

Group Plan

BENEFIT SUMMARY

Plan Document and Summary Plan Description for:
Idaho School District Council Self-Funded Benefit Trust

Plan Sponsor: **Teton School District #401**

This is a self-funded plan and is not an insurance policy and the Idaho School District Council Self-Funded Benefit Trust does not participate in the State Guaranty Association

PPO

Effective Date: September 1, 2017

Quick View

\$3,000 Individual Deductible

\$6,000 Combined Family Deductible

\$4,500 In-Network Individual Out-of-Pocket Limit

\$9,000 In-Network Family Out-of-Pocket Limit

Benefit Period: January 1 through December 31

09-17 SWS PPO (09012017)



An Independent Licensee of the Blue Cross and Blue Shield Association

PLAN UPDATES

To Your Group Plan

Please Read Carefully

Dear Statewide School Enrollee:

This *Plan Update* is a summary of the changes to your health insurance coverage effective on September 1, 2017. We encourage you to review this carefully. For reference, the words and terms capitalized in this document are defined in your member contract.

Major Medical Benefits

- Updated Outpatient Rehabilitation and Habilitation Therapy Services to be listed separately in the outline and include their own separate visit limits. Updated Inpatient Physical Rehabilitation Services to include Habilitation services language.
- Updated the Specifically Listed Preventive Care Services to include routine or scheduled well-baby and well-child examination hearing screenings.
- Added Nondiscrimination Statement and Language Assistance language to the outline.
- Modified the Women's Health and Cancer Rights Act Notice language in the outline.
- Clarified existing Residential Treatment Facility language included in the Psychiatric Care Services Section as well as updated the definitions of Residential Treatment Facility (Program) and Provider.
- Clarified covered Autotransplant services in the Transplant Services Section and moved the existing deceased donor exclusion to the general transplant exclusion section.
- Clarified the benefit for Keratoconus in the Prosthetic Appliances Section.

Prescription Drug

- Added general reference that Smoking Cessation Prescription Drugs are a Covered Service.
- Revised existing pharmacy discount language to include updated third party payer provisions.
- Added clarification on Dispensing Limitations on Specialty Drugs.

Prior Authorization

- Modified the Prior Authorization language to reflect the list of services that require Prior Authorization are listed on the BCI Web site, www.bcidaho.com.

Definitions

- Added definition for Therapeutic Boarding School.
- Modified definition of Physical Rehabilitation Plan of Treatment to coincide with Rehabilitation and Habilitation Inpatient services language.
- Removed last sentence included in the Psychiatric Hospital definition.

Exclusions and Limitations

- Added exclusion to clarify that centers, schools or Facilities which do not provide Outpatient Psychiatric Care Covered Services are not covered.

General Provisions Section

- Updated allowed third party payer provisions included in the Payment of Benefits Section.
- Updated the Out of Area Services Section to include current BlueCard language.

09.17 ASC SWS

PREFERRED BLUE (PPO) MASTER PLAN BENEFITS OUTLINE

This Benefits Outline describes the benefits in general terms. It is important to read the Summary Plan Description document in full for specific and detailed information that includes additional exclusions and limitations on benefits. Your manager of employee benefits should be able to help if you have questions.

For Covered Services under the terms of this Plan, Maximum Allowance is the amount established as the highest level of compensation for a Covered Service. There is more detailed information on how Maximum Allowance is determined and how it affects out-of-state coverage in the Definitions Section of the Summary Plan Description.

To locate a Contracting Provider in your area, please visit Blue Cross of Idaho's Web site at www.bcidaho.com. You may also call Blue Cross of Idaho's Customer Service Department at 208-331-7347 or 800-627-1188 for assistance in locating a Provider.

NONDISCRIMINATION STATEMENT: DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Blue Cross of Idaho's Customer Service Department. Call 1-800-627-1188 (TTY: 1-800-377-1363), or call the customer service phone number on the back of your card.

If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Blue Cross of Idaho's Grievances and Appeals Department at:

Manager, Grievances and Appeals
3000 East Pine Avenue, Meridian, Idaho 83642
Telephone: (800) 274-4018 ext.3838, Fax: (208) 331-7493
Email: grievances&appeals@bcidaho.com
TTY: 1-800-377-1363

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. Reference: <https://federalregister.gov/a/2016-11458>

Language Assistance

ATTENTION: If you speak Arabic, Chinese, French, German, Korean, Japanese, Persian (Farsi), Romanian, Russian, Serbo-Croatian, Spanish, Sudanic Fulfulde, Tagalog, Ukrainian, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 1-800-377-1363).

Arabic

مطوحة: إذا كنت تتحدث انكر اللغة، إني خدمتك المساعدة اللغوية تتولفك ابا لمالين. االصر بقم 1-800-627-1188 (مقر اهلا تفصلم ولا كيم: 1-800-377-1363).

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY: 1-800-377-1363)。

French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS: 1-800-377-1363).

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 1-800-377-1363).

Japanese 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188 (TTY: 1-800-377-1363) まで、お電話にてご連絡ください。

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 1-800-377-1363) 번으로 전화해 주십시오.

Persian-Farsi

توهه: گل هه باين افوسه تفنگويه مكنيد، بهدفي نايو صيت لگيرن بويا لهه فرا مهيه دشابه. اب (TTY: 1-800-377-1363) 1-800-627-1188 مقل بگويدي.

Romanian ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 1-800-377-1363).

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 1-800-377-1363).

Serbo-Croatian OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-377-1363).

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 1-800-377-1363).

Sudanese Fulfulde MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-627-1188 (TTY: 1-800-377-1363).

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 1-800-377-1363).

Ukrainian УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-627-1188 (телетайп: 1-800-377-1363).

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 1-800-377-1363).

ELIGIBILITY AND ENROLLMENT

To qualify as an Eligible Employee under this Plan, a person must be and remain a full-time employee of a Participating School District who regularly works at least 20 hours per week and is paid on a regular, periodic basis through the school district's payroll system. Pre-65 retirees may also be eligible.

(see the Summary Plan Description for additional Eligibility and Enrollment provisions)

PROBATIONARY PERIOD

The Participating School District will determine if there are certain probationary periods that must be satisfied before a new Eligible Employee can qualify for coverage under this Plan.

EMERGENCY SERVICES

For the treatment of Emergency Medical Conditions or Accidental Injuries of sufficient severity to necessitate immediate medical care by, or that require Ambulance Transportation Service to, the nearest appropriate Facility Provider, the Plan will provide In-Network benefits for Covered Services provided by either a Contracting or Noncontracting Facility Provider and facility-based Professional Providers only. If the nearest Facility Provider is Noncontracting, once the Participant is stabilized and is no longer receiving emergency care, the Plan (at its option) may transfer the Participant to the nearest appropriate Contracting Facility Provider for further care in order to continue to receive In-Network benefits for Covered Services. If the Participant is required to transfer, transportation to the Contracting Facility Provider will be a Covered Service under the Ambulance Transportation Service provision of this Plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE:

The Women's Health and Cancer Rights Act of 1998 requires health plans to provide the following mastectomy-related services.

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

OBSTETRIC OR GYNECOLOGICAL CARE NOTICE:

You do not need prior authorization from Blue Cross of Idaho or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetric or gynecology. The health care professional however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact a Blue Cross of Idaho district office at 800-365-2345.

Note: *In order to receive maximum benefits, some Covered Services require Emergency Admission Notification, Non-Emergency Preadmission Notification, and/or Prior Authorization. Please review the Inpatient Admission Notification Section, Prior Authorization Section and Attachment A of this Benefits Outline for specific details. Participants should check with Blue Cross of Idaho to determine if the treatment or service being considered requires Prior Authorization. All Inpatient Admissions and Emergency Admissions require Inpatient Notification Review or Emergency Admission Review, as appropriate.*

If a Participant chooses a Noncontracting or a nonparticipating Provider, the Participant may be responsible for any charges that exceed the Maximum Allowance.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

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Deductibles: Individual	Participant pays the first \$3,000 of In-Network and Out-of-Network Services for eligible expenses per Benefit Period.
Family <i>(No Participant may contribute more than the Individual Deductible amount toward the Family Deductible)</i>	Participants pay the first \$6,000 of In-Network and Out-of-Network Services for eligible expenses for all Participants under same Family Coverage per Benefit Period.

Out-of-Pocket Limits: <i>(See Plan for services that do not apply to the limit) (Includes applicable Deductible, Cost Sharing and Copayments)</i>	In-Network	Out-of-Network
Individual	Participant pays first \$4,500 of In-Network eligible expenses per Benefit Period	Participant pays first \$6,000 of Out-of-Network eligible expenses per Benefit Period
Family <i>(No Participant may contribute more than the Individual Out-of-Pocket Limit amount toward the Family Out-of-Pocket Limit)</i>	Participants pay a combination of \$9,000 of In-Network eligible expenses for all Participants under same Family Coverage per Benefit Period)	Participants pay a combination of \$12,000 of Out-of-Network eligible expenses for all Participants under same Family Coverage per Benefit Period
	<i>When the Out-of-Pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for services that do not apply to the limit as listed in the Plan.</i>	<i>When the Out-of-Pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for services that do not apply to the limit as listed in the Plan.</i>
Be aware that your actual costs for services provided by an Out-of-Network Provider may exceed this Plan's Out-of-Pocket Limit for Out-of-Network services. Your costs for the following Covered Services do not accumulate toward the Out-of-Network Out-of-Pocket Limit if delivered by an Out-of-Network Provider: Dental Services, Vision Services and Prescription Drug Services. In addition, Out-of-Network Providers can bill you for the difference between the amount charged by the Provider and the amount allowed by Blue Cross of Idaho, and that amount is not counted toward the Out-of-Network Out-of-Pocket Limit.		

SERVICES PLAN COVERS	AMOUNT OF PAYMENT	
	In-Network	Out-of-Network
Allergy Injections	Participant pays \$5 Copayment per visit if this is the only service provided during the visit	Plan pays 60% of Maximum Allowance after Deductible
Ambulance Transportation Services	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Breastfeeding Support and Supply Services <i>(Includes rental and/or purchase of manual or electric breast pumps. Limited to one (1) breast pump purchase per Benefit Period, per Participant. Hospital Grade Breast Pumps require Prior Authorization)</i>	Plan pays 100% of Maximum Allowance (Deductible does not apply)	Plan pays 60% of Maximum Allowance after Deductible

CS1B w/ma

Chiropractic Care Service	In-Network	Out-of-Network
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible
<i>A combined 18 visit Benefit Period Limit, per Participant</i>		
Dental Services Related to Accidental Injury	In-Network	Out-of-Network
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Diabetes Self-Management Education Services <i>(Only for Providers approved by BCI)</i>	In-Network	Out-of-Network
	Participant pays \$30 Copayment per visit	Plan pays 60% of Maximum Allowance after Deductible
Diagnostic Services <i>(Includes diagnostic mammograms)</i>	In-Network	Out-of-Network
	100% for first \$100 then Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Durable Medical Equipment	In-Network	Out-of-Network
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Emergency Services – Facility Services <i>(Copayment waived if admitted)</i>	In-Network	Out-of-Network
	Participant pays \$100 Copayment per hospital Outpatient emergency room visit, after which, Plan pays 80% of Maximum Allowance after Deductible	Participant pays \$100 Copayment per hospital Outpatient emergency room visit, after which, Plan pays 60% of Maximum Allowance after Deductible <i>(For treatment of Emergency Medical Conditions as defined in this Plan, Plan will provide In-Network benefits for Covered Services)</i>
Emergency Services – Professional Services	In-Network	Out-of-Network
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible <i>(For treatment of Emergency Medical Conditions as defined in this Plan, Plan will provide In-Network benefits for Covered Services)</i>
Home Health Skilled Nursing Care Services	In-Network	Out-of-Network
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Home Intravenous Therapy	In-Network	Out-of-Network
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 20% of Maximum Allowance after Deductible

	In-Network	Out-of-Network
Hospice Services	Plan pays 100% of Maximum Allowance (Deductible does not apply)	Plan pays 60% of Maximum Allowance after Deductible
	In-Network	Out-of-Network
Hospital Services	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
	In-Network	Out-of-Network
Maternity Services and/or Involuntary Complications of Pregnancy	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
	In-Network	Out-of-Network
Morbid Obesity	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
	<i>(combined Lifetime Benefit Limit is \$5,000 per Participant)</i>	
	In-Network	Out-of-Network
Orthotic Devices	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
	In-Network	Out-of-Network
Outpatient Habilitation Therapy Services <ul style="list-style-type: none"> • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy 	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
	<i>(Up to a combined total of 20 visits per Participant, per Benefit Period)</i>	
	In-Network	Out-of-Network
Outpatient Rehabilitation Therapy Services <ul style="list-style-type: none"> • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy 	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
	<i>(Up to a combined total of 20 visits per Participant, per Benefit Period)</i>	
	In-Network	Out-of-Network
Physician Office Visits <i>(any additional services, such as lab, x-ray, and other Diagnostic Services are subject to Deductible and Cost Sharing)</i>	Participant pays \$30 Copayment per visit	Plan pays 60% of Maximum Allowance after Deductible
	In-Network	Out-of-Network
Post-Mastectomy/Lumpectomy Reconstructive Surgery	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
	In-Network	Out-of-Network
Prescribed Contraceptive Services <i>(Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)</i>	Plan pays 100% of Maximum Allowance (Deductible does not apply)	Plan pays 60% of Maximum Allowance after Deductible

Prosthetic Appliances	In-Network	Out-of-Network
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Psychiatric Inpatient Services • Inpatient Facility and Professional Services	In-Network	Out-of-Network
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Psychiatric Outpatient Services • Outpatient Psychotherapy Services • Facility and other Professional Services	In-Network	Out-of-Network
	Participant pays \$30 Copayment per visit Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Rehabilitation or Habilitation Services	In-Network	Out-of-Network
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Skilled Nursing Facility	In-Network	Out-of-Network
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
	<i>(Up to a combined total of 30 days per Participant, per Benefit Period)</i>	
Surgical/Medical (Professional Services)	In-Network	Out-of-Network
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Therapy Services <i>(Includes Radiation, Chemotherapy, Renal Dialysis, and Growth Hormone)</i>	In-Network	Out-of-Network
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
Transplant Services	In-Network	Out-of-Network
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible

PRESCRIPTION DRUG BENEFITS

OUT-OF-POCKET LIMIT

Individual: Participant pays \$2,000 in Copayments and/or Cost Sharing per Benefit Period for a combination of all Prescription Drug charges incurred.

Family: Participants pay a combination of \$4,000 in Copayments and/or Cost Sharing per Benefit Period for a combination of all Prescription Drug charges incurred. *(No Participant may contribute more than the Individual Prescription Drug Out-of-Pocket Limit amount toward the Family Prescription Drug Out-of-Pocket Limit.)*

When the Prescription Drug Out-of-Pocket Limit is met, the Prescription Drug Benefits payable will increase to 100% of the Allowed Charge or the Usual Charge for the remainder of the Benefit Period.

<p>Retail</p> <p>Generic Drugs</p> <p>Brand Name Drugs</p>	<p>Participant pays \$0 Copayment and 20% Cost Sharing per prescription</p> <p>Participant pays \$10 Copayment and 20% Cost Sharing per prescription</p> <p>For <i>each</i> 30-day supply</p>
<p>Mail Order Pharmacy</p> <p>Generic Drugs</p> <p>Brand Name Drugs</p>	<p>Participant pays \$0 Copayment and 20% Cost Sharing per prescription</p> <p>Participant pays \$10 Copayment and 20% Cost Sharing per prescription</p> <p>For <i>each</i> 30-day supply</p>
<p>Prescribed Contraceptives</p>	<p>Plan pays 100% for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Web site, www.bcidaho.com; Deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one (1) time, as applicable to the specific contraceptive drug or supply.</p> <p>The Plan allows the right to request an exception for any FDA-approved contraceptive not included on BCI's formularies or one that is included with Cost Sharing. Under the exceptions process, if a Participant's attending Provider recommends a particular FDA-approved contraceptive based on a determination of Medical Necessity with respect to that Participant, the Plan will cover that service or item without Cost Sharing. Contact Customer Service to obtain the appropriate request form.</p>
<p>Note: Certain Prescription Drugs have generic equivalents. If the Participant requests a Brand Name Drug, the Participant is responsible for the difference between the price of the Generic Drug and the Brand Name Drug, regardless of the Preferred or Non-Preferred status.</p>	

Attachment A:
NON-EMERGENCY SERVICES REQUIRING PRIOR AUTHORIZATION ANNUAL NOTICE

NOTICE: Blue Cross of Idaho is acting on behalf of the Trust. Prior Authorization is required to determine if specified services are Medically Necessary and a Covered Service.

Prior Authorization is not a guarantee of payment. It is a pre-service determination of Medical Necessity based on information provided to Blue Cross of Idaho at the time the Prior Authorization request is made. Blue Cross of Idaho retains the right to review the Medical Necessity of services, eligibility of services and benefit limitations and exclusions after services are received. If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in Blue Cross of Idaho's Medical Necessity decision must be resolved by use of the Blue Cross of Idaho appeal process as outlined in the General Provisions Section. When Prior Authorization for a Covered Service is required of and obtained by or on behalf of a Participant, the Plan will provide benefits in accordance with the Prior Authorization and the terms of this Contract after the Covered Service has been provided except in cases of fraud, intentional misrepresentation, nonpayment of contribution, exhaustion of benefits or if the Participant for whom the Prior Authorization was granted is not enrolled at the time the Covered Service was provided.

Blue Cross of Idaho will respond to a request for Prior Authorization for the services listed below received from either the Provider or the Participant within two (2) business days of the receipt of the medical information necessary to make a determination. For additional information, please check with your Provider, call Customer Service at the telephone number listed on the back of the Participant's Identification Card or check the Web site at www.bcidaho.com.

For the complete list of services that require Prior Authorization under the categories below, refer to the BCI Web site, www.bcidaho.com.

- Non-emergent Inpatient admissions
- Specified surgical services
- Advanced imaging services (not applicable for Emergency room or Inpatient services):
- Other Outpatient or home based services
- Certain Prescription Drugs and Outpatient infusion therapy
- Non-emergent Ambulance transport
- Specialty lab services
- Certain mental health and substance abuse services
- Durable Medical Equipment, Prosthetics and Orthotics over a select dollar threshold

PREFERRED BLUE (PPO)

MASTER PLAN

AND

**SUMMARY PLAN
DESCRIPTION**

**PPO Plan Document and Summary Plan Description for:
Idaho School District Council Self-Funded Benefit Trust**

Administered by Blue Cross of Idaho

This is a self-funded plan and not an insurance policy and the Idaho School District Council Self-Funded Benefit Trust does not participate in the State Guaranty Association.

Group Name: Teton School District #401

Group # 10003631

Effective Date: September 1, 2017

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CONTACT INFORMATION

The Idaho School District Cooperative Service Council sponsors the Idaho School District Council Health and Welfare Plan, which provides various medical, dental and vision benefit programs through the Idaho School District Council Self-Funded Benefit Trust to active employees and pre-65 retirees and their eligible dependents. These medical, dental and vision benefits are not paid through an insurance policy. Rather, the Trust funds the payment of claims through employer and employee contributions up to a certain limit and then has an agreement for stop-loss coverage that pays for claims that exceed that limit. The Idaho Department of Insurance requires the Trust to provide an annual audit and to have an independent accredited actuary provide annual certification of the funding amounts and the contributions.

Blue Cross of Idaho (“BCI”) is the Contract Administrator. BCI may act on behalf of the Trust as directed. This Plan document and Summary Plan Description will be used to administer and determine the benefits under this Plan.

BLUE CROSS OF IDAHO CONTACT INFORMATION

For general information, please contact a local Blue Cross of Idaho office:

Meridian

Customer Service Department
3000 East Pine Avenue
Meridian, ID 83642

Lewiston

(208) 746-0531

Mailing Address

P.O. Box 7408
Boise, ID 83707
(208) 387-6683 (Boise Area)
1-800-365-2345

Mailing Address

P.O. Box 7408
Boise, ID 83707

Coeur d’Alene

1450 Northwest Blvd., Suite 106
Coeur d’Alene, ID 83814
(208) 666-1495

Pocatello

275 South 5th Ave., Suite 150
Pocatello, ID 83201
(208) 232-6206

Idaho Falls

1910 Channing Way
Idaho Falls, ID 83404
(208) 522-8813

Twin Falls

1503 Blue Lakes Blvd. N.
Twin Falls, ID 83301
(208) 733-7258

IDAHO DEPARTMENT OF INSURANCE CONTACT INFORMATION

Idaho Department of Insurance

Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise ID 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

HOW TO SUBMIT CLAIMS

A Participant must submit a claim to BCI in order to receive benefits for Covered Services. There are two ways for a Participant to submit a claim:

1. The health care Provider (hospital, doctor, or other facility or specialist) can file the claims for the Participant. Most Providers will submit a claim on a Participant's behalf if the Participant shows them a BCI identification card and asks them to send BCI the claim, or submit the claim to the local Blue Cross/Blue Shield plan in the area where services were received.
2. The Participant can send BCI the claim or submit the claim to the local Blue Cross/Blue Shield plan in the area where services were received.

I. To File A Participant's Own Claims

If a Provider prefers that a Participant file the claim, here is the procedure to follow:

1. Ask the Provider for an itemized billing. The itemized billing should show each service received and its procedure code and its diagnosis code, the date each service was furnished, and the charge for each service. BCI cannot accept billings that only say "Balance Due," "Payment Received" or some similar statement.
2. Obtain a Member Claim Form from the Provider or any of BCI's offices, and follow the instructions. Use a separate billing and Member Claim form for each patient.
3. Attach the billing to the Member Claim Form and send it to:

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

For assistance with claims or health benefit information, please call BCI Customer Service at (208) 331-7347 or 1-800-627-1188.

