Group Policy

ENROLLEE CERTIFICATE

Gold HSA 3700 Choice
Group: Clarity Credit Union
Group Number: 10036597
Policy Effective Date: January 1, 2024

Benefit Period: January 1 through December 31

Notice of Privacy Practices
Blue Cross of Idaho Health Services, Inc. (we, us, our) is committed to protecting the privacy of your personal financial and health information. We maintain physical, electronic, and procedural safeguards that comply with legal requirements. You can find an explanation of our privacy practices on our Website at www.bcidaho.com/about_us/privacy_policy.asp or by calling 1-877-488-7788.

Form No. NMCCS (01/24) GHSAPPO3700 (01/24), Policy No. HSAPPOP (01/24)

Blue Cross of Idaho

Your Rights and Protections Against Surprise Medical Bills

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

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care Provider, you may owe certain Out-of-Pocket costs, like a Copayment, Coinsurance, or Deductible. You may have additional costs or have to pay the entire bill if you see a Provider or visit a health care facility that isn't in your health plan's network.

"Out-of-Network" means Providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-Network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than In-Network costs for the same service and might not count toward your plan's Deductible or annual Out-of-Pocket Limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network Provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

YOU'RE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an Emergency Medical Condition and get emergency services from an Out-of-Network Provider or facility, the most they may bill you is your plan's In-Network cost-sharing amount (such as Copayments, Deductibles, and Coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an In-Network Hospital or Ambulatory Surgical Center

When you get services from an In-Network Hospital or Ambulatory Surgical Center, certain Providers there may be Out-of-Network. In these cases, the most those Providers can bill you is your plan's In-Network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these In-Network facilities, Out-of-Network Providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get Out-of-Network care. You can choose a Provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THESE PROTECTIONS:

- You're only responsible for paying your share of the cost (like the Copayments, Coinsurance, and Deductibles that you would pay if the Provider or facility was In-Network). Your health plan will pay any additional costs to Out-of-Network Providers and facilities directly.

- Generally, your health plan must:
- Cover emergency services without requiring you to get approval for services in advance (also known as "Prior Authorization").
- Cover emergency services by Out-of-Network Providers
- Base what you owe the Provider or facility (cost-sharing) on what it would pay an In-Network Provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or Out-of-Network services toward your In-Network Deductible and Out-of-Pocket Limit.

If you think you've been wrongly billed, contact the Idaho Department of Insurance by visiting the department's Web site at **http://www.doi.idaho.gov/nosurprises** or calling the Consumer Affairs section at 1-208-334-4319 or toll-free in Idaho at 1-800-721-3272. The federal phone number for information and complaints is 1-800-985-3059

Visit **http://www.doi.idaho.gov/nosurprises** for more information about your rights under this law.

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No Surprises Act Disclosures

Continuity of Care.
The federal No Surprises Act (H.R. 133, Public Law 116-260) (the "No Surprises Act") provides that if Insureds are currently receiving treatment for Covered Services from a Provider whose network status changes from In-Network to Out-of-Network during such treatment due to termination (non-renewal or expiration) of the Provider's contract, the Insured may be eligible to request continued care from their current Provider under the same terms and conditions that would have applied prior to termination of the Provider's contract for specified conditions and timeframes outlined in the No Surprises Act. This provision does not apply to Provider contract terminations for failure to meet appliable quality standard or for fraud. To find out if you are eligible for continuity of care benefits, please call the customer services phone number on the back of your identification card.

Independent Dispute Resolution (IDR).
The Group expressly delegates BCI to act as its representative for the open negotiation process and IDR process established under the No Surprises Act. When Insureds access Covered Services within a geographic area served by a Host Blue/outside the geographic area BCI serves, the Host Blue will be responsible for contracting and handling all open negotiation and IDR processes with its providers unless otherwise delegated to BCI by the Host Blue.

Provider Directories.
BCI agrees to make available an In-Network Provider directory on BCI's public facing website for all standard provider networks and to have response procedures in place for when an Insured asks by telephone or internet whether a particular Provider or facility is In-Network, as required by the No Surprises Act. The No Surprises Act provides that if an Insured receives a Covered Service from an Out-of-Network Provider and was informed incorrectly by BCI prior to receipt of the Covered Service that the Provider was In-Network, the Insured may be eligible for cost-sharing that would be no greater than if the service has been provided from an In-Network Provider.

Reporting.
The Group expressly delegates authority to BCI to submit the RxDC reports and narratives, Air Ambulance Data Collection (AADC) reporting, and the Gag Clause Prohibition Compliance Attestation (GCPCA) in accordance with the No Surprises Act. Blue Cross of Idaho will host all public disclosure of In-Network and Out-of-Network provider reimbursement rates on a public Blue Cross of Idaho web page in the required machine-readable format as required under the No Surprises Act.

POLICY UPDATE

Summary of updates made by Blue Cross of Idaho to your Enrollee Certificate

Dear Blue Cross of Idaho Enrollee,

We wanted to let you know about updates to your Enrollee Certificate that are effective on your contract renewal date. These changes are outlined below. Please review these changes carefully. For your convenience, the words and terms capitalized below are defined in your Enrollee Certificate, which is available by logging in to ***members.bcidaho.com***.

	2023		**2024**	
Plan Name	Gold HSA 3000		Gold HSA 3700	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*
Annual Deductible	$3,000 individual $6,000 family	$9,000 individual $18,000 family	$3,700 individual $7,400 family	$7,400 individual $14,800 family
Annual Out-of-Pocket Maximum Amount	$3,000 individual $6,000 family	$9,000 individual $18,000 family	$3,700 individual $7,400 family	$7,400 individual $14,800 family
Coinsurance	No Charge	No Charge	No Charge	No Charge
Doctor Office Visits	No charge after Deductible	No charge after Deductible	No charge after Deductible	No charge after Deductible
Inpatient Hospital Stays	No charge after Deductible	No charge after Deductible	No charge after Deductible	No charge after Deductible
Prescription Drugs	**Tier 1 Preferred Generic** - No charge after In-Network Individual/Family Deductible is met **Tier 2 Non-Preferred Generic** - No charge after In-Network Individual/Family Deductible is met **Tier 3 Preferred Brand Name** - No charge after In-Network Individual/Family Deductible is met **Tier 4 Non-Preferred Brand Name** - No charge after In-Network Individual/Family Deductible is met **Tier 5 Preferred Specialty and Generic Specialty** - No charge after In-Network Individual/Family Deductible is met **Tier 6 Non-Preferred Specialty**- No charge after In-Network Individual/Family Deductible is met **ACA Preventive** – No charge **HSA Preventive** – No charge		**Tier 1** - No charge after In-Network Individual/Family Deductible is met **Tier 2** - No charge after In-Network Individual/Family Deductible is met **Tier 3** - No charge after In-Network Individual/Family Deductible is met **Tier 4** - No charge after In-Network Individual/Family Deductible is met **Tier 5** - No charge after In-Network Individual/Family Deductible is met **Tier 6** - No charge after In-Network Individual/Family Deductible is met **ACA Preventive** – No charge **HSA Preventive** – No charge	

Updates:

- Increased the In-Network Individual Deductible and Out-of-Pocket amounts to $3,700 from $3,000.
- Increased the In-Network Family Deductible and Out-of-Pocket amounts to $7,400 from $6,000.
- Decreased the Out-of-Network Individual Deductible and Out-of-Pocket amounts to $7,400 from $9,000.
- Decreased the Out-of-Network Family Deductible and Out-of-Pocket amounts to $14,800 from $18,000.
- A new Cancer Care Program has been added. Please see **Attachment C: Cancer Care Program Disclosure** for more information.
- Added disclosures and information on when continuity of care benefits may be available to a member, procedures in the event provider directory discrepancies, and reporting BCI has been authorized to submit on behalf of the Group, pursuant to the No Surprises Act.
- Clarified that Explanation of Benefits (EOBs) will be delivered either by mail or electronically, if the member has consented to electronic delivery.
- **A new Rx Saving Solutions** has been added. Rx Savings Solutions is linked to your BCI Policy, so everything is personalized according to your medications and insurance. Please see the Prescription Drug Section for more information.
- Updated the **Formulary** definition to align with our formulary tiers. Prescription Drugs are organized into tiers and generally, lower tiers contain drugs that are more Cost Effective while higher tiers contain drugs that are more expensive.

Definitions:

- Clarified the definition of **Provider** to state that all Providers and Facilities must be licensed, certified, accredited and/or registered, where required, to render Covered Services.
- Removed definitions that were not used in the Policy.

Exclusions and Limitations:

- Several exclusions were clarified for elective abortions, employment-related routine examinations and laboratory tests, and reproductive procedures.

General Provision Section:

- Added language to the **Termination or Modification of an Insureds Coverage Under this Policy section** to clarify retroactive terminations.
- Removed the **Membership, Voting, Annual Meeting and Participation** provision.

BENEFITS OUTLINE:

This Benefits Outline describes the benefits of this Policy in general terms. It is important to read the Policy 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. If you receive this document and/or any other notices electronically, you have the right to receive paper copies of the electronic documents upon request at no additional charge.

Throughout this Policy, Blue Cross of Idaho may be referred to as BCI. For Covered Services under the terms of this Policy, 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. Insureds should check with BCI 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 an Insured chooses a Noncontracting or a nonparticipating Provider, the Insured may be responsible for any charges that exceed the Maximum Allowance.

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 the Attachment A for specific details.

See Attachment A of this Benefits Outline or the BCI Website, www.bcidaho.com for a complete list of services which require Prior Authorization.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE:

The Women's Health and Cancer Rights Act of 1998 requires health plans and insurers 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 obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please visit our Website at www.bcidaho.com. You may also call our Blue Cross of Idaho Customer Service Department at (208) 331-7347 or (800) 627-1188 for assistance in locating a Provider.

IDENTITY THEFT PROTECTION

Your healthcare coverage with Blue Cross of Idaho includes free credit monitoring, fraud detection and fraud resolution support. You, and the dependents on your plan, can sign up for this coverage beginning on the effective date of this Policy and it is available for the length of your coverage with Blue Cross of Idaho.

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho and Blue Cross of Idaho Care Plus, Inc., (collectively referred to as 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 Customer Service Department. Call 1-800-627-1188 (TTY: 711), 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 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: ***grievances&appeals@bcidaho.com***
TTY: 711

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***.

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 711).

Arabic انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1-800-627-1188 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 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：711)。

Farsi توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (TTY:711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

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:711）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: 711)번으로 전화해 주십시오.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिविइ: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

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: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

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: 711.

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: 711).

Form No. 3-1187 (09-20)

SGPPOIntro_(01/24)

Blue Cross of Idaho
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Form No. GHSAPPO3700 (01/24)

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding contract/policy, which contains all the terms and conditions of coverage and exclusions and limitations. Certain services not specifically noted may be excluded. Please refer to the contract/policy issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding contract/policy, the contract/policy will control.

CS26D

GOLD HSA 3700– SMALL EMPLOYER QUALIFED HEALTH PLAN
BENEFITS OUTLINE
Visit our Website at www.bcidaho.com to locate a Contracting Provider

	In-Network	Out-of-Network
Deductibles (per Benefit Period) *This Policy has a calendar year Deductible. With the exception of certain Preventive Care services, no payment is due from BCI under this Contract until the Deductible is met.*	**The Insured is responsible to pay these amounts:**	
Individual	$3,700	$7,400
Family *(No Insured may contribute more than the Individual Deductible amount toward the Family Deductible)*	$7,400	$14,800
Out-of-Pocket Limits (per Benefit Period) *This Contract has a calendar year Out-of-Pocket Limit.* *Includes applicable Deductible, Coinsurance and Copayments. (See Policy for services that do not apply to the limit)*	$3,700	$7,400
Individual	$7,400	$14,800
Family *(No Insured may contribute more than the Individual Out-of-Pocket Limit amount toward the Family Out-of-Pocket Limit)*		
Coinsurance *Unless specified otherwise below, the Insured pays the following Coinsurance amount*	No Charge after Deductible	No Charge after Deductible
Frequently used Covered Services - *Some services may require Prior Authorization.*		
Physician Office Visits	Deductible and Coinsurance	Deductible and Coinsurance
Preventive Care Covered Services *(Includes services, screenings and tests that have received a rating of A or B to the extent recommended by the U.S. Preventive Services Task Force and Health Resources and Services Administration. Further information and specifically listed Preventive Care Covered Services are available on the BCI Website, www.bcidaho.com)*	No Charge (Deductible does not apply)	Deductible and Coinsurance
Immunizations Specifically listed on the BCI Website, www.bcidaho.com.	No Charge (Deductible does not apply)	No Charge (Deductible does not apply)

TELEHEALTH SERVICES	
Telehealth Virtual Care Services	Telehealth Virtual Care Services are available for any category of covered outpatient services. The amount of payment and other conditions for in-person services will apply to Telehealth Virtual Care Services. Please see the appropriate section of the Benefits Outline for those terms.

PRESCRIPTION DRUG BENEFITS

- The Formulary will be made available to any Insured on request by contacting our Blue Cross of Idaho Customer Service Department at (208) 331-7347 or (800) 627-1188.
- Each non-Specialty Prescription Drug shall not exceed a 90 day supply at one (1) time.
- Each Specialty Prescription Drug shall not exceed a 30 day supply at one (1) time.
- Prescription Drug Services apply to the In-Network Out-of-Pocket Limits.

RETAIL OR BCI MAIL ORDER PHARMACIES	
Tier 1 **Tier 2** **Tier 3** **Tier 4** **Tier 5** **Tier 6**	No Charge per prescription after In-Network Individual/Family Deductible is met
ACA Preventive Prescription Drugs	No Charge
HSA Preventive Prescription Drugs	No Charge
Prescribed Contraceptives	No Charge

Note: Certain Prescription Drugs have generic equivalents. If the Insured requests a Brand Name Drug, the Insured 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.

COVERED SERVICES *Some services may require Prior Authorization.*	**In-Network**	**Out-of-Network**
	The Insured is responsible to pay these amounts:	
Advanced Imaging Services *(Outpatient services only)*	Deductible and Coinsurance	Deductible and Coinsurance
Allergy Injections	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance Transportation Service • **Ground Ambulance Services** • **Air Ambulance Services** *(Payment for Out-of-Network Air Ambulance Services is based on the Qualifying Payment Amount. Out-of-Network Air Ambulance Services accumulate towards the In-Network Out-of-Pocket Limit.)*	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance In-Network Deductible and In-Network Coinsurance
Breastfeeding Support and Supply Services *(Includes rental and/or purchase of manual or electric breast pumps. Limited to one (1) breast pump purchase per Benefit Period, per Insured.)*	No Charge (Deductible does not apply)	Deductible and Coinsurance
Chiropractic Care Services *Up to a combined In-Network and Out of-Network total of 18 visits per Insured, per Benefit Period.*	Deductible and Coinsurance	Deductible and Coinsurance
Dental Services Related to Accidental Injury	Deductible and Coinsurance	Deductible and Coinsurance
Diabetes Self-Management Education Services	Deductible and Coinsurance	Deductible and Coinsurance
Diagnostic Services - Laboratory and X-ray *(Including diagnostic mammograms)*	Deductible and Coinsurance	Deductible and Coinsurance

COVERED SERVICES *Some services may require Prior Authorization.*	**In-Network**	**Out-of-Network**
	The Insured is responsible to pay these amounts:	
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Services – Facility and Professional Services *(Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount.)*	In-Network Deductible and In-Network Coinsurance. Emergency Services accumulate towards the In-Network Out-of-Pocket Limit.	
Hearing Aids *(For Eligible Dependent Children Only. Benefits are limited to one (1) device per ear, every three (3) years, and includes forty-five (45) speech therapy visits during the first twelve (12) months after delivery of the covered device.)*	Deductible and Coinsurance	Deductible and Coinsurance
Home Health Skilled Nursing Care Services	Deductible and Coinsurance	Deductible and Coinsurance
Home Intravenous Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	No Charge after Deductible	Deductible and Coinsurance
Hospital Services	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Rehabilitation or Habilitation Services	Deductible and Coinsurance	Deductible and Coinsurance
Maternity Services and/or Involuntary Complications of Pregnancy	Deductible and Coinsurance	Deductible and Coinsurance
Mental Health and Substance Use Disorder Inpatient and Outpatient Services • **Facility and Professional Services**	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Applied Behavioral Analysis (ABA)	Deductible and Coinsurance	Deductible and Coinsurance
Treatment for Autism Spectrum Disorder	Covered the same as any other illness, depending on the services rendered. Please see the appropriate section of the Benefits Outline. Visit limits do not apply to Treatments for Autism Spectrum Disorder, and related diagnoses.	
Outpatient Cardiac Rehabilitation Services *Up to a combined In-Network and Out-of-Network total of 36 visits per Insured, per Benefit Period. An additional 36 visits may be available with Prior Authorization.*	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Habilitation Therapy Services • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy *Up to a combined In-Network and Out-of-Network total of 20 visits per Insured, per Benefit Period*	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Pulmonary Rehabilitation Services	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Rehabilitation Therapy Services • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy *Up to a combined In-Network and Out-of-Network total of 20 visits per Insured, per Benefit Period*	Deductible and Coinsurance	Deductible and Coinsurance
Palliative Care Services	No Charge after Deductible	Deductible and Coinsurance
Post-Mastectomy/Lumpectomy Reconstructive Surgery	Deductible and Coinsurance	Deductible and Coinsurance

COVERED SERVICES Some services may require Prior Authorization.	In-Network	Out-of-Network
	The Insured is responsible to pay these amounts:	
Prescribed Contraceptive Services *(Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation)*	No Charge (Deductible does not apply)	Deductible and Coinsurance
Skilled Nursing Facility *Up to a combined In-Network and Out-of-Network total of 30 days per Insured, per Benefit Period*	Deductible and Coinsurance	Deductible and Coinsurance
Sleep Study Services	Deductible and Coinsurance	Deductible and Coinsurance
Surgical/Medical (Professional Services)	Deductible and Coinsurance	Deductible and Coinsurance
Therapy Services *(Including Radiation, Chemotherapy, Renal Dialysis and Growth Hormone)*	Deductible and Coinsurance	Deductible and Coinsurance
Transplant Services	Deductible and Coinsurance	Deductible and Coinsurance
Be aware that your actual costs for services provided by an Out-of-Network Provider may exceed this Policy's Out-of-Pocket Limit for Out-of-Network services. Except as provided by the No Surprises Act, 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.		

