University of Idaho Health Benefits Trust

Retiree Health & Welfare Summary of Plan

For benefits effective January 1, 2019 to December 31, 2019

This book contains information for the:

- Medical and Prescription Drug Plans for Pre-Medicare and Medicare-eligible Retirees and Eligible Dependents
- Dental Plan
- Health Savings Account
- Employee Assistance Plan

This is not insurance and not covered under the guaranty fund

RETHW-16

About this Summary of Plan Document

This summary documentdescribes benefits available to eligible retirees as of January 1, 2019. Please review this booklet carefully to familiarize yourself with your eligible benefits coverage and your rights. If you provide coverage for any dependents, you should share this booklet with them.

The chapters in this booklet are summary plan descriptions of each of the benefit plans. Because they are only summaries, they may not contain every plan detail. Each plan is governed by the terms of a legal document called a plan document or a policy. Plan documentation and policies are available from Benefit Services. If the provisions of these summary descriptions differ from the plan documents or policies, the terms of the plan documents or policies will govern.

This Plan qualifies as a retiree-only plan and is exempt from many of the mandates implemented under the Affordable Care Act and other federal mandates, such as the Mental Health Parity Act and the Mental Health and Parity Equity Addiction Act.

The University may amend or terminate these plans or any benefits provided by these plans at any time. Neither this communication nor any of the University's policies for benefit plans should be considered a contract for purposes of employment or payment of compensation or benefits.

Table of Contents

Introduction

This section provides an overview of your University of Idaho retiree benefits and contains basic eligibility and coverage information.

Eligibility

Eligible Retirees

You may be eligible to participate in the retiree health plan when you retire from your University employment. This table describes eligibility rules for University benefits:

<table>
<tr><th colspan="5">Retiree Health Benefits
Tier I
Eligibility Chart</th></tr>
<tr><th rowspan="2">If you….</th><th rowspan="2">And meet at least one of these…</th><th colspan="3">You are eligible to enroll in….</th></tr>
<tr><th>Medical and Prescription Drug</th><th>Dental</th><th>Death Benefit</th></tr>
<tr><td>• Were hired on or before January 1, 2002

And

• Have been the primary subscriber on an active Health Plan for at least five (5) years</td><td>• Completion of 30 years of qualified service, regardless of age

Or
• Completion of 15 years of qualified service and attainment of age 64

Or

• Attainment of age 55 and completion of a number of years of qualified service where the sum of your years of service and your age is at least 80</td><td rowspan="2">Subsidized University Retiree medical coverage for yourself throughout your retirement. You may enroll eligible dependents, but you will pay 100% of the cost.

Prescription drug coverage is automatically provided with medical coverage. However, Plan B does not offer prescription drug benefits to Medicare eligible individuals. Plan B participants should enroll in Medicare Part D.</td><td rowspan="2">Subsidized University Retiree dental coverage is available to you until you are Medicare eligible. You may continue dental coverage for you and your dependents after Medicare eligibility, but you pay 100% of the cost of coverage.</td><td rowspan="2">Individuals enrolled in Supplemental Death Benefit coverage through the active employee health benefits receive $10,000 (or less determined at time of retirement) in University paid, Retiree only death benefit. (Individuals enrolled in Federal death benefits will not receive this coverage.)

You are also eligible to convert University of Idaho Basic and Optional Death Benefit coverage into an individual policy if your retirement occurs before your 75th birthday. The optional coverage is subject to age reduction rules determined and handled by the carrier.</td></tr>
<tr><td colspan="2">All criteria must have been met on or before September 30, 2007, but employee may retire later</td></tr>
</table>

Retiree Health Benefits Tier II Eligibility Chart				
If you….	**And meet at least one of these…**	**You are eligible to enroll in….**		
		Medical and Prescription Drug	**Dental**	**Life**
• Were hired on or before January 1, 2002 And • Have been the primary subscriber on an active Health Plan for at least 15 years	• Completion of 30 years of qualified service, regardless of age Or • Attainment of age 55 and completion of at least 15 years of qualified service where the sum is at least 80	Subsidized University Retiree medical coverage for yourself throughout your retirement. You may enroll eligible dependents, but you will pay 100% of the cost. Prescription drug coverage is automatically provided with medical coverage to pre-Medicare eligible participants. After Medicare eligibility, retirees receive a stipend to purchase prescription drug benefits.	Subsidized University Retiree dental coverage is available to you until you are Medicare eligible. You may continue dental coverage for you and your dependents after Medicare eligibility, but you pay 100% of the cost of coverage.	Eligibility to convert University of Idaho Basic and Optional Death Benefit coverage into an independent policy if your retirement occurs before your 75th birthday. The optional coverage is subject to age reduction rules determined by the carrier.
All criteria must have been met on or before June 30, 2011, but employee may retire later				

Retiree Health Benefits Tier III Eligibility Chart				
If you….	**And meet at least one of these…**	**You are eligible to enroll in….**		
		Medical and Prescription Drug	**Dental**	**Death Benefit**
• Were hired on or before January 1, 2002 And • Have been the primary subscriber on an active Health Plan for at least 20 years	• Completion of 30 years of qualified service, regardless of age Or • Attainment of age 55 and completion of at least 20 years of qualified service where the sum is at least 90	Subsidized University Retiree medical coverage for yourself throughout your retirement. You may enroll eligible dependents, but you will pay 100% of the cost. Prescription drug coverage is automatically provided with medical coverage to pre-Medicare eligible participants. After Medicare eligibility, retirees receive a stipend to purchase prescription drug benefits.	Subsidized University Retiree dental coverage is available to you until you are Medicare eligible. You may continue dental coverage for you and your dependents after Medicare eligibility, but you pay 100% of the cost of coverage.	Eligibility to convert University of Idaho Basic and Optional Death Benefit coverage into an independent policy if your retirement occurs before your 75th birthday. The optional coverage is subject to age reduction rules determined by the carrier.
All criteria must be met on or after July 1, 2011, but employee may retire later				

Retiree Health Benefits Tier IV Eligibility Chart			
If you….	**You are eligible to enroll in….**		
	Medical and Prescription Drug	**Dental**	**Death Benefit**
• Have been the primary subscriber on an active Health Plan for at least 10 years prior to retirement And • Have at least 10 years of qualified service And • Are at least 55 years of age, except that a person with a disability may qualify regardless of age	You may enroll yourself and your eligible dependents for retiree medical and prescription drug benefits, but you pay the full cost. When you and your dependents are Medicare eligible, you should enroll for prescription drug coverage; you will not be eligible to receive University-sponsored prescription drug coverage. You may convert up to 50% of your accrued sick time, up to 600 hours, to help pay for your coverage. Converted sick time may not be used to pay for dependent coverage. Sick time is eligible if it was earned at the University of Idaho after July 1, 1976.	You may continue to cover yourself and your eligible dependents in dental coverage, but you pay the full cost.	Eligibility to convert University of Idaho Basic and Optional Death Benefit coverage into an independent policy if your retirement occurs before your 75th birthday. The optional coverage is subject to age reduction rules determined by the carrier.

Retiree Health Benefits Disability Retirement Benefits Eligibility Chart			
If you….	**You are eligible to enroll in….**		
	Medical and Prescription Drug	**Dental**	**Life**
• Are a disabled person* of any age and qualify for disability retirement or retirement contribution replacement benefits from a state, Social Security and/or the University's Long-Term Disability plan And • Have had a University of Idaho active health plan enrollment for the prior 10 years	Subsidized University retiree medical coverage for yourself throughout your retirement. You may enroll your eligible dependents, but you pay 100% of the cost. When you and your dependents are Medicare eligible, you should enroll for prescription drug coverage; you will not be eligible to receive University-sponsored prescription drug coverage. You may convert up to 50% of your accrued sick time, up to 600 hours, to help pay for your coverage. Converted sick time may not be used to pay for dependent coverage. Sick time is eligible if it was earned at the University of Idaho after July 1, 1976.	Subsidized dental coverage is available to you until you are Medicare eligible. You may continue to cover your dependents and yourself after Medicare eligibility in dental coverage, but you pay 100% of the cost of coverage.	You have the option of electing Death Benefit through the retiree plan or continuing your active insurance. Please discuss with Benefit Services.

* If you become disabled and qualify for benefits under Tier I, II or III, you will be eligible to receive those benefits. You may also be eligible to continue active employee benefits for a limited period of time through COBRA. You should discuss with your options with Benefit Services.

Important Terms

Qualified service: Service while employed at the University of Idaho in a position eligible for University of Idaho active employee health benefits. Service to the University of Idaho will be counted if the employee has been on paid status at half time or greater. Employees on regular academic year appointments receive credit for 12 months of service, provided all other requirements of qualified service are met. See Faculty Staff Handbook 3730 for additional information.

Service while employed on a temporary hourly (TH) basis will not be recognized as qualified service. Qualified service performed prior to a break in service is permanently forfeited, unless it meets exceptions outlined in the *break in service* definition below.

Active health plan enrollment: You receive a year of active health plan enrollment credit for each calendar plan year in which you have been enrolled as a primary subscriber for medical, dental, life or disability benefits for active employees. See Faculty Staff Handbook 3730 for additional information.

Break in service: A break in service occurs when there is a separation from qualified service for one day or more. For purposes of this policy, after a break in service, an employee forfeits all prior qualified service, unless the employee had at least five years of continuous qualified service prior to the break in service. A break in service does not include the following: (1) periods of any category of approved paid or unpaid leave of absence; or (2) periods during which the employee is eligible for and has opted to remain on the lay-off roster. See Faculty Staff Handbook 3730 for additional information.

Part-time employees: Qualified part-time employees who are employed in a health benefits-eligible position are eligible for the Retiree Health Program upon retirement. Service credit for part-time employees will be earned based on a prorated percentage of their full-time status. An employee who temporarily reduces his or her hours of work and remains employed in a health benefits-eligible position may earn up to two years of full-time service credit if hours have been temporarily reduced to accommodate transitioning into retirement or to accommodate a family or personal matter. In either case, the employee must obtain written approval in advance from his or her supervisor and Benefit Services.

Eligible Dependents

If you elect retiree medical and dental benefits for yourself, you may enroll your eligible dependents who were enrolled for coverage under your active benefits on the date you retire.

To qualify as an eligible dependent, a person must be one of the following:

- Your spouse under a legally recognized marriage. You must be able to present proof of the legally recognized marriage to add a spouse. Your child under the age of 26 for purposes of the plan, a "child" means your:
- Biological child,
- Legally adopted child or a child placed with you for adoption,
- Stepchild,
- Child for whom you are the legal guardian, and/or
- Child who is required to be covered by a Qualified Medical Child Support Order (QMCSO). See *Qualified Medical Child Support Order (QMCSO)* for more information.

Coverage will terminate for your child on the last day of the month for which he or she turns age 26,unless he or she is incapable of self-support because of a physical or mental disability that began prior to age 26. A child is dependent for purposes of section 4980H for the entire calendar month during which he or she attains age 26. You must apply for this continuation within 31 days after the child reaches age 26. Documentation will be provided by Blue Cross of Idaho which will need to be submitted to Benefit Services.

To enroll eligible dependents applying for coverage under a QMCSO, contact Benefit Services and speak with a Benefits Enrollment Specialist.

You must enroll your eligible dependents when you are first eligible for retiree coverage; you will not be permitted to enroll them at a later date. Except in the case of a benefits-eligible spouse, as described below, after your retiree coverage begins, you only will be permitted to enroll eligible dependents you acquired *after* retirement through marriage, birth, adoption, placement for adoption, the establishment of legal guardianship; you may also enroll a child whom you are required to cover pursuant to a Qualified Medical Child Support Order (QMCSO). See the section the section *Making Changes*.

If your spouse is also a benefits-eligible employee. A spouse who is covered by the University of Idaho's active benefit plan, may be enrolled in the retiree health plan upon his or her separation from a benefits-eligible position and/or retirement if:

- He or she was eligible as your dependent at the time of your retirement, and
- You request to add your spouse to your coverage within 30 days of his or her separation from a benefits-eligible position and/or retirement.

If your spouse remarries, he or she may continue retiree health plan participation assuming he or she meets all other eligibility requirements. A new spouse of a former covered dependent spouse, or any other newly acquired dependent, may not be added to the Retiree Health Program. However, a dependent child of the retiree who is born after the death of the retiree may be added within 30 days of birth.

Qualified Medical Child Support Order (QMCSO)

You may be required to provide medical plan coverage for your child(ren) pursuant to a Qualified Medical Child Support Order (QMCSO). If you receive a court order to provide coverage, please contact the University's Benefits Enrollment Specialist. In some cases, the orders will be directed to the University from a court or child welfare agency. The Benefits Enrollment Specialist will determine whether the order is a QMCSO.

To be considered qualified, the order must:

- Specify the name and last known mailing address of the covered employee and the employee's child(ren) who are subject to the order.
- Indicate the type of coverage to be provided (or the manner in which such coverage will be determined).
- Identify the period covered by the order.
- Specify each plan to which the order applies.

If the medical child support order is qualified, you must enroll yourself, if you are not already enrolled, and the specified child(ren) for medical coverage. To learn more, contact Benefit Services and speak with the Benefits Enrollment Specialist.

Coverage Levels

For medical and dental coverage, you can enroll in any of the following coverage tiers:

- Retiree Only,
- Retiree + Spouse,
- Retiree + Child,
- Retiree + Children, and
- Retiree + Spouse + Child(ren).

How to Enroll for Coverage

When you are approaching retirement, work with the Benefit Services to determine your retiree health eligibility. You will receive enrollment materials with detailed instructions for enrolling yourself and your eligible dependents as well as the cost for coverage. You must return your completed enrollment forms to Benefit Services within 30 days of your life event. Coverage and contributions are retroactive to the first day of the month following the date your employment ends.

Once you and your dependents enroll in retiree health benefits, you may discontinue coverage at any time. To do so, contact Benefit Services. You will be required to send a letter or an email confirming your request. The only exception applies when a retiree returns to work at the University of Idaho and is covered by the active benefits program. In this case, you or your dependents may rejoin the retiree plan on the day following the end of employment in a health benefits-eligible position.

Each fall, the University will send you a letter notifying you of any changes to your coverage or coverage costs.

Making Changes

In general, the benefit elections you make when you initially enroll will remain in effect permanently. You may be permitted to change whom you cover for benefits under certain circumstances, including:

- Your marriage, divorce (including annulment) or legal separation.
- A child's birth, adoption or placement for adoption.
- Receipt of a Qualified Medical Child Support Order (QMCSO) requiring you to provide coverage for a child.
- Death of your spouse or child.
- Your child reaching the maximum age for coverage (age 26).

If you have an eligible change and want to make a change to whom you cover, you must make the allowed change(s) within 30 days of the event. If you've had a baby, adopted a child or had a child placed for adoption with you, you must make your election changes within 60 days of the birth, adoption or placement for adoption. You may only change whom you provide coverage for – you may not change your plan elections. You may drop coverage for covered dependents anytime with no opportunity to add them back on the Plan.

You pay for your retiree benefits on an after-tax basis.

You pay 100% of the cost of coverage for medical and prescription drug and dental coverage for your eligible dependents.

If You Don't Enroll: Default Coverage

If you do not enroll within 30 days of retirement, you will automatically be enrolled in the default coverage. Default coverage is Retiree Plan A. You will not have an opportunity to change your coverage option in the future.

Tier I, II, III and IV Retirees: Enrolling in Medicare Part D

If you are a Tier I retiree enrolled in Plan B, or a Tier II, III or IV retiree enrolled in Plan A or Plan B (see *Eligibility* section), your prescription drug benefits from the University end once you are eligible for Medicare. To start the process of enrolling in Medicare, either visit your local Social Security office. Call 1-800-772-1213 or you may enroll online at **https://www.socialsecurity.gov/medicare/apply.html**. Contact Social Security during the three-month period before you turn age 65. You can also find information about Medicare online at: **http://www.medicare.gov**.

Caution

Medicare enrollment (Parts A, B, C, or D) makes you ineligible to make HSA contributions.

In addition, enrollment for Social Security triggers automatic enrollment in Medicare Part A and makes you ineligible to contribute to an HSA. The IRS generally recommends that you stop making HSA contributions at least 6 months prior to enrolling in Medicare and/or applying for Social Security benefits.

When You Are Eligible for Medicare

Once you become eligible for Medicare, Medicare will become your primary medical coverage and your University retiree medical coverage will become your secondary coverage (note that there is a limited exception in the case of end-stage renal disease). The amount you pay for coverage may change at that time.

Additionally, if you are a Tier I retiree enrolled in Plan B or a Tier II, III or IV retiree enrolled in either Plan A or Plan B, you should enroll for Medicare Part D to receive prescription drug benefits.

Your covered dependent's medical coverage also may change when he or she reaches age 65, or becomes entitled to Social Security disability benefits or has end-stage renal disease, and becomes eligible for Medicare.

Enrolling for Medicare

You are required to enroll in Medicare as soon as you are eligible to do so. You are eligible for Medicare if:

- You are age 65,
- You worked for 10 years or more in Medicare-covered employment (i.e., you paid FICA taxes), and
- You have been a U.S. citizen or legal resident for five years or more.

You may also qualify for Medicare if you are younger than age 65 and are disabled or have end-stage renal disease.

You must enroll for Medicare Parts A and B in order to receive reimbursement for most eligible medical expenses.

To start the process of enrolling in Medicare, you need to either visit your local Social Security office or call 1-800-772-1213 or you may enroll online at **https://www.socialsecurity.gov/medicare/apply.html**. This should be done during the three-month period before you turn age 65. You can also find information about Medicare online at: **http://www.medicare.gov**.

As long as you enroll for Medicare prior to the date you first become eligible, coverage will start on the first day of the month in which you turn age 65. Your failure to enroll in Medicare Parts A and B when first eligible constitutes a waiver/disenrollment of all university health plan benefits including life and dental if applicable. If you are a disability retiree, you should apply for Medicare after you have received 24 months of Social Security disability benefits.

Caution

Medicare enrollment (Parts A, B, C, or D) makes you ineligible to make HSA contributions.

In addition, enrollment for Social Security triggers automatic enrollment in Medicare Part A and makes you ineligible to contribute to an HSA. The IRS generally recommends that you stop making HSA contributions at least 6 months prior to enrolling in Medicare and/or applying for Social Security benefits.

Paying for Coverage

What You Pay for Your Coverage

Your retiree contribution amount depends on:

- Your eligibility tier (as described in the *Eligibility* section),
- The plan in which you enroll, and
- The coverage level you elect.

You pay for your retiree benefits on an after-tax basis.

When you enroll — and each year thereafter — you will receive information on your costs for coverage. Rates are subject to increase. However, retirees eligible for Tier I benefits will have their rate increases capped at

- 10% of the previous year's rate.

What You Pay for Eligible Dependent's Coverage

You pay 100% of the cost of coverage for medical and prescription drug and dental coverage for your eligible dependents.

How You Pay for Coverage

You will receive a monthly billing statement from the University of Idaho. You may set up automatic payment by completing and submitting an ACH authorization form with our third party administrator. Forms can be found at **http://www.uidaho.edu/human-resources/benefits/retiree-medical**.

How to Convert Sick Time to Pay for Coverage

Tier IV retirees may be eligible to convert up to 50% of their University of Idaho accrued sick time, up to 600 hours, to pay for the cost of retiree medical and prescription drug coverage if not enrolled in Medicare. Pays coverage for the retiree only. Sick time is eligible if it was earned after July 1, 1976.

When Coverage Begins

If eligible, retiree coverage begins on the first day of the month following the effective date of retirement. In order to avoid a gap in coverage between the last day of work and the first day of coverage under the Retiree Health Program, coverage for eligible retgirees under the active health benefit program will continue until coverage under the Retiree Health Program begins. University of Idaho policies require your retirement date to coincide with the last working day in the calendar month or the end of the fiscal year. The last day of employment is generally the last day worked. In these instances, there will be no lapse in coverage, and medical deductibles, benefits and other maximums and limits from your active-employee plan may carry forward into the retiree health plan within the current plan year.

If you are participating in the University's medical plan at the time you enroll, your coverage will continue without interruption.

When Coverage Ends

Your coverage ends on the earliest of the following dates:

- The date you no longer meet the eligibility requirements defined in the *Eligibility* section,
- If the required payment for all plans of coverage is not received within 30 days of the date it is due.
- If you are eligible for Medicare Parts A and B and do not enroll for coverage when first eligible, or
- The University discontinues the Plan.

Your dependents' coverage will end on the earliest of the following dates:

- The date your coverage ends and/or the date a dependent no longer meets the eligibility requirements, as defined in the *Eligibility* section,
- 30 days after the last day of the period for which you paid your contributions toward dependent coverage,
- The date your dependent no longer qualifies as your dependent as defined in the *Eligible Dependents* section,
- If your dependent is eligible for Medicare Parts A and B and does not enroll for coverage,
- The date you elect to terminate your coverage or your dependent's coverage under the Plan or
- The University discontinues the Plan.

You are responsible for notifying the University when a spouse or child is no longer eligible for coverage. This includes notifying the University of a Divorce, death or a child reaching age 26.

Your dependents may be eligible to continue certain benefits after their coverage ends. See the *COBRA Continuation of Coverage* section for more details.

In the Event of Your Death

If you die while you and your spouse and eligible dependent child(ren) are covered under the plan, your spouse/eligible dependent child(ren) will be able to continue the coverage in which they were enrolled. Your surviving spouse and eligible dependent child(ren) will be responsible for paying the entire cost of coverage. They will be enrolled for coverage corresponding to their Medicare eligibility.

If a surviving dependent becomes covered under another group health plan (excluding Medicare) or does not make the required contribution within 30 days of the due date, coverage ends.

If your spouse remarries, he or she may continue retiree health plan participation assuming he or she meets all other eligibility requirements. A new spouse of a former covered dependent spouse, or any other newly acquired dependent of a former covered dependent spouse, may not be added to the Retiree Health Program. However, a dependent child of the retiree who is born after the death of the retiree may be added within 30 days of birth or adoption.