II. How Blue Cross Of Idaho Notifies The Participant

BCI will send the Participant an Explanation of Benefits (EOB) as soon as the claim is processed. The EOB will show all the payments BCI made and to whom the payments were sent. It will also explain any charges BCI did not pay in full. Participants should keep this EOB for their records.

INPATIENT NOTIFICATION SECTION

This section describes procedures that should be followed in order for Participants to receive the maximum benefits available for Covered Services. As specified, Non-Emergency Preadmission Notification or Emergency Admission Notification is required for all Inpatient services.

NOTE: Some Inpatient services also require the Provider to obtain Prior Authorization. Please refer to the Prior Authorization Section.

I. Non-Emergency Preadmission Notification

Non-Emergency Preadmission Notification is a notification to Blue Cross of Idaho by the Participant and is required for all Inpatient admissions except Covered Services subject to Emergency or Maternity delivery Admission Notification. A Participant should notify BCI of all proposed Inpatient admissions as soon as he or she knows they will be admitted as an Inpatient. The notification should be made before any Inpatient admission. Non-Emergency Preadmission Notification informs BCI, or a delegated entity, of the Participant's proposed Inpatient admission to a Licensed General Hospital, Alcohol or Substance Abuse Treatment Facility, Psychiatric Hospital, or any other Facility Provider. This notification alerts Blue Cross of Idaho of the proposed stay. When timely notification of an Inpatient admission is provided by the Participant to BCI, payment of benefits is subject to the specific benefit levels, limitations, exclusions and other provisions of this Plan.

For Non-Emergency Preadmission Notification call BCI at the telephone number listed on the back of the Participant's Identification Card.

II. Emergency Admission Notification

When an Emergency Admission occurs for Emergency Medical Conditions and notification cannot be completed prior to admission due to the Participant's condition, the Participant, or his or her representative, should notify BCI within twenty-four (24) hours of the admission. If the admission is on a weekend or legal holiday, BCI should be notified by the end of the next working day after the admission.

This notification alerts BCI to the emergency stay.

III. Continued Stay Review

BCI will contact the hospital utilization review department and/or the attending Physician regarding the Participant's proposed discharge. If the Participant will not be discharged as originally proposed, BCI will evaluate the Medical Necessity of the continued stay and approve or disapprove benefits for the proposed course of Inpatient treatment. Payment of benefits is subject to the specific benefit levels, limitations, exclusions and other provisions of this Plan.

IV. Discharge Planning

BCI will provide information about benefits for various post-discharge courses of treatment.

PRIOR AUTHORIZATION SECTION

NOTICE: *Prior Authorization is required to determine if the services listed in the Attachment A are Medically Necessary and a Covered Service.*

Prior Authorization is not a guarantee of payment. It is a pre-service determination of Medical Necessity based on information provided to Blue Cross of Idaho at the time the Prior Authorization request is made. Blue Cross of Idaho retains the right to review the Medical Necessity of services, eligibility of services and benefit limitations and exclusions after services are received. If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in Blue Cross of Idaho's Medical Necessity decision must be resolved by use of the Blue Cross of Idaho appeal process as outlined in the General Provisions Section. When Prior Authorization for a Covered Service is required of and obtained by or on behalf of a Participant, the Plan will provide benefits in accordance with the Prior Authorization and the terms of this Plan after the Covered Service has been provided except in cases of fraud, intentional misrepresentation, nonpayment of contribution, exhaustion of benefits or if the Participant for whom the Prior Authorization was granted is not enrolled at the time the Covered Service was provided.

Please refer to Attachment A of the Benefits Outline, check the BCI Web site at www.bcidaho.com, or call Customer Service at the telephone number listed on the back of the Participant's Identification Card to determine if the Participant's proposed services require Prior Authorization. To request Prior Authorization, the Contracting Provider must notify BCI of the Participant's intent to receive services that require Prior Authorization.

The notification may be completed by telephone call or in writing and must include the information necessary to establish that the proposed services are Covered Services under the Participant's Plan and Medically Necessary. BCI will respond to a request for Prior Authorization received from either the Provider or the Participant within two (2) business days of the receipt of the medical information necessary to make a determination.

Noncontracting Providers: The Participant is responsible for obtaining Prior Authorization when seeking treatment from a Noncontracting Provider. The Participant is financially responsible for services performed by a Noncontracting Provider when those services are determined to be not Medically Necessary. The Participant is responsible for notifying BCI if the proposed treatment will be provided by a Noncontracting Provider.

COMPREHENSIVE MAJOR MEDICAL BENEFITS SECTION

This section specifies the benefits a Participant is entitled to receive for the Covered Services described, subject to the other provisions of this Plan.

I. **Benefit Period**

The Benefit Period is the specified period of time during which a Participant's benefits for incurred Covered Services accumulate toward annual benefit limits, Deductible amounts and Out-of-Pocket Limits. If the Participant's Effective Date is after the Plan Date, the initial Benefit Period for that Participant may be less than twelve (12) months.

The Benefit Period for Hospice Covered Services is a continuous six (6) month period that begins when a Hospice Plan of Treatment is approved by Blue Cross of Idaho (BCI). The Participant may apply to BCI for an extension of the Hospice Benefit Period.

II. **Deductible**

A. **Individual**

The Individual Deductible is shown in the Benefits Outline.

B. **Family**

The Family Deductible is shown in the Benefits Outline.

III. **Out-Of-Pocket Limit**

The Out-of-Pocket Limit is shown in the Benefits Outline. Eligible Out-of-Pocket expenses include only the Participant's Deductible, Copayment and/or Cost Sharing for eligible Covered Services. If a Participant is admitted as an Inpatient at the end of a Benefit Period and the hospitalization continues uninterrupted into the succeeding Benefit Period, all eligible Out-of-Pocket expenses incurred for Inpatient Hospital Services are considered part of the Benefit Period in which the date of admission occurred.

Out-of-Pocket expenses associated with the following are not included in the Out-of-Pocket Limit:

- A. Out-of-Pocket expenses associated with the following are not included in the In-Network Out-of-Pocket Limit:
 1. Amounts that exceed the Maximum Allowance.
 2. Amounts that exceed benefit limits.
 3. Services covered under a separate Plan, if any.
 4. Noncovered services or supplies.
 5. Prescription Drug Covered Services.

- B. Out-of-Pocket expenses associated with the following are not included in the Out-of-Network Out-of-Pocket Limit:
 1. Amounts that exceed the Maximum Allowance.
 2. Amounts that exceed benefit limits.
 3. Dental care Covered Services.
 4. Services covered under a separate Plan, if any.
 5. Noncovered services or supplies.
 6. Vision care Covered Services
 7. Prescription Drug Covered Services.

IV. **Providers**

All Providers and Facilities must be licensed and/or registered by the state where the services are rendered, unless exempt by federal law, and must be performing within the scope of license in order for BCI to provide benefits.

V. **Covered Services**

Note: In order to receive benefits, some Covered Services require Prior Authorization. Please review the Prior Authorization Section for more specific details.

To be eligible for benefits, Covered Services must be Medically Necessary and must be provided to an eligible Participant under the terms of this Plan.

The Benefits Outline, attached to this Plan, is an easy reference document that contains general payment information and a descriptive list of Covered Services. Benefits for Covered Services may be subject to Copayments, Deductibles, Cost Sharing and other limits specified in the Benefits Outline. Only the following are eligible Major Medical expenses:

A. Hospital Services

1. Inpatient Hospital Services

a) Room And Board And General Nursing Service

Room and board, special diets, the services of a dietician, and general nursing service when a Participant is an Inpatient in a Licensed General Hospital is covered as follows:

- 1) A room with two (2) or more beds is covered. If a private room is used, the benefit provided in this section for a room with two (2) or more beds will be applied toward the charge for the private room. Any difference between the charges is a noncovered expense under this Plan and is the sole responsibility of the Participant.
- 2) If isolation of the Participant is: (a) required by the law of a political jurisdiction, or (b) required to prevent contamination of either the Participant or another patient by the Participant, then payment for approved private room isolation charges shall be in place of the benefits for the daily room charge stated in paragraph one (1).
- 3) Benefits for a bed in a Special Care Unit shall be in place of the benefits for the daily room charge stated in paragraph one (1).
- 4) A bed in a nursery unit is covered.

b) Ancillary Services

Licensed General Hospital services and supplies including:

- 1) Use of operating, delivery, cast, and treatment rooms and equipment.
- 2) Prescribed drugs administered while the Participant is an Inpatient.
- 3) Administration and processing of whole blood and blood products when the whole blood or blood products are actually used in a transfusion for A Participant; whole blood or blood plasma that is not donated on behalf of the Participant or replaced through contributions on behalf of the Participant.
- 4) Anesthesia, anesthesia supplies and services rendered by the Licensed General Hospital as a regular hospital service and billed by the same hospital in conjunction with a procedure that is a Covered Service.
- 5) All medical and surgical dressings, supplies, casts, and splints that have been ordered by a Physician and furnished by a Licensed General Hospital. Specially constructed braces and supports are not Covered Services under this section.
- 6) Oxygen and administration of oxygen.
- 7) Patient convenience items essential for the maintenance of hygiene provided by a Licensed General Hospital as a regular hospital service in connection with a covered hospital stay. Patient convenience items include, but are not limited to, an admission kit, disposable washbasin, bedpan or urinal, shampoo, toothpaste, toothbrush, and deodorant.
- 8) Diagnostic Services and Therapy Services.

If Diagnostic Services or Therapy Services furnished through a Licensed General Hospital are provided by a Physician under contract with the same hospital to perform such services and the Physician bills separately, then the Physician's services are a Covered Service.

2. Outpatient Hospital Services

a) **Emergency Care**

Licensed General Hospital services and supplies for the treatment of Accidental Injuries and Emergency Medical Conditions.

b) **Surgery**

Licensed General Hospital or Ambulatory Surgical Facility services and supplies including removal of sutures, anesthesia, anesthesia supplies and services. The furnished supplies and services must be in conjunction with a Covered Service rendered by an employee of one (1) of the above facilities who is not the surgeon or surgical assistant.

c) **Therapy Services**

3. Special Services

a) **Preadmission Testing**

Tests and studies required with the Participant's admission and accepted or rendered by a Licensed General Hospital on an Outpatient basis prior to a scheduled admission as an Inpatient, if the services would have been available to an Inpatient of a Licensed General Hospital. Preadmission Testing does not include tests or studies performed to establish a diagnosis.

Preadmission Testing benefits are limited to Inpatient admissions for Surgery. Preadmission Testing must be conducted within seven (7) days prior to a Participant's Inpatient admission.

Preadmission Testing is a Covered Service only if the services are not repeated when the Participant is admitted to the Licensed General Hospital as an Inpatient, and only if the tests and charges are included in the Inpatient medical records.

No benefits for Preadmission Testing are provided if the Participant cancels or postpones the admission to the Licensed General Hospital as an Inpatient. If the Licensed General Hospital or Physician cancels or postpones the admission then benefits are provided.

- b) Hospital benefits may be provided for dental extractions, or other dental procedures if certified by a Physician that a non-dental medical condition requires hospitalization to safeguard the health of the Participant. Non-dental conditions that may receive hospital benefits are:
- 1) Brittle diabetes.
 - 2) History of a life-endangering heart condition.
 - 3) History of uncontrollable bleeding.
 - 4) Severe bronchial asthma.
 - 5) Children under ten (10) years of age who require general anesthetic.
 - 6) Other non-dental life-endangering conditions that require hospitalization, subject to approval by BCI, on behalf of the Trust.

B. Skilled Nursing Facility

Benefits provided to an Inpatient of a Licensed General Hospital are also provided for services and supplies customarily rendered to an Inpatient of a Skilled Nursing Facility. Benefits are provided up to the annual maximum stay (the number of days for a maximum stay is shown in the Benefits Outline). If the Participant is receiving care at a Skilled

Nursing Facility at the end of a Benefit Period, this annual maximum stay benefit shall not renew the following Benefit Period until the Participant is discharged. However, no benefits are provided when the care received consists primarily of:

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

C. Ambulance Transportation Service

Ambulance Transportation Service is covered for Medically Necessary transportation of a Participant within the local community by Ambulance under the following conditions:

1. From a Participant's home or scene of Accidental Injury or Emergency Medical Condition to a Licensed General Hospital.
2. Between Licensed General Hospitals.
3. Between a Licensed General Hospital and a Skilled Nursing Facility.
4. From a Licensed General Hospital to the Participant's home.
5. From a Skilled Nursing Facility to the Participant's home.

For purposes of C.1., 2. and 3. above, if there is no facility in the local community that can provide Covered Services appropriate to the Participant's condition, then Ambulance Transportation Service means transportation to the closest facility that can provide the necessary service.

For purposes of this section, Ambulance means a specially designed and equipped vehicle used only for transporting the sick and injured.

D. Psychiatric Care Services

1. Covered Psychiatric Care services include Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP), Residential Treatment Program, psychological testing/neuropsychological evaluation testing and Electroconvulsive Therapy (ECT).

Payments for Inpatient or Outpatient Psychiatric Services apply to Covered Services furnished by any of the following:

- Licensed General Hospital
- Alcoholism or Substance Abuse Treatment
- Psychiatric Hospital
- Licensed Clinical Social Worker (LCSW)
- Licensed Clinical Professional Counselor (LCPC)
- Licensed Marriage and Family Therapist (LMFT)
- Clinical Psychologist
- Physician
- Residential Treatment Facility

2. Inpatient Psychiatric Care

The benefits provided for Inpatient hospital services and Inpatient medical services in this section are also provided for the care of Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, or any combination of these.

3. Outpatient Psychiatric Care

The benefits provided for Outpatient Hospital Services and Outpatient Medical Services in this section are also provided for Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, or any combination of these. The use of Hypnosis to treat a Participant's Mental or Nervous Condition is a Covered Service.

4. **Outpatient Psychotherapy Services** – Covered Services include professional office visit services, family, individual and/or group therapy.

E. Maternity Services

The benefits provided for Licensed General Hospital Services and Surgical/Medical Services are also provided for the maternity services listed below when rendered by a Licensed General Hospital or Physician to the Enrollee, Enrollee's spouse (if a Participant) or Eligible Dependent child (if a Participant). Nursery care of a newborn infant is not a maternity service.

Benefits are also provided for a Normal Pregnancy or Involuntary Complications of Pregnancy for enrolled Eligible Dependent children (if a Participant). Diagnostic x-ray and laboratory services related to pregnancy, childbirth or, miscarriage are covered.

1. **Normal Pregnancy**

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

2. **Involuntary Complications Of Pregnancy**

- a) Involuntary Complications of Pregnancy include, but are not limited to:
1. Cesarean section delivery, ectopic pregnancy that is terminated, spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible (miscarriage), puerperal infection, and eclampsia.
 2. Conditions requiring Inpatient confinement (when the pregnancy is not terminated), the diagnoses of which are distinct from pregnancy but are adversely affected or are caused by pregnancy. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but do not include false labor, occasional spotting, Physician-prescribed bed rest during pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
 3. If you have a birth, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child will include forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a cesarean section delivery. Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours or ninety-six (96) hours as applicable. For stays in excess of forty-eight (48) hours or ninety-six (96) hours, additional benefits may be available under the terms of Item III., Continued Stay Review, in the Inpatient Notification Section.

F. Transplant Services1. **Autotransplants**

Autotransplants of arteries, veins, ear bones (ossicles), cartilage, muscles, skin and tendons; teeth or tooth buds.

- a) The applicable benefits provided for hospital and Surgical/Medical Services are provided only for a recipient of Medically Necessary Autotransplant services. Autologous blood transfusion, FDA approved mechanical or biological heart valves, and implanting of artificial pacemakers are not considered Transplants and are a Covered Service if Medically Necessary.

2. **Transplants**

Transplants of corneas, kidneys, bone marrow, livers, hearts, lungs, heart/lung and pancreas/kidney combinations.

- a) The applicable benefits provided for Hospital and Surgical/Medical Services are provided for a recipient of Medically Necessary Transplant services.

- b) Benefits for a recipient of a bone marrow, liver, heart, lung, heart/lung or pancreas/kidney combination Transplant(s) are subject to the following conditions:
 - 1) The Transplant must be preauthorized by BCI.
 - 2) The recipient must have the Transplant performed at an appropriate Recognized Transplant Center. If the recipient is eligible for Medicare, the recipient must have the Transplant performed at a Recognized Transplant Center that is approved by the Medicare program for the requested Transplant Covered Services.
- c) If the recipient is eligible to receive benefits for these transplant services, Organ Procurement charges are paid for the donor (even if the donor is not a Participant). Benefits for the donor will be charged to the recipient's coverage.
- d) A travel allowance may be available when the Participant is traveling to and from a Blue Distinction Centers for Transplants (BDCT) for Transplant Services that have received Prior Authorization by BCI. The Participant will be notified of their eligibility for this allowance upon Prior Authorization of the scheduled Transplant services.

3. **Exclusions And Limitations**

In addition to any other exclusions and limitations of this Plan, the following exclusions and limitations apply to Transplant or Autotransplant services. No benefits are available under this Plan for the following:

- a) Transplants of brain tissue or brain membrane, islet tissue, pancreas, intestine, pituitary and adrenal glands, hair Transplants, or any other Transplant not specifically named as a Covered Service in this section; or for Artificial Organs including but not limited to, artificial hearts or pancreases.
- b) Any eligible expenses of a donor related to donating or transplanting an organ or tissue unless the recipient is a Participant who is eligible to receive benefits for Transplant services.
- c) The cost of a human organ or tissue that is sold rather than donated to the recipient.
- d) Transportation costs including but not limited to, Ambulance Transportation Service or air service for the donor, or to transport a donated organ or tissue.
- e) Living expenses for the recipient, donor, or family members.
- f) Costs covered or funded by governmental, foundation or charitable grants or programs; or Physician fees or other charges, if no charge is generally made in the absence of health benefits coverage.
- g) Any complication to the donor arising from a donor's Transplant Surgery is not a covered benefit under the Participant Transplant recipient's Plan or policy. If the donor is a BCI Participant, eligible to receive benefits for Covered Services, benefits for medical complications to the donor arising from Transplant Surgery will be allowed under the donor's policy.
- h) Costs related to the search for a suitable donor.
- i) No benefits are available for services, expenses, or other obligations of or for a deceased donor (even if the donor is a Participant).

G. **Surgical/Medical Services**

1. **Surgical Services**

- a) **Surgery**—Surgery performed by a Physician or other Professional Provider.
- b) **Multiple Surgical Procedures**—benefits for multiple surgical procedures performed during the same operative session by one (1) or more Physicians or other Professional Providers are calculated based upon the Maximum Allowance and payment guidelines.

- c) **Surgical Supplies**—when a Physician or other Professional Provider performs covered Surgery in the office, benefits are available for a sterile suture or Surgery tray normally required for minor surgical procedures.
- d) **Surgical Assistant**—Medically Necessary services rendered by a Physician or other appropriately qualified surgical assistant who actively assists the operating surgeon in the performance of covered Surgery where an assistant is required. The percentage of the Maximum Allowance that is used as the actual Maximum Allowance to calculate the amount of payment under this section for Covered Services rendered by a surgical assistant is 20% for a Physician assistant and 10% for other appropriately qualified surgical assistants.
- e) **Anesthesia**—in conjunction with a covered procedure, the administration of anesthesia ordered by the attending Physician and rendered by a Physician or other Professional Provider. The use of Hypnosis as anesthesia is not a Covered Service. General anesthesia administered by the surgeon or assistant surgeon is not a Covered Service.
- f) **Second And Third Surgical Opinion**
 - 1) Services consist of a Physician’s consultative opinion to verify the need for elective Surgery as first recommended by another Physician.
 - 2) Specifications:
 - a. Elective Surgery is covered Surgery that may be deferred and is not an emergency.
 - b. Use of a second consultant is at the Participant’s option.
 - c. If the first recommendation for elective Surgery conflicts with the second consultant’s opinion, then a third consultant’s opinion is a Covered Service.
 - d. The third consultant must be a Physician other than the Physician who first recommended elective Surgery or the Physician who was the second consultant.

2. **Inpatient Medical Services**

Inpatient medical services rendered by a physician or other Professional Provider to a Participant who is receiving Covered Services in a Licensed General Hospital or Skilled Nursing Facility.

Inpatient medical services also include consultation services when rendered to a Participant as an Inpatient of a Licensed General Hospital by another Physician at the request of the attending Physician. Consultation services do not include staff consultations that are required by Licensed General Hospital rules and regulations.

3. **Outpatient Medical Services**

The following Outpatient medical services rendered by a Physician or other Professional Provider to a Participant who is an Outpatient, provided such services are not related to pregnancy, Chiropractic Care, Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, except as specified elsewhere in this section:

- a) **Emergency Care**—medical care for the treatment of an Accidental Injury or Emergency Medical Condition.
- b) **Special Therapy Services**—deep radiation therapy or chemotherapy for a malignancy when such therapy is performed in the Physician’s office.
- c) **Home And Other Outpatient Services**—medical care for the diagnosis or treatment of an Accidental Injury, Disease, condition or Illness.
- d) **Preventive Care Services**
Benefits are provided for:
 - 1) Preventive Care Covered Services—See Benefits Outline for complete list. Dietary Counseling, also referred to as “medical nutritional counseling”, includes the assessment of a Participant’s overall nutritional status followed by the assignment of individualized diet, counseling, and/or specialized nutrition

therapies to treat a chronic illness or condition. Dietary Counseling is only covered under the Preventive Care Benefit and includes Dietary Counseling for Diabetes. Dietary Counseling is covered only if provided by a doctor of medicine (M.D.), doctor of osteopathy (D.O.), Registered Dietitian, Physician Assistant (P.A.), or a Nurse Practitioner (N.P.).