PEDIATRIC VISION CARE BENEFITS (VCSV) *(For Insureds under the age of 19 only)* **The Participating Provider is responsible for verifying benefits with the VCSV prior to rendering services. An Insured must provide the Participating Provider sufficient information to verify eligibility. Failure of the Insured to provide sufficient information may delay services and may affect benefit payment under this Policy.		
Service Frequency Limitations	• Insured may receive one (1) eye exam per Benefit Period • Insured may receive one (1) pair of Lenses and Frame per Benefit Period • Insured may receive one (1) Contact lens exam and Contact Lens materials (based on modality) in lieu of glasses (Lenses and Frame) per Benefit Period	
Vision Services	****Participating Provider** ***The Insured is responsible to pay these amounts:***	**Nonparticipating Provider** ***The Insured is responsible to pay these amounts:***
• **Exam** • **Lenses/Frame** • **Contact Lenses**	No Charge (Deductible does not apply**)**	50% of Maximum Allowance (Deductible does not apply)

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding contract/policy, which contains all the terms and conditions of coverage and exclusions and limitations. Certain services not specifically noted may be excluded. Please refer to the contract/policy issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding contract/policy, the contract/policy will control.

Attachment A:
NON-EMERGENCY SERVICES REQUIRING PRIOR AUTHORIZATION ANNUAL NOTICE
EFFECTIVE: January 1, 2024

NOTICE: Prior Authorization is required to determine if the specified services listed below are Medically Necessary and a Covered Service. 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.

If Non-Medically Necessary services are performed by Contracting Providers, without the Prior Authorization by Blue Cross of Idaho, and benefits are denied, the cost of said services are not the financial responsibility of the Insured. The Insured is financially responsible for Non-Medically Necessary services performed by a Provider who does not have a Provider contract with Blue Cross of Idaho.

Blue Cross of Idaho will respond to a request for Prior Authorization for the services listed below received from either the Provider or the Insured within seventy-two (72) hours for an expedited request or fourteen (14) days for a standard request 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 Insured's Identification Card or check the BCI Website at www.bcidaho.com.

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.

The following services require Prior Authorization:

Procedures:

- Radiation therapy
- Dental Surgery related to an accident
- Treatment of veins
- Reconstructive and plastic Surgery, including breast, eyelid, jaw and sinus
- Surgery for snoring or sleep problems
- Transplants (organ, tissue, etc.)
- Gender affirming services
- Other Inpatient and Outpatient surgical procedures
- Certain genetic and laboratory testing
- Wound Care and Hyperbaric Oxygen (HCO)

Services:

- Acute Inpatient hospitalization
- Long-term acute care hospital (LTACH) admissions
- Rehabilitation and long-term care facility admissions
- Skilled nursing facility admissions
- Sub-acute and transitional care admissions
- Non-emergency ambulance transport
- Behavioral Health Services
    - Psychological testing/neuropsychological evaluation testing
    - Electroconvulsive therapy (ECT)
    - Intensive outpatient program (IOP)
    - Partial hospitalization program (PHP)
    - Residential treatment center (RTC)
    - Transcranial Magnetic Stimulation (TMS)

- Advanced Imaging Specialty Health Services:
    - Sleep therapy including studies, appliances and treatment

- Magnetic Resonance Imaging (MRI)
- Computed Tomography (CT)
- Positron Emission Tomography (PET) scan
- Pain management
- Musculoskeletal procedures for spine and joints

Durable Medical Equipment:

- Equipment with costs of more than one thousand dollars ($1,000) (including rent-to-purchase items)
- Orthotic Devices and Prosthetic Appliances with costs of more than one thousand dollars ($1,000)

Pharmacy

- Certain Prescription Drugs (find a full list at ***members.bcidaho.com***)
- Chimeric antigen receptor (CAR) T-cell Therapy
- Growth hormone therapy
- Outpatient intravenous (IV) therapy for infusion drugs (find a list at ***members.bcidaho.com***)

Attachment B:
SmartShopper Savings and Incentive Program

SmartShopper is a voluntary program that allows Insureds to shop for eligible medical services, review cost and quality comparisons between local Contracting Providers, and receive a cash incentive for selecting a cost-effective Provider.

As part of the shopping experience, a list of available Contracting Providers along with any cash incentives associated with each Provider will be shown. When shopping for an eligible service, SmartShopper estimates the cost of the service at different Contracting Providers. If the Insured chooses to have a service performed by a cost-effective Provider, the Insured can earn a cash incentive.

Insureds remain free to seek care at the Provider of their choice regardless of whether the Provider is on the SmartShopper list or whether an incentive is available. Insureds with coverage under Medicaid or Medicare as their primary insurance are not eligible to receive incentives under the SmartShopper program.

SmartShopper incentive payments are processed within approximately sixty (60) days after the date the eligible Covered Services are received and are considered taxable income to the recipient.

For more information about SmartShopper, including a list of eligible services and answers to frequently asked questions, please log on to the Blue Cross of Idaho member account at *members.bcidaho.com* and access the Find Care tool to estimate costs and shop for services or call the SmartShopper Personal Assistant Team at 866-507-3528. The Personal Assistant Team is available Monday through Thursday from 8 a.m. to 8 p.m. and Friday from 8 a.m. to 6 p.m. ET.

Attachment C: ***(member disclosure)***

Cancer Care Program Disclosure

Cancer Care Program is a voluntary program that allows Insureds to receive a gift card incentive for completing certain preventive care screenings, such as breast cancer screenings, cervical screenings, colorectal screenings and HPV Vaccine.

Insureds must register for the program and activate an account to be eligible for incentives in one of the following ways:

1. Visit bcidaho.com/myhealthyrewards
2. Call the Cancer Care Program call center at (866) 685-2257
3. If you receive an activation kit, please mail the information back to:
   iCario
   PO BOX 7185
   Rantoul, Il 61866-9951

Insureds remain free to seek care at the Provider of their choice whether an incentive is available or not. Insureds with coverage under Medicaid or Medicare as their primary insurance are not eligible to receive incentives under the Cancer Care Program.

Incentives are processed within approximately sixty (60) days after the date the eligible Covered Services are received and are considered taxable income to the recipient.

If an Insured is unable to participate in any of the preventive care screenings required to earn an incentive, they may be entitled to a reasonable accommodation or an alternative standard. To request a reasonable accommodation or an alternative standard, contact (866) 685-2257

For more information about the Cancer Care Program, including a list of eligible services and answers to frequently asked questions, please call the Cancer Care Program call center at (866) 685-2257. The call center is available Monday through Friday from 6 a.m. to 8 p.m. and Saturday from 8 a.m. to 1 p.m. Mountain Time.

BLUE CROSS OF IDAHO
HEALTH SERVICE, INC.

2024 HSA PPO MASTER GROUP POLICY AND ENROLLEE CERTIFICATE

PREFERRED PROVIDER ORGANIZATION (PPO)

Form No. HSAPPOP (01/24)

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Additional Information

For assistance with claims or health benefit information, please call Customer Service at (208) 331-7247 or (800) 627-1188.

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

Meridian
Customer Service Department
3000 East Pine Avenue
Meridian, ID 83642

2929 W. Navigator Drive, Suite 140
Meridian, ID 83642

Mailing Address
PO Box 7408
Boise, ID 83707
(208) 387-6683 (Boise Area)
1-800-365-2345

Coeur d'Alene
1812 N. Lakewood Dr., Suite 200
Coeur d'Alene, ID 83814
(208) 666-1495

Pocatello
852 W. Quinn Rd.
Chubbuck, ID 83202
(208) 232-6206

Idaho Falls
3630 S. 25th E., Suite 1
Idaho Falls, ID 83404
(208) 522-8813

Twin Falls
428 Cheney Dr. W., Suite. 101
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

ELIGIBILITY AND ENROLLMENT SECTION

I. Eligibility and Enrollment

The Group decides which categories of its Employees and Dependents will have the opportunity to apply for coverage under this Policy in accordance with the Group's health plan documents or employee handbook. The Group will determine if there are certain probationary periods that must be satisfied before a new Eligible Employee can qualify for coverage under this Policy. Please contact your manager of employee benefits for the probationary period and any other restrictions applicable.

A. Eligible Employee

The Group decides which categories of its Employees and their dependents are eligible for coverage and establishes the other eligibility requirements of this Policy in the Group Application. To qualify as an Eligible Employee under this Policy, a person must regularly work at least 30 hours per week, or if specially negotiated between BCI and the Group at least 20 hours per week. An Eligible Employee must remain a full-time employee, sole proprietor, or partner of the Group who, and is paid on a regular, periodic basis through the Group's payroll system.

An Eligible Employee may also include public officers or government/municipality public employees without regard to the number of hours worked, or if permitted by the Group health plan documents a retiree of the Group, when designated by the Group within the Group Application.

B. Eligible Dependent

The Group decides which categories of dependents are eligible for coverage under this Policy as described in the Group Application. Notwithstanding any other provision of the Policy, if the benefits of the Policy are not available to certain dependents and certain categories of dependents are not eligible to enroll or receive benefits, references in this Contract do not apply.

If this Policy provides coverage for an Eligible Dependent spouse, a person must be and remain the Enrollee's spouse under a legally valid marriage.

If this Policy provides coverage for an Eligible Dependent child(ren), a person must be and remain one (1) of the following:

1. The Enrollee's or the Enrollee's spouse's natural child, stepchild, legally adopted child, child placed with the Enrollee or the Enrollee's spouse for adoption, or child for whom the Enrollee or the Enrollee's spouse has court-appointed guardianship or custody. The child must be under the age of twenty-six (26).
2. A child as described in the first sentence of subparagraph one (1) who has attained age twenty-six (26) provided:
    a) The child is medically certified as incapable of self-sustaining employment due to an intellectual disability or physical handicap that began prior to age twenty-six (26);
    b) The child is chiefly dependent upon the Enrollee or the Enrollee's spouse for support and maintenance; and
    c) The Enrollee submits proof of such child's incapacity and dependency as described in this subparagraph two (2) within thirty-one (31) days of such child's attainment of age twenty-six (26) and as subsequently required by BCI and/or the Group at reasonable intervals.

An Enrollee must notify BCI and/or the Group 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 occurred.

For the purposes of this Policy, the child of a Surrogate Mother will not be considered an Eligible Dependent of the Surrogate Mother or her spouse.

II. Enrollment

For an Eligible Employee to enroll themself and/or any Eligible Dependents for coverage under this Policy the Eligible Employee or Enrollee, as the case may be, must either complete a BCI application and the Group will submit it and any required premiums to BCI or request enrollment in this Policy through the Exchange. All applications must be received within the time period afforded by the applicable enrollment period.

A. Annual Open Enrollment Periods

Applications for coverage for an Eligible Employee will only be accepted by BCI during the Group's annual Open Enrollment Period, during the Eligible Employee's Initial Enrollment Period, or during a Special Enrollment Period as described in this section. If an Eligible Employee does not apply for coverage during these time periods, they must wait until the next Open Enrollment Period or Special Enrollment Period.

B. Initial Enrollment Period

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 Policy.

C. Enrollment of Eligible Dependents

1. If this Policy was selected through the Exchange, the Enrollee must apply to and receive approval from the Exchange to enroll an Eligible Dependent under this Policy. Applications to enroll Eligible Dependents may be submitted directly to BCI for those policies not selected through the Exchange.

2. Newborn/Adoption---When a newborn child is added and the monthly premium changes, a full month's premium is required for the child if their date of birth falls on the first (1st) through the fifteenth (15th) day of the month. No premium is required if the child's date of birth falls on the sixteenth (16th) through the last day of the month. An Enrollee's newborn Dependent, including adopted newborn children who are placed with the adoptive Enrollee within sixty (60) days of the adopted child's date of birth, are covered under this Policy from and after the date of birth for 60 days.

   A. Premium for the first sixty (60) days of coverage is due not less than thirty-one (31) days following receipt of a billing for the required premium. In order to continue coverage beyond the sixty (60) days outlined above, the Enrollee must complete an enrollment application within sixty (60) days of date of birth and submit the required premium, for the first sixty (60) days, within thirty-one (31) days of the date monthly billing is received and a notice of premium is provided to the Enrollee from the Group.

   B. 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 Policy, '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 Policy, "placed for adoption" means physical placement in the care of the adoptive Enrollee, 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 Enrollee signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

D. Special Enrollment Periods

Outside of the Eligible Employee's Initial Enrollment Period or annual Open Enrollment Period, an Eligible Employee or Eligible Dependent may enroll for coverage, unless otherwise noted, within thirty (30) days of the occurrence of one of the following events:

1. Loss of Minimum Essential Coverage or COBRA coverage;

2. Addition of an Eligible Dependent through marriage, birth, adoption or placement of adoption and coverage is requested under this Policy no later than sixty (60) days after the date of the event;

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 Policy 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 Policy no later than 60 days after the date of termination of such coverage;

5. In addition, if the Eligible Employee or Eligible Dependent enrolled in this Policy through the Exchange, the occurrence of the following events:
   a. Demonstration to the Exchange that the QHP in which the Eligible Employee or Eligible Dependent is enrolled substantially violated a material provision of its contract in relation to the Insured;
   b. Enrollment or non-enrollment in another QHP was unintentional, inadvertent or erroneous and was the result of the error, intentional misrepresentation, or inaction of an officer, employee, or agent of the Exchange as evaluated and determined by the Exchange;
   c. Access to new QHPs as a result of a permanent move;
   d. Status as an Indian, as defined in 25 U.S.C. 450b(d), allows enrollment in a QHP or change from one QHP to another one time per month.

   If the Eligible Enrollee or Eligible Dependent requested the Special Enrollment Period through the Exchange, the Exchange will determine the date the Special Enrollment Period begins.

E. Effective Dates of Coverage

Subject to receiving the applicable premium payment:

1. If the Eligible Employee or Eligible Dependent enrolled in this Policy during their Initial Enrollment Period or the Group's Open Enrollment Period, the Effective Date of coverage for an Eligible Employee and any Eligible Dependents listed on the Eligible Employee's application is the Group's Policy Date if the application is submitted to BCI by the Group or the exchange on or before the Policy Date.

2 Except as provided otherwise in this section, if enrollment is requested during an Initial Enrollment Period or annual Open Enrollment Period, the Effective Date of coverage for an Eligible Employee or an Eligible Dependent will be the first day of the month following the month of enrollment.

3 If enrollment is requested during a Special Enrollment Period due to the loss of Minimum Essential Coverage or marriage, the Effective Date of coverage will be the first day of the month following the marriage or loss of coverage.

4. The Effective Date of coverage for enrollment requested during a Special Enrollment Period 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.

5. For other enrollment requested though a Special Enrollment Period, if the application is received between the first and fifteenth day of the month, coverage will begin on the first day of the following month. If the application is received between the sixteenth day and the last day of the month, coverage will begin on the first day of the second month.

