOT 4 – 6.349 ACRES

Bonner County, Idaho
Section 10, Township 57 North, Range 2 West, B.M.

A PARCEL OF LAND LYING IN SECTION 10, TOWNSHIP 57 NORTH, RANGE 2 WEST, BOISE MERIDIAN, BEING LOT 4, TERRAPLANE PLACE, AS RECORDED IN BOOK 15 OF PLATS, PAGE 99, INSTRUMENT NO. 971472, RECORDS OF BONNER COUNTY, IDAHO, AND BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:

COMMENCING AT THE NORTH 1/4 CORNER OF SAID SECTION 10;

THENCE ALONG THE NORTH SECTION LINE, SOUTH 89°37'32" EAST, 25.09 FEET;
THENCE LEAVING SAID NORTH LINE, SOUTH 00°41'22" WEST, 100.02 FEET;
THENCE NORTH 89°48'20" EAST, 5.08 FEET TO THE NW CORNER, SAID LOT 4 AND THE POINT OF BEGINNING;

THENCE ALONG THE PERIMETER OF SAID LOT 4, THE FOLLOWING SEVEN (7) COURSES:

1. SOUTH 89°36'24" EAST, 389.08 FEET;
2. SOUTH 02°31'20" EAST, 116.39 FEET;
3. SOUTH 10°08'51" EAST, 235.82 FEET;
4. SOUTH 89°39'06" EAST, 192.04 FEET;
5. SOUTH 00°38'54" WEST, 212.54 FEET;
6. NORTH 89°37'36" WEST, 631.38 FEET;
7. NORTH 00°36'43" EAST, 560.70 FEET TO THE POINT OF BEGINNING ENCOMPASSING AN AREA OF 276,578 SQUARE FEET, (6.349 ACRES) MORE OR LESS.

Tyson L.A. Glahe, PLS

Digitally signed by Tyson L.A. Glahe, PLS
Date: 2023.08.18 09:29:46 -07'00'

PROFESSIONAL LAND SURVEYOR LICENSED 14879 STATE OF IDAHO TYSON L. A. GLAHE

EXHIBIT B

CONSENT OF MORTGAGEE

The undersigned, the Mortgagee under that certain Mortgage dated the _____ day of _____, _____, and filed the _____ day of _____, _____, as Document No. _____ in the Office of the County Recorder or Registrar of Titles in and for Bonner County, Idaho, for itself and its successors and assigns, does hereby consent to the foregoing Surface and Overhead Avigation Easement to which this Consent is attached as Exhibit B, and agrees to be bound by the terms thereof and agrees that its interest in the property described therein shall be subordinate to the covenants contained therein. In granting this consent, Mortgagee waives the right to consent to any subsequent amendment or modification of the Surface and Overhead Avigation Easement.

By _____ (signature)
<Name>
_____ (print)
<Name>
_____ (print)
<Title>
_____
<Business/Company name>

State of Idaho
ss.
County of Bonner

The foregoing instrument was acknowledged before me this ____ day of _____, 20___, by _____, the _____ of _____, a _____, on behalf of the _____.

_____ (signature)
Notary Public
Bonner County, Idaho

Prosecutor's Office

Prosecutor's Office #1

October 4, 2023

Memorandum

To: Commissioners

From: Louis Marshall
Bonner County Prosecutor

Re: Renewal of contract for municipal prosecutor legal services with the City of Sandpoint, Idaho.

Description: Under applicable Idaho law, cities are responsible for prosecuting all misdemeanors and infractions which occur within their territorial limits. However, counties routinely provide this service in exchange for compensation. For the last five years, the Bonner County Prosecutor's Office has contracted with the City of Sandpoint to do just that, to great success.

The purpose of this new agreement is to reflect increases in the cost Bonner County will incur to complete its obligations under the Contract. As such the total amount is increasing from $75,000 to $85,000.

Distribution: ____ Copy to BOCC Office
____ Copy to Louis Marshall, Bonner County Prosecutor

A suggested motion would be: **Mr. Chairman based on the information before us I move that the Board approve the contract between the Bonner County Prosecutor's Office and the City of Sandpoint for the provision of municipal prosecutor legal services and authorize the Chairman to sign the agreement administratively.**

Recommendation Acceptance: □ yes □ no _____ Date: _____
Commissioner Steven Bradshaw, Chairman

CONTRACT FOR
MUNICIPAL PROSECUTOR LEGAL SERVICES
CITY OF SANDPOINT, IDAHO

The Parties to this Contract for Municipal Prosecutor Legal Services are Louis Marshall, Bonner County Prosecutor, 127 South First Ave, Sandpoint, Idaho 83864 ("Bonner") and the City of Sandpoint, 1123 Lake Street, Sandpoint, Idaho 83864 ("the City"). Bonner and the City are referred to collectively herein as "the Parties."

WHEREAS, the City desires to contract with Bonner to perform the services of a City Prosecutor prosecuting misdemeanors and infractions occurring within Sandpoint City limits; and

WHEREAS, Bonner desires to contract with the City to provide services as a City Prosecutor;

NOW THEREFORE, for the mutual covenants and considerations described herein, the Parties agree as follows:

1. ROLE OF BONNER AND SCOPE OF WORK: Bonner agrees to provide legal services to the City, specifically prosecution of misdemeanors and infractions where a Sandpoint police officer is the citing and/or investigating officer.

2. FEES AND EXPENSES FOR MATTERS WITHIN THE SCOPE OF WORK: The City agrees to pay Bonner for its services at a rate of SEVEN THOUSAND EIGHTY-THREE DOLLARS AND THIRTY-THREE CENTS ($7,083.33) per month, for a total of EIGHTY-FIVE THOUSAND DOLLARS ($85,000) per year.