- 2) Immunizations—see Benefits Outline for complete list.
- e) **Physician Office Visit**—Physician office medical visits and consultations. Additional services, such as treatment and diagnosis of Mental/Nervous Conditions, or laboratory, x-ray, and other Diagnostic Services are not included in the Office Visit. Benefits for these services may be available under other areas in this Comprehensive Major Medical Section.
- f) **Allergy Injections**

H. Diagnostic Services

Diagnostic Services include mammograms. Tests to determine pregnancy and Pap tests are covered regardless of results. Benefits for Medically Necessary genetic testing are only available when Prior Authorization has been completed and approved by BCI.

I. Therapy Services

1. **Radiation Therapy**
2. **Chemotherapy**
3. **Renal Dialysis**
 - a) The Maximum Allowance for Renal Dialysis is 125% of the current Medicare allowed amount for In-Network and Out-of-Network Providers, unless a different rate is negotiated with the treating Provider.
4. **Physical Therapy**
 - a) Payment is limited to Physical Therapy Services related to Habilitative and Rehabilitative care, with reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time. Physical Therapy Services are covered when performed by:
 - 1) A Physician.
 - 2) A Licensed Physical Therapist provided the Covered Services are directly related to a written treatment regimen prepared by the Therapist.
 - 3) A Podiatrist.
 - b) No benefits are provided for:
 - 1) The following Physical Therapy Services when the specialized skills of a Licensed Physical Therapist are not required:
 - a) Range of motion and passive exercises that are not related to restoration of a specific loss of function but are useful in maintaining range of motion in paralyzed extremities.
 - b) Assistance in walking, such as that provided in support for feeble or unstable patients.
 - 2) Facility-related charges for Outpatient Physical Therapy Services, health club dues or charges, or Physical Therapy Services provided in a health club, fitness facility, or similar setting.
 - 3) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Physical Therapist.
 - 4) Maintenance, palliative or supportive care.
 - 5) Behavioral modification services.
5. **Occupational Therapy**
 - a) Payment is limited to Occupational Therapy Services related to Habilitative and Rehabilitative care, with reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time. Occupational Therapy Services are covered when performed by:

- 1) A Physician.
- 2) A Licensed Occupational Therapist, provided the Covered Services are directly related to a written treatment regimen prepared by a Licensed Occupational Therapist and approved by a Physician.
- b) No benefits are provided for:
 - 1) Facility-related charges for Outpatient Occupational Therapy Services, health club dues or charges, or Occupational Therapy Services provided in a health club, fitness facility, or similar setting.
 - 2) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Occupational Therapist.
 - 3) Maintenance, palliative or supportive care.
 - 4) Behavioral modification services.

6. **Speech Therapy**

Benefits are limited to Speech Therapy Services related to Habilitative and Rehabilitative care, with reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time. Speech Therapy Services are covered when performed by either of the following:

- a) A Physician.
- b) A Speech Therapist, provided the services are directly related to a written treatment regimen designed by the Therapist
- c) No benefits are provided for:
 - 1) Maintenance or supportive care.
 - 2) Behavioral modification services.

7. **Growth Hormone Therapy**

Benefits for this Therapy are only available as preauthorized and approved by BCI, on behalf of the Trust, when Medically Necessary.

8. **Home Intravenous Therapy (Home Infusion Therapy)**

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

Benefits for this Therapy are only available as preauthorized and approved by BCI, on behalf of the Trust, when Medically Necessary.

J. Home Health Skilled Nursing Care Services

Professional nursing services provided to a Homebound Participant that can only be rendered by a licensed registered nurse (R.N.) or a licensed practical nurse (L.P.N.), provided such nurse does not ordinarily reside in the Participant's household or is not related to the Participant by blood or marriage. The services must be Medically Necessary and preauthorized by BCI, on behalf of the Trust, and the patient's Physician and must not constitute Custodial Care. Services must be provided by a Medicare certified Home Health Agency and limited to intermittent Skilled Nursing Care. The patient's Physician must review the care at least every thirty (30) days. No benefits are provided during any period of time in which the Participant is receiving Hospice Covered Services.

K. Hospice Services

1. **Conditions**

Benefits are provided only for Hospice Covered Services included in a Hospice Plan of Treatment that has been preauthorized by BCI, on behalf of the Trust.

A Participant must specifically request Hospice benefits and must meet the following conditions to be eligible:

- a) The attending or primary Physician must certify that the Participant is a terminally ill patient with a life expectancy of six (6) months or less.
- b) The Participant must live within the Hospice's local geographical area.
- c) The Participant must be formally accepted by the Hospice.
- d) The Participant must have a designated volunteer Primary Care Giver at all times.
- e) Services and supplies must be prescribed by the attending Physician and included in a Hospice Plan of Treatment approved in advance by BCI. The Hospice must notify BCI within one (1) working day of any change in the Participant's condition or Plan of Treatment that may affect the Participant's eligibility for Hospice Benefits.
- f) Palliative care (which controls pain and relieves symptoms but does not provide a cure) must be appropriate to the Participant's Illness.

2. **Exclusions And Limitations**

No benefits are provided for:

- a) Hospice Services not included in a Hospice Plan of Treatment and not provided or arranged and billed through a Hospice.
- b) Continuous Skilled Nursing Care except as specifically provided as a part of Respite Care or Continuous Crisis Care.
- c) Hospice benefits provided during any period of time in which a Participant is receiving Home Health Skilled Nursing Care benefits.

L. Chiropractic Care Services

1. Benefits are limited to Chiropractic Care Services related to a significant medical condition necessitating appropriate Medically Necessary evaluation and Neuromusculoskeletal Treatment services. Chiropractic Care Services are covered when:
 - a) Services are directly related to a written treatment regimen prepared and performed by a Chiropractic Physician.
 - b) Services must be related to recovery or improvement in function, with reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time.
2. No benefits are provided for:
 - a) Surgery as defined in this Plan to include injections.
 - b) Laboratory and pathology services.
 - c) Range of motion and passive exercises that are not related to restoration of a specific loss of function.
 - d) Massage therapy, if not performed in conjunction with other modalities or manipulations.
 - e) Maintenance, palliative or supportive care.
 - f) Preventive or wellness care.
 - g) Facility-related charges for Chiropractic Care Services, health club dues or charges, or Chiropractic Care Services provided in a health club, fitness facility, or similar setting.
 - h) General exercise programs.
 - i) Diagnostic Services, except for x-rays to assist in the diagnosis and Neuromusculoskeletal Treatment plan as defined in this Plan.

M. Durable Medical Equipment

The lesser of the Maximum Allowance or billed charge for rental, (but not to exceed the lesser of the Maximum Allowance or billed charge for the total purchase price) or, at the option of BCI, on behalf of the Trust, the purchase of Medically Necessary Durable Medical Equipment required for therapeutic use. The Durable Medical Equipment must be prescribed by an attending Physician or other Professional Provider within the scope of license. No benefits are available for the replacement of any item of Durable Medical Equipment that has been used by a Participant for less than five (5) years (whether or not the item being replaced

was covered under this Plan). Benefits shall not exceed the cost of the standard, most economical Durable Medical Equipment that is consistent, according to generally accepted medical treatment practices, with the Participant's condition. If the Participant and his or her Provider have chosen a more expensive treatment than is determined to be the standard and most economical by BCI, the excess charge is solely the responsibility of the Participant. Equipment items considered to be common household items are not covered.

Due to ongoing service requirements and safety issues relating to oxygen equipment, BCI will not limit the cost of oxygen and the rental of oxygen delivery systems to the purchase price of the system(s).

N. Prosthetic Appliances

The purchase, fitting, necessary adjustment, repair, and replacement of Prosthetic Appliances including post-mastectomy prostheses.

Benefits for Prosthetic Appliances are subject to the following limitations:

1. The Prosthetic Appliance must be approved by BCI before the Participant purchases it.
2. Benefits shall not exceed the cost of the standard, most economical Prosthetic Appliance that is consistent, according to generally accepted medical treatment practices, with the Participant's condition. If the Participant and his or her Provider have chosen a more expensive treatment than is determined to be the standard and most economical by BCI, the excess charge is solely the responsibility of the Participant.
3. No benefits are provided for dental appliances or major Artificial Organs, including but not limited to, artificial hearts and pancreases.
4. Following cataract Surgery benefits for a required contact lens or a pair of eyeglasses are limited to the first contact lens or pair of eyeglasses, which must be purchased within ninety (90) days.
5. Benefits for required contact lens or a pair of eyeglasses for treatment of Keratoconus.
6. No benefits are provided for the rental or purchase of any synthesized, artificial speech or communications output device or system or any similar device, appliance or computer system designed to provide speech output or to aid an inoperative or unintelligible voice, except for voice boxes to replace all or part of a surgically removed larynx.

O. Orthotic Devices

Orthotic Devices include but are not limited to, Medically Necessary braces, back or special surgical corsets, splints for extremities, and trusses, when prescribed by a Physician, Chiropractic Physician, Podiatrist, Licensed Physical Therapist or Licensed Occupational Therapist. Arch supports, other foot support devices, orthopedic shoes, and garter belts are not considered Orthotic Devices. Benefits shall not exceed the cost of the standard, most economical Orthotic device that is consistent, according to generally accepted medical treatment practices, with the Participant's condition.

P. Dental Services Related To Accidental Injury

Dental services related to Accidental Injury rendered by a Physician or Dentist that are required as a result of an Injury to the jaw, to Sound Natural Tooth, mouth, or to the face. Such dental services shall be covered only for the 12-month period immediately following the date of Injury providing the Plan remains in effect during the twelve (12) month period.

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

Benefits for dental services under this provision shall be secondary to dental benefits available to a Participant under a dental policy of insurance, contract, or underwriting plan that is separate and distinct from this Plan.

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

No Benefits are available under this Plan for the following:

1. Procedures that are not Medically Necessary for the care of a Participant's covered dental condition; or that do not have uniform professional endorsement; or that are Experimental or Investigative in nature;
2. Charges incurred for services that were started prior to the Participant's Effective Date. The following guidelines will be used to determine the date on which a service shall be deemed to have been started:
 - a) For full dentures or partial dentures: on the date the final impression is taken.
 - b) For fixed bridges, crowns, inlays, or onlays: on the date the teeth are first prepared.
 - c) For root canal therapy: on the later of the date the pulp chamber is opened or the date canals are explored to the apex.
 - d) For periodontal Surgery: on the date the Surgery is actually performed.
 - e) For all other services: on the date the service is performed.
3. Cast restorations (crowns, inlays, or onlays) for teeth that are restorable by other means (i.e. by amalgam or composite fillings);
4. Replacement of an existing crown, inlay, or onlay that was installed within the immediately preceding five years or replacement of an existing crown, inlay, or onlay that can be repaired;
5. Appliances, restorations, or other services provided or performed solely to change, maintain, or restore vertical dimension or occlusion;
6. Any jaw implant procedure including, but not limited to, endosseous, staple, or blade implants. Blue Cross of Idaho may approve Benefits for endosseous implants if the cost of treatment does not exceed the cost of a covered alternative treatment (i.e. bridge);
7. Any procedure, service, or supply other than alveoloplasty or alveolectomy required to prepare the alveolus, maxilla or mandible for a prosthetic appliance. Excluded services include, but are not limited to, vestibuloplasty, stomatoplasty, and bone grafts (either synthetic or autogenous) to the alveolars, maxilla, or mandible;
8. Any procedure, service, or supply required directly or indirectly to treat a muscular, neural, orthopedic, or skeletal disorder, dysfunction, or Disease of the temporomandibular joint (jaw hinge) and its associated structures including, but not limited to, myofascial pain dysfunction syndrome;
9. Orthognathic Surgery, including, but not limited to, osteotomy, ostectomy, and other services or supplies to augment or reduce the upper or lower jaw;
10. Temporary dental services. Charges for temporary services are considered an integral part of the final dental services and are not payable separately;
11. Any service, procedure, or supply for which the prognosis for success is not reasonably favorable as determined by BCI; or
12. Myofunctional therapy, biofeedback procedures, athletic mouthguards, precision or semi-precision attachments, denture duplication, oral hygiene instruction, treatment of jaw fractures, or charges for acid etching.

Before providing Benefits for Covered Services, the Plan has the right to refer the Participant to a Dentist of its choice and at its expense to verify the need, quantity, and quality of dental work claimed as a Benefit under this section.

If a Participant transfers from the care of one Dentist to another Dentist during a Dental Treatment plan, or if more than one Dentist renders services for one dental procedure, the Plan will pay no more than the amount that it would have paid had but one Dentist rendered the service.

Q. Rehabilitation or Habilitation Services

Benefits are provided for Rehabilitation or Habilitation services subject to the following:

1. Admission for Inpatient Physical Rehabilitation must occur within one hundred twenty (120) days of discharge from an Acute Care Licensed General Hospital.
2. Continuation of benefits is contingent upon approval by BCI of a Rehabilitation or Habilitation Plan of Treatment and documented evidence of patient progress submitted to BCI at least twice each month.

R. Diabetes Self-Management Education Services

Diabetes Self-Management Education includes instruction in the basic skills of diabetes management through books/educational material as well as an individual or group consultation with a certified diabetes educator, nurse, or dietitian in an American Diabetes Association (ADA) or American Association of Diabetes Educators (AADE) certified program, or other accredited program approved by BCI.

S. Surgical Treatment For Morbid Obesity

For Covered Services for the surgical treatment of Morbid Obesity, for complications resulting from the surgical treatment of Morbid Obesity or for reversals or revisions of Surgery for Morbid Obesity when required to correct an immediately life-threatening condition, Blue Cross of Idaho shall pay or otherwise satisfy a percentage of the Maximum Allowance, up to the Lifetime Benefit Limit as shown in the Benefit Outline.

Benefits are provided for surgical treatment of Morbid Obesity subject to the following:

1. Surgery for Morbid Obesity is Medically Necessary to control other medical conditions that are eligible for Covered Services under this Plan and nonsurgical methods have been unsuccessful in treating the Morbid Obesity.
2. Surgery for Morbid Obesity is considered Medically Necessary when the Morbid Obesity is the result of persistent and uncontrollable weight gain that constitutes a present or potential threat to life.
3. Surgery for Morbid Obesity must be preauthorized by Blue Cross of Idaho.

T. Post-Mastectomy/Lumpectomy Reconstructive Surgery

Reconstructive Surgery in connection with a Disease related mastectomy/lumpectomy, including:

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

in a manner determined in consultation with the attending Physician and the Participant.

U. Prescribed Contraceptive Services

Covered Services include prescribed devices, injectable, insertable and implantable methods of temporary contraception, such as diaphragms, intrauterine devices (IUDs) and injections. Covered Services include tubal ligation.

There are no benefits for:

1. Over-the-counter items including, but not limited to condoms, spermicides, and sponges.
2. Prescribed contraceptives that could otherwise be purchased over-the-counter.
3. Oral contraceptive prescription drugs and other prescription hormonal contraceptives,

such as patches and rings. See Prescription Drug Benefit Section for oral contraceptive benefits.

V. Breastfeeding Support and Supply Services

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

Benefits for Medically Necessary Hospital Grade Breast Pumps are available only when Prior Authorization has been completed.

W. Approved Clinical Trial Services

Coverage is available for routine patient costs associated with an Approved Clinical Trial. Routine patient costs include but are not limited to Office Visits, diagnostic, laboratory tests and/or other services related to treatment of a medical condition. Routine patient costs are items and services that typically are Covered Services for a Participant not enrolled in an Approved Clinical Trial, but do not include:

1. An Investigational item, device, or service that is the subject of the Approved Clinical Trial;
2. Items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Participant; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

Prior Authorization is required if the routine patient costs include a Covered Service that requires Prior Authorization under this Plan. Approved Clinical Trials are subject to all other provisions of this Plan.

VI. Additional Amount Of Payment Provisions

Any amounts remaining unpaid for Covered Services under any other benefit section of this Plan (except the Supplemental Accident Benefit Section, if applicable), are not eligible for payment under this Comprehensive Major Medical Benefits section. For Covered Services eligible for benefits under more than one benefit section of this Plan, the amount paid for Covered Services may be applied to any benefit limit(s) in each benefit section. Except as specified elsewhere in this Plan, BCI, on behalf of the Trust, will provide the following benefits for Covered Services after a Participant has satisfied his or her individual Deductible or, if applicable, the family Deductible has been satisfied:

- A. For In-Network Services: Unless stated otherwise, for Major Medical Covered Services furnished in the state of Idaho, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance (shown in the Benefits Outline) if the Covered Services were rendered by a Provider. Several Providers are paid at different rates and/or have different benefit limitations as described in that specific benefit section and in the Benefits Outline.

For Out-of-Network Services: Unless stated otherwise, for Major Medical Covered Services rendered in the state of Idaho, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance (shown in the Benefits Outline) if the Covered Services were rendered by a Provider. Several Providers are paid at different rates and/or have different benefit limitations as described in that specific benefit section and in the Benefits Outline.

- B. For Major Medical Covered Services furnished outside the state of Idaho by a Provider, Blue Cross of Idaho shall provide the benefit payment levels specified in this section according to the following:
1. If the Provider has a PPO agreement for claims payment with the Blue Cross and/or Blue Shield plan in the area where the Covered Services were rendered, BCI will base the payment on the local plan's Preferred Provider Organization payment arrangement and allow In-Network benefits. The Provider shall not make an additional charge to a Participant for amounts in excess of BCI's payment except for Deductibles, Cost Sharing, Copayments, and noncovered services.
 2. If the Provider does not have a PPO agreement for claims payment with the Blue Cross and/or Blue Shield plan in the area where the Covered Services are rendered, BCI will base payment on the Maximum Allowance and allow Out-of-Network benefits. The Provider is not obligated to accept BCI's payment as payment in full. Neither BCI nor the Trust are responsible for the difference, if any, between BCI's payment and the actual charge.
- C. A Contracting Provider rendering Covered Services shall not make an additional charge to a Participant for amounts in excess of BCI's payment except for Deductibles, Cost Sharing, Copayments, and noncovered services.
- D. A Noncontracting Provider inside or outside the state of Idaho is not obligated to accept BCI's payment as payment in full. Neither BCI nor the Trust are responsible for the difference, if any, between BCI's payment and the actual charge, unless otherwise specified. Participants are responsible for any such difference, including Deductibles, Cost Sharing, Copayments, charges for noncovered services and the amount charged by the Noncontracting Provider that is in excess of the Maximum Allowance.
- E. **Emergency Services**
 For the treatment of Emergency Medical Conditions or Accidental Injuries of sufficient severity to necessitate immediate medical care by, or that require Ambulance Transportation Service to, the nearest appropriate Facility Provider, BCI, on behalf of the Trust, will provide In-Network benefits for Covered Services provided by either a Contracting or Noncontracting Facility Provider and facility-based Professional Providers only. If the nearest Facility Provider is Noncontracting, once the Participant is stabilized and is no longer receiving emergency care the Participant (at BCI's option, on behalf of the Trust,) may transfer to the nearest appropriate Contracting Facility Provider for further care in order to continue to receive In-Network benefits for Covered Services. If the Participant is required to transfer, transportation to the Contracting Facility Provider will be a Covered Service under the Ambulance Transportation Service provision of this Plan.

PRESCRIPTION DRUG BENEFITS SECTION

This section specifies the benefits an Individual is entitled to receive for Covered Services described, subject to the other provisions of this Plan.

I. Prescription Drug Copayment/Cost Sharing

The types and levels of benefits coverage regarding Prescription Drug Copayments and/or Cost Sharing are shown in the Benefits Outline.

Prescription Drugs:

For a thirty (30)-day or less supply of a Prescription Drug, the Individual is responsible for paying one (1) Cost Sharing and/or Copayment amount.

For a thirty-one (31)-day to sixty (60)-day supply of a Prescription Drug, the Individual is responsible for paying two (2) Cost Sharing and/or Copayment amounts.

For a sixty-one (61)-day to ninety (90)-day supply of a Prescription Drug, the Individual is responsible for paying three (3) Cost Sharing and/or Copayment amounts.

Diabetic Supplies:

Insulin syringes/needles have no Copayment and/or Cost Sharing if purchased within ninety (90) days of insulin purchase. All other supplies will be subject to applicable Copayment and/or Cost Sharing.

Providers

The following are Providers under this section:

- Licensed Pharmacist
- Participating Pharmacy/Pharmacist
- Physician

II. Dispensing Limitations

Retail:

Each covered prescription for a Prescription Drug is limited to no more than a ninety (90)-day supply. Specialty Drugs are limited to no more than a thirty (30)-day supply. However, prescriptions and Prescription Drugs may be subject to more restrictive quantity limits.

Mail Order:

Each covered prescription for a Mail Order Prescription Drug is limited to no more than a ninety (90)-day supply. Specialty Drugs are limited to no more than a thirty (30)-day supply. However, prescriptions and Prescription Drugs may be subject to more restrictive quantity limits. In addition, certain mail order Prescription Drugs may not be available under this Plan by mail order due to circumstances such as unstable shelf life, and required special storage conditions. Unless the doctor states on the prescription "dispense as written" (DAW), the mail order Participating Pharmacy will automatically substitute an approved generic drug if available and permissible by law.