ID Cards

You and your covered dependents will receive identification cards for medical, prescription drug and dental when your coverage begins. You may request additional cards; however, all cards will list the retiree's name only.

Remember to carry your ID cards with you at all times. If a provider wants to verify your or your dependent's coverage, have him or her call the number listed on the ID card. In addition, you should use your ID card to contact Blue Cross of Idaho or CVS Caremark or Silverscript and determine if you need preauthorization.

If You Move

If your address changes, contact Benefit Services.

Your Medical and Prescription Drug Coverage

The University offers you two medical plans from which to choose.

- Plan A (Traditional PPO Plan)
- Plan B (High Deductible Health Plan or "HDHP")

Your benefits within each plan will vary based on whether you are eligible for Medicare. This table describes how your University medical benefits work:

Feature	Pre-Medicare Eligible Participants		Medicare Eligible Participants	
	Plan A	**Plan B**	**Plan A**	**Plan B**
How eligible medical care services are covered	Receive primary medical and prescription drug benefits through the University plan. Please see the *Pre-Medicare Medical Plan Coverage At-a-Glance Chart* for more detailed coverage information.		The University requires you to enroll in Medicare Parts A and B when you are eligible. At that time, Medicare becomes your primary coverage; the University plan is your secondary coverage. Please review the *When You Have Other Coverage (Coordination of Benefits)* section for more information. When you incur an eligible medical expense, your benefits will be determined by the Medicare's maximum allowable charge for services. Then, the University plan may pay up to the difference between the Medicare payment and the amount that the plan would have paid had there been no coordination with Medicare. Keep in mind, the plan will pay benefits once you have satisfied your deductible. Please see the *Medicare Eligible Medical Plan Coverage At-a-Glance Chart* for more detailed coverage information.	
	Plan A is a traditional PPO Plan. In this plan, eligible, in-network preventive care is covered at 100%. For all other eligible health care services, you pay 100% of your covered health care expenses until you reach the annual deductible. Once you reach your deductible, you pay cost-sharing for covered services until you reach the cost-share maximum. After you reach the cost-share maximum, the plan pays 100% of your covered services for the remainder of the plan year.	Plan B is a qualified high deductible health plan (HDHP). You may be able to contribute to a Health Savings Account (HSA). In this plan, eligible, in-network preventive care is covered at 100%. In the HDHP, you pay 100% of your covered healthcare expenses until you reach the annual deductible. Once you reach your deductible, you pay cost-sharing for covered services until you reach the cost-share maximum. After you reach the cost-share maximum, the plan pays 100% of your covered services for the remainder of the plan year.		

Feature	Pre-Medicare Eligible Participants		Medicare Eligible Participants	
	Plan A	**Plan B**	**Plan A**	**Plan B**
How eligible prescription drugs are covered	You pay 100% of the cost of prescription drugs until you satisfy the separate prescription drug deductible. Once you meet the deductible, you and the University share the costs of your prescription drugs through copayments and cost-sharing. Please see *Prescription Drug Benefits* for more information.	You pay 100% of prescription drug costs until your eligible, combined medical and prescription drug expenses satisfy the deductible. Once you satisfy the deductible, you pay 30% of your prescription drug costs until you reach the cost-share maximum, then the plan pays 100% of covered services and prescription drugs. Please see *Prescription Drug Benefits* for more information.	If you are a Tier I retiree, you continue your prescription drug coverage through Plan A. Please see *Prescription Drug Benefits* for more information. All other retirees need to enroll in Medicare Part D to receive prescription drug benefits. Tier II and III retirees receive a University stipend to help pay for Medicare Part D coverage.	Plan B does not provide any prescription drug benefits to Medicare eligible individuals. Enroll in Medicare Part D to receive prescription drug benefits.
Network providers	Through this PPO plan, you may choose care from any provider you wish. You will receive greater benefits when you seek care from an in-network provider. When you visit an out-of-network provider, you will first need to meet the out-of-network deductible. You will also pay a higher out-of-network cost-sharing rate and have a separate out-of-network, cost-share maximum.	Plan B is considered an "Open Access PPO" plan. This means that except for preventive/wellness services, you may see any provider you choose, either in-network or out-of-network, without a reduction of benefit. However, you receive discounted rates, and you pay less out of your pocket, when you visit an in-network provider.	Plan A is considered an "Open Access PPO" plan. This means that except for preventive/wellness services, you may see any provider you choose, either in-network or out-of-network, without a reduction of benefit. However, you receive discounted rates, and you pay less out of your pocket, when you visit an in-network provider.	Plan B is considered an "Open Access PPO" plan. This means that except for preventive/wellness services, you may see any provider you choose, either in-network or out-of-network, without a reduction of benefit. However, you receive discounted rates, and you pay less out of your pocket, when you visit an in-network provider.
Opportunity to contribute to a Health Savings Account	No	Yes, please see the *Health Savings Account* section for more information.	No	No

How do I locate in-network providers?

To locate a provider in your area, please visit the Blue Cross of Idaho Web site at **www.bcidaho.com**. Click on "Find a Provider" and you will be taken to the searchable directory. You may also contact the Customer Services Department listed on your ID card to locate providers in or out of your area.

Pre-Medicare Medical Plan Coverage At-a-Glance Chart

This section provides you with detailed information on medical coverage for participants not yet eligible for Medicare.

Please note that while the chart provides a list of covered services, it is important to contact Blue Cross of Idaho before a service is provided to be sure it is covered and to determine if any special requirements need to be met, such as preauthorization. Contact Blue Cross of Idaho by calling the number listed on your ID card. Additionally, please review the *What the Medical Plans Cover* section for more detailed information.

Pre-Medicare Medical Plan Coverage At-a-Glance Chart			
	Plan A		**Plan B (HDHP with HSA Option)**
Benefit	**In-Network**	**Out-of-Network***	**In- and Out-of-Network***
Annual deductible (you pay)	$400 per individual	$600 per individual	$1,500 for self-only coverage
	$1,200 per family		$3,000 per family
Preventive care/ wellness services – for specifically listed services (plan pays) For services not listed, you pay your dedutible and cost-sharing amount	You pay nothing; plan pays 100%	Not Covered	You pay nothing; plan pays 100% of the maximum allowance for in-network services

Pre-Medicare Medical Plan Coverage At-a-Glance Chart				
	Plan A		Plan B (HDHP with HSA Option)	
Benefit	In-Network	Out-of-Network*	In- and Out-of-Network*	
Covered Preventive Care Services **Specifically Listed Services** Annual adult physical examinations; Bone density; Chemistry panels; Cholesterol screening; Colorectal cancer screening (colorectal cancer screening, fecal occult blood test); Complete Blood Count (CBC); Diabetes screening; Pap test; PSA test; Rubella screening; Screening EKG; Screening mammogram; Thyroid Stimulating Hormone (TSH); Transmittable diseases screening (Chlamydia,Gonorrhea, Human Immunodeficiency Virus (HIV), Human papillomavirus (HPV), Syphilis, Tuberculosis (TB)); Hepatitis B virus screening; Sexually transmitted infections assessment; HIV assessment; Screening and assessment for interpersonal and domestic violence; Urinalysis (UA); Aortic aneurysm ultrasound; Alcohol misuse assessment; Breast cancer (BRCA) risk assessment and genetic counseling and testing for high-risk family history of breast or ovarian cancer; Newborn metabolic screening (PKU, Thyroxine, Sickle Cell); Health risk assessment for depression; Newborn hearing test; Lipid disorder screening; Smoking cessation counseling visit; Dietary counseling (limited to 3 visits per participant, per benefit period); urinary incontinence screening, Behavioral counseling for participants who are overweight or obese; Preventive lead screening; Lung cancer screening for participants age 55 and older; Hepatitis C virus infection screening. **Women's Preventive Care Services** Well Woman visits (for recommended age-appropriate preventive services); breastfeeding support, supplies and counseling. **Well-Baby Care and Well-Child Care** Routine or scheduled well-baby and well-child examinations, including vision, hearing and developmental screenings; Dental fluoride application for participants age 5 and younger; **Maternity Benefits** Gestational diabetes screening for pregnant women; Iron defi ciency screening for pregnant women; Rh (D) incompatibility screening for pregnant women; and Urine culture for pregnant women. **Immunizations** Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rotavirus, Rubella, Tetanus, Varicella (Chicken Pox), Hepatitis A, Meningococcal, Human Papillomavirus (HPV) and Zoster. 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.				
Annual Medical Cost-share maximum (Once the deductible is satisfied, cost share is paid until the cost-share maximum is satisfied, then the plan pays for 100% of covered services. Please see "Cost-share Maximum" in the *General Benefit Information* section for more information.)				
Individual	$3,600	$5,200 per individual	$3,100	
Family	$ 10,800		$6,200	
Lifetime benefit maximum	Unlimited			
Ambulance transportation services (you pay)	20% of the maximum allowance after the deductible	35% of the maximum allowance after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Behavioral health benefits				
Inpatient services (you pay)	20% of the maximum allowance after the	35% of the maximum allowance	30% of the maximum	30% of the maximum

Pre-Medicare Medical Plan Coverage At-a-Glance Chart				
	Plan A		**Plan B (HDHP with HSA Option)**	
Benefit	**In-Network**	**Out-of-Network***	**In- and Out-of-Network***	
	deductible, and $100 per day copayment up to 3 days per year per person	after the deductible, and $100 per day copayment up to 3 days per year per person	allowance, after the deductible	allowance, after the deductible
Outpatient psychotherapy services (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Outpatient Applied Behavioral Analysis (ABA) (you pay) *(as part of an approved treatment plan)*	$25 copayment per visit, not subject to the deductible	35% of the maximum allowance, after deductible	30% of the maximum allowance, after deductible	
Treatment for Autism Spectrum Disorder (you pay) *(Services identified as part of the approved treatment plan)*	Covered the same as any other illness, depending on the services rendered. Please see the appropriate section of this table. Visit limits do not apply to Treatments for Autism Spectrum Disorder.	Covered the same as any other illness, depending on the services rendered. Please see the appropriate section of this table. Visit limits do not apply to Treatments for Autism Spectrum Disorder.	Covered the same as any other illness, depending on the services rendered. Please see the appropriate section of this table. Visit limits do not apply to Treatments for Autism Spectrum Disorder.	
Facility and other professional services (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Blood service (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Colonoscopy/sigmoidoscopy				
Preventive screening (plan pays)	You pay nothing; plan pays 100% of the maximum allowance	Not covered	You pay nothing; plan pays 100% of the maximum allowance	Not covered

Pre-Medicare Medical Plan Coverage At-a-Glance Chart				
	Plan A		**Plan B (HDHP with HSA Option)**	
Benefit	**In-Network**	**Out-of-Network***	**In- and Out-of-Network***	
Bariatric Surgery **(requires pre-authorization) (you pay)**	Separate $1,500 Deductible, then 20% of the maximum allowance after the separate Bariatric deductible (covered at a Blue Cross Centers of Excellence Provider Only)	Not covered	Separate $1,500 Deductible, then 30% of the maximum allowance after the separate Bariatric deductible (covered at a Blue Cross Centers of Excellence Provider Only)	Not covered
Diagnostic services related to Bariatric Surgery(you pay)	20% of the maximum allowance, after the separate Bariatric deductible (covered at a Blue Cross Centers of Excellence Provider Only)	Not covered	30% of the maximum allowance after the separate Bariatric deductible (covered at a Blue Cross Centers of Excellence Provider only)	
Contraceptive services (you pay)				
Birth control pills	See *Prescription Drug Benefits* section for more information			
Diaphragms & IUD **Depo Provera injections (you pay)**	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Dental services, related to accidental injury (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Diabetes self-management education (you pay)	20% of the maximum allowance, after the deductible	Not covered	30% of the maximum allowance, after the deductible for in-network services	Not covered
Diagnostic services (you pay) *excluding eligible wellness and preventive care services*	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Durable medical equipment/Prosthetics/Orthotics (you pay)(Up to a combined $300 per participant, per benefit period.	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible

Pre-Medicare Medical Plan Coverage At-a-Glance Chart				
	Plan A		**Plan B (HDHP with HSA Option)**	
Benefit	**In-Network**	**Out-of-Network***	**In- and Out-of-Network***	
Emergency services (you pay) (You may be balance-billed for out-of-network emergency services.)	20% of the maximum allowance, after the deductible *(Contracting and noncontracting facility providers and facility-based professional providers only)*	You pay 20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Hearing examination *Limited to one routine exam per participant per benefit period*	You pay nothing; plan pays 100%	Not Covered	Plan pays 100% of the maximum allowance	Not Covered
Hearing aid appliances and fitting exams (you pay) *Limited to $800 per participant per lifetime*	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Home health skilled nursing services	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Hospice services	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Hospital services (you pay) – Inpatient – Outpatient – Special services	20% of the maximum allowance, after the deductible $100 per day copayment up to 3 days per year per person for inpatient services	35% of the maximum allowance, after the deductible $100 per day copayment up to 3 days per year per person for inpatient services	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Implantables (for purpose of contraception) *Limited to once every five years*	Plan pays 100% of the maximum allowance, after deductible and $100 copayment	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Injections (you pay)	20% of the maximum allowance, after the deductible, $5 copayment per visit for allergy shots, not subject to deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible

Pre-Medicare Medical Plan Coverage At-a-Glance Chart				
	Plan A		Plan B (HDHP with HSA Option)	
Benefit	In-Network	Out-of-Network*	In- and Out-of-Network*	
Injections – Allergy (you pay)	$5 copayment per visit, not subject to the deductible for allergy shots	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Inpatient physical rehabilitation care (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Mammogram services				
Preventive screening (plan pays)	You pay nothing; plan pays 100% of the maximum allowance	Not covered	You pay nothing; plan pays 100% of the maximum allowance	Not covered
Diagnostic service (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Maternity services (you pay) *See* Bright Beginnings Early Prenatal Management Program *section for more information*	Physician Services: $250 copayment, then plan pays 100% (not subject to deductible or cost-sharing) Hospital Services: 20% of the maximum allowance after the deductible, and $100 per day copayment up to 3 days per year per person	35% of the maximum allowance after the deductible, and $100 per day copayment up to 3 days per calendar year	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Medical services (you pay) – Inpatient – Outpatient	20% of the maximum allowance, after the deductible	35% of the maximum allowance after the deductible,	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Outpatient cardiac rehabilitation services (you pay)	20% of the maximum allowance after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Outpatient pulmonary rehabilitation services (you pay)	20% of the maximum allowance after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible

Pre-Medicare Medical Plan Coverage At-a-Glance Chart				
	Plan A		**Plan B (HDHP with HSA Option)**	
Benefit	**In-Network**	**Out-of-Network***	**In- and Out-of-Network***	
Outpatient rehabilitation therapy services (you pay) – Occupational therapy – Physical therapy – Respiratory therapy – Speech therapy	20% of the maximum allowance after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Post-mastectomy/ lumpectomy reconstructive surgery (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Prescription drug services	CVS Caremark manages prescription drug benefits; please see the *Prescription Drug Benefits* section for more information.			
Selected therapy (you pay)	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Skilled nursing facility (you pay) *Limited to 30 combined inpatient days per benefit period*	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Tobacco cessation services				
Counseling-Tobacco cessation	Approved counseling services are covered at 100%			
Medications-Tobacco Cessation	Most generic prescription medications are covered at 100%			
Temporo-mandibular Joint (TMJ) Syndrome Services (you pay) (up to a combined $2,000 lifetime limit, per Participant) *Up to lifetime benefit of $2,000 (in- and out-of-network) per participant*	50% of the maximum allowance, after the deductible		30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Transplant services (you pay) *Limited to a lifetime benefit limit of $5,000 for related living expenses*	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible

* If your provider's charge is above the maximum allowance, you may be responsible for these additional charges.

Medicare Eligible Medical Plan Coverage At-a-Glance Chart

This section provides you with detailed information on medical coverage for Medicare-eligible participants.

Please note that while the chart provides a list of covered services, you may wish to contact Blue Cross of Idaho before a service is provided to confirm coverage. Contact Blue Cross of Idaho by calling the number listed on your ID card. Additionally, please review the *What the Medical Plans Cover* section for more detailed information.

Medicare Plan Options		
Benefit	**Plan A**	**Plan B**
Annual deductible (you pay)	$300 per individual	$1,500 per individual
Preventive care/wellness services (plan pays)	You pay nothing for eligible, in-network care; plan pays 100% of the maximum **allowance**	You pay nothing for eligible, in-network care; plan pays 100% of the maximum allowance

Covered Preventive Care Services

Specifically Listed Services
Annual adult physical examinations; Bone density; Chemistry panels; Cholesterol screening; Colorectal cancer screening (colonoscopy, sigmoidoscopy, fecal occult blood test); Complete Blood Count (CBC); Diabetes screening; Pap test; PSA test; Rubella screening; Screening EKG; Screening mammogram; Thyroid Stimulating Hormone (TSH); Transmittable diseases screening (Chlamydia,Gonorrhea, Human Immunodeficiency Virus (HIV), Human papillomavirus (HPV), Syphilis, Tuberculosis (TB)); Hepatitis B virus screening; Sexually transmitted infections assessment; HIV assessment; Screening and assessment for interpersonal and domestic violence; Urinalysis (UA); Aortic aneurysm ultrasound; Alcohol misuse assessment; Breast cancer (BRCA) risk assessment and genetic counseling and testing for high-risk family history of breast or ovarian cancer; Newborn metabolic screening (PKU, Thyroxine, Sickle Cell); Health risk assessment for depression; Newborn hearing test; Lipid disorder screening; Smoking cessation counseling visit; Dietary counseling (limited to 3 visits per participant, per benefit period); Behavioral counseling for participants who are overweight or obese; Preventive lead screening; Lung cancer screening for participants age 55 and older; Hepatitis C virus infection screening.

Women's Preventive Care Services
Well Woman visits (for recommended age-appropriate preventive services); breastfeeding support, supplies and counseling.

Well-Baby Care and Well-Child Care
Routine or scheduled well-baby and well-child examinations, including vision, hearing and developmental screenings; Dental fluoride application for participants age 5 and younger;

Maternity Benefits
Gestational diabetes screening for pregnant women; Iron defi ciency screening for pregnant women; Rh (D) incompatibility screening for pregnant women; and Urine culture for pregnant women.

Immunizations
Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rotavirus, Rubella, Tetanus, Varicella (Chicken Pox), Hepatitis A, Meningococcal, Human Papillomavirus (HPV) and Zoster. 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.

Medicare Plan Options		
Benefit	**Plan A**	**Plan B**
Annual Medical Cost-share maximum (Once the deductible is satisfied, cost-sharing is paid until the cost-share maximum is satisfied, then the plan pays for 100% of covered services. Please see "Cost-share Maximum" in the *General Benefit Information* section for more information.)		
Cost-share Maximum	$2,600 per individual	$3,100 per individual
Lifetime benefit maximum	Unlimited	
Ambulance transportation services (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Behavioral health benefits		
Inpatient services (you pay)	20% of the maximum allowance after the deductible, and $100 per day copayment up to 3 days per year per person	30% of the maximum allowance, after the deductible
Outpatient psychotherapy services (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Facility and other professional services (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Blood service (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Colonoscopy/sigmoidoscopy		
Preventive screening (plan pays)	You pay nothing; plan pays 100% of the maximum allowance	You pay nothing; plan pays 100% of the maximum allowance
Bariatric Surgery (Requires pre-authorization) (you pay)	Separate $1,500 deductible, then 20% of the maximum allowance after the separate Bariatric deductible (covered at a Blue Cross Centers of Excellence Provider Only)	Separate $1,500 deductible, then 30% of the maximum allowance after the separate Bariatricdeductible (covered at a Blue Cross Centers of Excellence Provider Only)
Diagnostic services related to Bariatric Surgery (you pay)	20% of the maximum allowance, after the separate Bariatric deductible (covered at a Blue Cross Centers of Excellence Provider Only)	30% of the maximum allowance, after the separate Bariatric deductible (covered at a Blue Cross Centers of Excellence Provider Only)
Contraceptive services (you pay)		
Birth control pills	See the *Prescription Drug Benefits* section for more information	Not covered
Diaphragms & IUD	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Depo Provera injections (you pay)		

Medicare Plan Options		
Benefit	**Plan A**	**Plan B**
Dental services, related to accidental injury (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Diabetes self-management education (you pay) *Limited to $500 per benefit period*	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible for in-network services
Diagnostic services (you pay) *Excluding eligible wellness and preventive care services*	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Durable medical equipment /Prosthetics/Orthotics (you pay) (up to a combined $300 per participant, per Benefit Period	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Emergency services (you pay) (You may be balance-billed for out-of-network emergency services.	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Hearing examination *Limited to one routine exam per participant per benefit period*	Plan pays 100% of the maximum allowance	Plan pays 100% of the maximum allowance
Hearing aid appliances and fitting exams (you pay) *Limited to $800 per participant per lifetime*	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Home health skilled nursing services	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Hospice services	20% of the maximum allowance, after the deductible *(only from a contracted Hospice)*	30% of the maximum allowance, after the deductible
Hospital services (you pay) – Inpatient – Outpatient – Special services	20% of the maximum allowance, after the deductible $100 per day copayment up to 3 days per year per person for inpatient services	30% of the maximum allowance, after the deductible

Medicare Plan Options		
Benefit	**Plan A**	**Plan B**
Implantables (for purpose of contraception) *Limited to once every five years*	Plan pays 100% of the maximum allowance, after the $100 copay	30% of the maximum allowance, after the deductible
Injections (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Injections – Allergy (you pay)	$5 copayment per visit, not subject to deductible for allergy shots	30% of the maximum allowance, after the deductible
Rehabilitation or Habilitation Services (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Mammogram services		
Preventive screening (plan pays**)**	You pay nothing; plan pays 100% of the maximum allowance for in-network services	You pay nothing; plan pays 100% of the maximum allowance for in-network services
Diagnostic service (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Maternity services (you pay) *See* Bright Beginnings Early Prenatal Management Program *section for more information*	Physician Services: $250 copayment, then plan pays 100% (not subject to deductible or cost-sharing) Hospital services: 20% of the maximum allowance after the deductible, and $100 per day copayment up to 3 days per year per person	30% of the maximum allowance, after the deductible
Medical services (you pay) – Inpatient – Outpatient	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Outpatient cardiac rehabilitation services (up to a combined total of 36 visits, per benefit period (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Outpatient pulmonary rehabilitation services (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Outpatient habilitation therapy services – Outpatient occupational therapy – Outpatient physical therapy – Outpatient respiratory therapy – Outpatient speech therapy	Plan pays 100% of the maximum allowance, after $25 copayment (not subject to the deductible)	You pay 30% of the maximum allowance, after deductible

Medicare Plan Options		
Benefit	**Plan A**	**Plan B**
Outpatient rehabilitation therapy services (you pay) – Occupational therapy – Physical therapy – Respiratory therapy – Speech therapy	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Post-mastectomy/ lumpectomy reconstructive surgery (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Prescription drug services (Tier I participants only)	SilverScript manages prescription drug benefits; please see the *Prescription Drug Benefits* section for more information	Not covered
Selected therapy (you pay)	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Skilled nursing facility (you pay) *Limited to 30 inpatient days per benefit period*	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Tobacco cessation services		
Counseling-Smoking Cessation	Approved counseling services are covered at 100%	
Medications-Smoking Cessation	Most generic prescriptions medications are covered at 100%	
Temporo-mandibular Joint (TMJ) Syndrome Services (you pay) *Up to lifetime benefit of $2,000 (in- and out-of-network) per participant*	50% of the maximum allowance, after the deductible	50% of the maximum allowance, after the deductible
Transplant services (you pay) *Limited to a lifetime benefit limit of $5,000 for related living expenses*	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible

Pre- Medicare and Medicare Eligible

Prescription Drug Benefits

When you enroll for medical benefits, you receive prescription drug benefits through the University's medical plan or a Medicare Part D plan, as described below:

<table>
<tr><th rowspan="2">Tier</th><th colspan="2">Pre-Medicare Eligible</th><th colspan="2">Post-Medicare Eligible</th></tr>
<tr><th>Plan A</th><th>Plan B</th><th>Plan A</th><th>Plan B</th></tr>
<tr><td>I</td><td rowspan="3">Participants receive prescription drug benefits with University medical benefits.</td><td rowspan="3">Participants receive prescription drug benefits with University medical benefits.</td><td>Participants receive prescription drug benefits with University medical benefits. Tier I only</td><td rowspan="3">Participants need to enroll for prescription drug benefits through Medicare Part D.</td></tr>
<tr><td>II</td><td rowspan="2">Participants need to enroll for prescription drug benefits through Medicare Part D. Tiers II, III and IV

Participants receive a stipend from the University to help pay for coverage. Tiers II and III only. See the How to Enroll for Coverage section for more information.</td></tr>
<tr><td>III</td></tr>
<tr><td>IV</td><td colspan="3">Participants need to enroll for prescription drug benefits through Medicare Part D. See the How to Enroll for Coverage section for more information.</td></tr>
</table>

This section describes how your prescription drug benefits through the University work for pre-Medicare eligible participants enrolled in Plan A or B and Medicare participants who are Tier I retirees enrolled in Plan A.