3. BILLING AND COMPENSATION: The City shall pay in monthly installments.

4. TERM: This Contract shall be in full force and effect beginning October 1, 2023, and shall renew on the anniversary of that date in each subsequent year unless amended or terminated by either Party.

5. TERMINATION: Either of the Parties may terminate this Contract for any reason or for no reason by giving thirty (30) days written notice to the other Party. Upon termination by either Party, the City agrees to pay to Bonner all fees and expenses for services performed prior to the date of termination.

7. CONFLICTS: Bonner agrees not to undertake representation of any person or entity in a manner adverse to the City's legal interests during the term of the contract. Further, Bonner agrees that, to the best of their actual knowledge, neither Bonner nor anyone in its firm who will be working on specific matters related to representation of the City, has personal, business, or financial interests or relationships which would cause a reasonable individual with knowledge of the relevant facts to question the integrity or impartiality of those who are or will be acting

as representatives of the City. Bonner agrees to evaluate on an on-going basis whether, in its professional judgment, a conflict may become apparent or imminent. In the event that Bonner believes a conflict may develop, Bonner will immediately communicate with City administrators about the perceived potential conflict.

8. INDEPENDENT CONTRACTORS: Bonner shall be an independent contractor to the City and shall not be an employee. This Contract does not create any partnership, joint venture, or relationship other than an independent contractor relationship. Neither Bonner, nor its partners, Of Counsel attorneys, agents, or employees shall be deemed an employee of the City for any purpose whatsoever, and Bonner shall not be eligible to participate in any benefit program provided by the City for its employees. Bonner shall be exclusively responsible for the payment of its own respective taxes, withholding payments, penalties, fees, fringe benefits, contributions to insurance and pension or other deferred compensation plans, including but not limited to worker's compensation and Social Security obligations, professional fees or dues.

9. ASSIGNMENT: Bonner shall not assign or transfer its interest in this Contract.

10. APPLICATION OF LAWS: This Contract shall be interpreted, construed, and governed according to the laws of the State of Idaho.

11. DISPUTE RESOLUTION: Any controversy, dispute, or disagreement arising out of or relating to this Contract, or any breach thereof, shall, unless otherwise agreed to by the Parties, be settled by confidential, informal, binding arbitration with an arbitrator mutually acceptable to the Parties. Each party shall bear its own attorneys' fees and costs for such dispute resolution.

12. NOTICE: All notices required to be sent under this Contract shall be in writing and sent by First Class U.S. Mail or Personal Delivery addressed:

To Bonner:
Bonner Prosecuting Attorney 127 South First Ave,
Sandpoint, Idaho 83864 ("Bonner").

To City:
Sandpoint City Administrator, 1123 Lake Street, Sandpoint,
Idaho 83864 ("the City").

Each Party shall have the continuing obligation to advise the other of any change of address.

13. AGREEMENT: This written authorization embodies the entire agreement between the Parties, and there are no other agreements, oral or written, with reference to this Contract. In case any one or more of the provisions

contained in the Contract shall be held unenforceable, the remaining provisions contained herein shall not be impaired thereby.

14. AMENDMENTS: No change or modification to this Contract shall be valid unless made in writing and signed by both Parties.

15. Board of Commissioners: Idaho Code §§ 31-2604 and 31-3113 allows prosecuting attorneys to contract with cities for such prosecutions with the unanimous approval of the Board of Commissioners. This contract is subject to such approval.

16. EFFECTIVE DATE: The effective date of this Agreement is October 1, 2023.

SIGNED AND AGREED TO on this 20th day of September 2023.

By: _____
Mayor for the City of Sandpoint

Attest:

_____
Melissa Ward, City Clerk

SIGNED AND AGREED TO on the 21 day of September 2023.

By: _____
Louis Marshall, Bonner County Prosecutor

SIGNED AND AGREED TO on the ___ day of _____ 2023.

By: _____
Steve Bradshaw, Chairman of the Bonner County Board of Commissioners

Attest:

_____
Michael Rosedale, County Clerk

No: 23-072
Date: September 20, 2023

RESOLUTION
OF THE CITY COUNCIL
CITY OF SANDPOINT

TITLE: CONTRACT WITH BONNER COUNTY PROSECUTOR FOR MUNICIPAL PROSECUTOR LEGAL SERVICES

WHEREAS: In Idaho, cities are responsible for prosecuting all misdemeanors and infractions that occur within their jurisdiction, and cities routinely contract with the county prosecutor for provision of these legal services;

WHEREAS: Prior to October 2018, the City had one (1) Prosecutor staff position and a contract with the Bonner County Prosecutor to provide backup coverage for the City position;

WHEREAS: In October 2018, the City entered into a contract with the Bonner County Prosecutor for municipal prosecutor legal services;

WHEREAS: City staff and the Mayor recommend entering into a renewal contract with the Bonner County Prosecutor's Office for services that provide the needed redundancy and backup in legal personnel to effectively provide prosecution services for City legal cases; and

WHEREAS: The renewal contract for FY2024 reflects an annual amount of $85,000, which is an increase of approximately 8% over the FY2023 contract to account for increased personnel costs.

NOW, THEREFORE, BE IT RESOLVED THAT: The Mayor, on behalf of the City, is authorized to sign and enter into the Contract for Municipal Prosecutor Legal Services with the Bonner County Prosecutor, a copy of which is attached hereto and made a part hereof as if fully incorporated herein.

Shelby Rognstad, Mayor

ATTEST:

Melissa Ward, City Clerk