III. Group Employee Premium Contribution and Enrollment Requirements

A. 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.

B. The Group agrees to pay a specified percentage of the premium for each Eligible Employee, and a specified percentage of the premium for each Eligible Dependent, if applicable. The Enrollee must pay the balance, if any, of the required premium. The Group agrees to collect required Enrollee premium payments through payroll withholding and make the required premium payments to BCI on or before the first of each month.

C. Before the Effective Date of the change, the Group shall submit all eligibility changes for Enrollees and Eligible Dependents on BCI's usual forms. It is the Group's responsibility to verify that all Insureds are eligible for coverage as specified in this Policy. BCI shall have the right to audit the Group's employment, payroll, and eligibility records to ensure that all Insureds are eligible and properly enrolled and to ensure that the Group meets enrollment requirements.

D. This Policy is issued 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 Enrollees. This Policy is issued upon the express condition that the Group continues to make the employer premium contribution specified in the Application for Group Coverage and this Policy. BCI may terminate this Policy if the percentage of Eligible Employees as Enrollees or the percentage of the employer premium contribution drops below the required level.

E. If the Group maintains regular monthly payments with the regular Group billing, an employer approved temporary leave of absence may continue for a maximum of three (3) months and then cease. On its regular billing, the Group will notify BCI of the Enrollee's date of departure for the leave of absence, and shall continue its regular employee premium contribution for the Enrollee's coverage during the leave of absence.

IV. Qualified Medical Child Support Order

A. If this Policy provides for Family Coverage, BCI will comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of Section 609 of ERISA and any other applicable federal or state laws. A medical child support order is any judgment, 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 an Enrollee 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 Policy, 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 Enrollee 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 Policy 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 Enrollee, the party who sent the order, and each affected child of such determination.

D. BCI 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

For reference, most terms defined in this section are capitalized throughout this Policy. Other terms may be defined where they appear in this Policy. Definitions in this Policy shall control over any other definition or interpretation unless the context clearly indicates otherwise.

Accidental 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 an Insured'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 an Insured's life and health. The immediate medical goal of Acute Care is to stabilize the Insured's condition, rather than upgrade or restore an Insured's abilities.

Admission—begins the first day an Insured becomes a registered Hospital bed patient or a Skilled Nursing Facility patient and continues until the Insured 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 Policy.

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.

Air Ambulance—medical transport by rotary wing air ambulance or fixed wing air ambulance as those terms are used in Medicare Regulations, including transportation that is certified as either a fixed wing or rotary wing air ambulance and such services and supplies as may be Medically Necessary.

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

Alcoholism Or Substance Use Disorder Acute Treatment—a licensed 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 Use Disorder, 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 Insured 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.

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.

Applied Behavior Analysis (ABA)—the process of systematically applying interventions based upon the principles of learning theory to make changes to socially significant behavior to a meaningful degree, and to demonstrate the interventions are responsible for the improvement in behavior.

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.

Autism Spectrum Disorder—means any of the pervasive developmental disorders, autism spectrum disorders, or related diagnoses as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

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

Benefit Period—the specified period of time in which an Insured's benefits for incurred Covered Services accumulate toward annual benefit limits, Deductible amounts and Out-of-Pocket Limits.

Benefits Outline—a listing of certain Covered Services specifying Coinsurance, Copayments, Deductibles and Benefit limitations and maximums under the Policy.

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

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

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.

Chiropractic Care—services rendered, referred, or prescribed by a Chiropractic Physician.

Chiropractic Physician—an individual licensed to practice chiropractic.

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.

Clinical Psychologist—an individual licensed to practice clinical psychology.

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

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 Policy, 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 Insured at home. A period of crisis is one in which the Insured's symptom management demands predominantly Skilled Nursing Care.

Contracting Provider—a Provider that has entered into a written agreement with BCI regarding payment for Covered Services rendered to an Insured under a PPO program.

Copayment—a designated dollar and/or percentage amount, separate from Coinsurance, that an Insured 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 an Insured's health condition, illness or injury and that is:

1. Provided in the most cost-appropriate setting consistent with the Insured'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 Insured's condition, Disease, Illness or injury.

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

Custodial Care—care designated principally to assist an Insured 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 an Insured is responsible to pay Out-of-Pocket per Benefit Period before BCI 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 an Insured'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 Insured'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 an Insured begins under this Policy.

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 an Enrollee's coverage. For the purposes of this Policy, the child of a Surrogate Mother will not be considered an Eligible Dependent of the Surrogate Mother or her spouse.

Eligible Employee Or Qualified Employee—an employee, sole proprietor or partner of a Group who is entitled to apply as an Enrollee as determined by the Group and described in the Group Application.

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

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, Mental or Nervous Condition, Substance Use Disorder or Addiction, or an Accidental Injury which requires immediate medical treatment to preserve life or prevent severe, irreparable harm to an Insured.

Emergency Medical Condition—a condition reflected by sudden and unexpected symptoms that are severe enough that a reasonably prudent layperson with average knowledge of health and medicine would expect extreme consequences to result without immediate medical care. These consequences include placing the health of the individual (or, regarding a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Emergency Medical Conditions, include but are not limited to, heart attacks, cerebrovascular accidents, poisonings, loss of consciousness or respiration, and convulsions, Mental or Nervous Condition, or Substance Use Disorder or Addiction.

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

Essential Health Benefits—the designated benefits required to be included in a Qualified Health Plan offered in the state of Idaho, including, Hospitalization, Ambulatory Services, Emergency Services, Maternity and Newborn Care, Mental Health, Rx Drugs, Laboratory Services, Preventive and Wellness Services and Chronic Disease Management, Pediatric Oral and Vision Care, Rehabilitative and Habilitative Services and Devices.

Exchange—Your Health Idaho, an insurance marketplace established by the state of Idaho that provides the opportunity to purchase Qualified Health Plans.

Family Coverage—Enrollment of an Enrollee and one or more Eligible Dependent(s) under this Policy.

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.

Freestanding Emergency Department—a health care facility that is geographically distinct and licensed separately from a Hospital under applicable state law and provides emergency services.

Ground Ambulance—a licensed ground vehicle that is specially designed and equipped for transporting the sick and injured.

Group—a sole proprietorship, partnership, association, corporation, or other entity that has applied for Group coverage and has agreed to comply with all the terms and requirements of this Policy.

Group Application—an application for coverage by the Group to specify group-specific details of coverage and eligibility requirements.

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

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 Skilled Nursing Care Services— the delivery of Skilled Nursing Care services under the direction of a Physician to a Homebound Insured. Home Health Skilled Nursing is generally intended to transition a Homebound patient from a hospital setting to a home or prevent a hospital stay, provided such nurse does not ordinarily reside in the Insured's household or is not related to the Insured by blood or marriage.

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 Insureds 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 care and treatment to be provided to an Insured by a Hospice. The written plan of care must be established and periodically reviewed by the attending Physician.

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 an Insured's awareness of it, and can be of known or unknown cause(s).

Injury—damage to a part of the body caused by trauma from a sudden, unforeseen outside force or object, occurring at an identifiable time and place, and without the Insured's foresight or expectation.

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

Inpatient—an Insured 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.

Insured—an Enrollee or an enrolled Eligible Dependent covered under this Policy.

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:

- 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.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of current published medical literature and investigations published in peer-reviewed journals. The quality of the studies and consistency of results will be considered. The evidence should demonstrate that the technology can measure or alter physiological changes related to a Disease, Injury, Illness, or condition. In addition, there should be evidence that such measurement or alteration affects health outcomes.
- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives.
- The technology must show improvement that is attainable outside the investigational 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 Center for Clinical Effectiveness (CCE) 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 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 treatment or Rehabilitative care of Mental or Nervous Conditions
    h) Place for the treatment or Rehabilitative care of Alcoholism or Substance Use Disorder or Addiction
    i) Place for Hospice care
    j) Residential Treatment Center
    k) 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 pharmacy.

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

Maximum Allowance—for Covered Services under the terms of this Policy, 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 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. If the Covered Services are rendered outside the state of Idaho by a Provider not contracting with a Blue Cross/Blue Shield affiliate in the location of the Covered Service, the Maximum Allowance is the lesser of the billed charge or the amount established by BCI as compensation for a Covered Service.

The Maximum Allowance may be determined using many factors, as applicable, 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; Qualifying Payment Amount, amount determined under an Independent Dispute Resolution (IDR) in accordance with surprise medical billing requirements under the federal No Surprises Act; 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.

Medical Food—a food which is formulated to be consumed or administered orally or enterally under the supervision of a Physician.

Medically Necessary (or Medical Necessity)—the Covered Service or supply recommended by the treating Provider to identify or treat an Insured'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 Insured.
2. Proven to be effective in improving health outcomes:
   a. For new treatment, effectiveness is determined by peer reviewed scientific evidence; or
   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 Insured 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 Policy.

The term Medically Necessary as defined and used in this Policy is strictly limited to the application and interpretation of this Policy, 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 Center for Clinical Effectiveness (CCE) 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.

Minimum Essential Coverage—the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

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 an Insured under a PPO program.

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

Occupational Therapist—an individual licensed to practice occupational therapy.

Office Visit—any direct, one-on-one examination and/or exchange, conducted in the Provider's office, between an Insured and a Provider, or members of their 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 Insured's place of residence may be considered an Office Visit.

Open Enrollment Period—the period of time chosen by the Group, other than during an Initial Enrollment Period or Special Enrollment Period, in which an Eligible Employee and/or Eligible Dependent may enroll in an available Qualified Health Plan offered by their employer, usually once a year.

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 an Insured is responsible for paying. Eligible Out-of-Pocket expenses include only the Insured’s Deductible, Copayments and Coinsurance for eligible Covered Services.

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

Palliative Care—is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening Illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical and psychosocial.

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.

Physical Rehabilitation—Medically Necessary, non-acute therapy rendered by qualified health care professionals. Physical Rehabilitation is intended to restore an Insured'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.

Podiatrist—an individual licensed to practice podiatry.

Policy—this Policy, which includes only the Benefits Outline, Group application and individual enrollment applications, if applicable, Insured identification cards, any written endorsements, riders, amendments, attachments, or any other written agreements between BCI and the Group executed by an authorized officer of BCI.

Policy Date—the date specified in this Policy when coverage commences for the Group.

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

Post-Stabilization Care Services—any additional items and services that are Covered Services under this Policy after an Insured is stabilized and as part of Outpatient observation or Inpatient or Outpatient stay with respect to the visit in which the emergency services are furnished.

Preadmission Testing—tests and studies required in connection with an Insured'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 Blue PPO—a preferred provider organization product offered through BCI.

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 Policy that requires Prior Authorization before services are rendered.

Primary Care Giver—a person designated to give direct care and emotional support to an Insured 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 Insured. A Primary Care Giver must be a volunteer who does not or expect or claim any compensation for services provided to the Insured.

Prior Authorization—the Provider's or the Insured's request to BCI, or delegated entity, for a Medical Necessity determination of an Insured'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, certified, accredited and/or registered, where required, to render Covered Services. For the purposes of this Policy, Providers include any facility or individual who provides a Covered Service while operating within the scope of their license, certification, accreditation and/or registration under applicable state law, unless exempted by federal law.

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 Use Disorder or Addiction. These services are provided by or under the supervision of a psychiatrist or as appropriate addictionologist, and twenty-four (24) hour nursing services are provided under the supervision of a licensed R.N.

Qualified Health Plan (QHP)—under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides Essential Health Benefits, follows established limits on cost sharing (like Deductibles, Copayments, and Out-of-Pocket maximum amounts), and meets other requirements. A Qualified Health Plan will have a certification by each Exchange in which it is sold.

Qualifying Payment Amount—the median contracted rates recognized by BCI as the maximum payment for the same or similar Covered Services provided by a Provider in same or similar specialty, in the same geographic area (increased by the consumer price index) in accordance with surprise medical billing requirements under the federal No Surprises Act.

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 an arrangement(s) 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.

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 an Insured. The written plan must be established and periodically reviewed by an attending Physician.

Residential Treatment Center—a Facility Provider licensed by the appropriate state/local authorities as a Residential Treatment Center that is primarily engaged in providing twenty-four (24) hour level of care, including twenty-four (24) hour onsite or on call nursing services and a defined course of therapeutic intervention and special programming in a controlled environment. Care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential Treatment Center does not include Custodial Care, outdoor behavioral health programs, half-way houses, supervised living, group homes, boarding houses or other similar facilities providing primarily a supportive and/or recreational environment, even if Mental Health or Substance Use Disorder counseling is provided in such facilities.

Respite Care—care provided to a Homebound Insured 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 Insured 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 an Insured 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 Insured.
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 Insured, 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 Use Disorder or Addiction.

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

Small Employer—any person, firm, corporation, partnership or association that is actively engaged in business that employed an average of at least two (2) Eligible Employees on the first day of the plan year, but no more than fifty (50) Eligible Employees, the majority of whom were employed within the state of Idaho. In determining the number of Eligible Employees—affiliated companies, or companies eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.

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.

Substance Use Disorder Or Addiction—a behavioral or physical disorder manifested by repeated excessive use of a drug or alcohol to the extent that it interferes with an Insured'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 Mother— a women who agrees to become pregnant and give birth to a child for another individual or couple (the "Intended Parents") in order to give the child to the Intended Parents whether or not the Surrogate Mother is the genetic mother of the child and whether or not the Surrogate Mother does so for compensation.

Telehealth Virtual Care Services—health care services conducted with technology that includes live audio and video communication between the Insured and a Provider in compliance with state and federal laws. No benefits are available for visits conducted by (a) audio-only communication when treatment by such method is not permitted under applicable law at the time of visit, (b) e-mail or (c) fax.

Temporomandibular Joint (TMJ) Syndrome—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.

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 Insured to help satisfactorily accomplish the ordinary tasks of daily living and tasks required by the Insured'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. Psychotherapy—evidence based therapies focused on cognitive and behavioral changes relevant to mental, neurological and substance use disorders.
8. Growth Hormone Therapy—treatment administered by intramuscular injection to treat children with growth failure due to pituitary disorder or dysfunction.
9. Home Intravenous Therapy (Home Infusion Therapy)—treatment provided in the home of the Insured 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.

Totally Disabled (or Total Disability)—as certified in writing by an attending Physician, a condition resulting from Disease, Illness or Accidental Injury causing:

1. An Enrollee's inability to perform the principal duties of the regular employment or occupation for which the Enrollee is or becomes qualified through education, training, or experience; and the Enrollee is not in fact engaged in any work profession, or avocation for fees, gain, or profit; or
2. An enrolled Eligible Dependent to be so disabled and impaired as to be unable to engage in the normal activities of an individual of the same age and gender.

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

Treatments for Autism Spectrum Disorder—means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder, or related diagnoses, by a licensed Physician or a licensed psychologist, including but not limited to behavioral health treatment, pharmacy care, psychiatric care, psychological care, and therapeutic care.

INPATIENT NOTIFICATION SECTION

This section describes procedures that should be followed in order for Insureds 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 Insured and is required for all Inpatient admissions except Covered Services subject to Emergency or Maternity delivery Admission Notification. An Insured should notify BCI of all proposed Inpatient admissions as soon as they know 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 Insured's proposed Inpatient admission to a Licensed General Hospital, Alcohol or Substance Use Disorder 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 Insured to BCI, payment of benefits is subject to the specific benefit levels, limitations, exclusions and other provisions of this Policy.

For Non-Emergency Preadmission Notification call BCI at the telephone number listed on the back of the Enrollee'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 Insured's condition, the Insured, or their representative, should notify BCI within seventy-two (72) 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 Insured's proposed discharge, when the Inpatient stay is complex, longer than expected and/or the expected treatment response is delayed. If the Insured is not going to 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 Policy.

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 of the Benefits Outline or on the Prior Authorization page of the BCI Website are Medically Necessary and a Covered Service. 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.***

If Non-Medically Necessary services are performed by Contracting Providers, without the Prior Authorization by Blue Cross of Idaho, and benefits are denied, the cost of said services are not the financial responsibility of the Insured. The Insured is financially responsible for Non-Medically Necessary services performed by a Provider who does not have a provider contract with Blue Cross of Idaho.

Prior Authorization is a request by the Insured's Contracting Provider to BCI, or delegated entity, for authorization of an Insured's proposed treatment. BCI may review medical records, test results and other sources of information to ensure that it is a Covered Service and make a determination as to Medical Necessity or alternative treatments.