Prescription drug benefits are managed by CVS Caremark & SilverScript.

The Prescription Drug Formulary

The CVS Caremark (pre-Medicare eligible) and SilverScript (Medicare eligible) formulary is a list of drugs approved for coverage under your pharmacy benefit. The formulary includes brand name and generic drugs that have undergone rigorous testing and are approved by the Food and Drug Administration (FDA).

How the Formulary Works

In most cases you will be responsible for a portion of the cost of each prescription you have filled. The portion you pay is your copayment or cost-sharing, and depending on the drug prescribed, your cost can vary. The CVS Caremark/SilverScript formulary has three tiers, with the first tier (i.e., generic drugs) costing you the least and the third tier (i.e., non-formulary brand name drugs) costing you the most. Asking your doctor to prescribe drugs listed in the first (i.e., generic drugs) or second tier (i.e., formulary brand name drugs) of the formulary can save you money.

Information on Drug Tiers

In Plan A, there are three tiers of prescription drugs subject to different payment levels. The list of covered drugs, their tier level, and formulary is available at **Caremark.com.**

- *Covered formulary generic drugs.* Generic drugs are the most affordable. A generic drug is labeled with the medication's basic chemical name and usually has a brand name equivalent. The U.S. Food and Drug Administration (FDA) requires generic drugs to have the same active chemical composition, same potency and be offered in the same form as their brand name equivalents. Generic drugs must meet the same FDA standards as brand name drugs and are tested and certified by the FDA to be as effective as their brand name counterparts.

  You will pay the least when your doctor prescribes generic drugs.

- *Covered formulary brand name drugs.* These are the preferred brand name drugs that have no generic equivalent. You're covered for these medications at a slightly higher cost than generic drugs.

  You will pay more for a brand name drug on CVS Caremark & Silverscript's formulary than for generics.

- *Covered non-formulary brand name drugs.* These are brand name drugs that either have equally effective and less costly generic equivalents or one or more brand name formulary options. You or your doctor may decide that a brand name non-formulary medication is best for you.

  You pay the highest copayment when your doctor prescribes a drug that is not on the Caremark & Silverscript'sformulary. If you purchase a brand name drug when an equivalent generic is available, you will pay the appropriate brand name copayment, plus 100% of the cost difference between the brand name and the generic drug. This is almost always 100% of the cost of the brand name drug. Formulary and preauthorization information can be found directly through Caremark and Silverscript.

Preauthorization

Your physician or pharmacist will tell you if your medication requires preauthorization. If preauthorization is required, your physician must provide documentation showing that the prescription is medically necessary. A determination will be made within 15 days of the request for preauthorization, or a request for additional information will be made to your physician.

If preauthorization is not obtained, you may be held responsible for the entire cost of the drug. Please refer to "Preauthorization" in the *Medical Management Program* section.

Quantity Limits

Certain drugs found on the formulary can only be dispensed in limited quantities. Your pharmacist can only dispense these drugs up to the predetermined limit. These drugs have been found to be less effective or even dangerous when taken at higher than normal doses. The quantity limit restrictions on these drugs are consistent with usage recommendations from the manufacturers.

For More Information

If you cannot find a drug you are using on the formulary, call the Customer Service number on the back of your member ID card If you have questions about any of your medications, please discuss them with your doctor or pharmacist.

Finding a CVS Caremark/Silverscript Network Pharmacy

It's easy to find a CVS Caremark or Silverscript Network Pharmacy Call 1-855-539-4715 if you are Medicare-eligible**. If you are not yet Medicare-eligible, you can call 1-888-202-1654 or log on to Caremark.com**

Using the Mail Order Pharmacy

Eligible participants can purchase a 90-day supply of prescription drugs from our mail order pharmacy. The mail order pharmacy can be used on a continued basis for prescription drugs that are used to treat chronic conditions, such as high blood pressure or diabetes.

To order a new prescription through the mail order pharmacy Contact CVS Caremark at 888-202-1654 or completing a Mail Order Form.

Flexibility in filling 90-day Prescriptions

You will now be able to receive a 90-day supply of prescription drugs either at a participating retail pharmacy or through the mail order pharmacy. You will pay three retail copayments for 90-day prescriptions filled at the retail pharmacy. Find a participating pharmacy by calling the number listed on your ID card. Keep in mind, you will continue to pay less for 90-day prescriptions when you use the mail order pharmacy.

Preauthorization

Certain prescription drugs may require preauthorization. If your physician prescribes a drug that requires preauthorization, you will be informed by the pharmacist. To obtain preauthorization, your physician must provide CVS Caremark with information describing the medical necessity for the prescription.

Utilization Review

CVS Caremark and Silverscript may review prescription drug use. If there are patterns of over-utilization or misuse of drugs, a participant's physician or pharmacist may be notified. CVS Caremark and Silverscript reserve the right to limit quantities to prevent over-utilization or misuse of prescription drugs.

Prescription drug benefits work differently in Plan A and Plan B.

Prescription Drug Benefits

Plan A

You pay for the full cost of prescription drugs until you meet the per-individual deductible (or two individual deductibles per family). The deductible amount is:

- Pre-Medicare: $125
- Post-Medicare: $225 Tier I Plan A enrolled in EGWP – Medicare Part D SilverScripts

Once you meet the deductible, you will pay 25% cost-sharing for your prescription drugs from the retail pharmacy. However, your cost-sharing amount will be subject to a minimum and maximum copayment. If you order from the mail order pharmacy, you will pay a flat dollar copayment. This table shows your costs after you've met the deductible.

Pre-Medicare Plan B Prescription Drug Benefits

In Pre-Medicare Plan B, you pay 100% of prescription drug costs until your eligible, combined medical and prescription drug expenses satisfy the deductible. Once you satisfy the deductible, you pay 30% of your prescription drug's cost until you reach the cost-share maximum, then the plan pays 100% of covered services.

In Pre-Medicare Plan B, amounts you pay for prescription drugs count toward the deductible. Amounts you pay in cost-sharing after you satisfy the deductible, count toward the cost-share maximum.

Prescription Drug Benefits At-a-Glance Chart

	Plan A			Pre-Medicare Plan B	
	Retail Pharmacy		Mail Order	Retail Pharmacy	Mail Order
	30-day or less supply through CVS Caremark or Silverscript network pharmacies	90 day or less supply through CVS Caremark or Silverscript network pharmacies	90-day supply through CVS Caremark or Silverscript	30-day or 90-day or less supply through CVS Caremark network pharmacies	90-day supply through CVS Caremark
Feature	**Pre-Medicare Medical Plan Coverage At-a-Glance Chart**				
Generic	25% $12 minimum / $25 maximum	25% $36 minimum/ $75 maximum	$36	30% after deductible	30% after deductible
Formulary Brand Name*	25%* $25 minimum / $75 maximum	25%* $75 minimum / $225 maximum	$75	30% after deductible	30% after deductible
Non-formulary Brand* Name	25%* $40 minimum / $100 maximum	25%* $120 minimum / $300 maximum	$120	30% after deductible	30% after deductible
Medicare Plan Options for Retirees in Tier I					
Generic	25% $12 minimum / $25 maximum	25% $36 minimum/ $75 maximum	$36	No coverage	
Formulary Brand Name*	25%* $25 minimum / $75 maximum	25%* $75 minimum / $225 maximum	$75		
Non-formulary Brand* Name	25%* $40 minimum / $100 maximum	25%* $120 minimum / $300 maximum	$120		

* **IMPORTANT!** If you purchase a brand name drug when an equivalent generic is available, you will pay the appropriate brand name copayment, plus 100% of the cost difference between the brand name and generic drugs. This is almost always 100% of the cost of the brand name drug.

Generic Drug Requirement for Plan A

You receive the highest level of benefit when you purchase generic drugs. Using generic drugs maximizes the value to both you and the University of Idaho by providing the same therapeutic effect as the more expensive equivalent brand name drug but at a fraction of the cost.

You can keep your copayments and contributions as low as possible without sacrificing quality by utilizing generic drugs whenever they are available.

If you purchase a brand name drug when an equivalent generic is available, you will pay the appropriate brand name copayment, plus 100% of the cost difference between the brand name and the generic drug. This is almost always 100% of the cost of the brand name drug.

> ***IMPORTANT!***
>
> Prescription drug cost-sharing and copayments in Plan A do not count toward satisfying the annual medical deductible or cost-share maximum.

What the Prescription Drug Plan Covers

The following are covered under the prescription drug plan:

- Prescription drugs approved by CVS Caremark or Silverscript.
- Compounded medication of which at least one ingredient is a prescription drug.
- Insulin and insulin syringes/needles
  Oral contraceptives and other prescription hormonal contraceptives, such as the Ortho Evra patch and NuvaRing. Generally only generic contraceptives will be zero-cost, but brand names may be covered if the pateint's physician verifies it is due to medical necessity.
- Medications prescribed for the treatment of erectile dysfunction or impotency.

Please note: Prescription drugs received while in the hospital are covered under the medical plan.

General Benefit Information

This section provides you with additional information on how your benefit plan operates.

Annual Deductible

There is an annual deductible that you must satisfy before certain services will be covered.

The deductible amount(s) you must satisfy depend on the plan option in which you are enrolled, your Medicare eligibility, and the number of individuals to whom you provide coverage.

The deductible amounts follow the member. This means, once the member is eligible for Medicare, any covered dependent will be subject to the Medicare-Eligible Plan's deductible amounts.

Each plan has its own deductible amount, as described in the *Medical Plan Coverage At-a-Glance Charts*. In general, benefit payments for each covered individual begin after he or she satisfies the individual deductible. However, if you are enrolled for family coverage under the HDHP with HSA Option (Plan B for pre-Medicare eligible retirees), benefit payments will not begin for any family member until the family deductible is satisfied.

In Plan A only, there are separate deductibles for care you receive in-network and out-of-network. Keep in mind, covered services that are counted toward the in-network deductible do not count toward the out-of-network deductible and vice versa.

Amounts over the maximum allowance for in- and out-of-network care do not apply to the deductible or the cost-sharemaximum.

In general, amounts you pay for covered services count toward satisfying the deductible. However, in Plan A, amounts you pay in copayments for medical and prescription drug covered services do not count toward satisfying the deductible.

Care Away from Home (Blue Card Access Program)

If you travel outside of your Blue Cross of Idaho coverage area or have dependents who live in other areas, coverage is available through the Blue Card Access program through the Blue Cross or combined Blue Cross Blue Shield networks. Blue Cross of Idaho also has negotiated arrangements throughout countries outside the United States. If you plan to travel abroad, or if you become ill while traveling, call the number on your ID card to locate a provider near where you will be visiting. These negotiated arrangements will provide you with care at the best rates and will often include arrangements for direct billing and payment.

Cost-Sharing

Cost-sharing operates like coinsurance. For covered services in Plan A and Plan B you pay a percentage of the maximum allowance toward a service's cost. Typically, you pay cost-sharing after the deductible is satisfied. Your cost-sharing amount depends on the covered service, as described in the *Medical Plan Coverage At-a-Glance Charts*.

Typically, you will continue paying cost-sharing for covered services until you satisfy the cost-share maximum. Once you have satisfied the cost-share maximum, the Plan pays 100% of covered services for the remainder of the plan year.

Cost-Share Maximum

The annual cost-share maximum provides additional protection for you by putting a "cap" on what you pay in cost-sharing for one year for covered services. Once your share of covered charges reaches the cost-share maximum, the plans pays 100% of most covered charges for the year. The cost-share maximum does not include the deductible or copayments.

The cost-share maximum you must meet depends on the Plan in which you are enrolled. Each Plan has its own cost-share maximum amounts, as described in the *Medical Coverage Plan At-a-Glance Chart*.

The cost-share maximum amounts follow the member. This means, once the member is eligible for Medicare, any covered dependent will be subject to the Medicare-Eligible Plan's cost-share maximum amounts.

In most plans, the individual cost-share maximum applies to each participant every calendar year. Once one participant satisfies the individual cost-share maximum, the Plan will begin paying 100% of covered charges for that participant.

Only the amounts you pay in cost-sharing count toward satisfying the cost-share maximum. Amounts you pay to satisfy the deductible and in copayments do not count toward the cost-share maximum.

Additionally, cost-share expenses associated with the following will not count toward satisfying the cost-share maximum:

- The annual deductible;
- Non-covered services or supplies received in- and out-of-network,
- Amounts that exceed the maximum allowance from in- and out-of-network care,
- Amounts that exceed the benefit period limits,
- Amounts that exceed the Medicare limiting charges, if applicable,
- Penalties for not receiving preauthorization,
- Amounts paid toward hearing aid appliances and fitting exams (Plan A only).

Lifetime Maximum

There is no limit on the lifetime benefit payable under either medical plan.

Maximum Allowance

The maximum allowance is the amount Blue Cross of Idaho will pay for a covered service.

The maximum allowance for covered services is the billed charge or the reasonable level of compensation Blue Cross of Idaho considers for a covered service, whichever is less. See the *Important Terms* section for more information.

NOTE: When using the services of an out-of-network provider, you are also responsible for any amount over the maximum allowance.

Special Provisions in the Pre-Medicare Plan A

- **Family cost-share maximum:** In this plan, combined expenses for all covered family members can be used to satisfy the cost-share maximum, even if each covered participant does not satisfy the individual cost-share maximum. No participant may contribute more than the individual cost-share maximum toward the family cost-share maximum.
- **In-network and out-of-network cost-share maximum:** The Pre-Medicare Plan A has separate cost-share maximums for in-network and out-of-network care, as described in the *Medical Plan Coverage At-a-Glance Chart*. Keep in mind, covered services that are counted toward the in-network cost-share maximum do not count toward the out-of-network cost-share maximum and vice versa.

In-Network Providers

If you enroll for medical benefits, you are *not* required to elect a primary care physician. However, you will receive the greatest benefits, and pay less out of pocket, when you seek services from a Blue Cross of Idaho PPO provider. In-network providers have agreed to terms that reduce costs to you and the University. All Providers and Facilities must be licensed and/or registered by the state where the services are rendered, unless exempt by federal law, and must be performing within the scope of license to be payable by the Plan. Network providers include:

- Ambulance transportation service,
- Ambulatory surgical facility (surgery center),
- Audiologist,
- Certified nurse-midwife,
- Certified registered nurse anesthetist,
- Chiropractic physician,
- Clinical nurse specialist,
- Alcoholism or substance abuse treatment facility,
- Contracting speech therapist,
- Clinical psychologist,
- Electroencephalogram (EEG) provider,
- Home intravenous therapy company,
- Hospice,
- Licensed Clinical Professional Counselor (LCPC),
- Licensed Clinical Social Worker (LCSW),
- Licensed Marriage and Family Therapist (LMFT),
- Licensed occupational therapist,
- Licensed physical therapist,
- Licensed rehabilitation hospital,
- Lithotripsy provider,
- Psychiatric hospital,

- Dentist/denturist,
- Diagnostic imaging provider,
- Durable medical equipment supplier,
- Freestanding diabetes facility,
- Freestanding dialysis facility,
- Home health agency,
- Independent laboratory,
- Licensed general hospital,
- Nurse practitioner,
- Optometrist/optician,
- Physician,
- Physician assistant,
- Podiatrist,
- Prosthetic and orthotic supplier,
- Radiation therapy center, and
- Skilled nursing facility.

How to Locate a Network Provider

To locate a provider in your area, please visit the Blue Cross of Idaho Web site at **www.bcidaho.com**. You may also call the customer services number listed on your ID card for assistance in locating a provider. In-network providers will work with Blue Cross of Idaho to complete any preauthorization requirements. You are responsible for obtaining preauthorization when seeking treatment from an out-of-network provider. You are financially responsible for services performed by an out-of-network provider when those services are determined to be not Medically Necessary. You are responsible for notifying BCI if the proposed treatment will be provided by an out-of-network provider.

Out-of-Network Providers

You may choose to use a healthcare provider who is not a Blue Cross of Idaho PPO network provider, but you should know that this will increase your cost-share costs. The Plan does not pay as large of a share of the charges of an out-of-network provider. Additionally, in the Pre-Medicare Plan A you will have to satisfy a separate out-of-network deductible and cost-share maximum. All Providers and Facilities must be licensed and/or registered by the state where the services are rendered, unless exempt by federal law, and must be performing within the scope of license to be payable by the Plan.

Claims for Benefits

You do not have to file a claim for benefits if you use a Blue Cross of Idaho in-network facility or other network provider. However, if you receive services from an out-of-network or other provider and the provider requires you to pay for services up front, claims should be submitted to:

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

You may download a claim form from **www.bcidaho.com**. Claims for services paid by a participant to an out-of-network provider must be submitted for reimbursement within 12 months of the date the services were rendered to be eligible for coverage.

As soon as Blue Cross of Idaho processes your claim, you will receive an Explanation of Benefits, or EOB. Your EOB will show payments Blue Cross of Idaho has made and to whom payments have been made. It will also provide any information on why a claim was denied or not paid in full.

Please contact the number on your ID card with questions about your claims and EOBs. See the *Claims Procedures for Medical Claims* section for more information on claims.

Women's Health and Cancer Rights Act

Federal law requires group health plans to provide coverage for the following services to a participant receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The medical benefits plan determines the manner of coverage in consultation with you and your attending physician. Coverage for breast reconstruction and related services will be subject to deductibles and cost-sharing amounts that are consistent with those that apply to other benefits under the medical benefits plan.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain preauthorization; see "Preauthorization" in the *Medical Management Program* section for more information.

Medical Management Program

Blue Cross of Idaho's medical management program helps ensure that you receive the right care in the right place at the right time.

Medical management helps you better manage your health, your healthcare and your costs. There are many benefits of medical management, including less work or school missed due to illness, enjoying a better quality of life, staying healthy and living longer. Additionally, you may save money by paying less out of your pocket for healthcare expenses.

The medical management program consists of a number of programs and provisions discussed in this section, including:

- Care management,
- Preauthorization,
- Non-emergency preadmission notifications,
- Emergency notifications,
- Continued stay review,
- Discharge planning,
- Disease management, and
- Bright Beginnings Early Prenatal Management Program.

Care Management

The care management program helps you coordinate care before, during and after treatment to ensure continuity of care for participants. It is a collaborative process among Blue Cross of Idaho, participants and providers. The program will help ensure you and your providers know what the Plan will cover.

Preauthorization

The preauthorization program is designed to ensure you get the most appropriate, cost-effective care for your condition(s). Under the program, Blue Cross of Idaho determines whether certain services and supplies are medically necessary or otherwise meet the requirements for plan coverage. Services that are authorized by Blue Cross of Idaho will be covered subject to all the other terms and conditions of the Plan. Services that are not authorized by Blue Cross of Idaho will not be covered, and you will be financially responsible if you choose to receive those services.

Generally, the provider will obtain the preauthorization, particularly if you use an in-network provider. However, if you use an out-of-network provider, it is your responsibility to make sure that the preauthorization is obtained. If your in-network provider fails to obtain the appropriate preauthorization, you will not be held responsible for the charges if the services are not authorized.