III. Amount of Payment

BCI or one (1) of its designated claims processing vendors, will provide the following benefits for Covered Services:

- A. The amount of payment for a covered Prescription Drug dispensed by a Participating Pharmacist is the balance remaining after subtracting the Prescription Drug Cost Sharing and/or Copayment from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.
- B. For a covered Prescription Drug dispensed by a Physician or a Licensed Pharmacist who is not a Participating Pharmacist, the Individual is responsible for paying for the Prescription Drug at the time of purchase and must submit a claim to BCI or one (1) of its designated claims processing vendors. The amount of payment for a covered Prescription Drug is the

- balance remaining after subtracting the Prescription Drug Cost Sharing and/or Copayment from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.
- C. The amount of payment for a covered Prescription Drug dispensed by a mail order Participating Pharmacy is the balance remaining after subtracting the Prescription Drug Copayment and/or Cost Sharing from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.
 - D. Submission of a prescription to a pharmacy is not a claim. If an Individual receives Covered Services from a pharmacy and believes that the Copayment, Cost Sharing or other amount is incorrect, the Individual may then submit a written claim to BCI requesting reimbursement of any amounts the Individual believes were incorrect. Refer to the Inquiry And Appeals Procedures in the General Provisions Section of this Plan.

IV. **Mandatory Generic Drug Substitution**

Certain Prescription Drugs are restricted to Generics for payment by BCI. Even if the Individual, the Physician or other duly licensed Provider requests the Brand Name Drug, the Individual is responsible for the difference between the price of the Generic and Brand Name Drug, plus any applicable Brand Name Drug Deductible/Copayment/Cost Sharing. The difference between the price of the Generic and Brand Name Drug shall not apply to the applicable Deductible and/or Out of Pocket Limits.

V. **Utilization Review**

Prescription Drug benefits include utilization review of Prescription Drug usage for the Individual's health and safety. If there are patterns of over-utilization or misuse of drugs the Individual's personal Physician and Pharmacist will be notified. BCI reserves the right to limit benefits to prevent over-utilization or misuse of Prescription Drugs.

VI. **Preauthorization**

Certain Prescription Drugs may require preauthorization. If the Individual's Physician or other Provider prescribes a drug, which required preauthorization, the Individual will be informed by the Provider or Pharmacist. To obtain preauthorization the Individual's Physician must notify BCI or its designated agent, describing the Medical Necessity for the prescription. Within a reasonable period of time, but not later than fifteen (15) days after BCI or its designated agent, receives a request for preauthorization, BCI or its designated agent, will notify the Individual and/or the attending Provider(s) of its determination, or BCI or its designated agent, may request additional information necessary to make an informed determination.

VII. **Covered Services**

As listed on the Formulary, Generic and Brand Name Prescription Drugs, certain allowed Compound Drugs and Diabetic Supplies. The drugs or medicines must be directly related to the treatment of an Illness, Disease, medical condition or Accidental Injury and must be dispensed pursuant to a written prescription by a Licensed Pharmacist or Physician on or after the Individual's Effective Date. Benefits for Prescription Drugs are available up to the limits stated in Item III. of this section.

Smoking cessation Prescription Drugs are a Covered Service.

VIII. **Definitions**

- A. **Allowed Charge**—the amount payable for a Prescription Drug as determined by the reimbursement formula agreed upon between the Participating Pharmacist and one (1) or more of BCI's designated claims processing vendors.
- B. **Brand Name Drug**—a Prescription Drug, approved by the FDA, that is protected by a patent and is marketed and supplied under the manufacturer's brand name.
- C. **Compound Drug**—a customized medication derived from two or more raw chemicals, powders or devices, of which at least one ingredient is a federal legend drug, prepared by a Pharmacist according to a prescriber's specifications.
- D. **Diabetic Supplies**—supplies that can be purchased at a Participating Pharmacy using the Participant's pharmacy benefit. Includes: insulin syringes, insulin pen needles, lancets, test strips (blood glucose and urine), and insulin pump supplies (reservoirs and syringes, administration sets, and access sets).

- E. Formulary**—a list of Covered Prescription Drugs approved by Blue Cross of Idaho's Pharmacy and Therapeutics Committee. This list is managed and subject to periodic review and amendment by the Pharmacy and Therapeutics Committee.

Prescription Drugs covered by the Prescription Drug Benefit are classified into one of four tiers as follows.

First Tier – Covered Generic Drugs.

Second Tier – Covered Preferred Brand Name Drugs: Brand Name Drugs that are preferred due to their quality and cost-effectiveness as determined by BCI's Pharmacy and Therapeutics Committee.

Third Tier – Covered Non-Preferred Brand Name Drugs.

Fourth Tier – Covered Specialty Drugs.

- F. Generic Drug**—a Prescription Drug, approved by the FDA, that has the same active ingredients, strength, and dosage as its Brand Name Drug counterpart.
- G. Nonparticipating Pharmacy/Pharmacist**—a Licensed Pharmacist, a retail, mail-order or Specialty Pharmacy that has not entered into a contract with one (1) or more of BCI's designated claims processing vendors for the purpose of providing Prescription Drug Covered Services to Participants under this Plan.
- H. Participating Pharmacy/Pharmacist**—a Licensed Pharmacist, a retail, mail-order or Specialty Pharmacy that has a contract with one (1) or more of BCI's designated claims processing vendors for the purpose of providing Prescription Drug Covered Services to Participants under this Plan.
- I. Pharmacy And Therapeutics Committee**—a committee of Physicians and Licensed Pharmacists established by BCI that recommends policy regarding the evaluation, selection, and therapeutic use of various drugs. The Committee also decides which drugs are eligible for benefits under this Plan.
- J. Prescription Drugs**—drugs, biologicals and Compounded prescriptions that are FDA approved and can be dispensed only according to a written prescription given by a Physician and/or duly licensed Provider, that are listed and accepted in the *United States Pharmacopeia*, *National Formulary*, or *AMA Drug Evaluations* published by the American Medical Association (AMA), that are prescribed for human consumption, and that are required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription."
- K. Specialty Drugs**—are injectable and non-injectable medications that are typically used to treat complex conditions and meet one or more of the following criteria:
- a) are biotech-derived or biological in nature;
 - b) are significantly higher cost than traditional medications;
 - c) are used in complex treatment regimens; require special delivery, storage and handling;
 - d) require special medication-administration training for patients;
 - e) require on-going monitoring of medication adherence, side effects, and dosage changes;
 - f) are available through limited-distribution channels;
 - g) and may require additional support and coordinated case management.
- L. Specialty Pharmacy**—a duly licensed Pharmacy that primarily dispenses Specialty Drugs.
- M. Usual Charge**—the lowest retail price being charged by a Licensed Pharmacist for a Prescription Drug at the time of purchase by a Participant.

IX. Prescription Drug Exclusions And Limitations

In addition to any other exclusions and limitations of this Plan, the following exclusions and limitations apply to this section and throughout the entire Plan, unless otherwise specified.

If a Participant receives a discount or other cost reduction, in any form, including but not limited to a coupon or discount card from a pharmaceutical manufacturer, pharmacy, other health care Provider, or Cost Sharing from a prohibited third party organization, the cost reduction or amount discounted toward the purchase of the Prescription Drug will not be applied to the Participant's

applicable Deductible amounts, and will not be applied to the Participant's Out of Pocket Limit for this Plan.

Blue Cross of Idaho prohibits direct or indirect payment by third parties unless it meets the standards set below.

Family, friends, religious institutions, private, not-for-profit foundations such as Indian tribes, tribal organizations, urban Indian organizations, state and federal government programs or grantees or sub-grantees such as the Ryan White HIV/AIDS Program and other similar entities are not prohibited. Cost Sharing contributions made from permitted third parties will be applied to the Participants applicable Deductible and/or Out-of-Pocket Limit.

Each of the following criteria must be met for BCI to accept a third party payment:

1. the assistance is provided on the basis of the Participant's financial need;
2. the institution/organization is not a healthcare Provider; and
3. 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 health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

To assist in appropriately applying Cost Sharing contributions made from a permitted third party to the Participants applicable Deductible and/or Out-of-Pocket Limit, the Participant is encouraged to provide notification to BCI if they receive any form of assistance for payment of their contribution, Cost Sharing, Copayment or Deductible amounts.

BCI will inform the Participant in writing of the reason for rejecting or otherwise refusing to treat a third party payment as a payment from the Participant and of the Participant's right to file a complaint with the Department of Insurance.

- A.** No benefits are provided for the following:
1. Drugs used for the termination of early pregnancy, and complications arising therefrom, except when required to correct an immediately life-endangering condition.
 2. Over-the-counter drugs other than insulin, even if prescribed by a Physician. Notwithstanding this exclusion, BCI, through the determination of the BCI Pharmacy and Therapeutics Committee may choose to cover certain over-the-counter medications when Prescription Drug benefits are provided under this Plan. Such approved over-the-counter medications must be identified by BCI in writing and will specify the procedures for obtaining benefits for such approved over-the-counter medications. Please note that the fact a particular over-the-counter drug or medication is covered does not require BCI to cover or otherwise pay or reimburse the Participant for any other over-the-counter drug or medication.
 3. Charges for the administration or injection of any drug, except for vaccinations listed on the Prescription Drug Formulary.
 4. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, and other non-medicinal substances except Diabetic Supplies, regardless of intended use.
 5. Drugs labeled "Caution—Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made to the Participant.
 6. Immunization agents, except for vaccinations listed on the Prescription Drug Formulary, biological sera, blood or blood plasma. Benefits may be available under the Medical Benefits Section of this Plan.
 7. Medication that is to be taken by or administered to a Participant, in whole or in part, while the Participant is an Inpatient in a Licensed General Hospital, rest home, sanatorium, Skilled Nursing Facility, extended care facility, convalescent hospital, nursing home, or similar institution which operates or allows to operate on its premises, a facility for dispensing pharmaceuticals.
 8. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order.

9. Any newly FDA approved Prescription Drug, biological agent, or other agent until it has been reviewed and approved by BCI's Pharmacy and Therapeutics Committee.
10. Any Prescription Drug, biological or other agent, that is:
 - a) Prescribed primarily to aid or assist the Participant in weight loss, including all anorectics, whether amphetamine or nonamphetamine.
 - b) Prescribed primarily to retard the rate of hair loss or to aid in the replacement of lost hair.
 - c) Prescribed primarily to increase fertility, including but not limited to, drugs which induce or enhance ovulation.
 - d) Prescribed primarily for personal hygiene, comfort, beautification, or for the purpose of improving appearance.
 - e) Prescribed primarily to increase growth, including but not limited to, growth hormone.
 - f) Provided by or under the direction of a Home Intravenous Therapy Company, Home Health Agency or other Provider approved by BCI. Benefits are available for this Therapy Service under the Major Medical Benefits Section of this Plan only as preauthorized and approved when Medically Necessary.
11. Lost, stolen, broken or destroyed medications, except in the case of loss due directly to a natural disaster.

ELIGIBILITY AND ENROLLMENT FOR EMPLOYEES SECTION

I. Eligibility And Enrollment

All Eligible Employees will have the opportunity to apply for coverage under this Plan. All applications submitted to Blue Cross of Idaho (BCI) by the Group now or in the future, will be for Eligible Employees or Eligible Dependents only.

A. Eligible Employee

Qualifications for eligibility are shown in the Benefits Outline.

B. Eligible Dependent

To qualify as an Eligible Dependent under this Plan, a person must be and remain one (1) of the following:

1. The Participating Employee’s spouse under a legally valid marriage.
2. The Participating Employee’s natural child, stepchild, legally adopted child, child placed with the Participating Employee for adoption, or child for whom the Participating Employee or the Participating Employee’s spouse has court-appointed guardianship or custody. The child must be:
 - a) Under the age of twenty-six (26); or
 - b) Medically certified as disabled due to intellectual disability or physical handicap *and* financially dependent upon the Participating Employee for support, regardless of age.
3. A Participating Employee must notify the BCI or the Trust within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate the last day of the month in which the change in eligibility status took place.

II. Leave Of Absence for Participating Employees

- A. Participating Employees who subsequently fail to fulfill the twenty (20) or thirty (30) hour-per-week employment requirement and who have been enrolled for nine (9) months or more, may retain coverage and receive benefits defined in this Plan while on a paid, approved leave of absence for a period not to exceed one (1) year; provided the Group continues to pay not less than fifty dollars (\$50.00) per month for each Participant and remits the entire contribution due with the payment for the other Participants. Coverage for an employee on a paid leave of absence in excess of twelve (12) months will be permitted only on an exception basis approved by the Plan.
- B. Participating Employees who fail to fulfill the twenty (20) or thirty (30) hour-per-week employment requirement and who have been enrolled for at least one (1) month may retain coverage and receive benefits defined in this Plan while on an unpaid, approved leave of absence for a period not to exceed one (1) year. The monthly contribution is the sole responsibility of the Participant and must be submitted with the Group payment for the other Participants.
- C. An unpaid leave of absence may be granted by the Participating School District, provided it does not exceed twelve (12) months, and that the Participant intends to return to employment with the Group at the end of the leave of absence.

III. Group Contribution for Participating Employees

The Group will pay a uniform amount for each classification of employee; i.e., certified/noncertified, but not less than a rate in proportion to full-time employment for each Participant from district funds. The balance of the contribution will be payroll-deducted from the Participant’s wage.

IV. Miscellaneous Eligibility And Enrollment Provisions

- A. The Group will collect Participating Employee contributions through payroll withholding and be responsible for making the required payments to the Trust through BCI on or before the first of each month. Unless required by state or federal law or unless agreed to in writing by the Trustees, the Group will not offer to its employees any other hospital,

medical, dental or surgical coverage that is not provided by or through this Plan, including but not limited to, coverage under a fee for service/indemnity plan, managed care organization or other similar program or plan, if such coverage is available to the Group through the Plan during the 12 month period from September 1 through August 31 of each year.

- B. This Plan is offered to the Group upon the express condition that a pre-established required percentage of the Eligible Employees specified in the Application for Group Coverage who meet the underwriting criteria of BCI are and continue to be Participating Employees. This Plan is issued under the express condition that the Group continues to make the employer contribution specified in the Application for Group Coverage and this Plan. BCI may terminate this Plan if the percentage of Eligible Employees as Participating Employees or the percentage of the employer contribution drops below the required level. It is understood that no Plan will be in effect unless 85% of all Eligible Employees enroll. Employees who certify enrollment under another employer Health Benefit Plan and for whom no cash-in-lieu payment is made are not included in the 85% calculation. Should the total enrollment of Eligible Employees fall below the required 85% the Plan will be subject to surcharge or discontinued at the next renewal date. Existing districts that do not meet this criteria must submit to the Trust a written plan showing how and when compliance will be accomplished.

- C.
 - 1. For an Eligible Employee to enroll himself or herself and any Eligible Dependents for coverage (or for an Participating Employee to enroll Eligible Dependents for coverage) the Eligible Employee or Participating Employee must complete an enrollment application and submit it and any required contributions to BCI in a manner approved by both BCI and the Trust.
 - 2. Except as provided otherwise in this section, the Effective Date of coverage for an Eligible Employee or an Eligible Dependent is the first day of the month following the month of enrollment.
 - 3. The Effective Date of coverage for an Eligible Employee and Eligible Dependents listed on the Eligible Employee's application is the Group's Plan Date, if the application is submitted to BCI by the Group on or before the Plan Date.

- D.
 - 1. Except as stated otherwise in subparagraphs D.2. and 3. below, the initial enrollment period is thirty (30) days for Eligible Employees and Eligible Dependents. The initial enrollment period begins on the date the Eligible Employees or Eligible Dependent first becomes eligible for coverage.
 - 2. A Participating Employee's newborn Dependent, including adopted newborn children who are placed with the adoptive Participating Employee within sixty (60) days of the adopted child's date of birth, are covered under this Plan from and after the date of birth for 60 days.

In order to continue coverage beyond the sixty (60) days outlined above, the Participating Employee must complete an enrollment application within sixty (60) days of date of birth and submit the required contribution, for the first sixty (60) days, within thirty-one (31) days of the date monthly billing is received and notice of contribution is provided to the Enrollee from the Trust.

The Effective Date of coverage will be the date of birth for a newborn natural child or a newborn child adopted or placed for adoption within sixty (60) days of the child's date of birth.

If the date of adoption or the date of placement for adoption of a child is more than sixty (60) days after the child's date of birth, the Effective Date of coverage will be the date of adoption or the date of placement for adoption. In this Plan, 'child' means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. In this Plan, "placed for

adoption” means physical placement in the care of the adoptive Participating Employee, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Participating Employee signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

3. The initial enrollment period is thirty (30) days for an Eligible Dependent who becomes eligible because of marriage. The initial enrollment period begins on the date of such marriage. The Effective Date of coverage is the first day of the month following the month of enrollment.

E. Late Participating Employee

If an Eligible Employee or Eligible Dependent does not enroll during the initial enrollment period described in Paragraph D. of this section or during a special enrollment period described in Paragraph F. of this section, the Eligible Employee or Eligible Dependent is a Late Participating Employee. Following the receipt and acceptance of a completed enrollment application, the Effective Date of coverage for a Late Participating Employee will be the date of the Group’s next Plan Date.

F. Special Enrollment Periods

An Eligible Employee or Eligible Dependent will not be considered a Late Participating Employee if:

1. **Individuals Losing Other Coverage** — An Eligible Participating Employee or Eligible Dependent losing other coverage may enroll for coverage under this Plan if each of the following conditions is met:
 - a) The Eligible Participating Employee or Eligible Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the Eligible Person or Eligible Dependent.
 - b) The Eligible Participating Employee’s or Eligible Dependent’s coverage described in subparagraph a):
 - (1) was under a COBRA continuation provision and the coverage under such provision was exhausted; or
 - (2) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.
 - c) Under the terms of this Plan, the Eligible Participating Employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph b)(1) or termination of coverage or employer contribution described in subparagraph b)(2).
2. **For Dependent Beneficiaries** —
 - a) If a person becomes an Eligible Dependent of an Participating Employee (or of an Eligible Employee who failed to enroll during a previous enrollment period) through marriage, birth, adoption before age 18 or placement for adoption before age 18, the Eligible Dependent (or, if not otherwise enrolled, the Eligible Person) may enroll, and in the case of the birth or adoption of a child, the spouse of the Participating Employee or Eligible Employee may enroll as an Eligible Dependent if such spouse is otherwise eligible for coverage.
 - b) The dependent special enrollment period under this subparagraph 2 shall be a period of 60 days and shall begin on the date of the marriage, birth, adoption or placement for adoption (as the case may be).
 - c) If a Participating Employee enrolls an Eligible Dependent during the dependent special enrollment period described in this subparagraph 2, the Effective Date of coverage shall be:

- (1) in the case of marriage, the first day of the month beginning after the date a completed application and any required contribution is received by Blue Cross of Idaho;
 - (2) in the case of an Eligible Dependent's birth, as of the date of such birth; or
 - (3) in the case of an Eligible Dependent's adoption or placement for adoption, the date of birth for an Eligible Dependent adopted or placed for adoption within 60 days of the Eligible Dependent's date of birth; and the date of such adoption or placement for adoption for an Eligible Dependent adopted or placed for adoption more than 60 days after the Eligible Dependent's date of birth.
3. The Eligible Employee and/or Eligible Dependent become eligible for a premium assistance subsidy under Medicaid or the Children's Health Insurance Program (CHIP) and coverage under this Plan is requested no later than 60 days after the date the Eligible Employee and/or Eligible Dependent is determined to be eligible for such assistance.
 4. Coverage under Medicaid or CHIP for an Eligible Employee and/or Eligible Dependent is terminated as a result of loss of eligibility for such coverage, and coverage is requested under this Plan no later than 60 days after the date of termination of such coverage.
- G. Eligible Employees and their enrolled Eligible Dependents who become eligible for retirement benefits by permanently separating from public employment in accordance with Idaho Code Title 59, Chapter 13 shall be continued on their former Group's benefit schedule until eligible for Medicare coverage. At the age of 65 or when otherwise eligible for Medicare, the Eligible retired Employee or Eligible Dependent shall be converted to the Statewide School Retiree Program, which is a Blue Cross of Idaho program that supplements Medicare.

V. Eligible Employees Changing To Other Participating School Districts

Coverage may be continuous for any Eligible Employee who changes employment to another Participating School District. There will be no waiting period for full benefit eligibility if there is no interruption in coverage.

VI. Retirement

If a Participant separates from public school employment by retirement in accordance with Idaho Code Title 59, Chapter 13, the Participant and/or his or her spouse shall be eligible for coverage under the retiree Plan of the Statewide Schools Group Program only if the Participant and/or his or her spouse have been continuously enrolled in the active employee Statewide Schools Group Program for the twelve (12) months immediately prior to the Participant's retirement. Any exceptions will require a health statement.

VII. Qualified Medical Child Support Order

- A. If this Plan provides for Family Coverage, BCI, on behalf of the Trust, will comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of applicable federal or state laws. A medical child support order is any judgement, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:
 1. Provides for child support with respect to a child of a Participating Employee or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under this Plan, or
 2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.
- B. A medical child support order meets the requirements of a QMCSO if such order clearly specifies:
 1. The name and the last known mailing address (if any) of the Participating Employee and the name and mailing address of each child covered by the order.

2. A reasonable description of the type of coverage to be provided by this Plan to each such child, or the manner in which such type of coverage is to be determined.
 3. The period to which such order applies.
- C.
1. Within fifteen (15) days of receipt of a medical child support order, BCI will notify the party who sent the order and each affected child of the receipt and of the criteria by which BCI determines if the medical child support order is a QMCSO. In addition, BCI will send an application to each affected child. The application must be completed by or on behalf of the affected child and promptly returned to BCI. With respect to a medical child support order, affected children may designate a representative for receipt of copies of notices sent to each of them.
 2. Within thirty (30) days after receipt of a medical child support order and a completed application, BCI will determine if the medical child support order is a QMCSO and will notify the Participating Employee, the party who sent the order, and each affected child of such determination.
- D. BCI, on behalf of the Trust, will make benefit payments to the respective party for reimbursement of eligible expenses paid by an enrolled affected child or by an enrolled affected child's custodial parent, legal guardian, or the Idaho Department of Health and Welfare.