Please refer to Attachment A of the Benefits Outline, check the Prior Authorization page of the BCI Website at www.bcidaho.com, or call Customer Service at the telephone number listed on the back of the Insured's Identification Card to determine if the Insured's proposed services require Prior Authorization. To request Prior Authorization, the Contracting Provider must notify BCI of the Insured'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 Insured's Policy and Medically Necessary. BCI will respond to a request for Prior Authorization received from either the Provider or the Insured within seventy-two (72) hours for an expedited request or fourteen (14) days for a standard request of the receipt of the medical information necessary to make a determination.

Noncontracting Providers: Please refer to Attachment A of the Benefits Outline, check the BCI Website at www.bcidaho.com, or call Customer Service at the telephone number listed on the back of the Insured's Identification Card to determine if the proposed services require Prior Authorization. The Insured is responsible for obtaining Prior Authorization when seeking treatment from a Noncontracting Provider. The Insured is financially responsible for services performed by a Noncontracting Provider when those services are determined to be not Medically Necessary. The Insured is responsible for notifying BCI if the proposed treatment will be provided by a Noncontracting Provider.

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.

General Benefit Information

This section describes the benefits an Insured is entitled to receive for Covered Services, subject to the conditions, limitations, exclusions, and other provisions of this Policy.

I. Benefit Period

The Benefit Period is the specified period of time during which an Insured accumulates annual benefit limits, Deductible amounts and Out-of-Pocket Limits. Please see the cover page of this Policy for the Benefit Period. If the Insured's Effective Date is after the Policy Date, the initial Benefit Period for that Insured may be less than twelve (12) months.

The Benefit Period for Hospice Covered Services is a continuous six-month period that begins when Blue Cross of Idaho approves the Hospice Plan of Treatment. The Insured may apply to BCI for an extension of the Hospice Benefit Period.

II. Choosing Benefit Options

HSA PPO allows Enrollees to choose between two different health care coverage options:

A. ***Individual Option:*** Coverage for only one member of a household.

B. ***Family Option:*** Coverage for two or more members of a household.

III. Individual and Family Option Deductibles

The *Individual and Family Option* Deductible amounts are stated in the Benefits Outline. Expenses incurred for noncovered services are not applicable to the *Individual Option* or the *Family Option* Deductibles.

A. ***Individual Option****:* An enrolled individual's Deductible, as specified in the Benefits Outline, consists of the total dollars contributed toward eligible Covered Services per Benefit Period.

B. ***Family Option****:* An enrolled family's Deductible, as specified in the Benefits Outline, consists of the total dollars contributed toward eligible Covered Services per Benefit Period for all Insureds covered under the same *Family Option.* No Insured may contribute more than the *Individual* Deductible amount toward the Family Deductible.

Should the federal government adjust the Deductible for high deductible plans as defined by the Internal Revenue Service, the Deductible amount in this Policy will be adjusted accordingly.

IV. Out-of-Pocket Limit

The Out-of-Pocket Limits for the *Individual Option* and the *Family Option* are stated in the Benefits Outline. The Out-of-Pocket Limit shall be based upon an Insured's eligible Out-of-Pocket expenses incurred during one Benefit Period. Eligible Out-of-Pocket expenses shall include only the Insured's Copayments, Deductible and Coinsurance for eligible Covered Services. When the Out-of-Pocket Limit is met, benefits payable for Covered Services increase 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 Policy.

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 Policy, if any.
4. Noncovered services or supplies.

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 Policy, if any.
5. Prescription Drug Covered Services.
6. Noncovered services or supplies.
7. Vision care Covered Services.

Should the federal government adjust the Out-of-Pocket Limit for high deductible plans as defined by the Internal Revenue Service, the Out-of-Pocket Limit amount in this Policy will be adjusted accordingly.

V. Additional Amount of Payment Provisions

Except as specified elsewhere in this Policy, BCI shall provide the following benefits for Covered Services after an Insured has satisfied their individual Deductible or, if applicable, the family Deductible has been satisfied:

A. For In-Network Services: Unless stated otherwise, for 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 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 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 an Insured for amounts in excess of BCI's payment except for Deductibles, Coinsurance, 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 were rendered, BCI will base the payment on the Maximum Allowance and allow Out-of-Network benefits. Except as provided by the federal No Surprises Act, the Provider is not obligated to accept BCI's payment as payment in full, and BCI is not 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 an Insured for amounts in excess of BCI's payment except for Deductibles, Coinsurance, Copayments and noncovered services.

D. BCI is not responsible for the difference, if any, between BCI's payment and the actual charge, unless otherwise specified. Except as provided by the federal No Surprises Act, Insureds are responsible for any such difference, including Deductibles, Coinsurance, Copayments charges for noncovered services, and the amount charged by the Noncontracting Provider that is in excess of the Maximum Allowance.

VI. Providers

All Providers and Facilities must be licensed, certified, accredited and/or registered, where required, to render Covered Services. For the purposes of this Policy, Providers include any facility or individual who provides a Covered Service while operating within the scope of their license, certification, accreditation and/or registration under applicable state law, unless exempted by federal law.

Covered Services

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

The Benefits Outline, attached to this Policy, is an easy reference document that contains general payment information and a descriptive list of Covered Services. The following are Covered Services when obtained in accordance with the terms and conditions of this Policy. Benefits are subject to the Copayments, Deductibles, Coinsurance, visit limits, exclusions, limitations, and other provisions as specified in this Policy. Blue Cross of Idaho shall provide the payment levels specified in the Benefits Outline for the Covered Services listed in this section.

To be eligible for benefits, Covered Services must be Medically Necessary and must be provided to an eligible Insured under the terms of this Policy. Coverage includes Medically Necessary care and treatment of a Congenital Anomaly for newborn and newly adopted children.

I. Ambulance Transportation Services

Ambulance transportation services are covered for Medically Necessary transportation of an Insured within the local community by Ambulance under the following conditions:

1. From an Insured'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 Insured's home.
5. From a Skilled Nursing Facility to the Insured's home.

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

Air Ambulance transportation services are covered only when Medically Necessary when geographic restraints prevent Ground Ambulance transportation to the nearest facility that can provide Covered Services appropriate to the Insureds condition, or ground transportation would put the health and safety of the Insured at risk.

Ground Ambulance and Air Ambulance services that are not for an Emergency Medical Conditions must be Medically Necessary and require Prior Authorization.

II. Applied Behavioral Analysis (ABA) - Outpatient

Benefits are covered for ABA services by Providers, including those rendered by a Provider who has obtained a Board Certified Behavioral Analysis (BCBA) certification issued by the Behavioral Analyst Certification Board.

III. 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 an Insured 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 Insured; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

IV. 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 Insured 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 Insured. Supply items considered to be personal care items or common household items are not covered.

V. Chiropractic Care Services

a) 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:
   (1) Services are directly related to a written treatment regimen prepared and performed by a Chiropractic Physician.
   (2) Services must be related to recovery or improvement in function, with reasonable expectation that the services will produce measurable improvement in the Insured's condition in a reasonable period of time.

b) No benefits are provided for:
   (1) Surgery as defined in this Policy to include injections.
   (2) Laboratory and pathology services.
   (3) Range of motion and passive exercises that are not related to restoration of a specific loss of function.
   (4) Massage therapy, if not performed in conjunction with other modalities or manipulations.
   (5) Maintenance, palliative or supportive care.
   (6) Preventive or wellness care.
   (7) 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.
   (8) General exercise programs.
   (9) Diagnostic Services, except for x-rays to assist in the diagnosis and Neuromusculoskeletal Treatment plan as defined in this Policy.

VI. Dental Services Related to Accidental Injury

Dental services which are rendered by a Physician or Dentist and required as a result of Accidental Injury to the jaw, Sound Natural Tooth, mouth, or to the face. Such services are covered only for the twelve (12) month period immediately following the date of injury providing the Policy remains in effect during the twelve (12) month period. Temporomandibular joint (TMJ) disorder and injuries as a result of chewing or biting are not considered Accidental Injuries, unless the source of injury is an act of domestic violence. No benefits are available under this section for Orthodontia or orthognathic services.

Benefits are provided for repair of damage to a Sound Natural Tooth, lips, gums, and other portions of the mouth, including fractures of the maxilla or mandible. Repair or replacement of damaged dentures, bridges, or other dental appliances is not covered, unless the appliance must be modified or replaced due to Accidental Injury to a Sound Natural Tooth which are abutting the bridge or denture.

Benefits for dental services under this provision shall be secondary to dental benefits available to an Insured under another benefit section of this Policy or available under a dental policy of insurance, contract, or underwriting plan that is separate and distinct from this Policy.

VII. Diabetes Self-Management Education Services - Outpatient

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.

VIII. 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.

IX. Durable Medical Equipment (DME)

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 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. 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 Insured's condition. If the Insured and their 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 Insured. 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).

X. Hearing Aids

Hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for the fitting for congenital or acquired hearing loss if without intervention may result in cognitive or speech development deficits are a Covered Service for Eligible Dependent Children. Benefits are limited to one (1) device per ear, every three (3) years, and includes forty-five (45) speech therapy visits during the first twelve (12) months after delivery of the covered device.

XI. Home Health Skilled Nursing Care Services

The delivery of Skilled Nursing Care services under the direction of a Physician to a Homebound Insured, provided such provider does not ordinarily reside in the Insured's household or is not related to the Insured by blood or marriage. The services 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 Insured is receiving Hospice Covered Services.

XII. Hospice Services

A. **Conditions**

An Insured must specifically request Hospice benefits and must meet the following conditions to be eligible:

1. The attending or primary Physician must certify that the Insured is a terminally ill patient with a life expectancy of six (6) months or less.
2. The Insured must live within the Hospice's local geographical area.
3. The Insured must be formally accepted by the Hospice.
4. The Insured must have a designated volunteer Primary Care Giver at all times.

XIII. Hospital Services - Inpatient

The following are Covered Services:

A. Room, Board and General Nursing Services

Room and board, special diets, the services of a dietician, and general nursing service when an Insured 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 Policy and is the sole responsibility of the Insured.
2. If isolation of the Insured is: (a) required by the law of a political jurisdiction, or (b) required to prevent contamination of either the Insured or another patient by the Insured, 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. Prescription Drugs administered while the Insured 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 an Insured; whole blood or blood plasma that is not donated on behalf of the Insured or replaced through contributions on behalf of the Insured.
4. Anesthesia, anesthesia supplies, and services rendered by the Licensed General Hospital as a regular Hospital service and billed by the Licensed General 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 a Covered Service 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 as specified in their respective sections in this Policy.

If Diagnostic Services or Therapy Services furnished through a Licensed General Hospital are provided in part or in full by a Physician under contract with the Licensed General Hospital to perform such services, and the Physician bills separately for such services, the Physician's services shall be a Covered Service.

XIV. Hospital Services - Outpatient

The following are Covered Services:

A. Emergency Services

Medical care to treat an Emergency Medical Condition or an Accidental Injury. Emergency room services include:

- Emergency room Physician and Facility services;
- Freestanding Emergency Department;
- Post-Stabilization Care Services;
- Equipment, supplies and drugs used in the emergency room;
- Inpatient Admission that is necessary even after Stabilization;
- Services and exams for Stabilization of an Emergency Medical Condition; and
- Equipment and devices, telemedicine services, Diagnostic Services, preoperative and postoperative services, and other items and services, rendered during the Emergency room visit.

For purposes of this section, Stabilization means that no material deterioration of the Emergency Medical Condition is likely to result from or occur during the transfer of the Insured from a facility.

B. Surgery

Licensed General Hospital or Ambulatory Surgical Facility services and supplies including removal of sutures, anesthesia, anesthesia supplies, and services rendered by an employee of the Licensed General Hospital or Ambulatory Surgical Facility who is not the surgeon or surgical assistant, in conjunction with a procedure that is a Covered Service.

C. Therapy Services as specified in the Therapy Services section of this Policy.

XV. Hospital Services - Special Services

A. Preadmission testing

Tests and studies required with the Insured'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 an Insured's Inpatient admission.

Preadmission Testing is a Covered Service only if the services are not repeated when the Insured 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 Insured 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. Dental Related Services

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 Insured. 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.

XVI. Inpatient Rehabilitation or Habilitation Services

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

A. Admission for Inpatient Physical Rehabilitation must occur within one hundred twenty (120) days of discharge from an Acute Care Licensed General Hospital.

B. 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.

XVII. Maternity Services and/or Involuntary Complications of Pregnancy

Diagnostic x-ray and laboratory services related to pregnancy, childbirth or, miscarriage are covered.

Nursery care of a newborn infant is not a maternity service.

A. 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.

B. Involuntary Complications of Pregnancy

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

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

XVIII. Medical Foods

Medical Foods for inborn errors of metabolism such as Phenylketonuria (PKU) or when a Provider has diagnosed the presence of inadequate nutritional oral intake related to a medical condition or due to a progressive impairment of swallowing or digestion.

XIX. Medical Services - Inpatient

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

Consultation services when rendered to an Insured 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.

XX. Medical Services - Outpatient

The following Outpatient medical services rendered by a Physician or other professional Provider to an Insured who is an Outpatient, provided such services are not related to pregnancy, Chiropractic Care,

Mental or Nervous Conditions and/or Substance Use Disorder or Addiction except as provided specifically elsewhere in this Policy.

A. **Home and Other Outpatient Visits**
Medical care visits and consultations for the examination, diagnosis, or treatment of a condition, Injury, Disease, or Illness.

B. **Physician Office Visits**
Medical care visits and consultations for the examination, diagnosis, or treatment of a condition, Injury, Disease, or Illness.

C. **Special Therapy Services**
Deep Radiation Therapy or Chemotherapy for a malignancy when such therapy is performed in the Physician's office.

D. **Other Therapy Services**
Other Therapy Services as specified in the Therapy Services section of this Policy.

E. **Telehealth Virtual Care Services**

XXI. Mental Health and Substance Use Disorder Services

1. Covered Mental Health and Substance Use Disorder services include Inpatient, Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP), Residential Treatment Center, Outpatient evaluation, management and Psychotherapy, psychological testing/neuropsychological evaluation testing and Inpatient and Outpatient Electroconvulsive Therapy (ECT).

2. **Inpatient Mental Health and Substance Use Disorder 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 Use Disorder or Addiction, or any combination of these.

3. **Outpatient Mental Health and Substance Use Disorder 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 Use Disorder or Addiction, or any combination of these. The use of Hypnosis to treat an Insured'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 Psychotherapy.

XXII. 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, or Licensed Physical Therapist, 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 Insured's condition.

For Insureds with Diabetes, when prescribed by a Licensed Provider, Covered Services include therapeutic shoes and inserts. Benefits are limited to the following, per Benefit Period: one (1) pair of custom-molded shoes and inserts, (1) one pair of extra-depth shoes, two (2) additional pairs of inserts for custom-molded shoes, and three (3) pairs of inserts for extra-depth shoes.

XXIII. Palliative Care Services

An Insured, or a Provider on behalf of the Insured, must specifically request services for Palliative Care. Palliative Care Covered Services are covered when a Provider has assessed that an Insured is in need of Palliative Care for a serious Illness (including remission support), life-limiting injury or end-of-life care, and is limited to the following:

A. Acute Inpatient, Skilled Nursing Facility or Rehabilitation based Palliative Care services.
B. Home Health pain and symptom management services.
C. Home Health psychological and social services including individual and family counseling.
D. Caregiver support rendered by a Provider to an Insured.
E. Advanced care planning limited to face-to-face services between a Provider and an Insured to discuss the Insured's health care wishes if they become unable to make decisions about their care.

XXIV. Post-Mastectomy/Lumpectomy Reconstructive Surgery

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

A. Reconstruction of the breast on which the mastectomy/lumpectomy was performed;
B. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
C. 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 Insured.

XXV. 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:

A. Over-the-counter items including, but not limited to condoms, spermicides, and sponges.
B. Prescribed contraceptives that could otherwise be purchased over-the-counter.
C. Oral contraceptive prescription drugs and other prescription hormonal contraceptives. See Prescription Drug Benefit Section for oral contraceptive benefits.

XXVI. Preventive Services

Benefits are provided for:

A. Preventive Care Covered Services, including services, screenings and tests that have received a rating of A or B to the extent recommended by the U.S. Preventive Services Task Force and Health Resources and Services Administration. Further information and specifically listed Preventive Care Covered Services are available on the BCI Website, www.bcidaho.com. The specifically listed Preventive Care Services on the BCI Website may be adjusted accordingly to coincide with federal government changes, updates, and revisions.
B. Immunizations as specifically listed on the BCI Website, www.bcidaho.com. All Immunizations are limited to the extent **recommended** by the Advisory Committee on Immunization Practices (ACIP) and may be adjusted accordingly to coincide with federal government changes, updates and revisions. Other immunizations not specifically listed on the BCI Website may be covered at the discretion of BCI when Medically Necessary and approved by the BCI Pharmacy and Therapeutics Committee.