In-network providers will work with Blue Cross of Idaho to complete any preauthorization requirements. You are responsible for obtaining preauthorization when seeking treatment from an out-of-network provider. However, it is always a good idea to check and ensure preauthorization has been completed. You are financially responsible for services performed by an out-of-network provider when those services are determined to be not Medically

Necessary. You are responsible for notifying BCI if the proposed treatment will be provided by an out-of-network provider.

Services Requiring Preauthorization

The following services require preauthorization:

Surgical services – inpatient or outpatient:

- Organ, cellular and tissue transplants,
- Arthroscopic surgery of the knee, hip, shoulder, wrist or jaw,
- Nasal and sinus procedures,
- Bariatric surgery and medications (Centers of Excellence Providers Only)
- Eyelid surgery,
- Spinal surgery,
- Jaw surgery,
- Gastric reflux procedures,
- Plastic and reconstructive surgery,
- Breast reduction surgery
- Surgery for snoring or sleep problems,
- Invasive treatment of lower extremity veins (including, but not limited to, varicose veins), and
- Inpatient stays including those that originate from an outpatient service.

Behavioral Health Services

The following behavioral health services require preauthorization:

- Outpatient psychotherapy services after the tenth visit (note, this does not include visits for medication management),
- Intensive outpatient program,
- Partial hospitalization program,
- Residential treatment program,
- Psychological testing/neurological evaluation testing, and
- Electroconvulsive therapy,
- Inpatient stays including those that originate from an outpatient service.

All providers, facilities, and treatment centers must be licensed under state law, certified, or accredited by the Joint Commission to be payable by the Plan. Additional information on providers can be found in the Important Terms section.

Other services that require preauthorization:

- Diabetes self-management education,
- Home intravenous therapy,
- Non-emergency ambulance services,
- Certain prescription drugs as listed on the **CVS** Caremark web site www.cvs.com
- Restorative dental services following accidental injury to sound natural teeth,
- Hospice services,
- Sleep Studies

- Home health skilled nursing services,
- Human growth hormone therapy, (available under prescription plan only)
- Outpatient cardiac rehabilitation services,
- Outpatient pulmonary rehabilitation services,
- Hospital grade breast pumps
- Genetic testing,
- Advanced imaging services (not applicable for emergency room inpatient services):
- Magnetic Resonance Imaging (MRI),
- Magnetic Resonance Angiography (MRA),
- Computed Tomography Scans (CT Scan),
- Positron Emission Tomography (PET), and
- Nuclear cardiology.

The following services require preauthorization when the expected charges exceed $500:

- Rental or purchase of durable medical equipment, except for oxygen therapy equipment related to Durable Medical Equipment,
- Prosthetic appliances,
- Orthotic devices, and
- Oral appliances for sleep apnea.

How to Preauthorize Services

To obtain preauthorization, call the number on the Blue Cross of Idaho ID card.

Blue Cross of Idaho will respond to a request for Prior Authorization received from either the provider or the participant 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. Blue Cross of Idaho may review medical records, test results and other sources of information to ensure a covered service is medically necessary and/or to suggest alternate treatments.

- ***If the service* is *authorized*,** Blue Cross of Idaho will notify your healthcare provider within one working day. Written/electronic confirmation will be provided to you and your healthcare provider within one working day of the telephone notice.
- ***If the service* is not *authorized,*** Blue Cross of Idaho will notify your healthcare provider e within 24 hours. Written/electronic confirmation to you and your healthcare provider will be provided within one working day of the telephone notice. Services will be continued without additional liability to you, except the applicable copayment or any deductible, until you have been notified that the service is no longer certified. If you choose to continue to receive care from a provider after notification that the services will not be covered, you will be responsible for the full cost of such services and such amount will not apply to any deductible or cost-share maximum. If you wish to appeal a decision by Blue Cross of Idaho, please review the information in the *Claims Procedures for Medical Claims* section.

Non-Emergency Preadmission Notification Requirement

You are required to notify Blue Cross of Idaho by calling the number on your ID card of all inpatient admissions (except for emergencies and maternity care). Please notify Blue Cross of Idaho as soon as you know you will be admitted.

Emergency Notification Requirement

When an emergency occurs and you cannot notify Blue Cross of Idaho before you are admitted to the hospital, you or a representative must contact Blue Cross of Idaho within 48 hours of the admission. If the admission is on a weekend or legal holiday, Blue Cross of Idaho should be notified by the end of the next working day after the admission.

Continued Stay Review

Blue Cross of Idaho will contact the hospital utilization review department and/or the attending physician the day before the proposed discharge date. If the patient will not be discharged as originally proposed, Blue Cross of Idaho will evaluate the medical necessity of the continued stay and approve or disapprove benefits for the proposed course of inpatient treatment.

Discharge Planning

When you are being discharged from the hospital, Blue Cross of Idaho will provide you with additional information and benefits for various post-discharge courses of treatment.

Disease Management Programs (Get Help with Managing Chronic Conditions)

The disease management feature of the medical benefits plan is available to help you and your covered dependents manage chronic health conditions. Disease management is based on the concept that many disease complications can be prevented if:

- Patients become active participants in controlling and managing their diseases through appropriate lifestyle changes and compliance with prescribed treatment, and
- People are given assistance in managing the risk factors before health conditions become chronic.

Disease management helps participants with chronic illnesses, such as asthma, diabetes, congestive heart disease or low back pain, avoid or minimize costly complications by focusing on compliance with well-accepted treatment protocols. Through your participation in the program you will also receive education and supportive resources.

Our disease management program supports the following chronic conditions:

- Diabetes,
- Asthma,
- Congestive heart failure, and
- Low back pain.

Participants with certain chronic conditions or a risk for developing these conditions will be contacted by a Blue Cross of Idaho medical professional and invited to voluntarily participate at no

cost. All information is confidential and, by law, cannot be shared with the University, staff members or family members without your permission.

Learn more about the disease management program or enroll by calling the customer service number on your ID card and asking for Disease Management Services or logging on to **www.bcidaho.com.**

Bright Beginnings Early Prenatal Management Program

Bright Beginnings is a no-cost prenatal program designed to promote healthy prenatal care to expectant mothers through education and support.

When a Participant enrolls, she receives a free copy of the *Mayo Clinic Guide to a Healthy Pregnancy*, which provides information on maintaining a healthy pregnancy and delivering a healthy baby. Upon completion of the initial registration, the pregnant woman receives a call from a Blue Cross of Idaho case manager who conducts a clinical assessment to determine risk status and offer services through the Blue Cross of Idaho high-risk pregnancy case management program if warranted. For each subsequent trimester, the case manager reaches out to evaluate the risk status again and provide support as needed. After delivery, the case manager contacts the mother again to offer a post delivery assessment for post partum depression and to ensure that mother and baby are engaged in appropriate follow up care.

If the Participant enrolls during the first trimester, she is eligible for an incentive for participation in the program and for attending all of her scheduled visits with her prenatal caregiver. During the third trimester, the enrolled member will receive a reminder to obtain the appropriate attestation that she has completed all of her visits and to submit it after delivery. Upon submission, the mother indicates her choice of either a $50 reimbursement toward a car seat, validated with proof of purchase for the car seat, or a $50 gift card for the baby. She will also receive a copy of the book *What to Expect – The First Year.*

Bright Beginnings is available to all eligible Participants. To enroll, the expectant member should call Blue Cross of Idaho at **1-800-741-1871** and leave her name, address, contact information, member ID number and current week of pregnancy.

What the Medical Plans Cover

The following are covered services when obtained in accordance with the terms and conditions of this Plan. Benefits are subject to the copayments, deductibles, cost-sharing, exclusions, limitations and other provisions as specified.

Note: To receive benefits, some covered services require preauthorization. Please review the *Preauthorization* section for more specific details.

Ambulance Transportation Services

For the purpose of this section, "Ambulance" means a specially designed and equipped vehicle used only for transporting the sick and injured. Coverage will be provided for medically necessary ambulance transportation of a participant within the local community:

- From a participant's home or scene of injury or emergency medical condition to a licensed general hospital,
- Between licensed general hospitals,
- Between a licensed general hospital and a skilled nursing facility,
- From a licensed general hospital to the participant's home, or
- From a skilled nursing facility to the participant's home.

If there is no facility in the local community that can provide covered services appropriate to the participant's condition, then ambulance transportation services mean transportation to the closest facility outside the local community that can provide the necessary service. Blue Cross of Idaho will also cover air ambulance transportation services for emergency services when it is medically necessary to use air transportation instead of ground transportation.

Benefits are available under this *Ambulance Transportation Services* section for medical services provided to a participant only if the participant is transported to a medical facility.

Behavioral Health Services (Psychiatric Care Services)

Behavioral health benefits provide coverage for inpatient and outpatient psychiatric, mental health and substance abuse services for you and your covered dependents. Your benefits are counted toward your medical plan deductible and are paid by cost-sharing in the same manner as any other major medical expense, see the *Medical Plan Coverage At-a-Glance Chart* for more information on how services are covered.

Covered psychiatric care services include intensive outpatient programs (IOP), partial hospitalization programs (PHP), residential treatment programs, psychological testing/neuropsychological evaluation testing and electroconvulsive therapy (ECT).

Payments for inpatient or outpatient psychiatric services apply to covered services furnished by any of the following:

- Licensed general hospital,
- Alcoholism or substance abuse treatment facility,
- Psychiatric hospital,
- Licensed Clinical Social Worker (LCSW),
- Licensed Clinical Professional Counselor (LCPC),

- Licensed Marriage and Family Therapist (LMFT),
- Clinical Psychologist, and
- Physician.

Inpatient Psychiatric Care

The benefits provided for inpatient hospital services and inpatient medical services in this section are also provided for the care of mental or nervous conditions, alcoholism, substance abuse or addiction, or any combination of these.

Outpatient Psychiatric Care

The benefits provided for outpatient hospital services and outpatient medical services in this section are also provided for mental or nervous conditions, alcoholism, substance abuse or addiction, or any combination of these. The use of hypnosis to treat a participant's mental or nervous condition is a covered service.

Outpatient Psychotherapy Services

Covered services include professional office visit services, and family, individual and/or group therapy.

> ***Don't forget about your EAP benefits!***
> Our Employee Assistance Plan (EAP) provides up to eight counseling sessions per household member at no cost to you. You may want to exhaust these sessions before seeking care through the behavioral health program. See the *Employee Assistance Plan* section for more information.

Obtaining Behavioral Health Services

The behavioral health program covers a wide array of mental health and chemical dependency problems. To obtain behavioral health services, call **1-800-743-1871**. When you call, you will be connected to a customer service representative who will work with you to match you with a provider in your area. Although you can select any provider, you will receive maximum benefits if you use a provider who is part of the network.

> ***Protecting Your Confidentiality***
> All program staff and providers are bound by strict confidentiality requirements. Blue Cross of Idaho follows all state and federal laws and regulations regarding the release of patient information. A patient must always provide written consent for such release, unless there is an emergency or legal exception. The release of records related to drug or alcohol abuse must not only follow written authorization by the patient but also appropriate federal regulations.

Applied Behavioral Analysis (ABA) - Outpatient

Benefits are provided for ABA services subject to the following:

1. Services must be identified as part of an approved treatment plan.
2. Continuation of benefits is contingent upon approval by BCI, on behalf of the Plan Administrator, of a plan of treatment.

Emergency Admissions

If you are admitted on an emergency basis, you and your provider should call **1-800-743-1871** within 48 hours to obtain authorization. If you seek emergency medical care under a masked behavioral health diagnosis (a condition that presents itself as a medical emergency, but is instead diagnosed as a behavioral health matter) from an out-of-network facility or provider, benefits will be considered without reduction if the rules for in-network medical care were followed based on the participant's medical plan choice and if Blue Cross of Idaho was promptly notified following behavioral health diagnosis.

Emergency Care

Emergency care means medical or dental care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or in the case of a pregnant woman, the health of her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction/impairment of any bodily organ or part.

The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Emergency Care.

Chiropractic Care Services

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:

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

No benefits are provided for:

- Surgery as defined in this Plan to include injections.
- Laboratory and pathology services.

Range of motion and passive exercises that are not related to restoration of a specific loss of function.

Massage therapy, if not performed in conjunction with other modalities or manipulations.Maintenance, palliative or supportive care.

- Preventive or wellness care.
- 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.
    - General exercise programs.
    - Diagnostic Services, except for x-rays to assist in the diagnosis and Neuromusculoskeletal Treatment plan as defined in this Plan.

Dental Services Related to Accidental Injury

Dental services rendered by a physician or dentist that are required as a result of an accidental injury to the jaw, sound natural tooth, mouth or face. Such dental services shall be covered only for the 12-month period immediately following the date of injury.

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

Benefits for covered dental services are secondary to dental benefits available to a participant under a dental policy of insurance, contract or underwriting plan that is separate from this Plan.

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

Before providing benefits for covered services, Blue Cross of Idaho has the right to refer the participant to a dentist of its choice and at its expense to verify the need, quantity and quality of dental work claimed as a benefit under this section.

If a participant transfers from the care of one dentist to another dentist during a dental treatment plan, or if more than one dentist renders services for one dental procedure, Blue Cross of Idaho will pay no more than the amount that it would have paid if only one dentist had rendered the service.

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) certified program.

Diagnostic Services

Diagnostic services are covered, provided such services are not related to chiropractic care. Diagnostic services include, but are not limited to, mammograms, routine lab tests, X-rays, MRIs, CAT scans, pregnancy tests and Pap tests. Tests to determine pregnancy and Pap tests are covered regardless of results. Benefits for medically necessary genetic testing are only available when preauthorization has been completed and approved by Blue Cross of Idaho.

Durable Medical Equipment (DME)

The Plan pays 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 Blue Cross of Idaho, the purchase of medically necessary durable medical equipment required for therapeutic use. The durable medical equipment must be prescribed by an attending physician or other professional provider within the scope of license. No benefits are available for the replacement of any item of durable medical equipment that has been used by a participant for less than five years (whether or not the item being replaced was covered under this plan). Benefits shall not exceed the cost of the standard, most economical durable medical equipment that is consistent, according to generally accepted medical treatment practices, with the participant's

condition. If the participant and his or her provider have chosen a more expensive treatment than is determined to be the standard and most economical by Blue Cross of Idaho, the excess charge is solely the responsibility of the participant. Equipment items considered to be common household items are not covered.

Emergency Services

Emergency services are those healthcare services that are provided in a licensed general hospital or other emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity including, but not limited to, severe pain, that the absence of immediate medical attention could result in:

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

Hearing Aid Appliances and Fitting Exam

Hearing aid appliances and fitting exams are subject to your plan's deductible and the $800 per participant lifetime limit. Any amount due to the provider above the $800 lifetime benefit limit will be the participant's responsibility. Amounts paid toward hearing aid appliances and fitting exams do not count toward your cost-share maximum except under the HDHP with HSA option (Plan B for pre-Medicare eligible retirees). Only services and Appliances provided by licensed medical providers are covered.

Hearing Examination

For in-network covered services, Blue Cross of Idaho will pay or otherwise satisfy a percentage of the maximum allowance up to the benefit limit as shown in the *Medical Plan Coverage At-a-Glance Chart.* Covered services include one routine wellness hearing examination per participant, per benefit period. Only services and Appliances provided by licensed medical providers are covered.

Home Health Skilled Nursing Care Services

The plan covers the delivery of Skilled Nursing Care services under the direction of a Physician to a homebound participant, provided this provider does not ordinarily reside in the participant's household or is not related to the participant 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 30 days. No benefits are provided during any period of time in which the participant is receiving hospice covered services.

Hospice Home Care Services

A participant must request hospice benefits specifically and must meet the following conditions to be eligible for hospice benefits:

- The attending or primary physician must certify that the participant is a terminally ill patient with a life expectancy of six months or less.
- The participant must live within the contracting hospice's local geographical area.
- The participant must be formally accepted by the contracting hospice.
- The participant must have a designated volunteer primary caregiver at all times.

- Services and supplies must be prescribed by the attending physician and included in a hospice plan of treatment approved in advance by Blue Cross of Idaho. The hospice must notify Blue Cross of Idaho within one working day of any change in the participant's condition or plan of treatment that may affect the participant's eligibility for hospice benefits.
- Palliative care, which controls pain and relieves symptoms but does not provide a cure, must be appropriate to the participant's illness.
- Exclusions and limitations. No benefits are provided for:
- Hospice services not included in a hospice plan of treatment and not provided or arranged and billed for through a contracting hospice.
- Continuous skilled nursing care services except as provided specifically as part of respite care or continuous crisis care.
- No hospice benefits will be provided during any period of time in which a participant is also receiving skilled nursing care services.

Hospital Services – Inpatient

The following are covered services:

- Room, board and general nursing services. Room and board, special diets, the services of a dietitian, and general nursing service when a participant is an inpatient in a licensed general hospital are covered as follows:
- (1) A room with two or more beds is covered. If a private room is used, the benefit provided in this section for a room with two or more beds will be applied toward the charge for the private room. Any difference between the charges is a non-covered expense under this plan and is the sole responsibility of the participant.
- (2) If isolation of the participant is: (a) required by the law of a political jurisdiction, or (b) required to prevent contamination of either the participant or another patient by the participant, then payment for approved private room isolation charges shall be in place of the benefits for the daily room charge stated in paragraph one.
- (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.
- A bed in a nursery unit is covered.
- Ancillary services. Licensed general hospital services and supplies, including:
- Use of operating, delivery, cast and treatment rooms and equipment.
- Prescription drugs administered while the participant is an inpatient.
- Administration and processing of whole blood and blood products when the whole blood or blood products are actually used in a transfusion for a participant; whole blood or blood plasma that is not donated on behalf of the participant or replaced through contributions on behalf of the participant.
- 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.
- 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.
- Oxygen and administration of oxygen.
- 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.

- Diagnostic services and therapy services as specified in their respective sections in this plan. 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.

Hospital Services – Outpatient

The following are covered services:

- Emergency care: Licensed general hospital services and supplies for the treatment of an accidental injury or an emergency medical condition.
- 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.

Therapy services as specified in the *Selected Therapy Services* paragraph.

Hospital Services – Preadmission Testing

- Tests and studies required with the participant's admission and accepted or rendered by a licensed general hospital on an outpatient basis prior to a scheduled admission as an inpatient, if the services would have been available to an inpatient of a licensed general hospital. Preadmission testing does not include tests or studies performed to establish a diagnosis.
- Preadmission testing benefits are limited to inpatient admissions for surgery. Preadmission testing must be conducted within seven days prior to a participant's inpatient admission.
- Preadmission testing is a covered service only if the services are not repeated when the participant is admitted to the licensed general hospital as an inpatient, and only if the tests and charges are included in the inpatient medical records.
- No benefits for preadmission testing are provided if the participant cancels or postpones the admission to the licensed general hospital as an inpatient. If the licensed general hospital or physician cancels or postpones the admission, then benefits are provided.
- Hospital benefits may be provided for dental extractions, or other dental procedures if certified by a physician that a non-dental medical condition requires hospitalization to safeguard the health of the participant. Non-dental conditions that may receive hospital benefits are:
- Brittle diabetes,
- History of a life-endangering heart condition,
- History of uncontrollable bleeding,
- Severe bronchial asthma,
- Children under 10 years of age who require general anesthesia, and
- Other non-dental, life-endangering conditions that require hospitalization, subject to approval by Blue Cross of Idaho.

Inpatient Physical Rehabilitation

For covered services rendered by a licensed general hospital or a licensed rehabilitation hospital, Blue Cross of Idaho will pay as shown in the *Medical Plan Coverage At-a-Glance Chart*.

Benefits are provided for inpatient physical rehabilitation subject to the following:

- Admission for inpatient physical rehabilitation must occur within 120 days of discharge from an acute care licensed general hospital.
- Continuation of benefits is contingent upon approval by Blue Cross of Idaho of a physical rehabilitation plan of treatment and documented evidence of patient progress submitted to Blue Cross of Idaho at least twice each month.

Mammography

Mammogram screening means the X-ray examination of the breast using equipment dedicated specifically for mammography, as well as the provider's interpretation of such examination.

Maternity Services

You have 60 days from the birth of a child to enroll him or her in benefits coverage. For more information about enrolling your newborn in benefits coverage, see the *Making Changes to Your Benefits During the Year* section.

The benefits provided for licensed general hospital services and surgical/medical services in this Plan are also provided for the maternity services listed below when rendered by a licensed general hospital or physician.

If you have a birth, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child will include 48 hours following a vaginal delivery and 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 48 hours or 96 hours as applicable. For stays in excess of 48 hours or 96 hours, additional benefits may be available; however, you must preauthorize those services. See the *Medical Management Program* section for more information.

Please note that nursery care of a newborn infant is not a maternity service.

Benefits are also provided for a normal pregnancy or involuntary complications of pregnancy as defined below.

- ***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.
- Involuntary complications of pregnancy including, but not limited to:
- Cesarean section delivery, ectopic pregnancy that is terminated, spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia and toxemia.
- 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.

- Benefits for termination of pregnancy are provided only if the participant suffers a life-endangering condition.

Medical Services – Inpatient

Inpatient medical services rendered by a physician or other professional provider to a participant who is receiving covered services in a licensed general hospital or covered skilled nursing facility.

Inpatient medical services also include consultation services when rendered to a participant as an inpatient of a licensed general hospital by another physician at the request of the attending physician. Consultation services do not include staff consultations that are required by licensed general hospital rules and regulations.

Medical Services – Outpatient

The following outpatient medical services rendered by a physician or other professional provider to a participant who is an outpatient, provided such services are not related to pregnancy, chiropractic care, mental or nervous conditions, alcoholism, substance abuse or addiction, except as specified elsewhere in this section:

- **Emergency care:** Medical care for the treatment of an accidental injury or emergency medical condition.
- **Special therapy services:** Deep radiation therapy or chemotherapy for a malignancy when such therapy is performed in the physician's office.
- **Home and other outpatient services:** Medical care for the diagnosis or treatment of an accidental injury, disease, condition or illness.
- **Wellness/preventive care services:** See *Preventive Care Services/Wellness* paragraph).