VIII. Family and Medical Leave Act

Employees of Employers subject to the Family and Medical Leave Act (FMLA) may be entitled to up to 12 weeks of unpaid, job-protected leave per year. For those employees eligible for leave under the FMLA, group health benefits may be maintained on the same terms and conditions as if the employee had been continuously employed during the leave.

- If the employee pays a portion of the contribution for group health plan benefit coverage and FMLA leave is paid, the employee's paycheck will continue to be reduced by an amount necessary to pay for the employee's share of the cost of coverage. If the employee does not want to receive the same group health plan benefit coverage during FMLA leave that the employee was receiving just prior to leave, the employee must inform the Employer before the leave starts.
- If the employee decides not to receive group health plan benefits during FMLA leave, the employee will be reinstated in these group health plan benefits upon returning to work at the end of FMLA leave.
- If FMLA leave is unpaid and the employee wishes to continue participation in the Plan, the employee must make arrangements with the Employer to pay for the coverage that the employee wishes to maintain during the course of leave. Eligibility to continue any coverage that requires payments from the employee may be cancelled if the employee does not make the required payments during the period of FMLA leave.
- If the Employer advances money by making any or all of these required payments for the employee, the Employer can recoup the amounts advanced through payroll deductions upon the employee's return to employment following FMLA leave to the extent permitted by law.
- If the employee fails to return from FMLA leave, and the reasons for failure are not beyond the employee's control, the employee is indebted to the Employer for the full amount of the cost of health coverage provided during FMLA leave. The Employer may deduct any such amounts owed by the employee from any compensable time payments owed to the employee upon termination for failure to return from an FMLA leave to the extent permitted by law.
- The employee should consult with the Employer before embarking on any FMLA qualified leave.

If Plan coverage terminates during the FMLA leave, coverage for benefits under this Plan will be reinstated for the employee and the employee's covered dependents if the employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the employee or the employee's dependent(s) had coverage under this Plan when the FMLA leave

started, and will be reinstated to the same extent that it was in force when that coverage terminated.

ELIGIBILITY AND ENROLLMENT FOR RETIREES SECTION

I. Eligibility And Enrollment

All Eligible Retirees will have the opportunity to apply for coverage under this Plan. All applications submitted to Blue Cross of Idaho (BCI) by the Group now or in the future, will be for Eligible Employees or Eligible Dependents only.

A. Eligible Retiree

1. Eligible Retiree is defined as: A retired employee who was employed by a Participating School District but who has permanently separated from public school employment in accordance with Idaho Code Title 59, Chapter 13.
2. The date the retiree becomes eligible for coverage in the Statewide School Retiree Program is on the first day of retirement in accordance with Idaho Code Title 59, Chapter 13, or the day a school district becomes a Participating School District, whichever is later.
3. A Retiree may, upon written request, defer enrollment in the Statewide School Retiree Program until a future date, thus postponing any draw on the unused sick leave account with PERSI.

During the period of deferment the Retiree must maintain continuous Trust coverage. The eligibility for Statewide School Retiree Program coverage ends should the School District from which the person retires move coverage for active employees to another insurance carrier.

B. Eligible Dependent

To qualify as an Eligible Dependent under this Plan, a person must be and remain one (1) of the following:

1. The Participating Employee’s spouse under a legally valid marriage.
2. The Participating Employee’s natural child, stepchild, legally adopted child, child placed with the Participating Employee for adoption, or child for whom the Participating Employee or the Participating Employee’s spouse has court-appointed guardianship or custody. The child must be:
 - a) Under the age of twenty-six (26); or
 - b) Medically certified as disabled due to intellectual disability or physical handicap *and* financially dependent upon the Participating Employee for support, regardless of age.
3. A Participating Employee must notify the BCI or the Trust within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate the last day of the month in which the change in eligibility status took place.

II. Loss Of Eligibility If A Participating School District Cancels

If the Participating School District through which the retired Participant was last employed cancels its coverage under the Plan and leaves the Statewide School Group Program, the retired Participant ceases to be an Eligible Retiree on the Effective Date of the cancellation.

III. Payment Of Contribution And Effective Date

A. All Eligible Retirees will have the opportunity to apply for coverage. In order to be eligible for retiree benefits, the Eligible Retiree must have continuous coverage from their former Group’s benefit schedule. All applications submitted to Blue Cross of Idaho now or in the future, must be for Eligible Retirees or Eligible Dependents only.

B. The contribution will be deducted from the Participant’s sick leave fund to the extent such funds are available. When the sick leave funds are exhausted, the contribution shall be deducted from the Participant’s pension fund to the extent such funds are available.

If there is a sufficient amount of funds in the Retiree’s sick leave and/or pension fund, the Public Employees Retirement System of Idaho agrees to collect required Retiree payments through withholding from the fund, be responsible for and make the payment to Blue

Cross of Idaho on or before the first of the month during the term of this Plan. If the Retiree's monthly pension and/or sick leave fund is less than the required payment, the Retiree shall be responsible for remitting the entire monthly subscription payment to Blue Cross of Idaho on or before the first of the month during the term of this Plan.

- C. For a person who is an Eligible Retiree and who applies for Single, Two-Party or Family Coverage on or before the first day he or she first becomes eligible as provided herein, the Effective Date is either the Participating School District's Plan Date, or the first day of the month after the person first becomes eligible, whichever is earlier. A Retiree may not add a Dependent who was not enrolled when the Retiree was an active employee under the Statewide School Group Program, except as provided for Eligible Dependents under paragraph III.F.

- D.
 - 1. For an Eligible Retiree to enroll himself or herself and any Eligible Dependents for coverage under this Plan (or for A Participant to enroll Eligible Dependents for coverage under this Plan) the Eligible Person or Participant, as the case may be, must complete a Blue Cross of Idaho application and submit it and any required contributions to Blue Cross of Idaho.
 - 2. Except as provided otherwise in this section, the Effective Date of coverage for an Eligible Retiree or an Eligible Dependent will be the first day of the month following the month of enrollment.
 - 3. The Effective Date of coverage for an Eligible Retiree and any Eligible Dependents listed on the Eligible Retiree's application is the Group's Plan Date if the application is submitted to Blue Cross of Idaho by the Group on or before the Plan Date.

- E. Eligible Retirees and Eligible Dependents shall be continued on this benefits schedule until eligible for Medicare coverage. When first eligible, Retirees and Eligible Dependents must enroll in Medicare (both Part A and Part B) in order to participate in the Statewide School Retiree Program that supplements Medicare.
 - 1. Except as stated otherwise in subparagraphs E2. and 3. below, the initial enrollment period is thirty (30) days for Eligible Employees and Eligible Dependents. The initial enrollment period begins on the date the Eligible Employee or Eligible Dependent first becomes eligible for coverage under this Plan.
 - 2. A Participant's newborn Dependent, including adopted newborn children who are placed with the adoptive Participant within sixty (60) days of the adopted child's date of birth, are covered under this Plan from and after the date of birth for sixty (60) days.

In order to continue coverage beyond the sixty (60) days outlined above, the Participant must complete an enrollment application and submit the required contribution within thirty-one (31) days of the date monthly billing is received by the Group and a notice of contribution is provided to the Participant by the Group.

When a newborn child is added and the monthly contribution changes, a full month's contribution is required for the child if his or her date of birth falls on the 1st through the 15th day of the month. No contribution for the first month is required if the child's date of birth falls on the 16th through the last day of the month.

The Effective Date of coverage will be the date of birth for a newborn natural child or a newborn child adopted or placed for adoption within sixty (60) days of the child's date of birth.

If the date of adoption or the date of placement for adoption of a child is more than sixty (60) days after the child's date of birth, the Effective Date of coverage will be the date of adoption or the date of placement for adoption. In this Plan, 'child' means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. In this Plan, "placed for adoption" means physical placement in the care of the adoptive Participant, or in those circumstances

in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Participant signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

3. The initial enrollment period is sixty (60) days for an Eligible Dependent who becomes eligible because of marriage. The initial enrollment period begins on the date of such marriage. The Effective Date of coverage is the first day of the month following the month of enrollment.

IV. Qualified Medical Child Support Order

- A. If this Plan provides for Family Coverage BCI, on behalf of the Trust, will comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of applicable federal or state laws. A medical child support order is any judgement, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:
 1. Provides for child support with respect to a child of a Participating Employee or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under this Plan, or
 2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.
- B. A medical child support order meets the requirements of a QMCSO if such order clearly specifies:
 1. The name and the last known mailing address (if any) of the Participating Employee and the name and mailing address of each child covered by the order.
 2. A reasonable description of the type of coverage to be provided by this Plan to each such child, or the manner in which such type of coverage is to be determined.
 3. The period to which such order applies.
- C.
 1. Within fifteen (15) days of receipt of a medical child support order, BCI will notify the party who sent the order and each affected child of the receipt and of the criteria by which BCI determines if the medical child support order is a QMCSO. In addition, BCI will send an application to each affected child. The application must be completed by or on behalf of the affected child and promptly returned to BCI. With respect to a medical child support order, affected children may designate a representative for receipt of copies of notices sent to each of them.
 2. Within thirty (30) days after receipt of a medical child support order and a completed application, BCI will determine if the medical child support order is a QMCSO and will notify the Participating Employee, the party who sent the order, and each affected child of such determination.
- D. BCI, on behalf of the Trust, will make benefit payments to the respective party for reimbursement of eligible expenses paid by an enrolled affected child or by an enrolled affected child's custodial parent, legal guardian, or the Idaho Department of Health and Welfare.

DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout this Plan. Other terms may be defined where they appear in this Plan. All Providers and Facilities must be licensed and/or registered by the state where the services are rendered, unless exempt by federal law, and must be performing within the scope of license in order for BCI to provide benefits. Definitions in this Plan shall control over any other definition or interpretation unless the context clearly indicates otherwise.

Accidental Injury or Injury—an objectively demonstrable impairment of bodily function or damage to part of the body caused by trauma from a sudden, unforeseen external force or object, occurring at a reasonably identifiable time and place, and without a Participant’s foresight or expectation, which requires medical attention at the time of the accident. The force may be the result of the injured party’s actions, but must not be intentionally self-inflicted unless caused by a medical condition or domestic violence. Contact with an external object must be unexpected and unintentional, or the results of force must be unexpected and sudden.

Acute Care—Medically Necessary Inpatient treatment in a Licensed General Hospital or other Facility Provider for sustained medical intervention by a Physician and Skilled Nursing Care to safeguard a Participant’s life and health. The immediate medical goal of Acute Care is to stabilize the Participant’s condition, rather than upgrade or restore a Participant’s abilities.

Admission—begins the first day a Participant becomes a registered Hospital bed patient or a Skilled Nursing Facility patient and continues until the Participant is discharged.

Adverse Benefit Determination—any denial, reduction, rescission of coverage, or termination of, or the failure to provide payment for, a benefit for services or ongoing treatment under this Plan.

Advisory Committee on Immunization Practices (ACIP)—a committee consisting of immunization field experts who provide guidance to the Center for Disease Control (CDC) and the Department of Health and Human Services (HHS), on the effective control of vaccine-preventable diseases in the United States. The committee develops written recommendations for the routine administration of vaccines to children and adults; to include dose, route, frequency of administration, precautions and contraindications.

Alcoholism—a behavioral or physical disorder manifested by repeated excessive consumption of alcohol to the extent that it interferes with a Participant’s health, social, or economic functioning.

Alcoholism Or Substance Abuse Treatment—a Provider that is acting under the scope of its license, where required, that is primarily engaged in providing detoxification and Rehabilitative care for Alcoholism, or Substance Abuse, or Addiction.

Ambulatory Surgical Facility (Surgery Center)—a Facility Provider that is Medicare Certified and/or otherwise acting under the scope of its license, where required, with a staff of Physicians, which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis.
2. Provides treatment by or under the supervision of Physicians and provides Skilled Nursing Care while the Participant is in the facility.
3. Does not provide Inpatient accommodations.
4. Is not primarily a facility used as an office or clinic for the private practice of a Physician or other Professional Provider.

Amendment (Amend)—a formal document signed by the representatives the Idaho School District Council Self-Funded Benefit Trust. The Amendment adds, deletes or changes the provisions of the Plan and applies to all covered persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.

American Psychiatric Association—an organization composed of medical specialists who work together to ensure effective treatment for all persons with a mental disorder.

American Psychological Association—a scientific and professional organization that represents psychology in the United States.

Approved Clinical Trial—a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to prevention, detection, or treatment of cancer or other life-threatening condition.

Artificial Organs—permanently attached or implanted man-made devices that replace all or part of a Diseased or nonfunctioning body organ, including but not limited to, artificial hearts and pancreases.

Autotransplant (Or Autograft)—the surgical transfer of an organ or tissue from one (1) location to another within the same individual.

Benefit Period—the specified period of time during which a Participant accumulates annual benefit limits, Deductible amounts and Out-of-Pocket Limits.

Benefits—the amount Blue Cross of Idaho will pay for Covered Services after Deductible requirements are met.

Blue Cross Of Idaho Health Services, Inc. (Blue Cross of Idaho or BCI)—a nonprofit mutual insurance company, hired by the Board of Trustees to act as the Contract Administrator to perform claims processing and other specific administrative services as outlined in the Plan and/or Administrative Services Agreement.

BlueCard—a program to process claims for most Covered Services received by Participants outside of BCI's service area while capturing the local Blue Cross and/or Blue Shield Plan's Provider discounts.

Blue Distinction Centers For Transplants (BDCT)—the BDCT are major Hospitals and research institutions located throughout the United States that are designated for Transplants.

Board of Trustees—the Board of Trustees of the Idaho School District Council Self-Funded Benefit Trust has all discretionary authority to interpret the provisions and control the operation and administration of the Plan within the limits of the law. All decisions made by the Board of Trustees, including final determination of Medical Necessity, shall be final and binding. The Board of Trustees also reserves the right to modify eligibility clauses for new Plan participants who join the Plan as a result of a merger, acquisition or for any employee who was covered under a labor agreement plan during a previous period of employment to which the employee's employer contributes, provided that coverage under this Plan begins within 31 days of the date coverage under the previous Plan terminates. The Idaho School District Council Self-Funded Benefit Trust may choose to hire a consultant and/or Contract Administrator to perform specified duties in relation to the Plan. The Board of Trustees also has the right to amend, modify or terminate the Plan at any time or in any manner as outlined in the Administrative Services Agreement.

The administration of the Plan document is under the supervision of the Board of Trustees. The Idaho School District Council acts on behalf of the Board of Trustees. The Board of Trustees has agreed to indemnify each employee in the Idaho School District Council for any liability he/she incurs as a result of acting on behalf of the Board of Trustees, except if such liability is due to his/her gross negligence or misconduct.

Certified Nurse-Midwife—an individual licensed to practice as a Certified Nurse Midwife.

Certified Registered Nurse Anesthetist—a licensed individual registered as a Certified Registered Nurse Anesthetist in the state in which services are rendered. Services rendered must be within the scope of the registration.

Chiropractic Care—services rendered, referred, or prescribed by a Chiropractic Physician, when those services are within the scope of the license held by the Chiropractic Physician.

Chiropractic Physician—an individual licensed to practice chiropractic in the state in which services are rendered.

Clinical Laboratory Improvement Amendments (CLIA)—a Centers for Medicare & Medicaid Services (CMS) program which regulates all human performed laboratory testing in the United States to ensure quality laboratory testing.

Clinical Nurse Specialist—an individual licensed to practice as a Clinical Nurse Specialist in the state in which services are rendered.

Clinical Psychologist—an individual licensed to practice clinical psychology in the state in which services are rendered.

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

Continuous Crisis Care—Hospice Nursing Care provided during periods of crisis in order to maintain a terminally ill Participant at home. A period of crisis is one in which the Participant's symptom management demands predominantly Skilled Nursing Care.

Contract Administrator—Blue Cross of Idaho has been hired as the Contract Administrator by the Board of Trustees to perform claims processing and other specified administrative services in relation to the Plan. The Contract Administrator is not an insurer of health benefits under this Plan, and does not exercise any of the discretionary authority and responsibility granted to the Board of Trustees. The Contract Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

Contracting Provider—a Provider that has entered into a written agreement with BCI to accept the Participant's Deductible and/or Cost Sharing plus BCI's Benefit payment as payment in full for Covered Services rendered to a Participant.

Copayment—a designated dollar and/or percentage amount, separate from Cost Sharing, that a Participant is financially responsible for and must pay to a Provider at the time certain Covered Services are rendered.

Cost Effective—a requested or provided medical service or supply that is Medically Necessary in order to identify or treat a Participant's health condition, illness or injury and that is:

1. Provided in the most cost-appropriate setting consistent with the Participant's clinical condition and the Provider's expertise. For example, when applied to services that can be provided in either an Inpatient hospital setting or Outpatient hospital setting, the Cost Effective setting will generally be the outpatient setting. When applied to services that can be provided in a hospital setting or in a physician office setting, the Cost Effective setting will generally be the physician office setting.
2. Not more costly than an alternative service or supply, including no treatment, and at least as likely to produce an equivalent result for the Participant's condition, Disease, Illness or injury.

Cost Sharing—the percentage of the Maximum Allowance or the actual charge, whichever is less, a Participant is responsible to pay Out-of-Pocket for Covered Services after satisfaction of any applicable Deductibles or Copayments, or both.

Covered Service—when rendered by a Provider, a service, supply, or procedure specified in this Plan for which benefits will be provided to a Participant.

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

Deductible—the amount a Participant is responsible to pay Out-of-Pocket before BCI, on behalf of the Trust, begins to pay benefits for most Covered Services. The amount credited to the Deductible is based on the Maximum Allowance or the actual charge, whichever is less.

Dentist—an individual licensed to practice Dentistry.

Dentistry Or Dental Treatment—the treatment of teeth and supporting structures, including but not limited to, the replacement of teeth.

Diagnostic Imaging Provider—a person or entity that is licensed, where required, and/or Medicare Certified (and/or otherwise acting under the scope of license) to render Covered Services.

Diagnostic Service—a test or procedure performed on the order of a Physician or other Professional Provider because of specific symptoms, in order to identify a particular condition, Disease, Illness, or Accidental Injury. Diagnostic Services, include but are not limited to:

1. Radiology services.
2. Laboratory and pathology services.
3. Cardiographic, encephalographic, and radioisotope tests.

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

Durable Medical Equipment—items which can withstand repeated use, are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of Accidental Injury, Disease or Illness, and are appropriate for use in the Participant's home.

Durable Medical Equipment Supplier—a business that is licensed, where required, and/or Medicare Certified (and/or otherwise acting under the scope of license) to sell or rent Durable Medical Equipment.

Effective Date—the date when coverage for a Participant begins under this Plan.

Electroconvulsive Therapy (ECT)—Electroconvulsive Therapy (ECT) is a treatment for severe forms of depression, bipolar disorder, schizophrenia and other serious mental illnesses that uses electrical impulses to induce a convulsive seizure.

Eligible Dependent—a person eligible for enrollment under a Participating Employee's coverage.

Eligible Employee—an employee of a Group who is entitled to apply as a Participating Employee.

Emergency Inpatient Admission—Medically Necessary Inpatient admission to a Licensed General Hospital or other Inpatient Facility due to the sudden, acute onset of a medical condition or an Accidental Injury which requires immediate medical treatment to preserve life or prevent severe, irreparable harm to a Participant.

Emergency Medical Condition—a condition in which sudden and unexpected symptoms are sufficiently severe to necessitate immediate medical care. Emergency Medical Conditions, include but are not limited to, heart attacks, cerebrovascular accidents, poisonings, loss of consciousness or respiration, and convulsions.

Emergency Admission Notification—notification by the Participant to BCI of an Emergency Inpatient Admission resulting in an evaluation conducted by BCI to determine the Medical Necessity of a Participant's Emergency Inpatient Admission and the accompanying course of treatment.

Family Coverage—the enrollment of a Participating Employee and two (2) or more Eligible Dependents under this Plan.

Freestanding Diabetes Facility—a person or entity that is recognized by the American Diabetes Association, and/or otherwise acting under the scope of its license, where required, to render Covered Services.

Freestanding Dialysis Facility—a Medicare Certified Facility Provider, or other Facility Provider acting under the scope of its license, that is primarily engaged in providing dialysis treatment, maintenance, or training to patients on an Outpatient or home care basis.

Group—the Idaho District School Council Self-Funded Benefit Trust, also referred to as the Trust.

Growth Hormone Therapy—Treatment administered by intramuscular injection to treat children with growth failure due to pituitary disorder or dysfunction.

Habilitation (or Habilitative)—developing skills and functional abilities necessary for daily living and skills related to communication of persons who have never acquired them.

Health Benefit Plan—the Idaho School District Council Self-Funded Benefit Trust. This coverage is not insurance and the Idaho School District Council Self-Funded Benefit Trust does not participate in the State Guaranty Association.

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

Home Health Agency—any agency or organization that provides Skilled Nursing Care services and other therapeutic services.

Home Health Aide—an individual employed by a Hospice, under the direct supervision of a licensed registered nurse (R.N.), who performs and trains others to perform, intermittent Custodial Care services which include but are not limited to, assistance in bathing, checking vital signs, and changing dressings.

Home Health Nursing—the delivery of Skilled Nursing services under the direction of a Physician to a Homebound patient in their home on an intermittent basis. Home Health Nursing is generally intended to transition a Homebound patient from a hospital setting to a home or prevent a hospital stay.