XXVII. 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:

A. 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 Insured's condition. If the Insured and their 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 Insured.
B. No benefits are provided for dental appliances or major Artificial Organs, including but not limited to, artificial hearts and pancreases.
C. 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.
D. Benefits for required contact lens or a pair of eyeglasses for treatment of Keratoconus.
E. 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.

XXIII. 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, including twenty-four (24) hour onsite nursing services. If an Insured is admitted for Skilled Nursing Services, the contract terms in effect on the date of the admission will apply to the Skilled Nursing Facility visit for the entire Inpatient stay. However, if an Insured's admission crosses Benefit Periods and the previous Benefit Period limit has been exhausted, BCI will credit the new Benefit Period limit without discharge. Skilled Nursing Facility care does not include Custodial Care, supervised living, or other similar facilities providing primarily a supportive and/or recreational environment, even if some Skilled Nursing Care is provided in such facilities. No benefits are provided when the care received consists primarily of:

A. Room and board, routine nursing care, training, supervisory or Custodial Care.
B. Care for senile deterioration, mental deficiency, or intellectual disability.
C. Care for Mental or Nervous Conditions and/or Substance Use Disorder or Addiction.
D. Maintenance Physical Therapy, hydrotherapy, Speech Therapy, or Occupational Therapy.

XXIX. Sleep Study Services

Services rendered, referred, or prescribed by a Physician to diagnose a sleep disturbance or disorder. Services may be performed in a sleep laboratory, monitored by a qualified Sleep Study technician or through a home Sleep Study, via a portable recording device.

XXX. Surgical Services

A. Surgical Services
1. Surgery performed by a Physician or other professional Provider.
2. Benefits for multiple surgical procedures performed during the same operative session by one or more Physicians or other professional Providers shall be calculated based upon Blue Cross of Idaho's Maximum Allowance and payment guidelines.

B. 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.

C. 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.

D. 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.

E. 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 Insured'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.

XXXI. Therapy Services

Benefits for Therapy Services include:

A. Chemotherapy

B. Growth Hormone Therapy

C. Home Intravenous Therapy (Home Infusion Therapy)
Benefits are limited to medications, services and/or supplies provided to or in the home of the Insured, 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.

D. Occupational Therapy
1. Payment is limited to Occupational Therapy services related to Habilitative and Rehabilitative care where there is a reasonable expectation that the services will produce measurable improvements in the Insured's condition in a reasonable period of time. Occupational Therapy Services are covered when performed by:
   a) A Physician.
   b) A Licensed Occupational Therapist provided the Covered Services are related directly to a written treatment regimen prepared by a Licensed Occupational Therapist and approved by a Physician.
2. No benefits are provided for:
   a) 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.
   b) 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.

E. Physical Therapy
1. Payment is limited to Physical Therapy services related to Habilitative and Rehabilitative care where there is a reasonable expectation that the services will produce measurable

improvements in the Insured's condition in a reasonable period of time. Physical Therapy Services are covered when performed by:

a) A Physician;
b) A Licensed Physical Therapist provided the Covered Services are related directly to a written treatment regimen prepared by the Physical Therapist.
c) A Podiatrist.

2. No benefits are provided for:
   a) The following Physical Therapy services when the specialized skills of a Licensed Physical Therapist are not required:
      (1) Range of motion and passive exercises that are not related to the restoration of a specific loss of function but are useful in maintaining range of motion in paralyzed extremities.
      (2) Assistance in walking, such as that provided in support for feeble or unstable patients.
   b) 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; or
   c) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a registered Physical Therapist.
3. Maintenance, palliative or supportive care.
4. Behavioral modification services.

F. Psychotherapy

Benefits are available for access to evidence-based Psychotherapies for Mental or Nervous Conditions, Alcoholism, or Substance Use Disorder or Addition disorders applied with the intent of improving functionality and symptom control. Psychotherapy is based on first a psychiatric evaluation, problem identification and then a resulting treatment plan focused on improving functionality. Psychotherapy services are covered when performed by either of the following:

a) Licensed behavioral health professional, (e.g. psychiatrist, Clinical Psychologist, Nurse Practitioners, social worker, Licensed Marriage and Family Therapist (LMFT), substance use counselor, etc).
b) Physicians and Nurse Practitioners in general medical settings.

G. Radiation Therapy

H. Renal Dialysis

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.

I. Speech Therapy

1. Benefits shall be limited to Speech Therapy services related to Habilitative and Rehabilitative care and cochlear implant therapy, where there is a reasonable expectation that the services will produce measurable improvement in the Insured's condition in a reasonable period of time.
2. Speech Therapy services are covered when performed by:
   a) A Physician.
   b) A Speech Therapist provided the services are related directly to a written treatment regimen designed by the Speech Therapist.
   c) No benefits are provided for:
      1. Maintenance, palliative or supportive care.
      2. Behavioral modification services.

XXXII. Transplant Services

A. **Autotransplants**

Autotransplants of arteries, veins, ear bones (ossicles), cartilage, muscles, skin hematopoietic, CAR T-Cell, and tendons; teeth or tooth buds, and other autotransplants as Medically Necessary.

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.

B. **Transplants**

Transplants of corneas, kidneys, bone marrow, livers, hearts, lungs, pancreas, islet tissue, hematopoietic, heart/lung and pancreas/kidney combinations, and other solid organ or tissue Transplants or combinations, and other Transplants as Medically Necessary.

1. The applicable benefits provided for Hospital and Surgical/Medical Services are provided for a recipient of Medically Necessary Transplant services.
2. The recipient must have the Transplant performed at an appropriate Recognized Transplant Center to be eligible for benefits for Transplant(s). 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.
3. 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 an Insured). Benefits for the donor will be charged to the recipient's coverage.
4. A travel allowance may be available for the Insured and one adult caregiver for those Insureds traveling to a Blue Distinction Centers for Transplants (BDCT), or in the case of a kidney transplant from a Recognized Transplant Center. Transplant Services must be Prior Authorized by BCI. The Insured will be notified of their eligibility for this travel allowance upon Prior Authorization of the scheduled Transplant services.

XXXIII. Treatment for Autism Spectrum Disorder

Treatment for Autism Spectrum Disorder, and related diagnoses.

PRESCRIPTION DRUG BENEFITS SECTION

This Prescription Drug Benefits Section specifies the benefits an Insured is entitled to receive for Covered Services described in this section, subject to all of the other provisions of this Policy.

Rx Savings Solutions. A new way to save on your Prescription Drug costs. Rx Savings Solutions is linked to your BCI Contract, so everything is personalized according to your medications and insurance.
How it Works:

- Rx Savings Solutions looks at the medications you take and finds other options that may save you money.
- Your online account shows which lower-cost prescriptions are available and lets you compare prices.
- Switch to a lower-cost option with ease. Rx Savings Solutions will handle everything with your doctor and pharmacy.
- Rx Savings Solutions will contact you anytime you can be spending less.

I. Prescription Drug Copayment/Coinsurance/Deductible

For the types and levels of benefits coverage regarding Prescription Drugs, see the Benefits Outline.

Diabetic Supplies:
Insulin syringes/needles have no Copayment if purchased within ninety (90) days of insulin purchase. All other supplies will be subject to applicable Coinsurance, Copayment and/or Deductible.

II. Providers

The following are Providers under this section:
Licensed Pharmacist
Participating Pharmacy/Pharmacist
Physician

III. 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, certain prescriptions and Prescription Drugs may be subject to more restrictive day-supply and allowed quantity limitations.

Mail Order:
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 day-supply and allowed quantity limitations. In addition, certain Prescription Drugs may not be available under this Policy by mail order due to circumstances such as unstable shelf life, and required special storage conditions.

IV. Amount of Payment

BCI or its designated Pharmacy Benefits Manager (PBM), 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 Copayment, Coinsurance and/or Deductible, if applicable 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 Insured is responsible for paying for the Prescription Drug at the time of purchase and must submit a claim to BCI or its PBM. The amount of payment for a covered Prescription Drug is the balance remaining after subtracting the Prescription Drug Copayment, Coinsurance and/or Deductible, if applicable, from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

C. Submission of a prescription to a pharmacy is not a claim. If an Insured receives Covered Services from a pharmacy and believes that the Copayment, Coinsurance or other amount is incorrect, the Insured may then submit a written claim to BCI requesting reimbursement of any amounts the Insured believes were incorrect. Refer to the Inquiry And Appeals Procedures in the General Provisions Section of this Policy.

D. The amount of payment for a covered Prescription Drug dispensed by an approved mail order Participating Pharmacy is the balance remaining after subtracting the Prescription Drug Copayment,

Coinsurance and/or Deductible, if applicable, from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

V. Mandatory Generic Drug Substitution

Certain Prescription Drugs are restricted to Generics for payment by BCI. Even if the Insured, the Physician or other duly licensed Provider requests the Brand Name Drug, the Insured is responsible for the difference between the price of the Generic and Brand Name Drug, plus any applicable Brand Name Drug Deductible/Copayment/Coinsurance. 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.

VI. Utilization Review

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

VII. Prior Authorization

Certain Prescription Drugs may require Prior Authorization. If the Insured's Physician or other Provider prescribes a drug, which requires Prior Authorization, the Insured will be informed by the Provider or Pharmacist. To obtain Prior Authorization the Insured's Physician must notify BCI or its designated agent, describing the Medical Necessity for the prescription. BCI or its designated agent, will respond to a request for Prior Authorization received from either the Insured's Physician or the Insured within seventy-two (72) hours for an expedited request or fourteen (14) days for a standard request of the receipt of the medical information necessary to make a determination.

VIII. 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 Insured's Effective Date. Benefits for Prescription Drugs are available up to the dispensing limitations stated in Item III. of this section.

Smoking cessation Prescription Drugs are a Covered Service.

IX. Definitions

A. **Allowed Charge**—the amount payable for a Prescription Drug dispensed to an Insured based on the reimbursement formula determined between BCI and its PBM plus the dispensing fee for a Prescription Drug dispensed by a retail pharmacy.

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 Insured'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 in accordance with the Pharmacy and Therapeutics Committee clinical review. This list is managed and subject to periodic review and amendment by Blue Cross of Idaho and the Pharmacy and Therapeutics Committee. Prescription Drugs covered by the Prescription Drug Benefit are organized into tiers. Generally, lower tiers contain Prescription Drugs that are more Cost Effective and provide a greater value when considering both clinical and financial attributes while higher tiers contain Prescription Drugs that are generally more expensive. Prescription Drugs on lower tiers may include a greater proportion of Preferred and Non-Preferred Generic Drugs while Prescription Drugs on higher tiers may include more Preferred and Non-Preferred Brand Name Drugs and Specialty Prescription Drugs.

ACA Preventive Drugs– ACA Mandated Preventive Drugs as specifically listed on the BCI Formulary on the BCI Website, www.bcidaho.com.

Prescribed Contraceptives – Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Formulary on the BCI Website, www.bcidaho.com. The day supply allowed shall not exceed a 90 day supply at one (1) time, as applicable to the specific contraceptive drug or supply.

BCI allows the right to request an exception for any FDA-approved, cleared or granted contraceptive not included on BCI's formularies or one that is included with cost sharing. Under the exceptions process, if an Insured's attending Provider recommends a particular FDA-approved, cleared or granted contraceptive based on a determination of Medical Necessity with respect to that Insured, BCI will cover that service or item without cost sharing. Contact Customer Service at the telephone number listed on the back of the Enrollee's Identification card to obtain the appropriate request form.

HSA Preventive Prescription Drugs - HSA Preventive Prescription Drugs as specifically listed on the BCI Formulary on the BCI Web site, www.bcidaho.com.

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. **Maintenance Prescription Drug**—a Prescription Drug, as determined by BCI or its designated agent, that an Insured takes on a regular or long-term basis for treatment of a chronic or on-going medical condition. It is not a Prescription Drug that an Insured takes for treatment of an acute medical condition.

H. **Nonparticipating Pharmacy/Pharmacist**—a Licensed Pharmacist, a retail, mail-order or Specialty Pharmacy that has not entered into a contract with BCI's PBM for the purpose of providing Prescription Drug Covered Services to Insureds under this Policy.

I. **Participating Pharmacy/Pharmacist**—a Licensed Pharmacist, a retail, mail-order or Specialty Pharmacy that has a contract with BCI's PBM for the purpose of providing Prescription Drug Covered Services to Insureds under this Policy.

J. **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 Policy.

K. **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."

L. **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; and
g. may require additional support and coordinated case management.

M. **Specialty Pharmacy**—a duly licensed Pharmacy that primarily dispenses Specialty Drugs.

N. **Usual Charge**—the lowest retail price being charged by a Licensed Pharmacist for a Prescription Drug at the time of purchase by an Insured.

If an Insured receives a discount , direct or indirect support, 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 Insured's applicable Deductible amounts, and will not be applied to the Insured's Out of Pocket Limit for this Policy.

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

Payments made on an Insured's behalf from 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 Insureds 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 Insured'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 Insureds applicable Deductible and/or Out-of-Pocket Limit, the Insured is encouraged to provide notification to BCI if they receive any form of assistance for payment of their premium, Coinsurance, Copayment or Deductible amounts.

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

PEDIATRIC VISION CARE BENEFITS SECTION
(VCSV)

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

I. Eligibility

Pediatric Vision Care Benefits are available through the end of the month following the Insured's nineteenth (19^{th}) birthday.

II. Coinsurance and Limitations on Frequency of Services

The Coinsurance amounts and limitations on frequency of services are shown in the Benefits Outline.

III. Providers

The following are Providers under this section:

- Optometrist (OD)
- Ophthalmologist (MD or DO)

IV. Procedures for Obtaining Covered Services

A. An Insured must contact the Vision Care Services Vendor (VCSV) Participating Provider to make an appointment to receive Covered Services. The doctor is responsible for verifying eligibility and obtaining the necessary authorization from the VCSV prior to the delivery of service. Each authorization is valid for fifteen (15) days. An Insured must provide the Participating Provider sufficient information to verify eligibility. Failure of the Insured to provide sufficient information may delay services and may affect benefit payment under this Policy.

B. Should the Insured obtain services from a Nonparticipating Provider, the Insured is responsible for making payment in full to the Provider and will be reimbursed by the VCSV in accordance with the benefits available for Covered Services under this section.

V. Covered Services

When rendered by a Provider, benefits are provided for the following services:

A.	Eye Examination	**E.**	Lined Bifocal Lenses*
B.	Frame	**F.**	Lined Trifocal Lenses*
C.	Single Vision Lenses*	**G.**	Contact Lens Exam and Contact Lenses in
D.	Lenticular Lenses*		place of eyeglasses

*Coverage includes Lenses in polycarbonate, plastic or glass. Scratch resistant and ultraviolet (UV) coatings also covered

A. Eye Examination

An eye vision examination regardless of its Medical Necessity, including but not limited to, the following services:

(NOTE: Each test may not be indicated for every patient.)

1. **Comprehensive Examination**—evaluation of the complete visual system with or without cycloplegia or mydriasis.
2. **Intermediate Examination**—brief or limited routine check-up or vision survey.
3. **Vision Analysis**—various tests for prescription Lenses.
4. **Tonometry**—measurement of eye tension for glaucoma.
5. **Biomicroscopy**—examination of the living eye tissue.
6. **Central And/Or Peripheral Field Study**—measurement of visual acuity in the central and/or peripheral field of vision.
7. **Dilation—**allows for a better view inside the eye, i.e., optic nerve blood vessels, etc.

B. Prescribed Lenses and Frames

When an eye examination indicates that new Lenses or a new Frame or both are necessary for the proper visual health and welfare of an Insured, they will be supplied, together with such professional services as necessary, which include but are not limited to:

1. Prescribing and ordering proper Lenses.
2. Assisting in the selection of a Frame.
3. Verifying the accuracy of the finished Lenses.
4. Proper fitting and adjustment of the eyeglasses.

The VCSV will limit the selection of Frames provided by Participating Providers. All Frames have a one-year manufacturer's warranty, and Lenses come with polycarbonate, scratch coating and ultraviolet (UV) protection included. If an Insured selects a Frame other than a Frame included in the allowed selection, the Nonparticipating Provider benefit level will be applied.

C. Contact Lenses

1. **Medically Necessary Contact Lenses**—Medically Necessary Contact Lenses are covered for Insureds when specific benefit criteria are satisfied and when prescribed by Insured's Participating Provider.

   When the Participating Provider receives prior approval for such cases, they are fully covered by the VCSV and are in place of the benefits described for Prescribed Lenses and Frames.