Outpatient Cardiac Rehabilitation Services

Cardiac rehabilitation is a covered service for participants who have a clear medical need and who are referred by their attending physician and (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months; (2) have had coronary bypass surgery; or (3) have stable angina pectoris. Services must adhere to Medicare guidelines and be preauthorized by Blue Cross of Idaho.

Outpatient Pulmonary Rehabilitation Services

Benefits will be provided for but not limited to the following diagnoses: COPD, chronic bronchitis, asthma, emphysema, bronchiectasis and restrictive lung disease. Services must adhere to Medicare guidelines and be preauthorized by Blue Cross of Idaho.

Orthotic Devices

Orthotic devices include, but are not limited to, medically necessary braces, back or special surgical corsets, splints for extremities and trusses, when prescribed by a physician, chiropractic physician, podiatrist, licensed physical therapist or licensed occupational therapist. Arch supports, other foot support devices, orthopedic shoes and garter belts are not considered orthotic devices. Benefits shall not exceed the cost of the standard, most economical orthotic device that is consistent, according to generally accepted medical treatment practices, with the

participant's condition. No benefits are available for the replacement of any item of orthotic devices that has been used by a participant for less than five (5) years (whether or not the item being replaced was covered under this Plan), with the exception of an orthotic device used by an Eligible Dependent child who has outgrown the item.

Outpatient Rehabilitation or Habilitation Services

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

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

Post-Mastectomy/Lumpectomy Reconstructive Surgery

Reconstructive surgery in connection with a disease-related mastectomy/lumpectomy, including:

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

Coverage is provided in a manner determined in consultation with the attending physician and the participant. The deductible and copayment requirements that apply to other covered services also apply to these post-mastectomy reconstructive and treatment services.

Prescription Drugs

Please see the *Prescription Drug Benefits* section for additional information.

Preventive Care Services/Wellness

Covered services are only available from PPO in-network providers and include the following:

Specifically Listed Services

Annual adult physical examinations; Bone density; Chemistry panels; Cholesterol screening; Colorectal cancer screening (colorectal cancer screening, fecal occult blood test); Complete Blood Count (CBC); Diabetes screening; Pap test; PSA test; Rubella screening; Screening EKG; Screening mammogram; Thyroid Stimulating Hormone (TSH); Transmittable diseases screening (Chlamydia,Gonorrhea, Human Immunodeficiency Virus (HIV), Human papillomavirus (HPV), Syphilis, Tuberculosis (TB)); Hepatitis B virus screening; Sexually transmitted infections assessment; HIV assessment; Screening and assessment for interpersonal and domestic violence; Urinalysis (UA); Aortic aneurysm ultrasound; Alcohol misuse assessment; Breast cancer (BRCA) risk assessment and genetic counseling and testing for high-risk family history of breast or ovarian cancer; Newborn metabolic screening (PKU, Thyroxine, Sickle Cell); Health risk assessment for depression; Newborn hearing test; Lipid disorder screening; Smoking cessation counseling visit; Dietary counseling (limited to 3 visits per participant, per benefit period); Behavioral counseling for participants who are overweight or obese; Preventive lead screening; Lung cancer screening for participants age 55 and older; Hepatitis C virus infection screening, urinary incontinence screening.

Women's Preventive Care Services

Well Woman visits (for recommended age-appropriate preventive services); breastfeeding support, supplies and counseling.

Well-Baby Care and Well-Child Care

Routine or scheduled well-baby and well-child examinations, including vision, hearing and developmental screenings; Dental fluoride application for participants age 5 and younger;

Maternity Benefits

Gestational diabetes screening for pregnant women; Iron defi ciency screening for pregnant women; Rh (D) incompatibility screening for pregnant women; and Urine culture for pregnant women.

Immunizations

Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rotavirus, Rubella, Tetanus, Varicella (Chicken Pox), Hepatitis A,
Meningococcal, Human Papillomavirus (HPV) and Zoster. 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.

Prosthetic Appliances

The plan covers 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:

- The prosthetic appliance must be approved by Blue Cross of Idaho before the participant purchases it.
- Benefits shall not exceed the cost of the standard, most economical prosthetic appliance that is consistent, according to generally accepted medical treatment practices, with the participant's condition. If the participant and his or her provider have chosen a more expensive treatment

than is determined to be the standard and most economical by Blue Cross of Idaho, the excess charge is solely the responsibility of the participant.

- No benefits are provided for dental appliances or major artificial organs including, but not limited to, artificial hearts and pancreases.
- 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 90 days of the surgery.
- 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.

Selected Therapy Services

Benefits for therapy services include:

- Chemotherapy,
- Enterostomal therapy,
- Home intravenous therapy (home infusion therapy), and
- Renal dialysis.

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

Benefits are available only as preauthorized and approved by Blue Cross of Idaho when medically necessary.

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. If the Participant is receiving care at a Skilled Nursing Facility at the end of a Benefit Period, benefits shall not renew the following Benefit Period until the Participant is discharged. However, no benefits are provided when the care received consists primarily of:

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

Tobacco Cessation Services

Approved counseling services and most prescription medications associated with smoking cessation are free of charge. To obtain a medication on tier I plan A, simply have your doctor complete a prescription and have it filled at an in-network pharmacy.

Surgical Services

The plan covers the following:

- Surgical services:
- Surgery performed by a physician or other professional provider.
- 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.
- **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.
- **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.
- **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.
- Second and third surgical opinion:
- Services consist of a physician's consultative opinion to verify the need for elective surgery as first recommended by another physician.
- Specifications:
    - > Elective surgery is covered surgery that may be deferred and is not an emergency.
    - > Use of a second consultant is at the participant's option.
    - > If the first recommendation for elective surgery conflicts with the second consultant's opinion, then a third consultant's opinion is a covered service.
    - > The third consultant must be a physician other than the physician who first recommended elective surgery or the physician who was the second consultant.

Temporomandibular Joint (TMJ) Syndrome

Benefits are provided as specified in the *Medical Plan Coverage At-a-Glance Chart* for services, including surgery and supplies related to orthognathics or to the misalignment or discomfort of the temporomandibular joint, including splinting services and supplies.

Therapy Services

Occupational Therapy

Payment is limited to occupational therapy services related to Habilitative and Rehabilitative care, with reasonable expectation that the services will produce immeasurable improvements in the participant's condition in a reasonable period of time. Occupational therapy services are covered when performed by:

- A physician, or
- 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.

Benefits are not provided for:

- 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.

- General exercise programs, even when recommended by a physician or a chiropractic physician, and even when provided by a licensed occupational therapist.
- Maintenance palliative or supportive care.
- Behavioral modification services.

Physical Therapy

- Payment is limited to physical therapy services related to habilitative and rehabilitative care with a reasonable expectation that the services will produce measurable improvements in the participant's condition in a reasonable period of time. Physical therapy services are covered when performed by:
- A physician,
- A licensed physical therapist, provided the covered services are related directly to a written treatment regimen prepared by the physical therapist, or
- A podiatrist.
- No benefits are provided for the following physical therapy services when the specialized skills of a licensed physical therapist are not required:
- 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,
- Assistance in walking, such as that provided in support for feeble or unstable patients,
- 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
- General exercise programs, even when recommended by a physician or a chiropractic physician, and even when provided by a licensed physical therapist.
- Maintenance, palliative, or supportive care.
- Behavioral modification services.

Speech Therapy

- Benefits are limited to speech therapy services related to habilitative and rehabilitative care with, a reasonable expectation that the services will produce measurable improvement in the participant's condition in a reasonable period of time.
- Speech therapy services are covered when performed by:
    - A physician, or
    - A speech therapist, provided the services are related directly to a written treatment regimen designed by the speech therapist.
- Maintenance, palliative, or supportive care.
- Behavioral modification services.

Transplant Services

- Transplants or autotransplants of arteries, veins, blood, ear bones, cartilage, muscles, skin hematopoietic, CAR T-Cell, and tendons; heart valves regardless of their source; implantation of artificial or mechanical pacemakers; and autotransplants of teeth or tooth buds and autotransplants as Medically Necessary.

- The applicable benefits provided for hospital services and surgical services in this plan are provided only for a recipient of medically necessary transplant services.
- No benefits are available for services, expenses or other obligations of or for a deceased donor, even if the donor is a plan participant.
- Transplants of corneas, kidneys, bone marrow, livers, hearts, lungs,pancreas, hematopoietic, heart-lung and pancreas-kidney combinations and other solid organ or tissue trasplants or combinations as Medically Necessary. The applicable benefits provided for hospital services and surgical services in this plan are also provided for a recipient of medically necessary transplant services.
- Benefits for transplant are subject to the following conditions:
    - The participant must have the transplant performed at an appropriate recognized transplant center. If the recipient is eligible for Medicare, the recipient must have the transplant performed at a recognized transplant center that is approved by the Medicare program for the requested transplant-covered service.
- If the recipient is eligible to receive benefits for these transplant services, organ procurement charges shall be paid for the donor, even if the donor is not a plan participant. Benefits for the donor shall be charged to the recipient's coverage.
- If the recipient is eligible to receive benefits for these transplant services, benefits for transportation and living expenses of the participant recipient and/or the participant recipient's immediate family shall be provided up to the lifetime benefit maximum, as shown in the *Medical Plan Coverage At-a-Glance Chart*. The benefit will be paid upon the following terms and conditions;
    - The benefits will be paid only for the listed expenses incurred by the recipient or the recipient's immediate family members.
    - The benefits will be reimbursed upon the submission to Blue Cross of Idaho of dated receipts showing the service provided, the cost of the service and the name, address and phone number of the service provider.
    - The listed expenses will not be reimbursed unless such expenses are incurred between the time period of five days prior to the transplant to 120 days after the transplant.
    - Blue Cross of Idaho reserves the exclusive right to deny payment of any such expenses it deems inappropriate, excessive or not in keeping with the intent of this provision.
- In addition to any other exclusions and limitations of this plan, the following exclusions and limitations apply to transplant services:
    - Transplants of brain tissue or brain membrane, islet tissue, intestine, pituitary and adrenal glands, hair transplants or any other transplant not named specifically as a covered service in this plan; or for artificial organs, including, but not limited to, artificial hearts or pancreases.
    - Any eligible expenses of a donor related to donating or transplanting an organ or tissue unless the recipient is a participant who is eligible to receive benefits for transplant services.
    - The cost of a human organ or tissue that is sold rather than donated to the recipient.
    - Transportation costs, including, but not limited to, ambulance service or air service for the donor or to transport a donated organ or tissue.
    - Living expenses for the donor or the donor's family members.
    - 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.

> Any complication to the donor arising from a donor's transplants. Surgery is not a covered benefit under the participant transplant recipient's plan. If the donor is a Blue Cross of Idaho participant, eligible to receive benefits for covered services, benefits for medical complications to the donor arising from transplant surgery will be allowed under the donor's policy.

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> Treatment for Autism Spectrum Disorder

> Payment is limited to Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder and Treatment for Autism Spectrum Disorder as identified in a treatment plan. Continuation of benefits is contingent upon approval by BCI of an ABA plan of treatment.

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> 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 you and your Provider have chosen a more expensive item than is determined to be the standard and most economical by BCI, the excess charge is your sole responsibility. Supply items considered to be personal care items or common household items are not covered.

What the Medical Plans Do Not Cover

The medical plans provide coverage for medically necessary services. They do not provide coverage for the following services, supplies, drugs or other charges, except as required by law:

- Not specifically listed as a covered service.
- Not medically necessary.
- In excess of the maximum allowance.
- 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 patient has a non-dental, life-endangering condition that makes hospitalization necessary to safeguard the patient's health and life.
- Not prescribed by or upon the direction of a physician or other professional provider; or that are furnished by any individuals or facilities other than licensed general hospitals, physicians and other providers.
- Investigational in nature.
- Provided for any condition, disease, illness or accidental injury covered, 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 such benefits or compensation are claimed, or losses are recovered from a third party.
- Provided or paid for by any federal governmental entity except when payment under this Plan is expressly required by federal law, or provided or paid for by any state or local governmental entity where its charges therefore would vary, or would be affected by the existence of coverage under this Plan.

- Provided for any condition, accidental injury, disease or illness suffered as a result of any act of war or any war, declared or undeclared.
- Furnished by a provider who is related to you by blood or marriage and who ordinarily lives in your household.
- 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.
- For surgery intended mainly to improve appearance or for complications arising from surgery intended mainly to improve appearance, except for:
- Reconstructive surgery necessary to treat an accidental injury, infection or other disease of the involved part, or
- Reconstructive surgery to correct congenital anomalies in a dependent child.
- Benefits for reconstructive surgery to correct an accidental injury are available even though the accident occurred while the participant was covered under a prior insurer's coverage.
- Rendered prior to the participant's effective date, or during an inpatient admission commencing prior to the participant's effective date except as specified as a covered service.
- For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance)
- 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.
- 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.
- For relaxation or exercise therapies, including but not limited to, educational, recreational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, homeopathic, or naturopathic, massage, or music even if prescribed by a Physician.
    - For telephone consultations and all computer or Internet communications, , except as specified as a covered service in this plan
- For failure to keep a scheduled visit or appointment, completion of a claim form, personal mileage, transportation, food or lodging expenses or mileage, transportation, food or lodging expenses billed by a physician or other professional provider.
- For inpatient admissions that are primarily for diagnostic services or therapy services; or for inpatient admissions when the patient is ambulatory and/or confined primarily for bed rest, special diet, behavioral problems, environmental change or treatment that does not require continuous bed care.
- 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.
- 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).
- 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.
- For any treatment of sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence, even if related to a medical condition, except as specified as a covered service under this plan. (Covered services include treatments for the self-determined gender identity of the Participant. Covered services also include hormone therapy and treatment for the

organs possessed by the Participant (e.g. prostate or ovary) regardless of gender identity.)

- Made by a licensed general hospital for failure to vacate a room on or before the established discharge hour.
- Not directly related to the care and treatment of an actual condition, illness, disease or accidental injury.
- Furnished by a facility that is primarily a place for treatment of the aged or that is primarily a nursing home, convalescent home or rest home.
- For acute care, rehabilitative care or diagnostic testing except as specified as a covered service in the plan; for mental or nervous conditions and substance abuse services not recognized by the American Psychiatric and American Psychological Associations.
- For any of the following, even if the service or supply is to treat a result of a congenital anomaly or a developmental problem and even if it is medically necessary — appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a covered service; for orthognathic surgery, including services and supplies to augment or reduce the upper or lower jaw; 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.
- For alveolectomy or alveoloplasty when related to tooth extraction.
- 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 an immediately life-endangering condition.
- For use of operating, cast, examination or treatment rooms or for equipment located in a provider's office or facility, except for emergency room facility charges in a licensed general hospital, unless specified as a covered service.
- For the reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties.
- Treatment for reproductive procedures, including, but not limited to, ovulation induction procedures and pharmaceuticals, artificial insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance reproductive ability, including but not limited to laboratory services, radiology services or similar services related to treatment for fertility or fertilization reproduction procedures.
- For transplant services and artificial organs, except as specified as a covered service.
- For acupuncture.
- 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. Additionally, reversals, revisions and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.
- For hospice home care, except as specified as a covered service.
- For pastoral, spiritual, bereavement counseling or marriage counseling.
- For homemaker and housekeeping services or home-delivered meals.
- 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.
- For treatment or other healthcare in connection with an illness, disease, accidental injury or

other condition that would otherwise be covered under any medical payments provision, no-fault provision, motorist provision or other first party or no-fault provision of any automobile, homeowner's or other similar policy of coverage, contract or underwriting plan.

- Any services or supplies for which you 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 coverage.
- For a routine or periodic mental or physical examination that is not connected with the care and treatment of an actual illness, disease or accidental injury or for an examination required on account of employment; or related to an occupational injury; for a marriage license; or for coverage, school or camp application; or a screening examination including routine hearing examinations, unless specified as a covered service.
- For immunizations except as provided as a covered service.
- For surgery for gynecomastia.
- For nutritional supplements.
- For replacements, nutritional formulas except, when administered enterally due to impairment in digestion and absorption of an oral diet and is the sole source of caloric need or nutrition in a participant.
- For vitamins and minerals, unless required through a written prescription and cannot be purchased over-the-counter.
- For an elective abortion, except to preserve the life of the female upon whom the abortion is performed.
- For alterations or modifications to a home or vehicle.
- For special clothing, including shoes (unless permanently attached to a brace).
- Provided to a person enrolled as an eligible dependent, but who no longer qualifies due to a change in eligibility status that occurred after enrollment.
- Provided outside the United States, if it would not be a covered service if it had been provided in the United States.
- For outpatient pulmonary and/or cardiac rehabilitation except as provided as a covered service.
- For complications arising from the acceptance or utilization of non-covered services.
- For the use of hypnosis, as anesthesia or other treatment, except as specified as a covered service.
- For dental implants, appliances, and/or prosthetics and/or treatment related to orthodontia, even when medically necessary, unless specified as a covered service.
- For arch supports, orthopedic shoes and other foot devices.
- Benefits for contraceptives, unless specified as a covered service.
- For wigs and cranial-molding helmets, unless used to protect post cranial vault surgery.
- 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.
- For the purchase of therapy or service dogs/animals and the cost of training/maintaining said animals.
- For the treatment of injuries sustained while operating a motor vehicle under the influence of alcohol and/or narcotics unless the injuries arose as result of a physical or mental health condition. For purposes of this Plan exclusion, "Under the influence" means a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred or no breathalyzer exam was performed or the person refused to submit to a requested breathalyzer

or blood test or was under the influence of illegal drugs.

Rendered after exhaustion of an established benefit limit, unless authorized at the discretion of the Plan Sponsor and in accordance with specific BCI medical criteria.

What's Not Covered Under the Prescription Drug Plan

In addition to other plan limitations and exclusions, the prescription drug benefit does not cover the following:

- Drugs used for the termination of early pregnancy and/or resulting complications, except when required to correct an immediately life-endangering condition.
- Over-the-counter drugs (other than insulin and smoking cessation drugs), even if prescribed by a physician.
- Special handling fees associated with any covered prescription drug.
- Drugs labeled "Caution – Limited by Federal Law to Investigational Use" or experimental drugs, even though a charge is made to the participant.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.
- Any newly FDA-approved prescription drug, biological agent or other agent, until it has been reviewed and approved by CVS Caremark or Silverscript.
- Prescription drugs, biological or other agents that are:
- Prescribed primarily to aid or assist in weight loss.
- An anorectic, amphetamine or stimulant, unless authorized by CVS Caremark or Silverscript.
- Prescribed primarily to slow the rate of hair loss or to aid in the replacement of lost hair.
- Prescribed primarily to increase fertility including, but not limited to, drugs that induce or enhance ovulation.
- Prescribed primarily for personal hygiene, comfort, beautification or the purpose of improving appearance.

Claims Procedures for Medical Claims

This section provides you with important information about how to file a claim for medical and prescription drug benefits. This section details the specific claim procedures by benefit type:

There are several types of health claims:

- **Pre-service Claim:** This is a claim for a benefit for which the plan conditions receipt of the benefit (in whole or in part) on approval of the benefit before medical care is received.
- **Urgent Care Claim:** This is a type of pre-service claim for medical care or treatment in which the application of the time periods for making pre-service claim determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- **Concurrent Care Claim:** This is a type of pre-service claim involving approval of ongoing treatment over a period of time or the number of treatments; some concurrent claims are also urgent care claims.
- **Post-Service Claim:** Any claim for a benefit that is not a pre-service or urgent care claim; a post-service claim involves reimbursing you or a provider for care you have already received; claims for reimbursement under the Healthcare FSA are considered post-service claims.

Failure to Follow Claims Procedures

Pre-Service Claim

If you fail to follow the claim procedures for filing a pre-service claim, you will be notified of the failure no later than five days after the failure — and the notice will describe the proper procedures for filing a claim. The five-day time frame only applies in the case of a failure:

- That involves communication made to an individual or department that customarily handles benefits matters, and
- That names a specific claimant; specific medical condition or symptom; and the specific treatment, service or product being requested.

Urgent Care Claim

If you fail to follow the claim procedures for filing an urgent care claim, you will be notified of the failure no later than 24 hours after the failure — and the notice will describe the proper procedures for filing a claim. The 24-hour time frame only applies in the case of a failure:

- That involves communication made to an individual or department that customarily handles benefits matters, and
- That names a specific claimant; specific medical condition or symptom; and the specific treatment, service or product being requested.

Failure to Provide Sufficient Information

Urgent Care or Urgent Concurrent (Ongoing) Care Claims

If you fail to provide sufficient information necessary to decide the claim, you will be notified no later than 24 hours after receipt of your claim about the specific, additional information that you need to submit. You will have at least 48 hours to provide the requested information.

Then, you will be notified of the claim decision no later than 48 hours after the earlier of:

- The date of receipt of the specific, additional information, or
- The end of the period during which you may provide this additional information.

Pre-Service Claim

If you fail to provide sufficient information necessary to decide the claim, and an extension is necessary because you failed to submit the necessary information, you will be notified within 15 days. The notice will specify what information is necessary to complete the claim and you will have at least 45 days to provide the requested information.

Post-Service Claim

If you fail to provide sufficient information necessary to decide the claim, and an extension is necessary because you failed to submit the necessary information, you will be notified within 30 days. The notice will specify what information is necessary to complete the claim and you will have at least 45 days to provide the requested information.

If you do not provide the requested information within the specified time frame, your claim will be decided without that information.

Timing of Notification of Claim Decision

You will receive written notification of the decision regarding your claim within the time frames noted below (based on the type of claim).