Home Intravenous Therapy (Home Infusion Therapy)—Treatment provided in the home of the Participant or other locations outside of a Licensed General Hospital, that is administered via an intravenous, intraspinal, intra-arterial, intrathecal, subcutaneous, enteral, or intramuscular injection or access device inserted into the body, at or under the direction of a Home Health Agency or other Provider approved by BCI.

Home Intravenous Therapy Company—a licensed, where required, and/or Medicare Certified (and/or otherwise acting under the scope of its license) pharmacy or other entity that is principally engaged in providing services, medical supplies, and equipment for certain home infusion Therapy Covered Services, to Participants in their homes or other locations outside of a Licensed General Hospital.

Hospice—a Medicare Certified (and/or otherwise acting under the scope of its license, if required) public agency or private organization designated specifically to provide services for care and management of terminally ill patients, primarily in the home.

Hospice Nursing Care—Skilled Nursing Care and Home Health Aide services provided as a part of the Hospice Plan of Treatment.

Hospice Plan Of Treatment—a written plan of care that describes the services and supplies for the Medically Necessary palliative care and treatment to be provided to a Participant by a Hospice. The written plan of care must be established and periodically reviewed by the attending Physician.

Hospital Grade Breast Pump—a stronger piston based breast pump that meets hospital requirements for electrical safety, cleaning and sterilization for rental between users. Typically used by a mother with a premature baby or a personal medical condition that affects milk production.

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

Illness—a deviation from the healthy and normal condition of any bodily function or tissue. An Illness can exist with or without a Participant’s awareness of it, and can be of known or unknown cause(s).

In-Network Services —Covered Services provided by a Contracting Provider.

Inpatient—a Participant who is admitted as a bed patient in a Licensed General Hospital or other Facility Provider and for whom a room and board charge is made.

Intensive Outpatient Program—Intensive Outpatient Program (IOP) is a treatment program that includes extended periods of therapy sessions, several times a week for a minimum of three (3) hours per day, a minimum of three (3) days per week and a minimum of nine (9) hours per week. It is an intermediate setting between traditional therapy sessions and partial hospitalization.

Investigational—any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes such as length of life, quality of life, and functional ability. A technology is considered investigational if, as determined by BCI, it fails to meet any one of the following criteria:

1. The technology must have final approval from the appropriate government regulatory body. This applies to drugs, biological products, devices, and other products/procedures that must have approval from the U.S. Food and Drug Administration (FDA) or another federal authority before they can be marketed. Interim approval is not sufficient. The condition for which the technology is approved must be the same as that BCI is evaluating.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of current published medical literature and investigations published in peer-reviewed journals. The quality of the studies and consistency of results will be considered. The evidence should demonstrate that the technology can measure or alter physiological changes related to a Disease, injury, Illness, or condition. In addition, there should be evidence that such measurement or alteration affects health outcomes.
3. The technology must improve the net health outcome. The technology’s beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
4. The technology must be as beneficial as any established alternatives.
5. The technology must show improvement that is attainable outside the investigational setting. Improvements must be demonstrated when used under the usual conditions of medical practice.

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

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

Keratoconus—a developmental or dystrophic deformity of the cornea in which it becomes cone-shaped due to a thinning and stretching of the tissue in its central area.

Licensed Clinical Professional Counselor (LCPC)—a licensed individual providing diagnosis and treatment of Mental or Nervous Conditions.

Licensed Clinical Social Worker (LCSW)—a licensed individual providing diagnosis and treatment of Mental or Nervous Conditions.

Licensed General Hospital—a short term, Acute Care, general hospital that:

1. Is an institution licensed in the state in which it is located and is lawfully entitled to operate as a general, Acute Care hospital.
2. Is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians, for compensation from and on behalf of its patients.
3. Has functioning departments of medicine and Surgery.
4. Provides twenty-four (24) hour nursing service by or under the supervision of licensed R.N.s.
5. Is not predominantly a:
 - a) Skilled Nursing Facility
 - b) Nursing home
 - c) Custodial Care home
 - d) Health resort
 - e) Spa or sanatorium
 - f) Place for rest
 - g) Place for the aged
 - h) Place for the treatment or Rehabilitative care of Mental or Nervous Conditions
 - i) Place for the treatment or Rehabilitative care of Alcoholism or Substance Abuse or Addiction
 - j) Place for Hospice care
 - k) Residential Treatment Facility
 - l) Transitional Living Center

Licensed Marriage And Family Therapist (LMFT)—a licensed individual providing diagnosis and treatment of Mental or Nervous Conditions.

Licensed Pharmacist—an individual licensed to practice pharmacology in the state in which services are rendered.

Licensed Rehabilitation Hospital—a Facility Provider principally engaged in providing diagnostic, therapeutic, and Physical Rehabilitation Services to Participants on an Inpatient basis.

Lifetime Benefit Limit—the greatest aggregate amount payable by the Plan on behalf of an Individual for specified Covered Services during all periods in which the Participant has been continuously enrolled with the Group. The Lifetime Benefit Limit shall only apply to Morbid Obesity Services as shown in the Benefits Outline.

Maximum Allowance—for Covered Services under the terms of this Plan, Maximum Allowance is the lesser of the billed charge or the amount established by BCI as the highest level of compensation for a Covered Service. If the Covered Services are rendered outside the state of Idaho by a Noncontracting or Contracting Provider with a Blue Cross and/or Blue Shield affiliate in the location of the Covered Services, the Maximum Allowance is the lesser of the billed charge or the amount established by the affiliate as compensation.

The Maximum Allowance is determined using many factors, including pre-negotiated payment amounts; diagnostic related groupings (DRGs); a resource based relative value scale (RBRVS); ambulatory payment classifications (APCs); the Provider's charge(s); the charge(s) of Providers with similar training and experience within a particular geographic area; Medicare reimbursement amounts; and/or the cost of rendering the Covered Service. Moreover, Maximum Allowance may differ depending on whether the Provider is Contracting or Noncontracting.

In addition, Maximum Allowance for Covered Services provided by Contracting or Noncontracting Dentists is determined using many factors, including pre-negotiated payment amounts, a calculation of charges submitted by Contracting Idaho Dentists, and/or a calculation of the average charges submitted by all Idaho Dentists.

Medicaid—Title XIX (Grants to States for Medical Assistance Programs) of the United States Social Security Act as amended.

Medically Necessary (or Medical Necessity)—the Covered Service or supply recommended by the treating Provider to identify or treat a Participant's condition, Disease, Illness or Accidental Injury and which is determined by BCI to be:

1. The most appropriate supply or level of service, considering potential benefit and harm to the Participant.
2. Proven to be effective in improving health outcomes;
 - a) For new treatment, effectiveness is determined by peer reviewed scientific evidence;
 - b) For existing treatment, effectiveness is determined first by peer reviewed scientific evidence, then by professional standards, then by expert opinion.
3. Not primarily for the convenience of the Participant or Provider.
4. Cost Effective for this condition.

The fact that a Provider may prescribe, order, recommend, or approve a service or supply does not, in and of itself, necessarily establish that such service or supply is Medically Necessary under this Plan.

The term Medically Necessary as defined and used in this Plan is strictly limited to the application and interpretation of this Plan, and any determination of whether a service is Medically Necessary hereunder is made solely for the purpose of determining whether services rendered are Covered Services.

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

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

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

These standards are the minimum health and safety requirements that providers and suppliers must meet in order to be Medicare and Medicaid Certified.

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

Morbid Obesity—a condition where an individual's weight is at least 100 pounds over or twice the ideal weight for frame, age, height and sex specified in the 1983 Metropolitan Life Insurance table, or the body mass index (BMI) is over 40 kg/meter squared.

Neuromusculoskeletal Treatment—means and includes diagnosis and treatment in the form of manipulation and adjustment of the vertebrae, disc, spine, back, neck and adjacent tissues in an Outpatient office or clinic setting and for acute or Rehabilitative purposes.

Noncontracting Provider—a Professional Provider or Facility Provider that has not entered into a written agreement with BCI regarding payment for Covered Services rendered to a Participant.

Nurse Practitioner—an individual licensed to practice as a Nurse Practitioner.

Occupational Therapist—an individual licensed to practice occupational therapy.

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

Office Visit—any direct, one-on-one examination and/or exchange, conducted in the Provider's office, between a Participant and a Provider, or members of his or her staff for the purposes of seeking care and rendering Covered Services. For purposes of this definition, a Medically Necessary visit by a Physician to a Homebound Participant's place of residence may be considered an Office Visit.

Ophthalmologist—a doctor of medicine (M.D.) who is both a medical doctor and a surgeon. The ophthalmologist is licensed to examine, diagnose and treat disorders and diseases of the eye and visual system of the brain, as well as prescribe corrective lenses (glasses or contacts).

Optometrist—a person who is licensed and specializes in optometry to examine, measure and treat certain visual defects by means of corrective lenses or other methods that do not require a license as a physician.

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

Orthotic Devices—any rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or Diseased body part.

Out-Of-Network Services—any Covered Services rendered by a Noncontracting provider.

Out-Of-Pocket Limit—the amount of Out-of-Pocket expenses incurred during one (1) Benefit Period that a Participant is responsible for paying. Eligible Out-of-Pocket expenses include only the Participant's Deductible, Copayments and Cost Sharing for eligible Covered Services.

Outpatient—a Participant who receives services or supplies while not an Inpatient.

Partial Hospitalization Program—Partial Hospitalization Program (PHP) is a treatment program that provides interdisciplinary medical and psychiatric services. Partial Hospitalization Program (PHP) involves a prescribed course of psychiatric treatment provided on a predetermined and organized schedule and provided in lieu of hospitalization for a patient who does not require full-time hospitalization.

Participant—a Participating Employee or an enrolled Eligible Dependent covered under this Plan.

Participating Employee—an Eligible Employee who has enrolled for coverage and has satisfied the requirements of the Eligibility and Enrollment Section.

Participating School District—a school district that has a current participation agreement with the Trust.

Physical Rehabilitation—Medically Necessary non-acute therapy rendered by qualified health care professionals. Physical Rehabilitation is intended to restore a Participant's physical health and well-being as close as reasonably possible to the level that existed immediately prior to the occurrence of a condition, Disease, Illness, or Accidental Injury.

Physical Therapist—an individual licensed to practice physical therapy.

Physician—a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) licensed to practice medicine.

Physician Assistant—an individual licensed to practice as a Physician Assistant.

Plan—the Idaho School District Council Self-Funded Benefit Trust including the Administrative Services Agreement between Blue Cross of Idaho and the Trust and Amendments and attachments to such agreement, and all benefit outlines and summary plan descriptions.

Plan Date—the date specified in this Plan on which coverage commences for the Group.

Plan Sponsor —the Idaho School District Cooperate Service Council.

Podiatrist—an individual licensed to practice podiatry.

Post-Service Claim—any claim for a benefit under this Plan that does not require Prior Authorization before services are rendered.

Preadmission Testing—tests and studies required in connection with a Participant’s Inpatient admission to a Licensed General Hospital that are rendered or accepted by the Licensed General Hospital on an Outpatient basis. Preadmission tests and studies must be done prior to a scheduled Inpatient admission to the Licensed General Hospital, provided the services would have been available to an Inpatient of that hospital. Preadmission Testing does not include tests or studies performed to establish a diagnosis.

Preferred Provider Organization (PPO)—a Health Benefit Plan in which the highest level of Benefits is received when the Participant obtains Covered Services from an In-Network Provider.

Prescription Drugs—drugs, biologicals, and Compounded prescriptions that are FDA approved and can be dispensed only according to a written prescription given by a Physician and/or duly licensed provider, that are listed with approval in the *United States Pharmacopeia*, *National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that are prescribed for human consumption, and that are required by law to bear the legend: “Caution—Federal Law prohibits dispensing without prescription.”

Pre-Service Claim—any claim for a benefit under this Plan that requires Prior Authorization before services are rendered.

Primary Care Giver—a person designated to give direct care and emotional support to a Participant as part of a Hospice Plan of Treatment. A Primary Care Giver may be a spouse, relative, or other individual who has personal significance to the Participant. A Primary Care Giver must be a volunteer who does not expect or claim any compensation for services provided to the Participant.

Primary Care Provider—a Professional Provider who is generally the first contact when a Participant seeks medical treatment. Benefits may include services for infants and children, immunizations, screening for infectious and communicable diseases, treating minor injuries and common complaints, and managing chronic disease. A Primary Care Provider includes, but is not limited to, general/family practice, pediatrics, internal medicine and obstetric and gynecology.

Prior Authorization—the Provider’s or the Participant’s request to BCI, or delegated entity, for a medical necessity determination of a Participant’s proposed treatment. BCI or the delegated entity may review medical records, test results and other sources of information to make the determination. Prior Authorization is not a determination of benefit coverage. Benefit coverage and eligibility for payment is determined solely by BCI.

Prosthetic and Orthotic Supplier—a person or entity that is licensed, where required, and Medicare Certified (or otherwise acting under the scope of its license) to render Covered Services.

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

Provider—a person or entity that is licensed, where required, to render Covered Services. For the purposes of this Plan, Providers include any facility or individual who provides a Covered Service while operating within the scope of their professional license and applicable state law, unless exempted by federal law.

1. Facility Providers
 - a. Ambulatory Surgical Facility (Surgery Center)
 - b. Alcoholism or Substance Abuse Treatment
 - c. CLIA Certified, Independent Laboratory
 - d. Home Intravenous Therapy Company
 - e. Hospice
 - f. Licensed Rehabilitation Hospital
 - g. Psychiatric Hospital
 - h. Diagnostic Imaging Provider
 - i. Freestanding Diabetes Facility
 - j. Freestanding Dialysis Facility
 - k. Home Health Agency
 - l. Licensed General Hospital
 - m. Prosthetic and Orthotic Supplier
 - n. Radiation Therapy Center
 - o. Residential Treatment Facility
 - p. Skilled Nursing Facility

2. Professional Providers
 - a. Ambulance Transportation Service
 - b. Audiologist
 - c. Certified Nurse-Midwife
 - d. Certified Registered Nurse Anesthetist
 - e. Chiropractic Physician
 - f. Clinical Nurse Specialist
 - g. Speech Therapist
 - h. Clinical Psychologist
 - i. Licensed Clinical Professional Counselor (LCPC)
 - j. Licensed Clinical Social Worker (LCSW)
 - k. Licensed Marriage and Family Therapist (LMFT)
 - l. Licensed Occupational Therapist
 - m. Licensed Physical Therapist
 - n. Dentist/Denturist
 - o. Durable Medical Equipment Supplier
 - p. Licensed Pharmacist
 - q. Nurse Practitioner
 - r. Optometrist/Optician
 - s. Physician
 - t. Physician Assistant
 - u. Registered Dietitian
 - v. Podiatrist

Psychiatric Hospital—a Facility Provider principally engaged in providing diagnostic and therapeutic services and Rehabilitation Services for the Inpatient treatment of Mental or Nervous Conditions, Alcoholism or Substance Abuse or Addiction. These services are provided by or under the supervision of a staff of Physicians, and continuous nursing services are provided under the supervision of a licensed R.N.

Radiation Therapy Center—a Facility Provider that is primarily engaged in providing Radiation Therapy Services to patients on an Outpatient basis.

Recognized Transplant Center—a Licensed General Hospital that meets any of the following criteria:

1. Is approved by the Medicare program for the requested Transplant Covered Services.
2. Is included in the Blue Cross and Blue Shield System's National Transplant Networks.
3. Has arrangements with another Blue Cross and/or Blue Shield Plan for the delivery of the requested Transplant Covered Services, based on appropriate approval criteria established by that Plan.
4. Is approved by BCI based on the recommendation of BCI's Medical Director.

Registered Dietitian—a professional trained in foods and the management of diets (dietetics) who is credentialed by the Commission on Dietetic Registration of the American Dietetic Association, or otherwise acting under the scope of their license, where required.

Rehabilitation (or Rehabilitative)—restoring skills and functional abilities necessary for daily living and skills related to communication that have been lost or impaired due to disease, illness or injury.

Rehabilitation or Habilitation Plan Of Treatment—a written plan which describes the services and supplies for the Rehabilitation or Habilitation care and treatment to be provided to a Participant. The written plan must be established and periodically reviewed by an attending Physician.

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

Respite Care—care provided to a Homebound Participant as part of a Hospice Plan of Treatment. The purpose of Respite Care is to provide the Primary Care Giver a temporary period of rest from the stress and physical exhaustion involved in caring for the Participant at home.

Skilled Nursing Care—nursing service that must be rendered by or under the direct supervision of a licensed R.N. to maximize the safety of a Participant and to achieve the medically desired result according to the orders and direction of an attending Physician. The following components of Skilled Nursing Care distinguish it from Custodial Care that does not require professional health training:

1. The observation and assessment of the total medical needs of the Participant.
2. The planning, organization, and management of a treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired result.
3. Rendering to the Participant, direct nursing services that require specialized training.

Skilled Nursing Facility—a licensed Facility Provider primarily engaged in providing Inpatient Skilled Nursing Care to patients requiring convalescent care rendered by or under the supervision of a Physician. Other than incidentally, a Skilled Nursing Facility is not a place or facility that provides minimal care, Custodial Care, ambulatory care, or part-time care services; or care or treatment of Mental or Nervous Conditions, Alcoholism, or Substance Abuse or Addiction.

Sleep Study—the continuous monitoring of physiological parameters, such as brain and breathing activity of the Participant during sleep.

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

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

Special Care Unit—a designated unit within a Licensed General Hospital that has concentrated facilities, equipment, and support services to provide an intensive level of care for critically ill patients.

Speech Therapy—The corrective treatment of a speech impairment resulting from a condition, Illness, Disease, Surgery, Injury, Congenital Anomaly, or previous therapeutic process.

Specialist Provider—a Professional Provider with an MD or DO designation that has received specialized training and has been certified in a specialty recognized by the American Board of Medical Specialties (ABMS) including, but not limited to cardiology, dermatology, endocrinology, gastroenterology, neurology, etc. A Specialist Provider generally provides expert advice or treatment for conditions that are beyond the scope and training of a Primary Care Provider.

Statewide School Group Program—the self-funded program for the pool of Participating School Districts who provide benefits for Eligible Employees and Eligible Retirees by selecting benefit options provided in the Plan.

Substance Abuse Or Addiction—a behavioral or physical disorder manifested by repeated excessive use of a drug or alcohol to the extent that it interferes with a Participant’s health, social, or economic functioning.

Surgery—within the scope of a Provider’s license, the performance of:

1. Generally accepted operative and cutting procedures.
2. Endoscopic examinations and other invasive procedures using specialized instruments
3. The correction of fractures and dislocations.
4. Customary preoperative and postoperative care.

Surrogate—an adult woman who enters into an agreement to bear a child conceived through assisted conception for intended parents.

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

Therapeutic Boarding School—a boarding school which provides educational and emotional development programs.

Therapy Services—Therapy Services include only the following:

1. Radiation Therapy—treatment of Disease by x-ray, radium, or radioactive isotopes.
2. Chemotherapy—treatment of malignant Disease by chemical or biological antineoplastic agents.
3. Renal Dialysis—treatment of an acute or chronic kidney condition, which may include the supportive use of an artificial kidney machine.
4. Physical Therapy—treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, or devices to relieve pain, restore maximum function, or prevent disability following a condition, Disease, Illness, Accidental Injury, or loss of a body part.
5. Occupational Therapy—treatment that employs constructive activities designed and adapted for a physically disabled Participant to help him or her satisfactorily accomplish the ordinary tasks of daily living and tasks required by the Participant’s particular occupational role.
6. Speech Therapy—corrective treatment of a speech impairment resulting from a condition, Illness, Disease, Surgery, or Accidental Injury; or from Congenital Anomalies, or previous therapeutic processes.
7. Growth Hormone Therapy—treatment administered by intramuscular injection to treat children with growth failure due to pituitary disorder or dysfunction.
8. Home Intravenous Therapy (Home Infusion Therapy)—treatment provided in the home of the Participant or other locations outside of a Licensed General Hospital, that is administered via an intravenous, intraspinal, intra-arterial, intrathecal, subcutaneous, enteral, or intramuscular injection or access device inserted into the body, at or under the direction of a Home Health Agency or other Provider approved by BCI.

Transplant—surgical removal of a donated organ or tissue and the transfer of that organ or tissue to a recipient.

Trust—the Idaho School District Council Self-Funded Benefit Trust, also the board of Trustees.

EXCLUSIONS AND LIMITATIONS SECTION

In addition to the exclusions and limitations listed elsewhere in this Plan, the following exclusions and limitations apply to the entire Plan, unless otherwise specified.

I. General Exclusions And Limitations

There are no benefits for services, supplies, drugs or other charges that are:

- A.** Not Medically Necessary. If services requiring Prior Authorization by Blue Cross of Idaho are performed by a Contracting Provider and benefits are denied as not Medically Necessary, the cost of said services are not the financial responsibility of the Participant. However, the Participant could be financially responsible for services found to be not Medically Necessary when provided by a Noncontracting Provider.
- B.** In excess of the Maximum Allowance.
- C.** For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an Accidental Injury or unless an attending Physician certifies in writing that the participant has a non-dental, life-endangering condition which makes hospitalization necessary to safeguard the Participant's health and life.
- D.** Not prescribed by or upon the direction of a Physician or other Professional Provider; or which are furnished by any individuals or facilities other than Licensed General Hospitals, Physicians, and other Providers.
- E.** Investigational in nature.
- F.** Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Participant is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts, or under Employer Liability Acts, or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Participant claims such benefits or compensation, or recovers losses from a third party.
- G.** Provided or paid for by any federal governmental entity except when payment under this Plan is expressly required by federal law, or provided or paid for by any state or local governmental entity where its charges therefore would vary, or would be affected by the existence of coverage under this Plan.
- H.** Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.
- I.** Furnished by a Provider who is related to the Participant by blood or marriage and who ordinarily dwells in the Participant's household.
- J.** Received from a dental, vision, or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- K.** For Surgery intended mainly to improve appearance or for complications arising from Surgery intended mainly to improve appearance, except for:
 - 1. Reconstructive Surgery necessary to treat an Accidental Injury, infection, or other Disease of the involved part; or
 - 2. Reconstructive Surgery to correct Congenital Anomalies in a Participant who is a dependent child.
 - 3. Benefits for reconstructive Surgery to correct an Accidental Injury are available even though the accident occurred while the Participant was covered under a prior insurer's coverage.
- L.** Rendered prior to the Participant's Effective Date.