2. **Elective Contact Lenses**—if an Insured chooses Contact Lenses from a Participating Provider for reasons other than those mentioned above, VCSV provides benefits as follows:
   In lieu of eyeglasses as described for Prescribed Lenses and Frames, elective Contact Lens services and materials are covered with the following service limitations:
   - Contact Lens Exam services (Fitting and evaluation) covered once per frequency period
   - Standard (one pair annually) = 1 Contact Lens per eye (total 2 lenses)
   - Monthly (six-month supply) = 6 Lenses per eye (total 12 lenses)
   - Bi-weekly (three-month supply) = 6 Lenses per eye (total 12 lenses)
   - Dailies (three-month supply) = 90 Lenses per eye (total 180 lenses)

   Contact Lenses are provided in place of spectacle lens and Frame benefits available herein.

3. **Reimbursement Allowance**—For Covered Services rendered by a Nonparticipating Provider, a determination of Medically Necessary versus Elective Contact Lenses will be consistent with Participating Provider services. Reimbursement for Medically Necessary and Elective Contact Lenses include a Contact Lens evaluation fee, fitting costs, and materials and is in place of all other benefits for materials, including eyeglass Lenses and Frame.

VI. Additional Amount of Payment Provisions

A. The VCSV will pay the Participating Provider directly in accordance with the agreement between the VCSV and the Participating Provider.

A Participating Provider shall not make an additional charge to an Insured for amounts in excess of VCSV's payment except for noncovered services and amounts above the Contact Lens materials coverage and service limitations.

B. If Covered Services are rendered by a Nonparticipating Provider:

1. The Insured is responsible for paying the Provider in full. The Insured will be reimbursed in accordance with the benefits available, if any, as shown in the Benefits Outline.

2. The Nonparticipating Provider is not obligated to accept VCSV's payment as payment in full. VCSV and Blue Cross of Idaho (BCI) are not responsible for the difference, if any, between VCSV's payment and the actual charge, any such difference is the Insured's responsibility.

3. Benefits for Covered Services are subject to the same time and supply limits as those described for Covered Services received from a Participating Provider. Covered Services obtained from a Nonparticipating Provider are in place of obtaining services from a Participating Provider.

VII. Definitions

A. Blended Lenses—bifocals that do not have a visible dividing line.
B. Coated Lenses—a substance added to a finished lens on one (1) or both surfaces.
C. Contact Lenses—ophthalmic corrective Lenses (either glass or plastic, ground or molded). They must be prescribed by an Optometrist or Ophthalmologist to be directly fitted to the Insured's eye.
D. Frame—a standard eyeglass Frame adequate to hold Lenses.
E. Lenses—ophthalmic corrective Lenses (either glass or plastic, ground or molded). They must be prescribed by an Optometrist or Ophthalmologist to improve visual acuity or performance and to be

fitted to a Frame. Amounts payable are based on a lens blank not more than sixty-one (61) millimeters in diameter, tinted no darker than the equivalent of Pink #1 or #2 and without photosensitive or anti-reflective properties.

F. **Nonparticipating Provider**—a Provider that has not entered into a written agreement with the VCSV regarding payment for Covered Services rendered to an Insured under this Policy.

G. **Orthoptics**—the teaching and training process for improvement of visual perception and coordination of the two (2) eyes for efficient and comfortable binocular vision.

H. **Participating Provider**—a Provider that has entered into a written agreement with the VCSV regarding payment for Covered Services rendered to an Insured under this Policy.

I. **Photochromic Lenses**—Lenses that change color with intensity of sunlight.

J. **Plano Lenses**— Lenses with refractive correction of less than ± .50 diopter.

K. **Tinted Lenses**—Lenses that have an additional substance added to produce constant tint.

L. **Vision Care Services Vendor (VCSV)**—an entity contracting with BCI to provide Vision Care Services to its Insureds.

VIII. Enrollee's Options

When an Insured selects any of the following options, VCSV pays the basic cost of the allowed Lenses, and the Insured is responsible for paying the additional costs for the following options:

1. Blended Lenses.
2. Contact Lenses, except as provided in this section.
3. Oversize Lenses.
4. Photochromic Lenses.
5. Tinted Lenses except Pink #1 and Pink #2.
6. Coating of the lens or Lenses.
7. Laminating of the lens or Lenses.
8. A Frame not included in the VCSV allowed selection.
9. Cosmetic Lenses.
10. Optional cosmetic processes.
11. Polycarbonate Lenses (except for Eligible Dependent Children).

IX. Inquiry and Appeals Procedures (For Pediatric Vision Care Services)

A. Informal Inquiry

For Pediatric Vision Care Benefits, BCI has delegated certain activities, including Appeals, to the VCSV, though BCI retains ultimate responsibility over these activities. For any initial questions concerning a claim, an Insured should call the VCSV phone number 800-877-7195. If the VCSV cannot resolve the Insured's concern to their satisfaction, the Insured or the Insured's authorized representative may submit a written request to the VCSV for review. A written request can be made by completing the form available on www.vsp.com Website or by sending the written request by mail to the VCSV at: Vision Service Plan, Attention: Complaint and Grievance Unit, PO Box 997100, Sacramento, CA 95899-7100. Verbal requests can be made by calling the VCSV phone number.

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

B. Formal Appeal

An Insured who wishes to formally appeal a Pre-Service Claim decision by BCI 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 Insured 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, physician designee, or a VCSV designee. For non-urgent claim appeals, BCI or a VCSV designee will mail a written reply to the Insured 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 Insured 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 Insured 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 or its VCSV designee's mailing of the initial reconsideration decision. A BCI Medical Director or its VCSV designee 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. An Insured who wishes to formally appeal a Post-Service Claims decision by BCI 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 Insured contends BCI's or a VCSV designee'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 Medical Director or physician designee if the appeal requires medical judgment. BCI or a VCSV designee shall mail a written reply to the Insured 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 Insured 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 Insured 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 (or a VCSV designee's) mailing of the initial reconsideration decision. A BCI Medical Director who is not the subordinate to the Medical Director, physician designee, or a VCSV 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. External Review

At BCI's discretion, an additional review is available for Adverse Benefit Determinations based upon medical issues including medical necessity and investigational treatment. An Insured must first exhaust both levels of the formal appeals process before submitting a request for External Review to the Appeals and Grievance Coordinator. A request for External Review must be sent within sixty (60) days of the date of Blue Cross of Idaho's second formal written appeal decision. External Review will be made by an impartial provider, associated with an independent review organization, who practices in the same or a similar specialty as the one involved in the review. The Independent Review Organization will issue a determination within sixty (60) days of receipt of the request for External Review.

Submission of an appeal for External Review is voluntary and does not affect an Insured's right to file a civil action under section 502(a) of the Employee Retirement Income Security Act (ERISA) following the exhaustion of the formal appeals process, except that the time to file such action shall be tolled while the External Review is pending

GENERAL EXCLUSIONS AND LIMITATIONS

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

I. General Exclusions and Limitations

No benefits will be provided 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 Insured. However, the Insured 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 Insured has a non-dental, life-endangering condition which makes hospitalization necessary to safeguard the Insured'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 Insured 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 Insured claims such benefits or compensation or recovers losses from a third party.

G. Provided or paid for by any federal governmental entity or unit except when payment under this Policy is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefore would vary, or are or would be affected by the existence of coverage under this Policy.

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 Insured by blood or marriage and who ordinarily dwells in the Insured'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 an Insured who is a dependent child.
3. Benefits for reconstructive Surgery to correct an Accidental Injury are available even though the accident occurred while the Insured was covered under a prior insurer’s coverage.

L. Rendered prior to the Insured's Effective Date.

M. For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance) even if prescribed by a Physician.

N. For exercise or relaxation 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.

O. For convenience items including but not limited to Durable Medical Equipment such as bath equipment, cold therapy units, duplicate items, home traction devices, or safety equipment.

P. For relaxation or exercise therapies, including but not limited to, educational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, homeopathic, or naturopathic, massage, or music.

Q. Recreational therapy or therapeutic recreation programs, which can include, but are not limited to, diabetes camps, adventure therapy, and/or wilderness therapy (which can include, but are not limited to, programs for outdoor behavioral health, childhood diabetes, and childhood cancer).

R. For telephone consultations, and all computer or Internet communications, except as provided by or in connection with Telehealth Virtual Care Services.

S. For failure to keep a scheduled visit or appointment; for completion of a claim form; for interpretation services; or for personal mileage, transportation, food or lodging expenses unless specified as a Covered Service in this Policy, or for mileage, transportation, food or lodging expenses billed by a Physician or other Professional Provider

T. For Inpatient admissions that are primarily for Diagnostic Services or Therapy Services; or for Inpatient admissions when the Insured is ambulatory and/or confined primarily for bed rest, special diet, environmental change or for treatment not requiring continuous bed care.

U. 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 Policy.

V. 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).

W. 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 Policy.

X. For hearing aids or examinations for the prescription or fitting of hearing aids, except as specified as a Covered Service in this Policy.

Y. For any treatment of sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence, except as related to a prostatectomy.

Z. Made by a Licensed General Hospital for the Insured's failure to vacate a room on or before the Licensed General Hospital's established discharge hour.

AA. Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.

AB. Furnished by a facility that is primarily a nursing home, a convalescent home, or a rest home.

AC. For Acute Care, Rehabilitative care, diagnostic testing except as specified as a Covered Service in this Policy; for Mental or Nervous Conditions and Substance Use Disorder or Addiction services not recognized by the American Psychiatric and American Psychological Associations.

AD. 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 Policy;
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;
4. For alveolectomy or alveoloplasty when related to tooth extraction.

AE. For weight control or treatment of obesity or morbid obesity, even if Medically Necessary, including but not limited to Surgery for obesity. For reversals or revisions of Surgery for obesity, except when required to correct a life-endangering condition.

AF. 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 Policy.

AG. For the reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties.

AH. Treatment for reproductive procedures, including but not limited to, ovulation induction procedures and pharmaceuticals, intrauterine insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance an Insured's reproductive ability, including but not limited to laboratory services, radiology services or similar services related to treatment for reproduction procedures.

AI. For Transplant services and Artificial Organs, except as specified as a Covered Service under this Policy.

AJ. For acupuncture.

AK. 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 Policy, if any. Additionally, reversals, revisions, and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.

AL. For Hospice, except as specified as a Covered Service in this Policy.

AM. For pastoral, spiritual, bereavement, or marriage counseling.

AN. For homemaker and housekeeping services or home-delivered meals.

AO. 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.

AP. For treatment or other health care of any Insured in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Insured to Covered Services under this Policy, if and to the extent those benefits are payable to or due the Insured 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 policy 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 Insured, and the Insured's heirs and personal representative against all insurers, underwriters, self-insurers or other such obligors contractually liable or obliged to the Insured, or their estate for such services, supplies, drugs or other charges so provided by BCI in connection with such Illness, Disease, Accidental Injury or other condition.

AQ. For which an Insured would have no legal obligation to pay in the absence of coverage under this Policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage, or charges in connection with work for compensation or charges; or for which reimbursement or payment is contemplated under an agreement with a third party.

AR. 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 for any employment related purpose; 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, except as specified as a Covered Service in this Policy.

AS. For immunizations, except as specified as a Covered Service in this Policy.

AT. For breast reduction Surgery or Surgery for gynecomastia.

AU. For nutritional supplements.

AV. 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 an Insured, or except as specified as a Covered Service in this Policy.

AW. For vitamins and minerals, unless required through a written prescription and cannot be purchased over the counter.

AX. For an elective abortion, except to preserve the life of the Insured upon whom the abortion is performed.

AY. For alterations or modifications to a home or vehicle.

AZ. For special clothing, including shoes (unless permanently attached to a brace).

AAA. 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.

AAB. Provided outside the United States, which if had been provided in the United States, would not be a Covered Service under this Policy.

AAC. For Outpatient cardiac Rehabilitation, unless specified as a Covered Service in this Policy.

AAD. For complications arising from the acceptance or utilization of services, supplies or procedures that are not a Covered Service.

AAE. For the use of Hypnosis, as anesthesia or other treatment, except as specified as a Covered Service.

AAF. 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 Policy.

AAG. For arch supports, orthopedic shoes, and other foot devices, unless specified as a Covered Service in this Policy.

AAH. For wigs.

AAI. For cranial molding helmets, unless used to protect post cranial vault surgery.

AAJ. 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.

AAK. For the purchase of Therapy or Service Dogs/Animals and the cost of training/maintaining said animals.

AAL. For procedures including but not limited to breast augmentation, liposuction, Adam's apple reduction, rhinoplasty and facial reconstruction and other procedures considered cosmetic in nature.

AAM. Any newly FDA approved Prescription Drug, biological agent, or other agent until it has been reviewed and implemented by BCI's Pharmacy and Therapeutics Committee.

AAN. For the treatment of injuries sustained while operating a motor vehicle under the influence of alcohol and/or narcotics. For purposes of this Policy exclusion, "Under the influence" as it relates to alcohol means having a whole blood alcohol content of .08 or above or a serum blood alcohol content of .10 or above as measured by a laboratory approved by the State Police or a laboratory certified by the Centers for Medicare and Medicaid Services. For purposes of this Policy exclusion, "Under the influence" as it relates to narcotics means impairment of driving ability caused by the use of narcotics not prescribed or administered by a Physician.

AAO. All services, supplies, devices and treatment that are not FDA approved.

AAP. Any services, interventions occurring within the framework of an educational program or institution; or provided in or by a school/educational setting; or provided as a replacement for services that are the responsibility of the educational system

II. Prescription Drug Exclusions and Limitations

In addition to any other exclusions and limitations of this Policy, the following exclusions and limitations apply to Prescription Drug Services. No benefits are available under this Policy for the following:

A. Drugs used for the termination of early pregnancy, and complications arising there from, except when required to correct an immediately life-endangering condition.

B. 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 Policy. 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 Insured for any other over-the-counter drug or medication.

C. Charges for the administration or injection of any drug, except for vaccinations listed on the Prescription Drug Formulary.

D. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, and other non-medicinal substances except Diabetic Supplies, regardless of intended use.

E. Drugs labeled "Caution—Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made to the Insured.

F. Immunization agents, except for vaccinations listed on the Prescription Drug Formulary, biological sera, blood or blood plasma. Benefits may be available under the Major Medical Benefits Section of this Policy.

G. Medication that is to be taken by or administered to an Insured, in whole or in part, while the Insured 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.

H. 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.

I. Any Prescription Drug, biological or other agent, which is:

a) Prescribed primarily to aid or assist the Insured 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.
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 Policy.

J. Lost, stolen, broken or destroyed Prescription Drugs except in the case of loss due directly to a natural disaster.

III. Transplant Exclusions and Limitations

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

A. Transplants of brain tissue or brain membrane, 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 an Insured 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, except as specifically listed as a Covered Service in this Policy.

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 insurance coverage.

G. Any complication to the donor arising from a donor's Transplant Surgery is not a covered benefit under the Insured Transplant recipient's Policy. If the donor is a BCI Insured, 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 an Insured).

IV. Hospice Exclusions and Limitations

In addition to any other exclusions and limitations of this Policy, the following exclusions and limitations apply to Hospice Services. No benefits are available under this Policy for the following:

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 an Insured is receiving Home Health Skilled Nursing Care benefits.

V. **Pediatric Vision Care Exclusions and Limitations**

In addition to any other exclusions and limitations of this Policy, the following exclusions and limitations apply to Pediatric Vision Care Benefits Section. No benefits are available for professional services or materials connected with:

A. Orthoptics or other vision training and any associated supplemental testing; Plano Lenses; or two (2) pair of eyeglasses in place of bifocals.

B. Replacement of Lenses, Frames or Contact Lenses furnished hereunder that are lost or broken (Lenses, Frames or Contact Lenses are only replaced at the normal intervals when Covered Services are otherwise available).

C. Medical or surgical treatment of the eye(s).

D. Any eye examination or any corrective eyewear required by an employer as a condition of employment.

E. Low vision aids.

VI. Preexisting Condition Waiting Periods

There is no preexisting condition waiting period for benefits available under this Policy.

CLAIMS ADMINISTRATION

I. How to File a Claim

An Insured must submit a claim to Blue Cross of Idaho in order to receive benefits for Covered Services. There are two ways for an Insured to submit a claim:

A. The health care Provider (Hospital, Physician, or other facility or specialist) can file the claim for the Insured. Most Providers will submit a claim to BCI on an Insured's behalf if the Insured shows them a BCI identification card and asks them to send BCI the claim, or

B. The Insured can send BCI the claim.

II. To File an Insured's Own Claims

If a Provider prefers that an Insured file the claim, here is the procedure the Insured needs to follow:

A. Ask the Provider for an itemized billing. This should show each service received and its procedure code, the date it was furnished, and the charge for each service. BCI cannot accept billings that only say "Balance Due," "Payment Received," or some similar statement.