Type of Claim	Timing of Notification	Extension
Urgent care	As soon as possible, taking into account the medical demands, but not later than 72 hours after receipt of the claim.	Not applicable
Concurrent care – *Urgent claim for ongoing care:* Extension of the course of treatment or number of treatments	As soon as possible, taking into account the medical demands, but not later than 24 hours after receipt of the claim (provided that you submitted a claim at least 24 hours before the expiration of the course of treatment or number of treatments); if you did not submit a claim at least 24 hours before the expiration of the course of treatment or number of treatments, the notice of claim decision will be provided no later than 72 hours after receipt.	Not applicable

Type of Claim	Timing of Notification	Extension
Concurrent care – *Non-urgent claim for ongoing care:* Reduction or elimination of a course of treatment before the end of the course of treatment or number of treatments	Sufficiently in advance of the reduction or termination of a course of treatment to allow time for you to appeal and get a review before the benefit is reduced or eliminated.	Not applicable.
Pre-service	Within a reasonable period of time appropriate to the medical circumstances but not later than 15 days after receipt of the claim.	Initial notification may be extended up to 15 days if an extension is necessary due to matters beyond the control of the plan; you will be notified before the end of the first 15-day period why the extension is necessary and when a decision is expected to be made.
Post-service	Within a reasonable period of time appropriate to the medical circumstances but not later than 30 days after receipt of the claim.	Initial notification may be extended up to 15 days if an extension is necessary due to matters beyond the control of the plan; you will be notified before the end of the first 30-day period why the extension is necessary and when a decision is expected to be made.

If Your Claim Is Denied

If your claim is denied, in whole or in part, you will receive a written notice that contains the information described below. (In the case of an urgent care claim, you may be notified orally. And within three days of this oral notification, you will receive a written notice that contains the information described below.) For purposes of this claim and appeal procedure, a benefit determination includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

- A determination of an individual's eligibility to participate in coverage,
- A determination that a benefit is not a covered benefit,
- The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits, or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

In addition, if your coverage is rescinded (terminated retroactively), that decision also will be considered a benefit determination which can be appealed as provided in this section.

The notice of initial denial will contain the following information:

- Identify the claim involved (e.g the date of service, health care provider, claim amount if applicable).
- State that, upon free of charge, the diagnosis code and/or treatment code, and their corresponding meanings will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review.
- The specific reason(s) for the denial including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim.

- Contain a statement that you are entitled, upon request, free access to and copies of documents relevant to your claim;
- Provide an explanation of the Plan's internal appeal along with time limits information regarding how to initiate an appeal;
- The specific plan provisions on which the denial is based.
- If an internal rule, guideline, protocol or other similar criterion was relied upon to determine a claim, you will either receive a copy of the actual rule, guideline, protocol or other criterion or a statement that the rule, guideline, protocol or other criterion was used and that you can request a copy free of charge.
- If the denial is based on a provision such as medical necessity, experimental treatment or a similar exclusion or limit, you will either receive an explanation of the scientific or clinical judgment for the determination based on the plan terms and your medical circumstances, or a statement that you can receive the explanation free of charge upon request.
- A description of any additional material or information needed to perfect the claim and an explanation of why it is necessary.
- An explanation of the expedited claim review procedure, for an urgent care claim.
- Disclose the availability of and contact information for any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is relevant).
- If applicable, include an offer of assistance in the appropriate non-English language to satisfy the ACA's culturally and linguistically appropriate requirements.
- Such other information as required by 45 CFR §147.136(b)(2)(E).

As a plan participant in the State of Idaho, you have access to an independent external review process; please see the *Independent External Review* section for more information.

Filing an Appeal

You or your authorized representative may appeal a claim decision by submitting a written appeal to the appropriate Claims Administrator. If you want someone else to represent you, you must include a signed Blue Cross of Idaho's "Appointment of an Authorized Representative" form with the request before Blue Cross of Idaho, on behalf of the University, determines that an individual has been authorized to act on your behalf. The form can be found on Blue Cross of Idaho's Web site **www.bcidaho.com**.You must make this request within 180 calendar days of the date you receive written notice of the denied claim.

You or your authorized representative will be given reasonable access to all documents, records and information relevant to the claim for benefits, and you may request copies free of charge. You can also submit written comments, documents, records and other information relating to the claim. Review of your claim will take into account all comments, documents, records and other information, without regard to whether such information was submitted or considered in the initial benefit determination.

If the Claims Administrator relies on or generates any new evidence during the appeal process or bases its appeal decision on a new rationale, it will provide you with the new evidence or rationale

to you free of charge, as soon as possible and sufficiently in advance of the appeal decision deadline to give you the opportunity to respond.

In case of an urgent care claim that is denied, you can submit a request for an expedited appeal to the Claims Administrator either orally or in writing. All necessary information, including the decision on review, may be transmitted by phone, fax or other similarly expeditious method.

Decision on Appeal

The appeal will be considered by someone who did not make the initial decision and who is not a subordinate of the party who made that decision. In either case, this level fiduciary (or "appeals fiduciary") will not defer to the initial benefit determination and will consider all comments, documents, records and other information you submit for the claim, even if the information was not submitted or considered in the initial benefit determination. If the initial denial was based on a medical judgment, the appeals fiduciary will consult with a healthcare professional who has appropriate training and experience in the medical field. This healthcare professional will not be an individual who was consulted in connection with the initial benefit determination or the subordinate of any such individual. The appeals fiduciary will identify any medical or vocational experts whose advice was sought in making the earlier determination.

Timing of Notification of Appeal Decision

In most cases, you will receive written notification of the appeal decision within the following time frames after the Claims Administrator receives your request for review:

Type of Appeal	Timing of Notification
Urgent care	As soon as possible, taking into account the medical demands, but not later than 72 hours after receipt of the appeal request
Concurrent care – Urgent	As soon as possible, taking into account the medical demands, but not later than 72 hours after receipt of the appeal request
Concurrent care – Non-urgent	Before a reduction or termination of benefits would occur
Pre-service	A reasonable period of time appropriate to the medical circumstances; if there are two levels of appeal, notification on the first-level will be made no more than 15 days after receipt of the first-level appeal request and notification on the second-level will be made no more than 15 days after receipt of the second-level appeal request
Post-service	A reasonable period of time appropriate to the medical circumstances; if there are two levels of appeal, notification on the first-level will be made no more than 30 days after receipt of the first-level appeal request and notification on the second-level will be made no more than 30 days after receipt of the second-level appeal request

If your appeal is denied, in whole or in part, you will receive a written notice (a final adverse benefit determination) that contains:

- The specific reason(s) for the denial,
- The specific plan provisions on which the denial is based,
- A statement that you are entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the claim.
- If an internal rule, guideline, protocol or other similar criterion was relied upon to deny your

claim, you will either receive a copy of the actual rule, guideline, protocol or other criterion or a statement that the rule, guideline, protocol or other criterion was used and that you can request a copy free of charge, and

- If the denial is based on a provision such as medical necessity, experimental treatment or a similar exclusion or limit, you will either receive an explanation of the scientific or clinical judgment for the determination based on the plan terms and your medical circumstances, or a statement that you can receive the explanation free of charge upon request.
- Such other information as required by 45 CFR 147.136(b)(2)(E).

If the claims administrator fails to adhere to the timeframes set out above or otherwise fails to meet the requirements of this section, a claimant will be deemed to have exhausted the internal appeals process and may initiate the External Review process described below or pursue any applicable remedies under state law.

Legal Action

You cannot bring legal action to recover any benefit under a University benefit plan if you do not file a claim for a benefit and seek timely review of an adverse benefit determination. In addition, no legal action may be brought more than one year after an appeal has been denied.
This section summarizes how medical information about you may be used and disclosed. It also describes how you can access this information.

Your Right 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 the claims administrator If you or your authorized representative requests an independent external review of a claim, the decision made by the independent reviewer will be binding and final on both the Trust and you. Except in limited circumstances, you or your authorized representative will have no further right to have the claim reviewed by a court, arbitrator, mediator or other dispute resolution entity.

If the claims administrator, on behalf of the University, issues a final adverse benefit determination of your request to provide or pay for a health care service or supply, you may have the right to have the claims administrator's decision reviewed by health care professionals who have no association with the claims administrator. You have this right only if the claims administrator's denial decision involved:

- The medical necessity of your health care service or supply, or
- The claims administrator's determination that your health care service or supply was investigational.

You must first exhaust the claims administrator internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal. Exhaustion of the appeals process is not required if Claims Administrator failed to respond to a standard appeal within thirty-five (35) days in writing or to an urgent appeal within three business days of the date the Participant filed the appeal, unless the Participant requested or agreed to a delay. The Claims Administrator may also agree to waive the exhaustion requirement for an external review request. The Participant may file for an internal urgent appeal with Claims Administrator and

for an expedited external review with the Idaho Department of Insurance at the same time if the Participant's request qualifies as an "urgent care request" defined on the next page.

You may submit a written request for an external review to:

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

For more information and for an external review request form:

- See the department's Web site, **www.doi.idaho.gov**, or
- Call the department's telephone number, **1-208-334-4250**, or toll-free in Idaho, **1-800-721-3272.**

You may act as your own representative in a request or you may name another person, including your treating health care provider, to act as an authorized representative for a request. If you want someone else to represent you, you must include a signed Blue Cross of Idaho "Appointment of an Authorized Representative" form with the request before Blue Cross of Idaho, on behalf of the Plan Administrator, determines that an individual has been authorized to act on your behalf. The form can be found on Blue Cross of Idaho's web-site at www.bcidaho.com.. Your 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. The department will not act on an external review request without your completed authorization form. If the request qualifies for external review, the claims administrator's final adverse benefit determination will be reviewed by an independent review organization selected by the Department of Insurance. The University will pay the costs of the review.

Standard External Review Request: You must file a written external review request with the Department of Insurance within four months after the date the claims administrator issues a final notice of denial.

1. Within seven days after the Department of Insurance receives the request, the Department of Insurance will send a copy to the claims administrator.
2. Within 14 days after the claims administrator receives the request from the Department of Insurance, it will review the request for eligibility. Within five business days after the claims administrator completes that review, it will notify you and the Department of Insurance in writing if the request is eligible or what additional information is needed. If the claims administrator denies the eligibility for review, you 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 days of receipt of the claims administrator's notice. The Department of Insurance will also notify you in writing.
4. Within seven days of the date you receive the Department of Insurance's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, the claims administrator and the Department of Insurance within 42 days after receipt of an external review request.

Expedited External Review Request: A Participant may file a written "urgent care request" with the Department of Insurance for an expedited external review of a pre-service or concurrent service denial. The Participant may file for an internal urgent appeal with the Claims Administrator 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 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 you or your dependent's life or health or the ability of the to regain maximum function; or
2. In the opinion of the covered provider with knowledge of the covered person's medical condition, would subject you or your dependent to severe pain that cannot be adequately managed without the disputed care or treatment; or the treatment would be significantly less effective if not promptly initiated.

The Department of Insurance will send your request to the claims administrator. The claims administrator claims administrator will determine, no later than the second full business day, if the request is eligible for review. The claims administrator will notify you and the Department of Insurance no later than one business day after the claims administrator's decision if the request is eligible. If the claims administrator denies the eligibility for review, you 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 the claims administrator's notice. The Department of Insurance will also notify you. The independent review organization must provide notice of its decision to you, the claims administrator and the Department of Insurance within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses the claims administrator's denial, the claims administrator will notify you and the Department of Insurance of the approval of coverage as soon as reasonably practicable, but not later than one business day after making the determination.

Binding Nature of the External Review Decision: The external review decision by the independent review organization will be final and binding on both the Trust and you. **This means that if you elect to request external review, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of the claims administrator's denial after the independent review organization issues its final decision.** If you choose 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.

Your Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This section is intended to satisfy HIPAA's requirement to provide you with notice that the University complies with the HIPAA privacy rules with respect to safeguarding your health information that is created, received or maintained by the University's healthcare plans.

The University's healthcare plans need to create, receive and maintain records that contain health information about you to administer the plans and provide you with healthcare benefits. Under the HIPAA privacy rules, the University's healthcare plans may use and disclose health information about you.

The University's Pledge Regarding Health Information Privacy

The privacy policy and practices of the University's healthcare plans protect the confidential health information that identifies you or could be used to identify you and relate to a physical or mental health condition or the payment of your healthcare expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, or as otherwise permitted or required by federal and state health information privacy laws.

HIPAA Privacy and Security

Certain authorized individuals of the University's workforce perform services in connection with administration of the Plan. To perform these services, it is necessary for certain employees to have access to PHI.

Under the standards for privacy of individually identifiable health information, these individuals are permitted to have such access to the following:

General. The Plan will not disclose PHI to any authorized individual of the University's workforce unless the requirements of this section are met. PHI will generally mean individually identifiable health information about the past, present and future physical or mental health condition of an individual, including information about treatment or payment for treatment.

Permitted Uses and Disclosures for Plan Administration. PHI disclosed to Authorized Individuals of the University's workforce will be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions will include all payment and health care operations. Generally, payment is defined as any activity undertaken by the Plan to collect money due to it or to determine or fulfill its responsibility for payment of benefits due under the Plan. Health care operations include activities related to payment and plan

administration. Plan administration functions do not include employment-related functions or functions in connection with other benefit plans.

Prohibition on Use or Disclosure of Genetic Information for Underwriting Purposes. The Plan will not use or disclose PHI that is genetic information for underwriting information. Underwriting purposes means, with respect to the Plan:

1. rules for, or determination of, eligibility (included enrollment and continued eligibility) under the Plan;
2. the computation of contribution amounts under the Plan;
3. the application of any preexisting condition exclusion under the Plan, coverage or policy, and
4. other activities related to the creation, renewal, or replacement of a contract of health benefits.

Authorized employees/individuals. The Plan will disclose PHI only to authorized individuals of the University's workforce who are authorized to receive PHI and only to the extent and in the minimum amount necessary for these individuals to perform Plan functions. These individuals include:

- the Director of Human Resources
- employees working in the benefits department;
- employees working in the Information Technology Department who support those working in the benefits department.

Use and Disclosure Restricted. An Authorized Individual of the University's workforce who receives PHI will use or disclose the PHI only to the extent necessary to perform his or her duties with respect to the Plan's administrative functions.

Resolution of Issues of Noncompliance. In the event that any Authorized Individual of the University's workforce uses or discloses PHI other than as permitted by the privacy standards, the incident will be reported to the Privacy Official. The Privacy Official will take appropriate action, including:

- Investigation of the incident to incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
- Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;
- Mitigating any harm caused by the breach, to extent practicable; and
- Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

Certification of Employer. The University must provide certification to the Plan that it agrees to:

- Not use or further disclose the PHI other than as permitted or required by the plan documents or as required by law;

- Ensure that any agent or subcontractor, to whom it provides PHI received from the Plan. agrees to the same restrictions and conditions that apply to the University with respect to such information;
- Not use or disclose PHI for employment-related actions and decisions and in connection with any other benefit or employee benefit plan of the University;
- Report to the Plan any use or disclosure of PHI of which it becomes aware that it is inconsistent with the uses or disclosures permitted or required by law;
- Make available PHI to individual Plan covered individuals in accordance with Article 164.524 of the Privacy Standards;
- Make available PHI by for amendment by individual Plan covered individuals and incorporate any amendments to PHI in accordance with Article 164.526 of the Privacy standards;
- If feasible, return or destroy all PHI received from the Plan that the University maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and ensure the adequate separation between the Plan (including Authorized Individuals of the Employer's workforce) and the Employer, as required by Article 164.504(f)(2)(iii) of the privacy standards.

Compliance with HIPAA Security Standards. If the University creates, receives, maintains, or transmits Electronic PHI of behalf of the Plan (other than enrollment/disenrollment information, summary health information, and information disclosed pursuant to a HIPAA-compliant authorization, which are not subject to these restrictions, the University will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and University (i.e. the firewall is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which it becomes aware as follows: University will report to the Plan, with such frequency and as such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, University will report to the Plan as soon as feasible any successful unauthorized access, use disclosure, modification, or destruction of Electronic PHI or interference with systems operation in an information system containing Electronic PHI.

Electronic Protected Health Information or Electronic PHI means Protected Health Information that is transmitted by or maintained in electronic media.

Subrogation and Right of Reimbursement

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

As a condition of receiving benefits for Covered Services in such an event, the Participant or his or her personal representative shall furnish Blue Cross of Idaho in writing with the names, 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 Participant or his or her personal representative concerning the injury, harm or loss. In addition, the Participant shall furnish the name and contact information of the liability insurer and 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, on behalf of the Plan Administrator may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

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

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

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

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

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

Blue Cross of Idaho's subrogation and reimbursement rights shall take priority over the Participant's rights both for 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, the Plan'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 Participant, even if there are deficiencies in any recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Participant and Blue Cross of Idaho.

Collections or recoveries made by a Participant 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 this Plan, or any subsequent Plan provided by this Plan Sponsor. Thereafter, Blue Cross of Idaho, on behalf of the Plan Administrator, shall have no obligation to provide any further benefits or make any further payment until the Participant has incurred medical expenses in treatment of such injury, harm or loss equal to such Special Credit.

Out-of-Area Services
Overview

BCI has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and

procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever Participants access healthcare services outside the geographic area BCI serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

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

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

A. BlueCard® Program

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

1. Liability Calculation Method Per Claim – In General

a. Participant Liability Calculation

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

b. The Plan Sponsor Liability Calculation

The calculation of the Plan Sponsor liability on claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to BCI by the Host Blue under the contract between the Host Blue and the Provider. Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its participating healthcare Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, the Plan Sponsor may be liable for the excess amount even when the Participant’s deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider’s participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the billed charge.

2. Claims Pricing

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

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

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

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

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

3. BlueCard Program Fees and Compensation

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

B. Return of Overpayments

Recoveries from a Host Blue or its participating and nonparticipating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/healthcare Provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to BCI they will be credited to the Plan Sponsor 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 Plan Sponsor as a percentage of the recovery.

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

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

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

D. Nonparticipating Providers Outside BCI Service Area

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

E. Blue Cross Blue Shield Global Core

1. General Information

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

- **Inpatient Services**

In most cases, if Participants contact the BCBS Global Core Service Center for assistance, hospitals will not require Participants to pay for covered Inpatient services, except for their deductibles, cost sharing, etc.. In such cases, the hospital will submit Participant claims to the BCBS Global Core service center to initiate claims processing. However, if the Participant paid in full at the time of service, the Participant must submit a claim to obtain reimbursement for Covered

Services. **Participants must contact Blue Cross of Idaho to obtain precertification for non-emergency Inpatient services.**

- **Outpatient Services**

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

- **Submitting a BCBS Global Core Claim**

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

2. BCBS Global Core-Related Fees

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

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

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

Important Notice from the University of Idaho about Your Prescription Drug Coverage and Medicare

This notice affects you if you are eligible for Medicare or you have a spouse or dependent who is eligible for Medicare. You may also need the information in this notice if/when you, your spouse or your dependent becomes Medicare-eligible. All Plan B participants and participants in Plan A who qualify for Tier II, III, IV or disability retiree benefits must apply to receive prescription drug benefits through Medicare Part D once they are Medicare eligible.

The purpose of this notice is to advise you that the prescription drug coverage you have under the University medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in2019. (This is known as “creditable coverage.”)

University of Idaho Prescription Drug Benefits Are Considered Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the University of Idaho and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining a Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is included at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage: Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

1. University of Idaho has determined that the prescription drug coverage offered by the medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.
2. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher contribution (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year thereafter during the annual enrollment period..

However, if you lose your current creditable coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Will You Pay A Higher Contribution (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the University of Idaho and you are Medicare-eligible, but you don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher contribution (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable coverage, your monthly contribution may go up by at least 1% of the Medicare base beneficiary contribution per month for every month that you did not have that coverage. For example, if you go nineteen months without Creditable Coverage, your contribution may consistently be at least 19% higher than the Medicare base beneficiary contribution. You may have to pay this higher contribution (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about This Notice Or Your Current Prescription Drug Coverage

Contact Benefit Services at **uidahobenefits@hroffice.com** or **1-208-885-3697** or 1-800-646-6174.

In addition to getting this notice each year, you will also get it before the next period you can join a Medicare drug plan, and if your coverage through University of Idaho changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at **www.socialsecurity.gov**, or call them at **1-800-772-1213 (TTY 1-800-325-0778).**

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable Coverage and, therefore, whether or not you are required to pay a higher contribution (a penalty).

Coordinating Benefits With Other Coverages

If you or your eligible dependents are covered by more than one medical plan, reimbursements are coordinated between plans so benefits are not duplicated.

How the Plans Coordinate Coverage

Your medical benefits plan has maintenance of benefits (MOB) provision. This provision coordinates benefit payments from all medical plans that cover you and your eligible dependents, so that plan benefits are maintained at the level set by this plan after payments from all sources of coverage have been considered.

When you have a claim for expenses covered by two or more plans, one plan pays benefits first. This is known as the primary plan. The other plan(s), called the secondary plan(s), then determines how much of the covered services, if any, are to be paid from the secondary plan(s). The Order of Benefit Determination rules on the next page govern which plan will be considered primary and pay first, and which plan(s) will be considered secondary.

A "plan" is any of the following that provides benefits or services for medical or dental care or treatment:

- Group and non-group insurance contracts,
- Health maintenance organization (HMO) contracts and subscriber 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 coverage in automobile "no fault" and traditional automobile "fault" type contracts.
- Medicare or any other ~~federal~~ governmental plan, as permitted by law,
- Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no MOB among the separate parts of the plan.

If separate plans are used to provide coordinated coverage for a group member, the separate plans are considered parts of the same plan, and there is no MOB among those separate plans.

A plan does not include:

- Hospital indemnity coverage or other fixed indemnity coverage,
- Accident-only coverage,
- Specified disease or specified accident coverage,
- Limited benefit health coverage, as defined by state law,
- School accident-type coverage,
- Benefits provided in long-term policies services,
- Medicare supplement policies, or
- Medicare, state plans under Medicaid or any other federal governmental plan, unless permitted by law.

When this medical benefits plan is primary, it pays or provides its benefits according to this plan's terms of coverage and without regard to the benefits of any other plan.

When this medical benefits plan is secondary, it pays the amount necessary to ensure that the total combined amount you receive from this medical benefits plan and the primary plan is no greater than the amount you would have received under this medical benefits plan alone.

Example of Secondary Plan Payment

Under the Order of Benefit Determination Rules, if your enrolled spouse also has medical coverage through his or her employer, your spouse's employer's plan will be the primary payer. The University's benefit plan will be the secondary payer. This means the University's benefit plan will pay up to the amount allowed under this plan's coverage *less* the amount the primary plan already has paid.