- M.** For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance), or convenience items or services even if prescribed by a Physician, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs, spas, hot tubs, whirlpool baths, waterbeds or swimming pools and therapies, including but not limited to, educational, recreational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, homeopathic, or naturopathic, massage, or music.
- N.** For telephone consultations; and all computer or Internet communications, except as specified as a Covered Service in this Plan.
- O.** For failure to keep a scheduled visit or appointment; for completion of a claim form; or for personal mileage, transportation, food or lodging expenses, or for mileage, transportation, food or lodging expenses billed by a Physician or other Professional Provider.
- P.** For Inpatient admissions that are primarily for Diagnostic Services or Therapy Services; or for Inpatient admissions when the Participant is ambulatory and/or confined primarily for bed rest, special diet, behavioral problems, environmental change, or for treatment not requiring continuous bed care.
- Q.** For Inpatient or Outpatient Custodial Care; or for Inpatient or Outpatient services consisting mainly of educational therapy, behavioral modification, self-care or self-help training, except as specified as a Covered Service in this Plan.
- R.** For any cosmetic foot care, including but not limited to, treatment of corns, calluses, and toenails (except for surgical care of ingrown or Diseased toenails).
- S.** Related to Dentistry or Dental Treatment, even if related to a medical condition; or orthoptics, eyeglasses or Contact Lenses, or the vision examination for prescribing or fitting eyeglasses or Contact Lenses, unless specified as a Covered Service in this Plan.
- T.** For hearing aids or examinations for the prescription or fitting of hearing aids.
- U.** For any treatment of either gender leading to or in connection with transsexual Surgery, gender transformation, sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence, even if related to a medical condition.
- V.** Made by a Licensed General Hospital for the Participant's failure to vacate a room on or before the Licensed General Hospital's established discharge hour.
- W.** Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.
- X.** Furnished by a facility that is primarily a place for treatment of the aged or that is primarily a nursing home, a convalescent home, or a rest home.
- Y.** For Acute Care, Rehabilitative care, diagnostic testing except as specified as a Covered Service in this Plan; for Mental or Nervous Conditions and Substance Abuse or Addiction services not recognized by the American Psychiatric and American Psychological Associations.
- Z.** For any of the following:
 1. For appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a Covered Service in this Plan;
 2. For orthognathic Surgery, including services and supplies to augment or reduce the upper or lower jaw;
 3. For implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw

- hinge), including splinting services and supplies except as specified as a Covered Service under this Plan;
4. For alveolectomy or alveoloplasty when related to tooth extraction.
- AA.** For weight control or treatment of obesity, even if Medically Necessary, including but not limited to Surgery for obesity or for reversals or revisions of Surgery for obesity, except as specifically provided as a Covered Service in this Plan.
- BB.** For use of operating, cast, examination, or treatment rooms or for equipment located in a Contracting or Noncontracting Provider's office or facility, except for Emergency room facility charges in a Licensed General Hospital, unless specified as a Covered Service in this Plan.
- CC.** For the reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties.
- DD.** Treatment for infertility and fertilization procedures, including but not limited to, ovulation induction procedures and pharmaceuticals, artificial insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance a Participant's reproductive ability, including but not limited to laboratory services, radiology services or similar services related to treatment for fertility or fertilization procedures. Any expenses, procedures or services related to Surrogate pregnancy, delivery or donor eggs.
- EE.** For Transplant services and Artificial Organs, except as specified as a Covered Service under this Plan.
- FF.** For acupuncture.
- GG.** For surgical procedures that alter the refractive character of the eye, including but not limited to, radial keratotomy, myopic keratomileusis, Laser-In-Situ Keratomileusis (LASIK), and other surgical procedures of the refractive-keratoplasty type, to cure or reduce myopia or astigmatism, even if Medically Necessary, unless specified as a Covered Service in a Vision Benefits Section of this Plan, if any. Additionally, reversals, revisions, and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.
- HH.** For Hospice, except as specified as a Covered Service in this Plan.
- II.** For pastoral, spiritual, bereavement or marriage counseling.
- JJ.** For homemaker and housekeeping services or home-delivered meals.
- KK.** For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.
- LL.** For treatment or other health care of any Participant in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Participant to Covered Services under this Plan, if and to the extent those benefits are payable to or due the Participant under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's, or other similar plan of insurance, contract, or underwriting plan.

In the event Blue Cross of Idaho (BCI) for any reason makes payment for or otherwise provides benefits excluded by the above provisions, it shall succeed to the rights of payment or reimbursement of the compensated Provider, the Participant, and the Participant's heirs and personal representative against all insurers, underwriters, self-insurers, or other such obligors contractually liable or obliged to the Participant, or his or

her estate for such services, supplies, drugs or other charges so provided by BCI in connection with such Illness, Disease, Accidental Injury or other condition.

- MM.** Any services or supplies for which a participant would have no legal obligation to pay in the absence of coverage under this Plan or any similar coverage; or for which no charge or a different charge is usually made in the absence of health benefits or insurance coverage or for which reimbursement or payment is contemplated under an agreement entered into with a third party.
- NN.** For a routine or periodic mental or physical examination that is not connected with the care and treatment of an actual Illness, Disease or Accidental Injury or for an examination required on account of employment; or related to an occupational injury; for a marriage license; or for insurance, school or camp application; or for sports participation physicals; or a screening examination including routine hearing examinations, unless specified as a Covered Service under this Plan.
- OO.** For immunizations except as specifically provided as a Covered Service in the Plan.
- PP.** For breast reduction Surgery or Surgery for gynecomastia.
- QQ.** For nutritional supplements.
- RR.** For replacements or nutritional formulas except, when administered enterally due to impairment in digestion and absorption of an oral diet and is the sole source of caloric need or nutrition in a Participant.
- SS.** For vitamins and minerals, unless required through a written prescription and cannot be purchased over the counter.
- TT.** For an elective abortion, except to preserve the life of the female upon whom the abortion is performed, unless benefits for an elective abortion are specifically provided by a separate Endorsement to this Plan.
- UU.** For alterations or modifications to a home or vehicle.
- VV.** For special clothing, including shoes (unless permanently attached to a brace).
- WW.** Provided to a person enrolled as an Eligible Dependent, but who no longer qualifies as an Eligible Dependent due to a change in eligibility status that occurred after enrollment.
- XX.** Provided outside the United States, which if had been provided in the United States, would not be a Covered Service under this Plan.
- YY.** For outpatient pulmonary and/or outpatient cardiac Rehabilitation, except as specified as a Covered Service under this Plan.
- ZZ.** For complications arising from the acceptance or utilization of noncovered services.
- AAA.** For the use of Hypnosis, as anesthesia or other treatment, except as specified as a Covered Service.
- BBB.** For dental implants, appliances, (with the exception of sleep apnea devices) and/or prosthetics, and/or treatment related to Orthodontia, even when Medically Necessary, unless specified as a Covered Service in this Plan.
- CCC.** For arch supports, orthopedic shoes, and other foot devices.
- DDD.** For wigs.
- EEE.** For cranial molding helmets, unless used to protect post cranial vault surgery.

- FFF.** For surgical removal of excess skin that is the result of weight loss or gain, including but not limited to association with prior weight reduction (obesity) surgery.
- GGG.** For the purchase of Therapy or Service Dogs/Animals and the cost of training/maintaining said animals.
- HHH.** Any services or supplies furnished by a Therapeutic Boarding School, a facility that is primarily a health resort, or sanatorium, Residential Treatment Facility, transitional living center ,except as specified as an Outpatient Psychiatric Care Covered Service listed in the Plan.

GENERAL PROVISIONS SECTION

I. Termination Or Modification Of A Participant’s Coverage Under This Plan

- A.** If a Participating Employee ceases to be an Eligible Employee or the Group does not remit the required contribution, the Participating Employee’s coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day of the last month for which payment was made. If the Group does not remit the required payments as required by the Administrative Services Agreement and Blue Cross of Idaho elects to terminate this Agreement, the Participating Employee’s coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day for which the Group reimbursed Blue Cross of Idaho for the payment of claims and administrative fees.

- B.** Except as provided in this paragraph, coverage for a Participant who is no longer eligible under this Plan will terminate on the date a Participant no longer qualifies as a Participant, as defined in the Eligibility and Enrollment Section. Coverage will not terminate because of age for a Participant who is a dependent child incapable of self-sustaining employment who is medically certified as disabled, who became so incapable prior to reaching the age limit, and who is chiefly dependent on the Participating Employee for support and maintenance, provided the Participating Employee, within thirty-one (31) days of when the dependent child reaches the age limit, has submitted to BCI (at the Participating Employee’s expense) a Physician’s certification of such dependent child’s incapacity. BCI, on behalf of the Trust, may require, at reasonable intervals during the two (2) years following when the child reaches the age limit, subsequent proof of the child’s continuing disability and dependency. After two (2) years, BCI, on behalf of the Trust, may require such subsequent proof once each year. Coverage for the dependent child will continue so long as this Plan remains in effect, the child’s disability and financial dependency exists, and the child has not exhausted benefits.

- C.** Termination or modification of this Plan automatically terminates or modifies all of the Participant’s coverage and rights hereunder. It is the responsibility of the Group to notify all of its Participants of the termination or any modification of this Plan, and BCI’s notice to the Group, upon mailing or any other delivery, constitutes complete and conclusive notice to the Participants.

- D.** Except as otherwise provided in this Plan, no benefits are available to a Participant for Covered Services rendered after the date of termination of a Participant’s coverage.

- E.** The Trust may terminate or retroactively rescind a Participant’s coverage under this Plan for any intentional misrepresentation, omission, or concealment of fact by, concerning, or on behalf of any Participant that was or would have been material to the Trust’s acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.

- F.** Prior to legal finalization of an adoption, the coverage provided in this Plan for a child placed for adoption with a Participating Employee continues as it would for a naturally born child of the Participating Employee until the first of the following events occurs:
 - 1. The date the child is removed permanently from placement and the legal obligation terminates, or
 - 2. The date the Participating Employee rescinds, in writing, the agreement of adoption or the agreement assuming financial responsibility.

If one (1) of the foregoing events occurs, coverage terminates on the last day of the month in which such event occurs.

- G.** Coverage under this Plan will terminate for an Eligible Dependent on the last day of the month he or she no longer qualifies as an Eligible Dependent due to a change in eligibility status.

II. Benefits After Termination Of Coverage

A. Continuation of Coverage Under Federal Law

As mandated by federal law, the Plan offers optional continuation of coverage to the Participating Employee and their covered dependents if coverage ends due to one of the following qualifying events:

1. Termination of the Participating Employee’s employment for any reason, except gross misconduct as defined in the Participating School District’s personnel policies. Coverage may continue for the Participating Employee and/or their Eligible Dependents.
2. A reduction in hours worked by the Participating Employee that results in loss of Plan eligibility. Coverage may continue for the Participating Employee and/or their Eligible Dependents.
3. The Participating Employee’s death. Coverage may continue for their Eligible Dependents.
4. Divorce or legal separation from the Participating Employee’s spouse. Coverage may continue for that spouse and the Eligible Dependents.
5. The Participating Employee becomes entitled to Medicare. Coverage may continue for Eligible Dependents that are not entitled to Medicare.
6. Loss of eligibility of covered dependent children due to Plan eligibility requirements. Coverage may continue for that dependent.

To choose this continuation of coverage, an individual must be a Participating Employee or an enrolled Eligible Dependent under the Plan on the day before the qualifying event. Choosing this continuation of coverage may interfere with the Participant’s ability to receive coverage, which may be subsidized, under a state or federal exchange.

B. Notification Requirement

The Participating Employee or the Eligible Dependent has the responsibility to inform the Trust of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of continuation coverage rights.

The Group has the responsibility of notifying BCI of your death, termination of employment, reduction in hours, or entitlement to Medicare within 30 days of the qualifying event.

BCI, on behalf of the Trust, will notify a qualifying individual of continuation coverage rights within 14 days of notification. The qualifying individual then has 60 days to elect continuation coverage. Failure to elect continuation coverage within 60 days after being notified by BCI, on behalf of the Trust, will result in loss of continuation of coverage rights.

C. Cost of Continuation Coverage

The cost of continuation coverage is determined by the Trust and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable contribution cannot exceed 102% of the Trust’s cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150% of the Trust cost of coverage.

The qualified individual must make the first payment within 45 days of notifying the Contract Administrator (BCI) of selection of continuation coverage. Future payments can be made in monthly installments within 30 days of the due date. Rates and payment schedules are established by the Trust and may change when necessary due to Plan modifications.

The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

D. Maximum Period of Continuation Coverage

The maximum period of continuation coverage for individuals who qualify due to termination of employment or reduction in hours worked is 18 months from the date of the qualifying event.

If a qualifying individual is disabled (as determined by the Social Security Administration) at the Participating Employee's time of termination or reduction in hours or is declared disabled within the first sixty (60) days of continuation coverage, continuation coverage for the qualifying individual may be extended to twenty-nine (29) months provided the qualifying individual notifies the Contract Administrator (Blue Cross of Idaho) within the eighteen (18) month continuation coverage period and within sixty (60) days after they receive notification of disability from the Social Security Administration (SSA).

The maximum period of continuation coverage for individuals who qualify due to any other described qualifying event, except bankruptcy, is 36 months from the date of the qualifying event.

E. Multiple Qualifying Events

Should the Eligible Dependent(s) experience more than one qualifying event, they may be eligible for an additional period of continued coverage not to exceed a total of thirty-six (36) months from the date of the first qualifying event. For example, if the Participating Employee terminates employment, the Participating Employee and any enrolled Eligible Dependents may be eligible for eighteen (18) months of continued coverage. If during this eighteen (18) month period a second qualifying event (divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent) takes place, then the original eighteen (18) months of continuation coverage can be extended to thirty-six (36) months from the date of the original qualifying event date for the enrolled Eligible Dependent qualified beneficiaries. If a second event occurs, it is the qualified beneficiary's responsibility to notify BCI.

F. When Continuation Coverage Ends

Continuation Coverage ends on the earliest of:

1. The date the maximum continuation period expires.
2. The date the qualifying individual becomes entitled to coverage under Medicare.
3. The last period for which payment was made when coverage is cancelled due to nonpayment of the required cost.
4. The date the Trust no longer offers a group health plan to any of its employees.
5. The date the qualifying individual becomes covered under another group health plan.

III. Contract Between BCI And The Group

This Plan is part of the contract between BCI and the Group. This Plan shall not be construed as a contract between BCI and any Participant.

IV. Applicable Law

This Plan shall be governed by and interpreted according to the laws of the state of Idaho.

V. Benefits To Which Participants Are Entitled

- A.** Subject to all of the terms of this Plan, a Participant is entitled to benefits for Covered Services in the amounts specified in the benefit sections and/or in the Benefits Outline.

- B.** In the event of an Inpatient Admission that occurs prior to the Group's transfer to BCI and the Effective Date of coverage under this Plan, benefits will be provided only when the Participant receives services that are Covered Services under this Plan. The outgoing carrier has primary responsibility for providing benefits for the Inpatient treatment from the date of admission until the first of the following events occur:
- The Participant is discharged,
 - The Benefit Period under the previous coverage ends, or
 - Until benefits under the outgoing carrier's policy are exhausted.
- C.** BCI will provide benefits for Covered Services incurred following the Effective Date of coverage reduced by the benefits paid by the outgoing carrier.
- D.** Benefits will be provided only if Covered Services are prescribed by, or performed by, or under the direction of a Physician or other Professional Provider and are regularly and customarily included in such Providers' charges.
- E.** Covered Services are subject to the availability of Licensed General Hospitals and other Facility Providers and the ability of the employees of such Providers and of available Physicians to provide such services. The Trust and/or BCI shall not assume nor have any liability for conditions beyond its control which affect the Participant's ability to obtain Covered Services.
- F.** The Board of Trustees of the Idaho School District Council Self-Funded Benefit Trust intends the Plan to be permanent, but because future conditions affecting the Idaho School District Council Self-Funded Benefit Trust cannot be anticipated or foreseen, the Board of Trustees of the Idaho School District Council Self-Funded Benefit Trust reserves the right to amend, modify, or terminate the Plan at any time (pursuant to Idaho Code and Rules), which may result in the termination or modification of the Participants' Coverage. Expenses incurred prior to the Plan modification or termination will be paid as provided under the terms of the Plan prior to its modification or termination. Any material change made to this Plan will be provided in writing within sixty (60) days of the Effective Date of change.
- VI. Notice Of Claim**
BCI will process claims for benefits on behalf of the Group according to the Administrative Services Agreement between the parties. A claim for Covered Services must be submitted within one year from the date of service and must include all the information necessary for BCI, on behalf of the Board of Trustees, to determine benefits.
- VII. Release And Disclosure Of Medical Records And Other Information**
- A.** In order to effectively apply the provisions of this Plan, BCI may obtain information from Providers and other entities pertaining to any health related services that the Participant may receive or may have received in the past. BCI may also disclose to Providers and other entities, information obtained from the Participant's transactions such as policy coverage, contributions, payment history and claims data necessary to allow the processing of a claim and for other health care operations. To protect the Participant's privacy, BCI treats all information in a confidential manner. For further information regarding BCI's privacy policies and procedures, the Participant may request a copy of BCI's Notice of Privacy Practices by contacting Customer Service at the number provided in this Plan.
- B.** As a condition of coverage under this Plan, each Participant authorizes Providers to testify at BCI's request as to any information regarding the Participant's medical history, services rendered, and treatment received. Any and all provisions of law or professional ethics forbidding such disclosures or testimony are waived by and in behalf of each Participant.
- VIII. Exclusion Of General Damages**
Liability under this Plan for benefits conferred hereunder, including recovery under any claim or breach of this Plan, shall be limited to the actual benefits for Covered Services as provided herein

and shall specifically exclude any claim for general damages, including but not limited to, alleged pain, suffering or mental anguish, or for economic loss, or consequential loss or damages.

IX. Payment Of Benefits

Blue Cross of Idaho provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

- A.** BCI, on behalf of the Trust, is authorized by the Participant to make payments directly to Providers rendering Covered Services to the Participant for benefits provided under this Plan. Notwithstanding this authorization, BCI, on behalf of the Trust, reserves and shall have the right to make such payments directly to the Participant. Except as provided by law, BCI's right, on behalf of the Trust, to pay a Participant directly is not assignable by a Participant nor can it be waived without BCI, on behalf of the Trust, nor may the right to receive benefits for Covered Services under this Plan be transferred or assigned, either before or after Covered Services are rendered. Payments will also be made in accordance with any assignment of rights required by state Medicaid plan.
- B.** Blue Cross of Idaho prohibits direct or indirect payment by third parties unless it meets the standards set below.

Family, friends, religious institutions, private, not-for-profit foundations such as Indian tribes, tribal organizations, urban Indian organizations, state and federal government programs or grantees or sub-grantees such as the Ryan White HIV/AIDS Program and other similar entities are not prohibited from paying contribution on behalf of an individual receiving medical treatment. Cost Sharing contributions made from permitted third parties will be applied to the Participants applicable Deductible and/or Out-of-Pocket Limit.

Each of the following criteria must be met for BCI to accept a third party payment:

1. the assistance is provided on the basis of the Participant's financial need;
2. the institution/organization is not a healthcare Provider; and
3. 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 health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

To assist in appropriately applying Cost Sharing contributions made from a permitted third party to the Participants applicable Deductible and/or Out-of-Pocket Limit, the Participant is encouraged to provide notification to BCI if they receive any form of assistance for payment of their contribution, Cost Sharing, Copayment or Deductible amounts.

Contributions submitted in violation of this provision will not be accepted and the Enrollee's Plan may be terminated for non-payment. Cost Sharing contributions made from non-permitted third parties will not be applied to the Participants applicable Deductible and/or Out-of-Pocket Limit. BCI will inform the Participant in writing of the reason for rejecting or otherwise refusing to treat a third party payment as a payment from the Participant and of the Participant's right to file a complaint with the Department of Insurance.

- C.** Once Covered Services are rendered by a Provider, BCI, on behalf of the Trust, shall not be obliged to honor Participant requests not to pay claims submitted by such Provider, and BCI, on behalf of the Trust, shall have no liability to any person because of its rejection of such request; however, in its sole discretion, for good cause, BCI, on behalf of the Trust, may nonetheless deny all or any part of any Provider claim.

X. Participant/Provider Relationship

- A.** The choice of a Provider is solely the Participant's.
- B.** BCI does not render Covered Services but only makes payment for Covered Services received by Participants. BCI and the Trust are not liable for any act or omission or for

the level of competence of any Provider, and BCI and the Trust have no responsibility for a Provider's failure or refusal to render Covered Services to a Participant.

- C. The use or nonuse of an adjective such as Contracting or Noncontracting is not a statement as to the ability of the Provider.

XI. Participating Plan

BCI may, in its sole discretion, make an agreement with any appropriate entity (referred to as a Participating Plan) to provide, in whole or in part, benefits for Covered Services to Participants, but it shall have no obligation to do so.