B. Obtain a Member Claim Form from the BCI Website, www.bcidaho.com, from the Provider or any of BCI's offices, and follow the instructions. Use a separate billing and Member Claim Form for each patient involved.

C. 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

III. Time Limits for Filing Claims

Blue Cross of Idaho must receive a written notice of claim for payment for a Covered Service no later than one year from the date a Covered Service is rendered, except if it is not reasonably possible to give notice of proof within this timeframe. BCI will deny any claim not received within this time limit.

IV. Processing of the Filed Claim

Blue Cross of Idaho makes its claim payment decisions based on the information it has when a claim is received. BCI makes every effort to process claims as quickly as possible. BCI will send an Insured an Explanation of Benefits (EOB) by mail or electronically, if the Insured has consented to electronic delivery, as soon as the claim is processed. The Explanation of Benefits will show all of the payments BCI made and to whom BCI sent the payment. It will also explain any charges BCI did not pay in full. If an Insured would like a paper copy of their Explanation of Benefits, they may request one from BCI Customer Service

GENERAL PROVISIONS SECTION

I. Acceptance

This Policy is effective as of the Policy Effective Date and will continue on a month-to-month basis, subject to being modified or terminated pursuant to the provisions of this Policy. The Group agrees to accept this Policy and signifies its acceptance by payment of its premium.

Blue Cross of Idaho agrees, in consideration of the group enrollment agreement or master group application and premium payments when due, and subject to all the terms of this Policy, to provide each Insured of the Group the benefits of this Policy, beginning on the Policy Effective Date and continuing on a month-to-month basis thereafter, unless modified or terminated as provided by this Policy

II. Entire Policy—Changes

This Policy, which includes the Benefits Outline, Group and individual applications enrollment data and information, Insured identification cards, and any written endorsements, riders, amendments or other written agreements, and any policies, terms, conditions, or requirements incorporated by reference at bcidaho.com approved in writing by an authorized Blue Cross of Idaho (BCI) officer, is the entire Policy between the Group and BCI. No agent or representative of BCI, other than a BCI officer, may change this Policy or waive any of its provisions. This Policy supplants and replaces any and all previous oral or written agreements, certificates, contracts, policies or representations, which shall have no further force and effect.

III. Records of Insured Eligibility and Changes in Insured Eligibility

A. The Group shall furnish all data required by BCI for it to provide coverage of the Group's Insureds under this Policy. In addition, the Group shall provide written notification to BCI within thirty (30) days of the Effective Date of any changes in an Insured's enrollment and benefit coverage status under this Policy.

B. A notification by the Group to BCI must be furnished on BCI approved forms, and according to rules and regulations of BCI. The notification must include all information reasonably required by BCI to effect changes, and must be accompanied by payment of applicable premiums.

IV. Termination Or Modification of This Policy

A. Pursuant to the provisions of this Subsection III., the Group or BCI may unilaterally terminate this Policy. BCI may unilaterally modify the terms of this Policy, including but not limited to, benefits, Deductibles, Out-of-Pocket Limits, premiums, and other provisions. Unless specified otherwise in this Policy, such termination or modification may be accomplished by giving written notice to the other party at least sixty (60) days in advance of the Effective Date of the termination or modification. Except for modifications resulting from statutory and/or regulatory changes affecting benefits, BCI may modify benefits only at the time of the Group's annual renewal of coverage.

If there is a modification and its Effective Date is not January 1 or the Groups renewal date, all amounts previously credited to an Insured's Deductible, Out-of-Pocket Limit or benefit limit during the Benefit Period in which the modification is made shall be credited against the Insured's Deductible, Out-of-Pocket or benefit limit under this Policy as modified for the remainder of that Benefit Period. If any portion of the Out-of-Pocket Limit is increased during the Benefit Period, the additional amount of the Deductible, Copayment and/or Coinsurance must be met for the Insured to satisfy the new Out-of-Pocket Limit. If an Insured is admitted for Inpatient Hospital Services and the Out-of-Pocket Limit and/or any other contract terms are changed during that admission, the Out-of-Pocket Limit and the contract terms in effect on the date of admission will apply to the Inpatient Hospital Services for the entire hospital stay. If any Out-of-Pocket Limit is increased during the Benefit Period benefit payments to an Insured who has already met the previous Out-of-Pocket Limit will be reduced until the new Out-of-Pocket Limit is satisfied. If an Insured is admitted for Inpatient Hospital Services and any contract terms are changed during that admission, the contract terms in effect on the date of admission will apply to the Inpatient Hospital Services for the entire hospital stay. If a Deductible is increased during a Benefit Period, the additional amount must be satisfied before benefit payments from BCI resume.

However, this provision does not obligate BCI to provide benefits beyond the term of this Policy. The Group agrees that it will notify Insureds of any changes in benefits, Deductibles, Out-of-Pocket

Limits, or premiums, at least thirty (30) days prior to the Effective Date of such modifications, including providing Insureds a revised Summary of Benefits and Coverage (SBC), when required. The Group's subsequent payment of premiums shall constitute conclusive documentation that the Group and its Insureds have accepted and agreed to any such modification(s).

B. This Policy may be unilaterally terminated by BCI for any of the following:

1. For the Group's fraud or intentional misrepresentation of a material fact.
2. For the Group's failure to maintain the enrollment percentage specified in the Application for Group Coverage. BCI may randomly audit enrollment to ensure compliance. Failure to provide information requested in the audit may also result in termination.
3. For the Group's failure to make the employer premium contribution specified in the Eligibility and Enrollment Section.
4. In the case where this Policy is available to the Group only through an association as defined in Idaho Code § 41-2202, the membership of the Group in the association (on the basis of which the coverage of this Policy is provided) ceases but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any Insured.
5. If BCI elects not to renew all of its Health Benefit Plans delivered or issued for delivery to Small Employers in the state of Idaho. In which case, BCI will provide notice to the Group and its Insureds of such nonrenewal at least one hundred eighty (180) days in advance of the date of nonrenewal.

C. If the Group fails to pay premiums as agreed in the Eligibility and Enrollment Section, this Policy will terminate without notice at the end of the period for which the last premiums were paid. A payer financial institution's return of or refusal to honor a check or draft constitutes nonpayment of premiums. This Policy does not have a grace period; however, if the Group makes payment of the premiums within thirty (30) days after the due date, BCI will reinstate this Policy as of the due date. No benefits are available during this thirty (30) day period unless all premiums are properly paid before expiration of the thirty (30) day period. BCI reserves the right to apply a twelve percent (12%) annualized interest fee on any portion of the balance owed by the Group to BCI that remains unpaid thirty (30) days or more beyond the original due date.

V. Termination Or Modification of An Insured's Coverage Under This Policy

A. If an Enrollee ceases to be an Eligible Employee or the Group does not remit the required premium, the Enrollee'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.

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

C. Termination or modification of this Policy automatically terminates or modifies all of the Insureds' coverage and rights hereunder. It is the responsibility of the Group to notify all of its Insureds of the termination or any modification of this Policy, and BCI's notice thereof to the Group, upon mailing or any other delivery, shall constitute complete and conclusive notice to the Insureds.

D. Except as otherwise provided in this Policy, no benefits are available to an Insured for Covered Services rendered after the date of termination of an Insured's coverage.

E. BCI may retroactively terminate coverage for an Insured when the Insured has performed an act that constitutes fraud or makes an intentional misrepresentation of a material fact. If BCI discovers that an Insured has made any intentional misrepresentation, omission, or concealment of fact in obtaining coverage under this Policy which was or would have been material to BCI’s acceptance of a

risk, extension of coverage, provision of benefits or payment of any claim, BCI may take action against the Group, including but not limited to, increasing the Group's premiums.

F. Prior to legal finalization of an adoption, the coverage provided in this Policy for a child placed for adoption with an Enrollee continues as it would for a naturally born child of the Enrollee 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 Enrollee rescinds, in writing, the agreement of adoption or the agreement assuming financial responsibility.

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

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

H. The Group may retroactively terminate an Insured no more than ninety (90) days prior to the date BCI receives the request if the following conditions are satisfied: 1) the Insured had no expectation of coverage after the requested effective date of termination; and 2) the retroactive cancellation is due to a delay in administrative record-keeping that occurred in the normal course of business. If an Insured for whom the Group requests retroactive termination has incurred claims after the requested termination date for which BCI has already paid before the request for termination was received, Premium is due and must be paid for the Insured for the monthly period in which Claims were incurred.

VI. Benefits After Termination of Coverage

A. When this Policy remains in effect but an Insured's coverage terminates for reasons other than those specified in General Provision IV.F., benefits will be continued:

1. If the Insured is eligible for and properly elects continuation coverage in accordance with the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments thereto.

   Most employers who employ twenty (20) or more people on a typical business day are subject to COBRA. If the Group is subject to COBRA, an Insured may be entitled to continuation coverage. Insureds should check with the Group for details.
2. For Covered Services of an Insured who is being treated as an Inpatient on the day the Insured's coverage terminates, but only until the Insured is discharged, or the end of the Benefit Period in which coverage terminated or until benefits are exhausted, whichever occurs first. Benefits for Covered Services are limited to the Inpatient treatment of the condition, Accidental Injury, Disease or Illness causing the Inpatient confinement.

B. When the Group or BCI terminates this Policy, benefits will be continued:

1. For Covered Services of an Insured who is being treated as an Inpatient on the day the Insured's coverage terminates, but only until the Insured is discharged, or the end of the Benefit Period in which coverage terminated or until benefits are exhausted, whichever occurs first. Benefits for Covered Services are limited to the Inpatient treatment of the condition, Accidental Injury, Disease or Illness causing the Inpatient confinement.
2. For Covered Services directly related to a pregnancy that existed on the date of termination, in accordance with state law and regulations. Such Covered Services are subject to all the terms, limitations, and provisions of this Policy and will be provided for no more than twelve (12) consecutive months following the date coverage terminates or until the conclusion of the pregnancy, or until replacement coverage is in effect according to Replacement Coverage General Provisions section of this Policy, whichever occurs first.
3. For Covered Services directly related to a Total Disability that existed on the date of termination, in accordance with state law and regulations. Such Covered Services are subject to all the terms, limitations, and provisions of this Policy and will be provided for no more than twelve (12) consecutive months following the date coverage terminates or until the Total Disability ceases, whichever occurs first.

VII. Contract Between BCI and The Group—Description Of Coverage

This policy is a contract between BCI and the Group. BCI will provide the Group with copies of the Policy to give to each Enrollee as a description of coverage or provide electronic access to the Policy, but this Policy shall not be construed as a contract between BCI and any Enrollee. BCI's mailing or any other delivery of this Policy to the Group constitutes complete and conclusive issuance and delivery thereof to each Enrollee.

VIII. Applicable Law

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

IX. Notice

Any notice required under this Policy must be in writing. BCI's notices to the Group will be sent to the Group's mailing address or electronic address as they appear on BCI's records, and mailing or any other delivery to the Group constitutes complete and conclusive notice to the Insureds. Notice given to BCI must be sent to BCI's address contained in the Group Application. The Group shall give BCI immediate written notice of any change of address for the Group or any of its Insureds. BCI shall give the Group immediate written notice of any change in BCI's address. When BCI is required to give advice or notice, the depositing of such advice or notice with the U.S. Postal Service, regular mail, or the other delivery, including electronic distribution, conclusively constitutes the giving of such advice or notice on the date of such mailing or delivery.

X. Benefits To Which Insureds Are Entitled

A. Subject to all of the terms of this Policy, an Insured 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 Policy, benefits will be provided only when the Insured receives services that are Covered Services under this Policy. The outgoing carrier has primary responsible for providing benefits for the Inpatient treatment from the date of admission until the first of the following events occur:

- The Insured is discharged,
- The Benefit Period under the previous coverage ends, or
- Until benefits under the outgoing carrier's policy are exhausted.

BCI will provide benefits for Covered Services incurred following the Effective Date of coverage reduced by the benefits paid by the outgoing carrier.

C. 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.

D. 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. BCI shall not assume nor have any liability for conditions beyond its control which affect the Insured's ability to obtain Covered Services.

XI. Notice of Claim

BCI is not liable under this Policy to provide benefits unless a proper claim is furnished to BCI that shows Covered Services have been rendered to an Insured. A claim must be submitted within one (1) year from the date a Covered Service is rendered. The claim must include all the data necessary for BCI to determine benefits.

XII. Release and Disclosure of Medical Records and Other Information

A. In order to effectively apply the provisions of this Policy, BCI may obtain information from Providers and other entities pertaining to any health related services that the Insured may receive or may have received in the past. BCI may also disclose to Providers and other entities, information obtained from the Insured's transactions such as policy coverage, premiums, payment history and claims data necessary to allow the processing of a claim and for other health care operations. To protect the Insured's privacy, BCI treats all information in a confidential manner. For further information regarding BCI's privacy policies and procedures, the Insured may request a copy of BCI's Notice of Privacy Practices by contacting Customer Service at the number provided in this Policy.

B. As a condition of coverage under this Policy, each Insured authorizes Providers to testify at BCI's request as to any information regarding the Insured'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 Insured.

XIII. Exclusion of General Damages

Liability under this Policy for benefits conferred hereunder, including recovery under any claim or breach of this Policy, is 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.

XIV. Payment of Benefits

A. The Insured authorizes BCI to make payments directly to Providers rendering Covered Services to the Insured for benefits provided under this Policy. Notwithstanding this authorization, BCI reserves and shall have the right to make such payments directly to the Insured. Except as provided by law, BCI's right to pay an Insured directly is not assignable by an Insured nor can it be waived without BCI's concurrence, nor may the right to receive benefits for Covered Services under this Policy be transferred or assigned, either before or after Covered Services are rendered.

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 premium on behalf of an individual receiving medical treatment. Cost sharing contributions made from permitted third parties will be applied to the Insureds 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 Insured'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 Insureds applicable Deductible and/or Out-of-Pocket Limit, the Insured is encouraged to provide notification to BCI if they receive any form of assistance for payment of their premium, Coinsurance, Copayment or Deductible amounts. Premiums submitted in violation of this provision will not be accepted and the Enrollee's Policy may be terminated for non-payment. Cost sharing contributions made from non-permitted third parties will not be applied to the Insureds applicable Deductible and/or Out-of-Pocket Limit. BCI will inform the Insured in writing of the reason for rejecting or otherwise refusing to treat a third party payment as a payment from the Insured and of the Insured's right to file a complaint with the Department of Insurance

C. Once Covered Services are rendered by a Provider, BCI is not obliged to honor Insured requests not to pay claims submitted by such Provider, and BCI shall have no liability to any person because of its rejection of such request. However, for good cause and in its sole discretion, BCI may nonetheless deny all or any part of any Provider claim.

XV. Insured/Provider Relationship

A. The choice of a Provider is solely the Insured's.

B. BCI does not render Covered Services but only makes payment for Covered Services received by Insureds. BCI is not liable for any act or omission or for the level of competence of any Provider, and BCI has no responsibility for a Provider's failure or refusal to render Covered Services to an Insured.

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

XVI. 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 Insureds, but it shall have no obligation to do so.

XVII. Coordination of This Policy's Benefits With Other Benefits

This Policy is a high deductible health plan that is compatible with an HSA. An Insured is ineligible for an HSA if they are also covered under a health plan that is not a high deductible health plan. If the Insured is enrolled in other health insurance coverage consistent with the provisions below, the provisions below will be applied to this Policy.

This Coordination of Benefits (COB) provision applies when an Insured 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 Insured 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, Coinsurance and Copayments, that is covered at least in part by any Contract covering the Insured. 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 Insured 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 an Insured 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 an Insured 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 it not an Allowable Expense.

   d) If an Insured 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 Group, 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 an Insured 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.

2. 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.

3. 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.

4. 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 Insured 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 Insured as a dependent is the Secondary Contract. However, if the Insured is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Contract covering the Insured as a dependent; and primary to the Contract covering the Insured 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 Insured 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:

i. 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;

ii. 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;

iii. 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;

iv. 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 an Insured as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Contract. The Contract covering that same Insured as a retired or laid-off employee is the Secondary Contract. The same would hold true if an Insured is a dependent of an active employee and that same Insured 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 an Insured 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 Insured as an employee, member, subscriber or retiree or covering the Insured 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 Insured as an employee, member, policyholder, subscriber, or retiree longer is the Primary Contract and the Contract that covered the Insured 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

A. 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.

B. 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 Insureds it has paid or for whom it has paid; or any other Insured or organization that may be responsible for the benefits or services provided for the covered Insured. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

XVIII. Benefits For Medicare Eligibles Who Are Covered Under This Policy

A. If the Group has twenty (20) or more employees, any Eligible Employee or spouse of an Eligible Employee who becomes or remains an Insured of the Group covered by this Policy after becoming eligible for Medicare (due to reaching age sixty-five (65)) is entitled to receive the benefits of this Policy as primary.