For example, let's say that the University's benefit plan provides 80 percent coverage, your spouse's plan covers 50 percent, and your spouse has a covered, payable expense of $100. Your spouse's primary plan will pay 50 percent of the charge ($50), and the University's benefit plan will then pay 80 percent of the charge *less* $50 (in this case, $30) toward the remaining eligible expense.

But if your spouse's plan pays 80 percent and the University's benefit plan also allows 80 percent, no payment will be made by the University's benefit plan; this is because the maximum benefit of 80 percent has already been paid for the service.

Coordination of Benefits with Medicare

When you or your dependent reaches age 65 or becomes disabled, you or your dependent (as applicable) may be eligible for Medicare benefits. Medicare generally provides coverage for people age 65 or older, as well as for people entitled to Social Security disability benefits and those with end-stage renal disease. Once you become eligible for Medicare, Medicare will become your primary medical coverage and your University retiree medical coverage will become your secondary coverage (note that there is a limited exception in the case of end-stage renal disease).

Once you become eligible for Medicare, you should enroll in Medicare Parts A and B to remain eligible for the University of Idaho retiree health plan. That is because the Retiree Medical Plan integrates with Medicare on a maintenance of benefits basis as if you were enrolled in both Parts – even if you are not. If you do not enroll in Medicare Parts A and B, you may not receive the benefits you are entitled to and, therefore, may end up paying more for your medical care. In addition, you may be subject to late enrollment penalties if you don't enroll in Medicare when first eligible.

You should apply for Medicare two to three months before reaching age 65. Contact your local Social Security office before you reach age 65 for more information about Medicare and your eligibility.

Coordination of this Plan's Benefits with Other Benefits

The following Order of Benefit Determination Rules governs the order in which each plan will pay a claim for benefits.

- A plan that covers a patient as an active employee or a primary beneficiary is primary over a plan that covers the patient as a dependent.
- When both parents have medical coverage for their child(ren), the plan of the parent whose birthday comes earlier in the year is the primary plan. If the parents are divorced or legally separated, special rules apply:
- The plan of the natural parent with custody of a dependent child is primary. If the parent with custody remarries, the plan of the stepparent with custody pays second, the plan of the parent without custody pays third and the plan of the stepparent without custody pays last.
- However, if a court decree places financial responsibility for the dependent child's medical care on one parent, that parent's plan always pays first, regardless of who has custody of the child. The plan of the parent with custody pays second, the plan of the stepparent with custody pays third and the plan of the stepparent without custody pays last.
- A plan that covers the person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. A plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
- If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of such a person is the primary plan, and the plan covering that same person pursuant to COBRA or other continuation law is the secondary plan.
- If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan, and the plan that covered the person for the shorter period of time is the secondary plan.

You may be asked, on an annual basis, to provide or confirm information about other plans under which you or your dependents are covered.

Important Terms

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 a participant's foresight or expectation, that requires medical attention at the time of the accident. The force may be the result of the injured party's actions, but must not be intentionally self-inflicted unless caused by a medical condition or domestic violence. Contact with an external object must be unexpected and unintentional, or the results of force must be unexpected and sudden.

Acute care: Medically necessary inpatient treatment in a licensed general hospital or other facility provider for sustained medical intervention by a physician and skilled nursing care to safeguard a participant's life and health. The immediate medical goal of acute care is to stabilize the participant's condition, rather than upgrade or restore a participant's abilities.

Administrative Services Agreement: a formal agreement between BCI and the Plan Administrator outlining responsibilities, general administrative services and benefit payment services.

Admission: Begins the first day a participant becomes a registered hospital bed patient or a Skilled Nursing Facility patient and continues until the participant is discharged.

Adverse benefit determination: Any denial, reduction or termination of, or the failure to provide payment for, a benefit for services or ongoing treatment.

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

Alcoholism or substance abuse treatment facility: A facility provider that is engaged primarily in providing detoxification and rehabilitative care for alcoholism or substance abuse or addiction. To be payable by this Plan, a facility must be licensed as an alcoholism or substance abuse treatment facility (licensure requirements may vary by state) or must be accredited by The Joint Commission.

Ambulance: A vehicle or other mode of transportation, licensed by the state, designed and operated to provide medical services and transport to medical facilities.

Ambulatory surgical facility (surgery center): A facility provider, with an organized staff of physicians, that:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis.
- Provides treatment by or under the supervision of physicians and provides skilled nursing care services when the participant is in the facility.
- Does not provide inpatient accommodations appropriate for a stay of longer than 12 hours.
- Is not primarily a facility used as an office or clinic for the private practice of a physician or other professional provider.

- **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.

Artificial organs: Permanently attached or implanted man-made devices that replace all or part of a diseased or non-functioning body organ, including, but not limited to, artificial hearts and pancreases.

Autism Spectrum Disorder: means any of the pervasive developmental disorders or autism spectrum disorders 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.

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.

Benefit period: The specified period of time in which a participant's benefits for incurred covered services accumulate toward annual benefit limits, deductible amounts and cost-share limits.

Benefits: The amount the University will pay for covered services after deductible requirements are met.

Blue Cross of Idaho Health Service, Inc. (Blue Cross of Idaho): A non-profit mutual insurance company, hired by University of Idaho to act as the third party contract administrator to perform claims processing and other specific administrative services as outlined in the plan and/or administrative services agreement.

BlueCard: A program to process claims for most covered services received by participants outside of Blue Cross of Idaho's service area.

Certified nurse-midwife: An individual licensed to practice as a certified nurse-midwife. A Midwife may **not** independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. Expenses associated with a pre-planned home birth are [are not] payable by this Plan.

Certified registered nurse anesthetist: A licensed individual registered as a certified registered nurse anesthetist by the state in which services are rendered. Services rendered must be within the scope of the registration.

Chemotherapy: The treatment of malignant disease by chemical or biological antineoplastic agents.

Chiropractic care: Services rendered, referred or prescribed by a chiropractic physician, when those services are within the scope of the license held by the chiropractic physician.

Chiropractic physician: An individual licensed to provide chiropractic care in the state in which services are rendered.

Claims administrator: Third party contractor also referred to as third party contract administrator or contract administrator with fiduciary responsibility. Performs claims processing, medical necessity determinations, medical reviews and prior authorization approvals in accordance with the Plan Administrator and the law. (See also Plan Administrator for final fiduciary responsibilities).

Clinical nurse specialist: An individual licensed to practice as a clinical nurse specialist.

Clinical psychologist: An individual licensed to practice clinical psychology in the state in which services are rendered.

Cost-sharing: Works like coinsurance. The percentage of the maximum allowance or the actual charge, whichever is less, a participant is responsible to pay out of pocket for covered services after satisfaction of any applicable deductibles or copayments, or both.

Congenital anomaly: A condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or a developmental defect or disease. In this plan, the term significant deviation is defined to be a deviation that 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 to maintain a terminally ill participant at home. A period of crisis is one in which the participant's symptom management demands predominantly skilled nursing care services.

Copayment: The amount a participant must pay directly to a provider for covered services. A copayment is typically a flat dollar amount that is due to the provider at the time certain covered services are provided. Office visit copayments are pre-deductible. Amounts paid in copayments do not work to satisfy the deductible or cost-share maximum.

Cost-share maximum: The amount of cost-share expenses incurred during a plan year that a participant is responsible for paying. Eligible cost-share expenses include only the participant's cost-sharing for covered services. The cost-share maximum does not include deductibles or copayments.

Covered provider: A provider specified in this plan from whom a participant must receive covered services to be eligible to receive benefits.

Covered service: When rendered by a covered provider, a service, supply or procedure specified in this plan for which benefits will be provided to a participant.

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

Deductible: The amount a participant is responsible to pay out of pocket per benefit period before the plan begins to pay benefits for 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 in the state in which services are rendered.

Dentistry or dental treatment: The treatment of teeth and supporting structures, including, but not limited to, replacement of teeth.

Diagnostic imaging provider: A Medicare-certified person or entity that is licensed, where required, to render covered services.

Diagnostic service: A test or procedure performed on the order of a physician or other provider because of specific symptoms, in order to identify a particular condition, disease, illness or injury. Diagnostic services include, but are not limited to:

- Radiology services,
- Laboratory and pathology services, and/or
- Cardiographic, encephalographic and radioisotope tests.

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

Durable medical equipment: Items that can withstand repeated use, are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of injury, disease or illness, and are appropriate for use in the participant's home.

Durable medical equipment supplier: A business that is Medicare-certified and licensed, where required, to sell or rent durable medical equipment.

Effective date: The date when coverage for a participant begins under this plan.

Electroencephalogram (EEG) provider: A facility provider that participates with Medicare and has technologists certified by the American Board of Registration of Electroencephalographic and Evoked Potential Technologies to render covered services.

Eligible dependent: A person eligible for enrollment under an employee's coverage as specified in the *Eligibility* section.

Eligible employee: An employee who is eligible to enroll for benefits as discussed in the *Eligibility* section.

Emergency inpatient admission: Medically necessary inpatient admission to a licensed general hospital or other inpatient facility due to the sudden, acute onset of a medical condition or an accidental injury that requires immediate medical treatment to preserve life or prevent severe, irreparable harm to a participant.

Emergency medical condition: A condition in which sudden and unexpected symptoms are sufficiently severe to require immediate medical care. Emergency medical conditions include, but are not limited to, heart attacks, cerebrovascular accidents, poisoning, loss of consciousness or respiration, and convulsions.

Emergency or maternity admission notification: Notification by the participant to Blue Cross of Idaho of an emergency inpatient admission resulting in an evaluation conducted by Blue Cross of Idaho to determine the medical necessity of a participant's emergency inpatient admission or unscheduled maternity admission, and the accompanying course of treatment.

Employer: University of Idaho, which also is the plan administrator.

Enterostomal therapy: Counseling and assistance provided by a specifically trained enterostomal therapist to participants who have undergone a surgical procedure to create an artificial opening into a hollow organ (e.g., colostomy).

Freestanding diabetes facility: A person or entity that is recognized by the American Diabetes Association to render covered services.

Freestanding dialysis facility: A facility provider that is primarily engaged in providing dialysis treatment, maintenance or training to patients on an outpatient or home care basis.

Growth hormone therapy: Treatment administered by intramuscular injection to treat children with growth failure due to pituitary disorder or dysfunction.

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 and meets one of the following three tests:

1. It is approved by Medicare and/or accredited by The Joint Commission; or
2. It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
3. If licensing is not required, it meets all of the following requirements:
    - has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home.
    - has a full-time administrator.
    - is run according to rules established by a group of professional health care providers including Physicians and Registered Nurses (RNs).
    - maintains written clinical records of services provided to all patients.
    - its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.
    - its employees are bonded.
    - maintains malpractice insurance coverage

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 that 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 Participant. 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 Participant's household or is not related to the Participant by blood or marriage.

Home intravenous therapy (home infusion therapy): Treatment provided in the home of the participant or other locations outside of a licensed general hospital, that is administered via an intravenous, intraspinal, intra-arterial, intrathecal, subcutaneous, enteral or intramuscular injection or access device inserted into the body, at or under the direction of a home health agency or other provider approved by Blue Cross of Idaho.

Home intravenous therapy company: A Medicare-certified and licensed, where required, pharmacy that is principally engaged in providing services, medical supplies and equipment for

certain home infusion therapy covered services, to participants in their homes or other locations outside of a licensed general hospital.

Hospice: A Medicare-certified public agency or private organization designed specifically to provide services for care and management of terminally ill patients, primarily in the home. The hospice agency must meet one of the following tests:

1. It is approved by Medicare; or is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. If licensing is not required, it meets all of the following requirements:
    - provides 24 hour-a-day, 7 day-a-week service.
    - is under the direct supervision of a duly qualified Physician.
    - has a full-time administrator.
    - has a nurse coordinator who is a Registered Nurse (RN) with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
    - the main purpose of the agency is to provide Hospice services.
    - maintains written records of services provided to the patient.
    - maintains malpractice insurance coverage.

Hospice nursing care: Skilled nursing care services and home health aide services provided as a part of the hospice plan of treatment.

Hospice plan of treatment: A written plan of care that describes the services and supplies for the medically necessary palliative care and treatment to be provided to a participant by a hospice. The written plan of care must be established and periodically reviewed by the attending physician.

Hospice therapy services: Hospice therapy services include only the following:

- Hospice physical therapy — the treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain, enable a participant to maintain basic functional skills and manage symptoms.
- Respiratory therapy.
- Speech therapy.

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

Illness: A deviation from the healthy and normal condition of any bodily function or tissue. An illness can exist with or without a participant's awareness of it, and can be of known or unknown cause(s).

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 participant's foresight or expectation.

In-network provider: A provider that has entered into a written agreement with Blue Cross of Idaho to accept the participant's and Blue Cross of Idaho payments as payments in full for covered services.

In-network services: Covered services provided by an in-network provider.

Inpatient: A participant who is admitted as a bed patient in a licensed general hospital or other facility provider and for whom a room and board charge is made.

Investigational: Any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product) that 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 Blue Cross of Idaho, 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 Blue Cross of Idaho 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, Blue Cross of Idaho 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 Blue Cross of Idaho, and Blue Cross of Idaho Medical Policies. Blue Cross of Idaho also considers, at its discretion, current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

Blue Cross of Idaho reserves the right to interpret the meaning of the terms used in this definition and any policies or procedures, which support this definition.

Licensed clinical professional counselor (LCPC): An individual providing diagnosis and treatment of mental or nervous conditions.

Licensed clinical social worker (LCSW): An individual providing diagnosis and treatment of mental or nervous conditions.

Licensed general hospital: A short-term, acute care, general hospital that:

- Is an institution duly licensed in and by the state in which it is located, and thereby is lawfully entitled to operate as a general, acute care hospital. The facility may also be accredited as a hospital by The Joint Commission.

- 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.
- Has functioning departments of medicine and surgery.
- Provides 24-hour nursing service by or under the supervision of licensed registered nurses.
- Is not predominantly a:
- Skilled nursing facility,
- Nursing home,
- Custodial care home,
- Health resort,
- Spa or sanatorium,
- Place for rest,
- Place for the treatment or rehabilitative care of alcoholism or substance abuse or addiction,
- Place for the treatment or rehabilitative care of mental or nervous conditions,
- Place for hospice care,
- Residential treatment facility, and/or
- Transitional living center.

Licensed marriage and family therapist (LMFT): A licensed individual providing diagnosis and treatment of mental or nervous conditions.

Licensed pharmacist: An individual licensed to practice pharmacology in the state in which services are rendered.

Licensed rehabilitation hospital: A facility provider principally engaged in providing diagnostic, therapeutic and physical rehabilitation services to participants on an inpatient basis.

Maximum allowance: For covered services under the terms of this plan, maximum allowance is the lesser of the billed charge or the amount established as the highest level of compensation for a covered service. If the covered services are rendered outside the state of Idaho by an in-network or out-of-network provider with a Blue Cross and/or Blue Shield affiliate in the location of the covered services, the maximum allowance is the lesser of the billed charge or the amount established by the affiliate as compensation.

The maximum allowance is determined using many factors, including pre-negotiated payment amounts; diagnostic-related groupings (DRGs); a resource-based relative value scale (RBRVS); ambulatory payment classifications (APCs); the provider's charge(s); the charge(s) of providers with similar training and experience within a particular geographic area; Medicare reimbursement

amounts; and/or the cost of rendering the covered service. Moreover, maximum allowance may differ depending on whether the provider is in- or out-of-network.

In addition, maximum allowance for covered services provided by contracting or non-contracting dentists is determined using many factors, including pre-negotiated payment amounts, a calculation of charges submitted by contracting Idaho dentists, and/or a calculation of the average charges submitted by all Idaho dentists.

Medicaid: Title XIX (grants to states for medical assistance programs) of the United States Social Security Act as amended.

Medically necessary (or medical necessity): The covered services or supplies required to identify or treat a participant's condition, disease, illness or accidental injury and which, as recommended by the treating physician or other covered provider and as determined by Blue Cross of Idaho, are:

- The most appropriate supply or level of service, considering potential benefits and harms to the participant,
- Proven to be effective in improving health outcomes,
- For new treatments, effectiveness is determined by scientific evidence,
- For existing treatments, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion,
- Not primarily for the convenience of the participant or covered provider, and/or
- Cost-effective for this condition, compared to alternative treatments, including no treatment. Cost-effectiveness does not necessarily mean lowest price.

When applied to the care of an inpatient, it further means that the participant's medical symptoms or condition are such that the services cannot be safely and effectively provided to the participant as an outpatient.

The fact that a covered provider may prescribe, order, recommend or approve a service or supply does not, in and of itself, necessarily establish that such service or supply is medically necessary under this plan.

The term medically necessary as defined and used in this plan is strictly limited to the application and interpretation of this plan, and any determination of whether a service is medically necessary hereunder is made solely for the purpose of determining whether services rendered are covered services.

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

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

Medicare-certified: Centers for Medicare and Medicaid Services (CMS) develops standards that healthcare organizations must meet 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 to be Medicare- and Medicaid-certified. As a condition of their contract with Blue Cross of Idaho, certain in-network providers must be certified by Medicare.

Mental or nervous condition: Means and includes mental disorders, mental illnesses, psychiatric illnesses, mental conditions and psychiatric conditions (whether organic or inorganic, whether of biological, non-biological, chemical or non-chemical 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.

Nurse practitioner: An individual licensed to practice as a nurse practitioner. (NP), Family Nurse Practitioner (FNP) or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate health care practitioners and bills and is able to be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered.

Occupational therapist: An individual licensed to practice occupational therapy.

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

Office visit: Any direct, one-on-one examination and/or exchange, conducted in the covered provider's office, between a participant and a provider, or members of his or her staff for the purposes of seeking care and rendering covered services. For purposes of this definition, a medically necessary visit by a physician to a homebound participant's place of residence may be considered an office visit.

Optometrist: An individual licensed to practice optometry.

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 related directly to the removal of an organ or tissue. 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 provider: A professional provider or facility provider that has not entered into a written agreement with Blue Cross of Idaho.

Out-of-network services: Any covered services rendered by an out-of-network provider.

Outpatient: A participant who receives services or supplies while not an inpatient.

Outpatient psychiatric facility: A facility provider that, for compensation from or on behalf of its patients, is engaged primarily in providing outpatient diagnostic and therapeutic services for treatment of mental or nervous conditions and/or substance abuse or addiction. To be payable by this Plan, a facility must be licensed as a psychiatric facility (licensure requirements may vary by state) or must be accredited by The Joint Commission.

Pain rehabilitation: An intensive inpatient program administered by qualified healthcare professionals, under the orders of an attending physician, to a participant who is suffering from chronic, intractable pain, regardless of its origin, that has failed to respond to medical or surgical treatment. Pain rehabilitation is intended to teach the participant how to control and cope with pain and regain normal function.

Participant: An eligible employee or his or her enrolled eligible dependent.

Physical rehabilitation: Medically necessary, non-acute therapy rendered by qualified healthcare professionals, intended to restore a participant's physical health and well-being as closely as reasonably possible to the level that existed immediately prior to the occurrence of a condition, disease, illness or injury.

Physical rehabilitation plan of treatment: A written plan established and reviewed periodically by an attending physician that describes the services and supplies for the physical rehabilitation care and treatment to be provided to a participant.

Physical therapist: An individual licensed to practice physical therapy.

Physical therapy: The 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, injury or loss of a body part. Physical therapy does not include educational training or services designed to develop a physical function.

Physician: A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) licensed to practice medicine. to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

Physician assistant: An individual licensed to practice as a physician assistant, who acts within the scope of his or her license and acts under the supervision of a Physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising Physician; and bill and be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered.

Plan(s)—a self-insured program(s) maintained by the Plan Sponsor for the purpose of providing health care benefits to the Plan Participants.

Plan administrator: The plan administrator, University of Idaho, is the fiduciary of the plan, and has all final discretionary authority to interpret the provisions and control the operation and administration of the plan within the limits of the law. All decisions made by the plan administrator, including final determination of medical necessity, shall be final and binding on all parties. (See claims administrator for additional fiduciary responsibilities).

Post-service claim: Any claim for a benefit under this plan that does not require preauthorization before services are rendered.

Preadmission testing: Tests and studies required in connection with a participant's inpatient admission to a licensed general hospital that are rendered or accepted by the licensed general hospital on an outpatient basis. Preadmission tests and studies must be done prior to a scheduled inpatient admission to the licensed general hospital, provided the services would have been available to an inpatient of that hospital. Preadmission testing does not include tests or studies performed to establish a diagnosis.

Preferred Provider Organization (PPO): A health benefit plan in which the highest level of benefits is received when the participant obtains covered services from an in-network provider.

Prescription drugs: Drugs, biologicals and compounded prescriptions that can be dispensed only according to a written prescription given by a physician, that are listed with approval in the *United States Pharmacopoeia, 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 display the legend: “Caution — Federal Law prohibits dispensing without prescription.”

Pre-service claim: Any claim for a benefit under this plan that requires preauthorization before services are rendered.

Primary caregiver: A person designated to give direct care and emotional support to a participant as part of a hospice plan of treatment. A primary caregiver may be a spouse, relative or other individual who has personal significance to the participant, such as a neighbor or friend. A primary caregiver must be a volunteer who does not charge a fee or expect or claim any other compensation for services provided to the participant.

Preauthorization: The provider's request to Blue Cross of Idaho, or delegated entity, for authorization of a participant's proposed treatment. Blue Cross of Idaho, on behalf of the Plan Administrator, 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.

Prosthetic and orthotic supplier: A person or entity that is Medicare-certified and licensed, where required, 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, or accredited by the Joint Commission, where required, to render covered services. For the purposes of this plan, providers include the following:

- Facility providers:
    - Ambulatory surgical facility (surgery center),
    - Alcoholism or substance abuse treatment facility,
    - Electroencephalogram (EEG) provider,
    - Home intravenous therapy company,
    - Hospice,
    - Licensed rehabilitation hospital,
    - Lithotripsy provider,
    - Psychiatric hospital,
    - Diagnostic imaging provider,
    - Freestanding diabetes facility,
    - Freestanding dialysis facility,
    - Home health agency, or
    - Independent laboratory.
    - Licensed general hospital.