XII. Coordination Of This Plan's Benefits With Other Benefits

This Coordination of Benefits (COB) provision applies when a Participant has health care coverage under more than one (1) Contract. Contract is defined below.

The Order of Benefit Determination Rules govern the order in which each Contract will pay a claim for benefits. The Contract that pays first is called the Primary Contract. The Primary Contract must pay benefits in accordance with its policy terms without regard to the possibility that another Contract may cover some expenses. The Contract that pays after the Primary Contract is the Secondary Contract. The Secondary Contract may reduce the benefits it pays so that payments from all Contracts does not exceed one hundred percent (100%) of the total Allowable Expenses.

A. Definitions

1. A Contract 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 Contract and there is no COB among those separate contracts.
 - a) Contract includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - b) Contract 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; benefit for non-medical components of long-term care policies; Medicare supplement policies; Medicare or any other federal governmental plans, unless permitted by law.

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

2. This Contract means, in a COB provision, the part of the Contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Contracts. Any other part of the Contract providing health care benefits is separate from this plan. A Contract may apply one (1) COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, any may apply under COB provision to coordinate other benefits.
3. The Order of Benefit Determination Rules determine whether This Contract is a Primary Contract or Secondary Contract when the Participant has health care coverage under more than one (1) Contract. When This Contract is primary, it determines payment for its benefits first before those of any other Contract without considering any other Contract's benefits. When This Contract is secondary, it

determines its benefits after those of another Contract and may reduce the benefits it pays so that all Contract benefits do not exceed one hundred percent (100%) of the total Allowable Expense.

4. Allowable Expense is a health care expense, including Deductibles, Cost Sharing and Copayments, that is covered at least in part by any Contract covering the Participant. When a Contract provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Contract covering the Participant is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

- a) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Contracts provides coverage for private hospital room expenses.
 - b) If a Participant is covered by two (2) or more Contracts that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
 - c) If a Participant is covered by two (2) or more Contracts that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 - d) If a Participant is covered by one (1) Contract that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Contract that provides its benefits or services on the basis of negotiated fees, the Primary Contract's payment arrangement shall be the Allowable Expense for all Contracts. However, if the provider has contracted with the Secondary Contract to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Contract's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Contract to determine its benefits.
 - e) The amount of any benefit reduction by the Primary Contract because a covered person has failed to comply with the Contract provisions is not an Allowable Expense. Examples of these types of Contract provisions include second surgical opinions, pre-certificate of admissions, and preferred provider arrangements.
5. Closed Panel Plan is a Contract that provides health care benefits to covered persons primarily in the form of 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.
 6. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

B. Order Of Benefit Determination Rules

When a Participant is covered by two (2) or more Contracts, the rules for determining the order of benefit payments are as follows:

1. The Primary Contract pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Contract.
 - a) Except as provided in Paragraph 2.b) below, a Contract that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Contracts state that the complying Contract is primary.
 - b) 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 Contract 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.

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

3. Each Contract determines its order of benefits using the first of the following rules that apply:
 - a) Non-Dependent or Dependent. The Contract that covers the Participant other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Contract and the Contract that covers the Participant as a dependent is the Secondary Contract. However, if the Participant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Contract covering the Participant as a dependent; and primary to the Contract covering the Participant as other than a dependent (e.g. a retired employee); then the order of benefits between the two Contracts is reversed so that the Contract covering the Participant as an employee, member, policyholder, subscriber or retiree is the Secondary Contract and the other Contract is the Primary Contract.

 - b) Dependent Child Covered Under More Than One Contract. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Contract the order of benefits is determined as follows:
 - 1) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Contract of the parent whose birthday falls earlier in the calendar year is the Primary Contract; or If both parents have the same birthday, the Contract that has covered the parent the longest is the Primary Contract.
 - 2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - a) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Contract of that parent has actual knowledge of those terms, that Contract is primary. This rule applies to Contract year commencing after the Contract is given notice of the court decree;
 - b) If a court decree states that both parents are responsible for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) shall determine the order of benefits;

- c) If a court decree states both parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
- d) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - 1) The Contract covering the Custodial Parent;
 - 2) The Contract covering the spouse of the Custodial Parent;
 - 3) The Contract covering the non-Custodial Parent; and then
 - 4) The Contract covering the spouse of the non-Custodial Parent.

For a dependent child covered under more than one Contract of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

- c) Active Employee or Retired or Laid-off Employee. The Contract that covers a Participant as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Contract. The Contract covering that same Participant as a retired or laid-off employee is the Secondary Contract. The same would hold true if a Participant is a dependent of an active employee and that same Participant is a dependent of a retired or laid-off employee. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.
- d) COBRA or State Continuation Coverage. If a Participant whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Contract, the Contract covering the Participant as an employee, member, subscriber or retiree or covering the Participant as a dependent of an employee, member, subscriber or retiree is the Primary Contract and the COBRA or state or other federal continuation coverage is the Secondary Contract. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.
- e) Longer or Shorter Length of Coverage. The Contract that covered the Participant as an employee, member, policyholder, subscriber, or retiree longer is the Primary Contract and the Contract that covered the Participant the shorter period of time is the Secondary Contract.
- f) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Contracts meeting the definition of Contract. In addition, This Contract will not pay more than it would have paid had it been the Primary Contract.

C. Effect On The Benefits Of This Contract

1. When This Contract is secondary, it may reduce its benefits so that the total benefits paid or provided by all Contracts during a Contract year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Contract will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Contract that is unpaid by the Primary Contract. The Secondary Contract may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Contract, the total benefits paid or provided by all Contracts for the claim do not exceed the total Allowable Expenses for that claim. In addition, the Secondary Contract shall credit to its Contract deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
2. If a covered person 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 Contract and other Closed Panel Plans.

D. Facility Of Payment

A payment made under another Contract may include an amount that should have been paid under This Contract. If it does, BCI 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 Contract. BCI 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.

E. Right Of Recovery

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

XIII. Benefits For Medicare Eligibles Who Are Covered Under This Plan

- A. If the Group has twenty (20) or more employees, any Eligible Employee or spouse of an Eligible Employee who becomes or remains a Participant of the Group covered by this Plan after becoming eligible for Medicare (due to reaching age sixty-five (65)) is entitled to receive the benefits of this Plan as primary.
- B. If the Group has one hundred (100) or more employees or the Group is an organization which includes an employer with one hundred (100) or more employees, any Eligible Employee, spouse of an Eligible Employee or dependent child of an Eligible Employee who becomes or remains a Participant of the Group covered by this Plan after becoming eligible for Medicare due to disability is entitled to receive the benefits of this Plan as primary.
- C. A Participant eligible for Medicare based solely on end stage renal Disease is entitled to receive the benefits of this Plan as primary for eighteen (18) months only, beginning with the month of Medicare entitlement, if Medicare entitlement is effective before March 1, 1996. If Medicare entitlement is effective on or after March 1, 1996, the Participant is entitled to receive the benefits of this Plan as primary for thirty (30) months only, beginning with the month of Medicare entitlement.
- D. The Group’s retirees, if covered under this Plan, and Eligible Employees or spouses of Eligible Employees (if a Participant) who are not subject to paragraphs A., B. or C. of this provision and who are Medicare eligible, will receive the benefits of this Plan reduced by any benefits available under Medicare. This applies even if the Participant fails to enroll in Medicare or does not claim the benefits available under Medicare.

XIV. Incorporated By Reference

All of the terms, limitations and exclusions of coverage contained in this Plan are incorporated by reference into all sections and Amendments and are as effective as if fully expressed in each one unless specifically noted to the contrary.

XV. Inquiry And Appeals Procedures

If the Participant's claim for benefits is denied and BCI issues an Adverse Benefit Determination, the Participant must first exhaust any applicable internal appeals process described below prior to pursuing legal action.

A. Informal Inquiry

For any initial questions concerning a claim, a Participant should call or write BCI's Customer Service Department. BCI's phone numbers and addresses are listed on the Explanation of Benefits (EOB) form and in the Contact Information section of this Plan.

B. Formal Appeal

A Participant who wishes to formally appeal a Pre-Service Claim decision by BCI, on behalf of the Trust, may do so through the following process:

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and the documents in support of such appeals may be submitted by phone or facsimile. The appeal should set forth the reasons why the Participant contends BCI's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.
2. After receipt of the appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by a BCI Medical Director or physician designee. For non-urgent claim appeals, BCI will mail a written reply to the Participant within fifteen (15) days after receipt of the written appeal. Urgent claim appeals will be notified orally within seventy-two (72) hours. If the original decision is upheld, the reply will state the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible taking into account the medical exigencies of each claim.
3. Furthermore, the Participant or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.
4. If the original, non-urgent claim decision is upheld upon reconsideration, the Participant may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within thirty (30) days of BCI's mailing of the initial reconsideration decision. A BCI Medical Director who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt.

C. A Participant who wishes to formally appeal a Post-Service Claims decision by BCI, on behalf of the Trust, may do so through the following process:

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. This written appeal should set forth the reasons why the Participant contends BCI's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.
2. After receipt of the written appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by a BCI Medical Director, or physician

designee if the appeal requires medical judgment. BCI shall mail a written reply to the Participant within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will list the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible.

3. Furthermore, the Participant or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.
4. If the original decision is upheld upon reconsideration, the Participant may send an additional written appeal to the Appeals and Grievance Coordinator requesting *further review*. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within sixty (60) days of BCI's mailing of the initial reconsideration decision. A BCI Medical Director who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will issue a final decision after consideration of all relevant information, if the appeal requires medical judgment. A final decision on the appeal will be made within thirty (30) days of its receipt. If the appeal does not require medical judgment, a BCI Vice President who did not decide the initial appeal will issue the decision.

D. Participant's Rights to an Independent External Review

Please read this carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with BCI. If a Participant or their authorized representative requests an independent external review of a claim, the decision made by the independent reviewer will be binding and final on the Idaho School District Council Self-Funded Benefit Trust..

If BCI, on behalf of the Trust, issues a final Adverse Benefit Determination of a Participant's request to provide or pay for a health care service or supply, a Participant may have the right to have BCI's decision reviewed by health care professionals who have no association with BCI. A Participant has this right only if BCI's denial decision involved:

- The Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Participant's health care service or supply, or
- BCI's determination that a Participant's health care service or supply was Investigational.

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

A Participant may submit a written request for an external review to:

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

For more information and for an external review request form:

- See the department's web site, www.doi.idaho.gov, or

- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

A Participant may act as their own representative in a request or a Participant may name another person, including a Participant's treating health care provider, to act as an authorized representative for a request. If a Participant wants someone else to represent them, a Participant must include a signed "Appointment of an Authorized Representative" form with the request. A Participant's written external review request to the Department of Insurance must include a completed form authorizing the release of any medical records the independent review organization may require 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 a Participant's completed authorization form. If the request qualifies for external review, BCI's final adverse benefit determination will be reviewed by an independent review organization selected by the Department of Insurance. The Trust will pay the costs of the review.

Standard External Review Request: A Participant must file a written external review request with the Department of Insurance within four (4) months after the date BCI issues a final notice of denial.

1. Within seven (7) days after the Department of Insurance receives the request, the Department of Insurance will send a copy to BCI.
2. Within fourteen (14) days after BCI receives the request from the Department of Insurance, we will review the request for eligibility. Within five (5) business days after BCI completes that review, we will notify the Participant and the Department of Insurance in writing if the request is eligible or what additional information is needed. If BCI denies the eligibility for review, the Participant may appeal that determination to the Department.
3. If the request is eligible for review, the Department of Insurance will assign an independent review organization to your review within seven (7) days of receipt of BCI's notice. The Department of Insurance will also notify the Participant in writing.
4. Within seven (7) days of the date you receive the Department of Insurance's notice of assignment to an independent review organization, The Participant may submit any additional information in writing to the independent review organization that they want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to the Participant, BCI and to the Department of Insurance within forty-two (42) days after receipt of an external review request.

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

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

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

The Department of Insurance will send your request to us. BCI will determine, no later than the second (2nd) full business day, if the request is eligible for review. BCI will notify

the Participant and the Department of Insurance no later than one (1) business day after BCI's decision if the request is eligible. If BCI denies the eligibility for review, the Participant may appeal that determination to the Department of Insurance.

If the request is eligible for review, the Department of Insurance will assign an independent review organization to the review upon receipt of BCI's notice. The Department of Insurance will also notify the Participant. The independent review organization must provide notice of its decision to the Participant, BCI and to the Department of Insurance within seventy-two (72) hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within forty-eight (48) hours of notice of its decision. If the decision reverses BCI's denial, BCI will notify the Participant and the Department of Insurance of BCI's intent to pay for the covered benefit as soon as reasonably practicable, but not later than one (1) business day after receiving notice of the decision.

Binding Nature of the External Review Decision:

The external review decision by the independent review organization will be final and binding on both the Trust and the Participant. **This means that if the Participant elects to request external review, the Participant will be bound by the decision of the independent review organization. The Participant will not have any further opportunity for review of BCI's denial after the independent review organization issues its final decision.** If the Participant chooses not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

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

XVI. Reimbursement of Benefits Paid By Mistake

If BCI mistakenly makes payment for benefits on behalf of a Participating Employee or his or her Eligible Dependent(s) that the Participating Employee or his or her Eligible Dependent(s) is not entitled to under this Plan, the Participating Employee must reimburse the erroneous payment to BCI, on behalf of the Trust.

The reimbursement is due and payable as soon as BCI notifies the Participating Employee and requests reimbursement. BCI, on behalf of the Trust, may also recover such erroneous payment from any other person or Provider to whom the payments were made. If reimbursement is not made in a timely manner, BCI, on behalf of the Trust, may reduce benefits or reduce an allowance for benefits as a set-off toward reimbursement.

Even though BCI, on behalf of the Trust, may elect to continue to provide benefits after mistakenly paying benefits, BCI, on behalf of the Trust, may still enforce this provision. This provision is in addition to, not instead of, any other remedy BCI, on behalf of the Trust, may have at law or in equity.

XVII. Subrogation and Reimbursement Rights Of Blue Cross Of Idaho

The benefits of this Plan will be available to a Participant when he or she is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereinafter referred to as "third party"). To the extent that such benefits for Covered Services are provided or paid for by Blue Cross of Idaho, on behalf of the Trust under this Plan or any other Blue Cross of Idaho plan, agreement, certificate, contract or plan, Blue Cross of Idaho, on behalf of the Trust shall be subrogated and succeed to the rights of the Participant or, in the event of the Participant's death, to the rights of his or her heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Services in such an event, the Participant or his or her personal representative shall furnish Blue Cross of Idaho in writing with the names and addresses of the third party or parties that caused or are responsible, or may have caused or may

be responsible for such injury, harm or loss, and all facts and information known to the Participant or his or her personal representative concerning the injury, harm or loss.

The Trust may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

Subrogation is taking over the Participant's right to receive payments from other parties. The Participant or his or her legal representative will transfer to Blue Cross of Idaho, on behalf of the Trust any rights he or she may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Participant. Thus, Blue Cross of Idaho, on behalf of the Trust may initiate litigation at its sole discretion, in the name of the Participant, against any third party or parties. Furthermore, the Participant shall fully cooperate with Blue Cross of Idaho in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice Blue Cross of Idaho's subrogation rights and efforts. Blue Cross of Idaho, on behalf of the Trust will be reimbursed in full for all benefits paid even if the Participant is not made whole or fully compensated by the recovery. Moreover, Blue Cross of Idaho and the Trust are not responsible for any attorney's fees or other expenses or costs incurred by the Participant without the prior written consent of Blue Cross of Idaho and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by Blue Cross of Idaho, on behalf of the Trust, or otherwise.

Additionally, Blue Cross of Idaho, on behalf of the Trust may at its option elect to enforce its right of reimbursement from the Participant, or his or her legal representative, of any benefits paid from monies recovered as a result of the injury, harm or loss. The Participant shall fully cooperate with Blue Cross of Idaho, on behalf of the Trust in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice the Plans reimbursement rights and efforts.

The Participant shall pay Blue Cross of Idaho, on behalf of the Trust as the first priority, and Blue Cross of Idaho shall have a constructive trust and an equitable lien on, all amounts from any recovery by suit, settlement or otherwise from any third party or parties or from any third party's or parties' insurer(s), indemnitor(s) or underwriter(s), to the extent of benefits provided by Blue Cross of Idaho, on behalf of the Trust under this Plan, regardless of how the recovery is allocated (*i. e.*, pain and suffering) and whether the recovery makes the Participant whole. Thus, Blue Cross of Idaho will be reimbursed by the Participant, or his or her legal representative, from monies recovered as a result of the injury, harm or loss, for all benefits paid even if the Participant is not made whole or fully compensated by the recovery. Moreover, Blue Cross of Idaho and the Trust are not responsible for any attorney's fees or other expenses or costs incurred by the Participant without the prior written consent of Blue Cross of Idaho and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by Blue Cross of Idaho, on behalf of the Trust, or otherwise.

To the extent that Blue Cross of Idaho, on behalf of the Trust provides or pays benefits for Covered Services, Blue Cross of Idaho's rights of subrogation and reimbursement extend to any right the Participant has to recover from the Participant's insurer, or under the Participant's "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions, and workers' compensation benefits.

Blue Cross of Idaho, on behalf of the Trust shall have the right, at its option, to seek reimbursement from, or enforce its right of subrogation against, the Participant, the Participant's personal representative, a special needs trust, or any trust, person or vehicle that holds any payment or recovery from or on behalf of the Participant including the Participant's attorney.

Blue Cross of Idaho's subrogation and reimbursement rights shall take priority over the Participant's rights both for expenses already incurred and paid by Blue Cross of Idaho, on behalf of the Trust for Covered Services, and for benefits to be provided or payments to be made by Blue Cross of Idaho, on behalf of the Trust in the future on account of the injury, harm or loss giving rise to Blue Cross of Idaho's subrogation and reimbursement rights. Further, the Plans

subrogation and reimbursement rights for incurred expenses and/or future expenses yet to be incurred are primary and take precedence over the rights of the Participant, even if there are deficiencies in any recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Participant and the Trust.

Collections or recoveries made in excess of such incurred Plan expenses shall first be allocated to such future Plan expenses, and shall constitute a special Deductible applicable to such future benefits and services under this or any subsequent Plan. Thereafter, Blue Cross of Idaho, on behalf of the Trust shall have no obligation to make any further payment or provide any further benefits until the benefits equal to the special Deductible have been incurred, delivered, and paid by the Participant.

XVIII. Out-of-Area Services

Overview

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

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

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

A. BlueCard® Program

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

1. Liability Calculation Method Per Claim – In General

a. Participant Liability Calculation

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

b. The Trust Liability Calculation

The calculation of the Trust liability on claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to BCI by the Host Blue under the contract between the Host Blue and the Provider. Sometimes, this

negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its participating healthcare Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, the Trust may be liable for the excess amount even when the Participant's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the billed charge.

2. Claims Pricing

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

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

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

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

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

3. BlueCard Program Fees and Compensation

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

B. Return of Overpayments

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

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

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

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

D. Nonparticipating Providers Outside BCI Service Area

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

E. Blue Cross Blue Shield Global Core

1. General Information

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

- **Inpatient Services**

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

- **Outpatient Services**

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

- **Submitting a BCBS Global Core Claim**

When Participants pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Participants should complete a BCBS Global Core claim form and send the claim form with the Provider's itemized bill(s) to the BCBS Global Core service center address on the form to initiate claims processing. The claim form is available from Blue Cross of Idaho, the BCBS Global Core service center, or online at www.bcbsglobalcore.com. If Participants need assistance with their claim submissions, they should call the BCBS Global Core service center at 1 .800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

2. BCBS Global Core-Related Fees

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

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

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

XIX. Individual Benefits Management

Individual Benefits Management allows BCI to provide alternative benefits in place of specified Covered Services when alternative benefits allow the Participant to achieve optimum health care in the most Cost-Effective way.

The decision to allow alternative benefits will be made by BCI on a case-by-case basis. BCI may allow alternative benefits in place of specified Covered Services when a Participant, or the Participant's legal guardian and his or her Physician concur in the request for and the advisability of alternative benefits. The Trust reserves the right to modify, limit, or cease providing alternative benefits at any time.

A determination to cover alternative benefits for a Participant shall not be deemed to waive, alter, or affect BCI's right to reject any other requests or recommendations for alternative benefits.

XX. Coverage And Benefits Determination

BCI is vested with authority and discretion to determine eligibility for coverage and whether a claim for benefits is covered under the terms of this Plan, based on all the terms and provisions set forth in this Plan, and also to determine the amount of benefits owed on claims which are covered.

XXI. Health Care Providers Outside the United States

The benefits available under this Plan are also available to Participants traveling or living outside the United States. The Inpatient Notification and Prior Authorization requirements will apply. If the Provider is a Contracting Provider with BlueCard, the Contracting Provider will submit claims for reimbursement on behalf of the Participant. Reimbursement for Covered Services will be made directly to the Contracting Provider. If the Health Care Provider does not participate with BlueCard, the Participant will be responsible for payment of services and submitting a claim for reimbursement to BCI. BCI will require the original claim along with an English translation. It is the Participant's responsibility to provide this information.

BCI will reimburse covered Prescription Drugs purchased outside the United States by Participants who live outside the United States where no suitable alternative exists. Reimbursement will also be made in instances where Participants are traveling and new drug therapy is initiated for acute conditions or where emergency replacement of drugs originally prescribed and purchased in the United States is necessary. The reimbursable supply of drugs in travel situations will be limited to an amount necessary to assure continuation of therapy during the travel period and for a reasonable period thereafter.

Finally, there are no benefits for services, supplies, drugs or other charges that are provided outside the United States, which if had been provided in the United States, would not be a Covered Service under this Plan.