B. An Insured eligible for Medicare based solely on end stage renal disease is entitled to receive the benefits of this Policy 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 Insured is entitled to receive benefits of this Policy as primary for thirty (30) months only, beginning with the month of Medicare entitlement. Medicare is secondary during the 30 month period, known as the coordination period. When this Policy is primary, it pays in accordance with the terms of this Policy. In certain circumstances, such as when using a Noncontracting Provider, Insureds may be responsible for amounts in excess of the Maximum Allowance. Medicare does not typically permit billing for amounts in excess of the Maximum Allowance, when it is primary. Insureds should contact Medicare for more information about their options.

C. The Group's retirees, if covered under this Policy, and Eligible Employees or Insured spouses of Eligible Employees who are not subject to paragraphs A., B. or C. of this provision and who are Medicare eligible, will receive the benefits of this Policy reduced by any benefits available under Medicare. This applies even if the Insured fails to enroll in Medicare or does not claim the benefits available under Medicare.

XIX. Indemnity By The Group and Blue Cross of Idaho

The Group and BCI agree to defend, indemnify, and hold the other party harmless from and against any claim, demand, expense, loss, damage, cost, judgment, fee, or liability the other party may receive, incur, or sustain that is caused by or arises by reason of any misstatement, intentional misrepresentation, oversight, error, omission, delay, or mistake in providing the other party or any Insured notice or advice of any relevant fact, event, or matter pertinent to claims, benefits, or coverage under this Policy.

XX. Incorporated By Reference

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

XXI. Inquiry and Appeals Procedures

If the Insured's claim for benefits is denied and BCI issues an Adverse Benefit Determination, the Insured 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, an Insured 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 Policy.

B. Formal Appeal

An Insured who wishes to formally appeal a Pre-Service Claim decision by BCI may do so through the following process:

1. An Insured may have an authorized representative pursue a benefit claim or an appeal of an Adverse Benefit Determination on their behalf. BCI requires that an Insured execute BCI's "Appointment of Authorized Representative" form before BCI determines that an individual has been authorized to act on behalf of the Insured. The form can be found on BCI's Website at www.bcidaho.com.

2. 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 Insured contends BCI's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.
3. 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 Insured 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.
4. Furthermore, the Insured 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.
5. If the original, non-urgent claim decision is upheld upon reconsideration, the Insured 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. An Insured who wishes to formally appeal a Post-Service Claims decision by BCI 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 Insured contends BCI's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.
2. An Insured may have an authorized representative pursue a benefit claim or an appeal of an Adverse Benefit Determination on their behalf. BCI requires that an Insured execute BCI's "Appointment of Authorized Representative" form before BCI determines that an individual has been authorized to act on behalf of the Insured. The form can be found on BCI's Website at www.bcidaho.com.
3. 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 Insured 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.
4. Furthermore, the Insured 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.
5. If the original decision is upheld upon reconsideration, the Insured 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. Insured'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 an Insured 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 BCI. The Insured or their authorized representative will have the right to further review the claim by a court, arbitrator, mediator or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as more fully explained below under "Binding Nature of the External Review Decision."

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

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

An Insured 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 Insured filed the appeal, unless the Insured requested or agreed to a delay. BCI may also agree to waive the exhaustion requirement for an external review request. The Insured 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 Insured's request qualifies as an "urgent care request" defined below.

An Insured 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 Website, www.doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

An Insured may act as their own representative in a request or an Insured may name another person, including an Insured's treating health care provider, to act as an authorized representative for a request. If an Insured wants someone else to represent them, an Insured must include a signed BCI's "Appointment of an Authorized Representative" form with the request before BCI determines that an individual has been authorized to act on behalf of the Insured. The form can be found on BCI's Website at www.bcidaho.com. An Insured'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 an Insured'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. BCI will pay the costs of the review.

Standard External Review Request: An Insured 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 Insured 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 Insured 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 Insured 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 Insured 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 Insured, BCI and to the Department of Insurance within forty-two (42) days after receipt of an external review request.

Expedited External Review Request: An Insured 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 Insured 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 Insured or the ability of the Insured to regain maximum function;
2. In the opinion of the Provider with knowledge of the covered person's medical condition, would subject the Insured 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 Insured 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 Insured 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 Insured. The independent review organization must provide notice of its decision to the Insured, 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 Insured 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:
If the Group is subject to the federal Employee Retirement Income Security Act (ERISA) laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on BCI. The Insured may have additional review rights provided under federal ERISA laws.

If the Group is not subject to ERISA requirements, the external review decision by the independent review organization will be final and binding on both BCI and the Insured. **This means that if the Insured elects to request external review, the Insured will be bound by the decision of the independent review organization. The Insured will not have any further opportunity for review of BCI's denial after the independent review organization issues its final decision.** If the Insured 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.

XXII. Plan Administrator—COBRA and ERISA

BCI is not the plan administrator for compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) and any amendments to it; nor is BCI the plan administrator for the Employee Retirement Income Security Act (ERISA) and any amendments to it.

Except for services BCI has agreed to perform regarding COBRA, the Group is responsible for satisfaction of notice, disclosure, and other obligations if these laws are applicable to the Group.

XXIII. Reimbursement of Benefits Paid By Mistake

If BCI mistakenly makes payment for benefits on behalf of an Enrollee or their Eligible Dependent(s) that the Enrollee or their Eligible Dependent(s) is not entitled to under this Policy, the Enrollee must reimburse the erroneous payment to BCI.

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

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

XXIV. Subrogation and Reimbursement Rights of Blue Cross of Idaho

The benefits of this Policy will be available to an Insured when the Insured 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 under this Policy or any other Blue Cross of Idaho plan, agreement, certificate, contract or policy, Blue Cross of Idaho shall be subrogated and succeed to the rights of the Insured or, in the event of the Insured's death, to the rights of their heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Services in such an event, the Insured or their personal representative shall furnish Blue Cross of Idaho in writing with the names, addresses, and contact information 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 Insured or their personal representative concerning the injury, harm or loss. In addition, the Insured shall furnish the name and contact information of the liability insurer or its adjuster of the third party including the policy number of any liability insurance that covers, or may cover, such injury, harm, or loss.

Blue Cross of Idaho may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

Subrogation is taking over the Insured's right to receive payments from other parties. The Insured or their legal representative will transfer to Blue Cross of Idaho any rights the Insured may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Insured. Thus, Blue Cross of Idaho may initiate litigation at its sole discretion, in the name of the Insured, against any third party or parties. Furthermore, the Insured 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 will be reimbursed in full for all benefits paid even if the Insured is not made whole or fully compensated by the recovery. Moreover, Blue Cross of Idaho is not responsible for any attorney's fees or other expenses or costs incurred by the Insured without 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 Insured hires regardless of whether amounts recovered are used to repay benefits paid by Blue Cross of Idaho, or otherwise.

Additionally, Blue Cross of Idaho may at its option elect to enforce its right of reimbursement from the Insured, or their legal representative, of any benefits paid from monies recovered as a result of the injury, harm or loss. The Insured 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 reimbursement rights and efforts.

The Insured shall pay Blue Cross of Idaho 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 under this Policy, regardless of how the recovery is allocated (*i.e.*, pain and suffering) and whether the recovery makes the Insured whole. Thus, Blue Cross of Idaho will be reimbursed by the Insured, or their legal representative, from monies recovered as a result of the injury, harm or loss, for all benefits paid even if the Insured is not made whole or fully compensated by the recovery. Moreover, Blue Cross of Idaho is not responsible for any attorney's fees or other expenses or costs incurred by the Insured without 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 Insured hires regardless of whether amounts recovered are used to repay benefits paid by Blue Cross of Idaho, or otherwise.

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

Blue Cross of Idaho shall have the right, at its option, to seek reimbursement from, or enforce its right of subrogation against, the Insured, the Insured'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 Insured including the Insured's attorney.

Blue Cross of Idaho's subrogation and reimbursement rights shall take priority over the Insured's rights both for benefits provided and payments made by Blue Cross of Idaho, and for benefits to be provided or payments to be made by Blue Cross of Idaho in the future on account of the injury, harm or loss giving rise to Blue Cross of Idaho's subrogation and reimbursement rights. Further, Blue Cross of Idaho's subrogation and reimbursement rights for such benefits and payments provided or to be provided are primary and take precedence over the rights of the Insured, 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 Insured and Blue Cross of Idaho.

Collections or recoveries made by an insured for such injury, harm or loss in excess of such benefits provided and payments made shall first be allocated to such future benefits and payments that would otherwise be owed by the Plan on account of the injury, harm or loss giving rise to Blue Cross of Idaho's subrogation and reimbursement rights, and shall constitute a Special Credit applicable to such future benefits and payments that would otherwise be owed by Blue Cross of Idaho under this or any subsequent Blue Cross of Idaho Plan or coverage. Thereafter, Blue Cross of Idaho shall have no obligation to provide any further benefits or make any further payments until the Insured has incurred medical expenses in treatment of such injury, harm, or loss equal to such Special Credit.

XXV. Independent Blue Cross and Blue Shield Plans

The Group (on behalf of itself and its participants) hereby expressly acknowledges its understanding this Policy constitutes a contract solely between the Group and BCI, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCI to use the Blue Cross Service Marks in the state of Idaho, and that BCI is not contracting as the agent of the Association. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Policy based upon representations by any person, entity or organization other than BCI and that no person, entity or organization other than BCI shall be held accountable or liable to the Group for any of BCI's obligations to the Group created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of BCI other than those obligations created under other provisions of this Policy.

XXVI. Statements

In the absence of fraud, all statements made by an applicant or the policyholder or by an enrolled person shall be deemed representations and not warranties, and no statement made for the purpose of acquiring insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the enrolled person.

XXVII. Out-of-Area Services

Overview

Blue Cross of Idaho 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 Enrollees access healthcare services outside the geographic area Blue Cross of Idaho 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 Blue Cross of Idaho serves, Enrollees 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, Enrollees 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. Blue Cross of Idaho remains responsible for fulfilling our contractual obligations to Enrollees. Blue Cross of Idaho payment practices in both instances are described below.

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits, except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by Blue Cross of Idaho to provide the specific service or services.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Enrollees access Covered Services within the geographic area served by a Host Blue/outside the geographic area Blue Cross of Idaho serves, 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.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar Copayment, the calculation of the Enrollee 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 Blue Cross of Idaho by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare Provider contracts. The negotiated price made available to Blue Cross of Idaho 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.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to Providers or refunds received or anticipated to be received from Providers). However, the BlueCard Program requires that the amount paid by the Enrollee is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Blue Cross of Idaho in determining your premiums.

B. Special Cases: Value-Based Programs

BlueCard Program

Blue Cross of Idaho has included a factor for bulk distributions from Host Blues in the Group's premium for Value-Based Programs when applicable under this Policy. Additional information is available upon request.

If Blue Cross of Idaho has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group's Enrollees, Blue Cross of Idaho will follow the same procedures for Value-Based Programs as noted above for the BlueCard Program.

C. Prepayment Review and Return of Overpayments

If a Host Blue conducts prepayment review activities including, but not limited to, data mining, itemized bill reviews, secondary claim code editing, and DRG audits, the Host Blue may bill BCI up to a maximum of 16 percent of the savings identified, unless an alternative reimbursement arrangement is agreed upon by BCI and the Host Blue, and these fees may be charged to the Group. If a Host Blue engages a third party to perform these activities on its behalf, the Host Blue may bill BCI the lesser of the full amount of the third-party fees or up to 16 percent of the savings identified, unless an alternative reimbursement arrangement is agreed upon by BCI and the Host Blue, and these fees may be charged to the Group.

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 Group 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 Group as a percentage of the recovery.

D. 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 insured accounts. If applicable, Blue Cross of Idaho will include any such surcharge, tax or other fee in determining the Group's premium.

E. Nonparticipating Providers Outside Blue Cross of Idaho Service Area

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

F. Blue Cross Blue Shield Global Core

General Information

If Enrollees 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 Enrollees with accessing a network of Inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when Enrollees receive care from Providers outside the BlueCard service area, the Enrollees will typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if Enrollees contact the BCBS Global Core e service center for assistance, hospitals will not require Enrollees to pay for covered Inpatient services, except for their Deductibles, Coinsurance, and/or Copayments, if applicable. In such cases, the hospital will submit Enrollee claims to the BCBS Global Core service center to initiate claims processing. However, if the Enrollee paid in full at the time of service, the Enrollee must submit a claim to obtain reimbursement for Covered Services. **Enrollees 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 Enrollees to pay in full at the time of service. Enrollees must submit a claim to obtain reimbursement for Covered Services.

Submitting a BCBS Global Core Claim

When Enrollees pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Enrollees 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 Enrollees 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.

XXVIII. Replacement Coverage

If this Policy replaces prior group coverage within sixty (60) days of the date of termination of prior coverage, BCI shall immediately cover all employees and dependents validly covered under the prior coverage at the date of termination who meet BCI's eligibility requirements and who would otherwise be eligible for coverage under this Policy, regardless of any exclusions or limitations relating to active employment or nonconfinement.

If an Insured is hospitalized on the date this Policy becomes effective, BCI will reduce the benefits of this Policy by an amount paid or payable by the prior Group coverage. This applies until the hospitalized Insured's coverage is terminated in accordance with the terms of this Policy.

In the case of an Insured who was Totally Disabled on the date of termination of prior coverage, BCI will deduct from any benefits payable under this Policy the amount of benefits under the prior Group coverage pursuant to an extension of benefits provision for Insureds who are Totally Disabled.

XXIX. Individual Benefits Management

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

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

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

XXX. Coverage And Benefits Determinations

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 Policy, based on all the terms and provisions set forth in this Policy, and also to determine the amount of benefits owed on claims which are covered.

XXXI. Health Care Providers Outside the United States

The benefits available under this Policy are also available to Insureds 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 Insured. Reimbursement for Covered Services will be made directly to the Contracting Provider. If the Health Care Provider does not participate with BlueCard, the Insured 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 Insured's responsibility to provide this information.

BCI will reimburse covered Prescription Drugs purchased outside the United States by Insureds who live outside the United States where no suitable alternative exists. Reimbursement will also be made in instances where Insureds 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 Policy.

XXXII. Summaries of Benefits and Coverage

BCI shall timely prepare (and update) Summaries of Benefits and Coverage (SBC) for the Policy(s) as required by Section 2715 of the Public Health Service Act (PHSA). The SBC(s) will be provided by BCI in an electronic format to the Group for distribution to its employees, dependents, retirees and COBRA eligible Insureds if applicable.

The Group shall provide all necessary benefit plan information in a timely manner to BCI for the preparation of the Group's SBC(s). The SBC(s) will be distributed to its employees, dependents, retirees and COBRA eligible Insureds if applicable by the Group in compliance with requirements of Section 2715 of the PHSA.

Insured's Rights and Responsibilities

I. As the Insured, you have the right to:

A. Receive considerate and courteous care with respect for personal privacy, dignity and confidentiality.
B. Receive Medically Necessary and appropriate care or services from any Provider listed in the provider directory.
C. Receive information in clear and understandable terms, and ask questions to ensure you understand what you are told by your Provider and other medical personnel.
D. Make decisions about your care, including accepting and refusing medical or surgical treatments.
E. Give informed consent to treatment and to make advance treatment directives, including the right to name a surrogate decision maker in the event you cannot participate in decision making.
F. Discuss your medical records with your Provider and have health records kept confidential, except when disclosure is required by law or to further your treatment.
G. Be provided with information about your Health Benefit Plan, its services, and the practitioners providing care.
H. Communicate any concerns with your Health Benefit Plan regarding care or services you received, receive an answer to those concerns within a reasonable time, and initiate the complaint and grievance procedure if you are not satisfied.

II. As the Insured, you have the responsibility to:

A. Ask questions of your Provider until you fully understand the care you are receiving.
B. Follow the advice of your health care Provider, including that regarding medications. Comply with all treatment follow-up plans, and be aware of the medical consequences of not following instructions.
C. Communicate openly and honestly with your health care Provider regarding your medical history, health conditions, and the care you receive.
D. Keep all scheduled health care appointments and provide advance notification to the appropriate Provider if it is necessary to cancel an appointment.
E. Know how to use the services of your Health Benefit Plan properly.

In witness whereof, Blue Cross of Idaho Health Service, Inc., by its duly authorized officer, has executed this Policy.

Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID 83707

Paul Zurlo
President, Health Markets