- Prosthetic and orthotic supplier.
- Radiation therapy center.
- Skilled nursing facility.

o Professional providers:
- Ambulance transportation service,
- Certified nurse-midwife,
- Certified registered nurse anesthetist,
- Certified speech therapist,
- Chiropractic physician,
- Clinical nurse specialist,
- Clinical psychologist,
- Licensed clinical professional counselor (LCPC),
- Licensed clinical social worker (LCSW),
- Licensed marriage and family therapist (LMFT),
- Dentist/denturist,
- Durable medical equipment supplier,
- Licensed occupational therapist,
- Licensed pharmacist,
- Licensed physical therapist,
- Nurse practitioner,
- Optometrist/optician,
- Physician,
- Physician assistant, and/or
- Podiatrist.

Psychiatric hospital: A facility provider principally engaged in providing diagnostic and therapeutic services and rehabilitation services for the inpatient treatment of mental or nervous conditions, alcoholism or substance abuse or addiction, licensed under state law or accredited by The Joint Commission.. These services are provided by or under the supervision of a staff of physicians, and continuous nursing services are provided under the supervision of a licensed registered nurse. A psychiatric hospital provides these services for compensation from and on behalf of its patients.

Radiation therapy: The treatment of disease by X-ray, radium or radioactive isotopes.

Radiation therapy center: A facility provider that is primarily engaged in providing radiation therapy services to patients on an outpatient basis and is licensed under state law or accredited by The Joint Commission.

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Recognized transplant center: A licensed general hospital that:

- o Is approved by the Medicare program for the requested transplant covered services,
- o Is included in the Blue Cross and Blue Shield System's National Transplant Network,
- o Has arrangements with another Blue Cross and/or Blue Shield Plan for the delivery of the requested transplant covered services, based on appropriate approval criteria established by that plan, and

- Is approved by Blue Cross of Idaho based on the recommendation of Blue Cross of Idaho's medical director.

Renal dialysis: The treatment of an acute or chronic kidney condition, which may include the supportive use of an artificial kidney machine.

Residential Treatment Program/Facility/Care: is an intermediate non-hospital inpatient setting with 24-hour care that operates 7 days a week, for individuals with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. All Providers and Facilities must be licensed and/or registered by the state where the services are rendered, unless exempt by federal law, and must be performing within the scope of license to be payable by the Plan.

Respiratory therapy: Introduction of dry or moist gases into the lungs for treatment purposes.

Respite care: Care provided to a homebound participant as part of a hospice plan of treatment for the purpose of providing the primary caregiver a temporary period of rest from the stress and physical exhaustion involved in caring for the participant at home.

Skilled nursing care: Nursing service that must be rendered by or under the direct supervision of a licensed registered nurse to maximize the safety of a participant and to achieve the medically desired result according to the orders and direction of an attending physician. The following components of skilled nursing care distinguish it from custodial care that does not require professional health training:

- The observation and assessment of the total medical needs of the participant,
- The planning, organization and management of a treatment plan involving multiple services, where specialized healthcare knowledge must be applied to attain the desired result, and
- Rendering to the participant of 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 and meets all of the following requirements:

1. It is accredited by The Joint Commission as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
2. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with at least one licensed Registered Nurse on duty at all times; and
5. It maintains a daily medical record of each patient who is under the care of a licensed Physician; and

6. It is not (other than incidentally) a home for maternity care, rest, domiciliary care (non-skilled/custodial care, or care of individuals who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or mentally ill; and
7. It is not a hotel or motel.

Other than incidentally, a skilled nursing facility is not a place or facility that provides minimal care, custodial care, ambulatory care or part-time care services, or care or treatment of mental or nervous conditions, alcoholism or substance abuse or addiction.

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 for the provision of an intensive level of care for critically ill patients.

Speech therapy: The corrective treatment of a speech impairment resulting from a condition, illness, disease, surgery, injury, congenital anomaly or previous therapeutic process.

Substance abuse or addiction: A behavioral or physical disorder manifested by repeated excessive use of a drug or alcohol to the extent that it interferes with a participant's health, or the participant's social or economic functioning.

Surrogate—a woman 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 is the genetic mother of the child and whether or not the Surrogate does so for compensation.

Surgery: The performance, within the scope of a provider's license, of:

- Generally accepted operative and cutting procedures,
- Endoscopic examinations and other invasive procedures utilizing specialized instruments,
- The correction of fractures and dislocations, and
- Customary preoperative and postoperative care.

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:

- Chemotherapy,
- Enterostomal therapy,
- Growth hormone therapy,
- Home intravenous therapy,
- Occupational therapy,
- Physical therapy,
- Radiation therapy,
- Renal dialysis
- Respiratory therapy, and/or
- Speech therapy

Third party contract administrator: See claims administrator.

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 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.

Dental Coverage

Dental coverage encourages you and your family to take good care of your teeth and gums. You may continue dental coverage for yourself and your eligible dependents. What you pay for dental coverage depends on the coverage Tier for which you are eligible, please see the *Eligibility* section for more information.

Delta Dental of Idaho administers all dental plan options and provides access to its Premier and PPO networks of dental providers. (The PPO network provides the best discount.)

How the Plan Works

The plan pays a percentage of eligible dental charges. As a plan participant, you may visit any dentist you choose — a Delta Dental network provider, *or* a non-network dentist. Delta Dental has two participating provider networks: Delta Dental Premier and Delta Dental PPO. Some dentists participate in both networks.

However, it's usually to your benefit to visit a participating dentist in the Delta Dental Premier or Delta Dental PPO network. When you use a Delta Dental participating provider:

- You don't have to file claim forms;
- You typically pay less for services because the provider charges a negotiated rate; and
- You cannot be billed for any charges above the negotiated fee the provider has agreed to charge.

If you use a **non-participating dentist,** you may need to pay additional out-of-pocket expenses. If the dentist is a non-participating dentist, Delta Dental will base the benefit on the lesser of the submitted amount or Delta Dental's non-participating dentist fee. It is your responsibility to make full payment to the non-participating dentist for charges above Delta Dental's non-participating dentist fee.

How to Locate Delta Dental Participating Dentists

You can find names of Delta Dental participating providers by logging on to **www.deltadentalid.com.**

Dental Plan Coverage At-a-Glance Chart

The following table summarizes the coverage available under the dental plan. You will see that dental benefits fall into four "classes" of covered services. Additionally, please review the *What the University of Idaho Dental Plan Covers* section for more detailed information.

Dental Plan Benefits	
Annual Deductible (you pay)	You pay $50 per covered person for covered services, up to a maximum deductible of $150
Annual Maximum Benefit	$1,000 per covered person
Class I Benefits – Diagnostic services – Preventive services – X-rays	Plan pays 100%, not subject to the deductible*
Class II Benefits – Oral surgical services – Endodontic services – Periodontic services (including periodontal cleaning) – Minor restorative services	Plan pays 80% after the deductible*
Class III Benefits** – Major restorative services – Prosthodontic services – Implants	Plan pays 50% after the deductible*
Class IV Benefits: Orthodontia	Not covered

* For services provided by non-participating dentists, plan benefit payments are based on the lesser of the submitted amount or Delta Dental's non-participating dentist fee.

** A one-year waiting period applies to receive coverage for Class III services. Participation under the active dental plan satisfies the one-year waiting period.

General Benefit Information

This section provides you with additional information on your benefits.

Annual Deductible

The dental plan has an annual deductible you must satisfy before the plan will pay benefits for certain services during that calendar year. There is *no deductible* for Class I services.

Annual Maximum Benefit

The maximum total benefit that the plan will pay annually for each covered person for covered services.

Predetermination Review

To help you and your dentist know in advance how much the plan will pay for a specific treatment, ask your dentist to submit a predetermination review form outlining the proposed services and expected costs. Although not required, predetermination reviews are strongly encouraged when expenses are expected to exceed $200. During a predetermination review, the claims administrator reviews proposed dental treatments and expected charges before treatment begins. A predetermination confirms how much Delta Dental will pay for proposed treatment and the

patient's payment portion of the treatment. Delta Delta's statement of estimated benefits is valid if treatment is performed within 90 days of when the predetermination is processed.

What the University of Idaho Dental Plan Covers

The following are covered services when obtained in accordance with the terms and conditions of this plan. Benefits are subject to the deductibles, cost-sharing, exclusions, limitations and other provisions as specified.

Benefits under the plan are divided into four classes. The following list shows the specific services under each class. Note that the dental plan does not cover all classes of benefits.

Class I Benefits: Diagnostic and Preventive Services, X-rays

- **Diagnostic and Preventive Services:** Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease including:
- **Periodic oral examination:** A benefit up to twice per calendar year.
- **Comprehensive oral examination:** A benefit once every three calendar years and is applied toward the examination benefit.
- **Cleaning of teeth and gums:** A benefit up to twice per calendar year. A periodontal cleaning (covered as a Class II benefit) may be used toward the twice-per-calendar-year cleaning benefit.
- **Preventive fluoride treatment:** A benefit for children under age 19 — once in any 12-month period.
- **Radiographs:** X-rays as required for routine care or as necessary for the diagnosis of a specific condition.
- **Bitewing X-rays:** A benefit once in any period of 12 consecutive months.
- **Full mouth X-rays *(including bitewing X-rays)*:** A benefit once in any five-year period. **Note:** A panoramic X-ray that includes bitewing X-rays on the same date of service counts as fulfilling both the full-mouth X-ray benefit paid once in five years and the bitewing X-ray benefit paid once in 12 months.
- **Occlusal X-rays**: A benefit twice in a 12-consecutive-month period.
- **Space Maintainers**: are benefits prior to age 19. Re-cementation of a space maintainer is a benefit once in a 12-month period. Replacement of a space maintainer is a benefit only if additional extractions are performed or to accommodate growth.

Class II Benefits: Basic Services

- **Oral Surgery Services:** Extractions and dental surgery, including pre- and post-operative care.
  A once-per-lifetime benefit is payable for: extractions (per tooth); removal of cysts, tumors, lesions and foreign bodies; alveoloplasty; incision and drainage of abscess; frenulectomy; and excision of hyperplasic tissue. Excision of pericoronal gingiva is a benefit once in a 60-month period.
- **Endodontic Services:** Treatment of teeth with diseased or damaged nerves, including:
  - **Root canals**, including root canal retreatment 24 months after the initial root canal.
  - **Apical surgery**, once in a 24-month period.
  - **Pulpotomy**, limited to primary teeth. For benefit purposes, a pulpectomy and/or root canal on a primary tooth is covered as a pulpotomy.

- **Periodontal Services:** Treatment of diseases of the gums and supporting structures of the teeth. This includes periodontal maintenance following active therapy (periodontal cleaning). Benefits include:
- **Root planing** — Once in any two-year period.
- **Periodontal surgery** — Once in any three-year period.
- **Sealants:** A benefit for molar and bicuspid teeth, on the occlusal surface, once every three years up to age 16.
- **Minor Restorative Services:** Services to rebuild and repair natural tooth structure when damaged by disease or injury. Benefits include:
- Amalgam (silver) and resin (white) fillings, payable once per surface per tooth within a 24-month period paid at resin fee.
- Prefabricated crowns (stainless steel, resin) on primary teeth, payable once in a 24-month period.
- Inlays are benefited as the corresponding filling material with the patient responsible up to the submitted charge for the cost of a regular filling, depending on type of material used, as covered under Class I.
- Crown/denture/bridge recementation, repair and adjustment are a benefit six months after the initial placement and once in a 24-month period.
- **Emergency Palliative Treatment:** Emergency treatment to temporarily relieve pain.
- **General Anesthesia and IV Conscious Sedation:** Benefits when administered for oral surgical and periodontal surgical procedures.

Class III Benefits: Major Services

A one-year waiting period applies before you are eligible for coverage for Class III benefits. Coverage under the active dental plan works to satisfy the one-year waiting period.

- **Major Restorative Services:** Services to rebuild and repair natural tooth structure when damaged by disease or injury, including crowns when teeth cannot be restored with another filling. Benefits include:
- Cast (indirect) restorations (including veneers, crowns and onlays) on the same tooth are payable once in any seven-year period.
- Porcelain, porcelain substrate and cast (indirect) restorations are not payable for children under age 16. If these types of restorations are placed on permanent teeth of dependent children under age 16, the benefit is limited to a plastic or stainless steel crown, with the participant responsible for the balance of the submitted fee. In this case the benefit is allowed once in a two-year period.
- For benefit purposes, onlays and porcelain veneers are covered the same as porcelain-fused-to-metal crowns, with the participant responsible for the balance of the submitted fee.
- Denture rebase and reline are a benefit six months after the initial placement and once in a 24-month period.
- Crown build-ups (including pins), prefabricated post and core build-ups, and cast post and core buildups are a benefit once in a two-year period.

- **Prosthodontic Services:** Services and appliances that replace missing natural teeth (such as bridges, partial dentures and complete dentures). Benefits include:
- One complete upper and one complete lower denture: Once in any seven-year period.
- Partial denture or fixed bridge: Once in any seven-year period.
- Reline or complete replacement of denture base material: Once in any two-year period per appliance.
- Fixed bridges and removable cast partials: Not payable for children under age 16.

  Implant Benefit: An implant body, implant abutment and the prosthesis placed on the implant are a covered benefit, with a lifetime benefit of $900 per implant per tooth. All implants placed in an edentulous to partially edentulous arch have a lifetime benefit of $900 per arch. Removal of an implant or repair to an implant abutment is not covered. All procedures directly related to the implant will be paid at 50%, up to a lifetime maximum benefit of $900 per implant per tooth. The $900 allowance counts toward the dental plan's annual maximum.
- **Occlusal Guard:** A benefit once in a 24-month period. Occlusal guard reline/repair is a benefit within 12 months of insertion.

What's Not Covered

Covered expenses do not include, and no payment will be made for, the following charges if incurred:

- Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws.
- Benefits or services that are available from any government agency, political subdivision, community agency, foundation or similar entity. This provision does not apply to any programs provided under Title XIX Social Security Act (i.e., Medicaid).
- Services, as determined by Delta Dental, for correction of congenital or developmental malformations.
- Services for cosmetic surgery or dentistry for cosmetic (aesthetic) reasons.
- Veneers placed for cosmetic purposes only.
- Services or appliances started before an individual became eligible under the plan.
- Prescription drugs, pre-medications and/or relative analgesia. General anesthesia and/or intravenous sedation other than for covered oral surgery. Charges for hospitalization, laboratory tests and examinations, and any additional fees charged by the dentist for hospital treatment.
- Preventive control programs, including home care items.
- Charges for failure to keep a scheduled visit with the dentist.
- Repair, relines or adjustments of occlusal guards.
- Occlusal (complete) equilibration.
- Charges for completion of forms. A participating dentist may not make these charges to an eligible participant.
- Lost, missing or stolen appliances of any type, and replacement or repair of orthodontic appliances.
- Services for which no valid dental need can be demonstrated, that are specialized techniques, or that are experimental in nature as determined by the standards of generally accepted dental practice.
- Experimental procedures not yet approved by Delta Dental.

- Appliances, surgical procedures and restorations for increasing vertical dimension; for restoring occlusion; or for replacing tooth structure loss resulting from attrition, abrasion or erosion.
- Treatment by someone other than a dentist, except for services performed by a licensed dental hygienist or denturist within the scope of his or her license.
- Those benefits excluded by the policies and procedures of Delta Dental, including the processing policies.
- Services or supplies for which no charge is made, for which the patient is not legally obligated to pay or for which no charge would be made in the absence of Delta Dental coverage.
- Services or supplies received as a result of defect or injury due to an act of war, declared or undeclared.
- Services that are covered under a hospital, surgical/medical or prescription drug program.
- Appliances, restorations or services for the diagnosis or treatment of disturbances of the temporomandibular joint dysfunction (TMD). Refer to the Medical Benefits Plan summary plan description.
- Myofunctional therapy.
- Oral hygiene instruction and dietary instruction.
- Plaque control programs.
- Duplicate dentures.
- Periodontal splinting, including crowns or bridgework.
- The dental plan administrator is not obligated to pay claims received more than 12 months after the date of service.

Claims for Dental Benefits

This section provides you with important information about how to file a claim for dental benefits.

How to File a Claim

You do not have to file a claim for benefits if you use a Delta Dental of Idaho participating provider (a provider who belongs to the Delta Dental Premier or Delta Dental PPO network). However, if you receive services from a non-participating provider, the provider may require payment in full at the time of service. All dental claims should be submitted to:

Delta Dental of Idaho
P.O. Box 2870
Boise, ID 83701

Claims for services paid by a participant to an out-of-network provider must be submitted for reimbursement within 12 months of the date the services were rendered in order to be eligible for coverage.

After Delta Dental of Idaho processes your claim, you will receive an Explanation of Benefits, or EOB. Your EOB will show payments Delta Dental of Idaho has made and to whom payments have been made. It will also provide any information on why a claim was denied or not paid in full.

Please contact the number on your ID card with questions about your claims and EOBs. See the *If Your Claim Is Denied* section for more information on claims.

If Your Claim Is Denied

If your claim is denied, in whole or in part, you will receive a written notice that contains the information described below.

- The specific reason(s) for the denial.
- The specific plan provisions on which the denial is based.
- If an internal rule, guideline, protocol or other similar criterion was relied upon to determine a claim, upon request you can receive either a copy of the actual rule, guideline, protocol or other criterion, or a statement that the rule, guideline, protocol or other criterion was used.
- If the denial is based on a provision such as medical necessity, experimental treatment or a similar exclusion or limit, you will either receive an explanation of the scientific or clinical judgment for the determination based on the plan terms and your medical circumstances, or a statement that you can receive the explanation free of charge upon request.
- A description of any additional material or information needed to process the claim and an explanation of why it is necessary.

Appealing a Denied Claim

You or your authorized representative may appeal a claim decision by submitting a written appeal to Delta Dental. You must make this request within 12 months following receipt of the denied claim. You must submit your request for appeal in writing and state why it is believed the claims decision was incorrect.

Upon request, you or your authorized representative will be given reasonable access to all documents, records and information relevant to the claim for benefits, and you may request copies free of charge. You can also submit written comments, documents, records and other information relating to the claim. Review of your claim will take into account all comments, documents, records and other information, without regard to whether such information was submitted or considered in the initial benefit determination.

Third Party Committee's Review

The appeal will be considered by someone who did not make the initial decision and who is not a subordinate of the party who made that decision. If the initial denial was related to dental necessity, experimental treatment or a clinical judgment in applying contract terms, the appeal will be reviewed by a third party committee. This committee will consist of three dentists who have the appropriate training and experience in dentistry and who are neither the dental consultant who made the initial decision nor the subordinate of the consultant.

Timing of Notification of Appeal Decision

You will receive a decision on your claim within 60 days of Delta Dental's receipt of your appeal.

Coordinating Benefits with Other Coverages

If you have dental coverage under another dental plan, such as through your spouse's employer, benefits will be coordinated.

Through coordination of benefits, payments for dental services for you and your eligible dependents will be coordinated between your Delta Dental plan benefits and the other employer's dental plan. This means that benefits are adjusted so that benefits equal to more than 100% of covered charges are not paid on your behalf.

Coordination of benefit rules determine which plan pays first. The plan that pays first is called the primary plan. Other plans are secondary and pay benefits after the primary plan.

The end result of Coordination of Benefits is that for covered services, the secondary plan picks up a portion of the payment, up to the allowed amount, for the service.

The order of payment (which plan pays as primary and which plan pays as secondary) is determined using the following rules.

The plan that covers a patient as an employee pays as primary. If there is another plan covering the patient as a spouse or dependent, this plan would pay secondary.

This plan determines benefits using the first of the following rules that applies:

- If children are covered under both parents' dental plan coverage, the "birthday rule" applies. The plan of the parent whose birthday (month and day) comes first in the calendar year pays first. If both parents have the same birthday, the plan that has covered the parent for the longest period will pay first.
- When parents are separated or divorced:
- If a court has given financial responsibility for the child's healthcare expenses to one parent, that parent's dental plan pays first.
- If a court order has not given financial responsibility for a child's healthcare expenses, the order of benefits will be determined in the following order:
    - Plan of the parent with primary legal custody of the children,
    - Plan of the spouse of the parent with primary legal custody,
    - Plan of the parent without legal custody, and
    - Plan of the spouse of the parent without legal custody.
- A plan that covers a patient as an active employee or as the dependent of an active employee pays before a plan covering him or her as a retired or laid-off employee. (If the other plan does not include this provision, it does not apply.)
- A plan that covers a patient as an active employee or as the dependent of an active employee pays before a plan covering him or her through COBRA coverage. (If the other plan does not include this provision, it does not apply.)
- For oral surgical procedures that qualify under the medical plan, the medical plan always pays as primary and Delta Dental pays secondary.
- If none of the above situations applies, the plan that has covered the person for the longest period of time pays first.

The primary plan pays benefits as if no other plan were in effect. If there is a balance of charges after the primary plan has paid, the secondary plan pays benefits. When the Delta Dental plan is the secondary plan, payment is reduced so that total benefits paid by all plans are not more than the total allowed amount for services rendered.

Employee Assistance Plan (EAP)

The Employee Assistance Program (EAP) is a free, confidential service that provides eligible retirees and their families with the opportunity to discuss personal problems with a professional counselor, receive unlimited telephone and Internet access to resource and referral information, and obtain other self-help information.

You do not have to enroll in a medical plan to participate in the EAP. However, if you are enrolled in a medical plan, you may be able to maximize your benefits by accessing the free services of the EAP before using behavioral health benefits, which require you to pay a share of the cost.

Services Provided

The EAP's Master's-level, licensed professional counselors are available to you and your family 24 hours a day, 365 days a year. Counselors can help with any situation that creates stress including:

- Family problems,
- Stress/anxiety,
- Personal relationships,
- Depression,
- Grief,
- Anger management,
- Substance abuse,
- Legal concerns,
- Finances,
- Workplace,
- Aging, and
- Abuse.

How the Program Works

You can call the EAP at **1-800-999-1077. Emergency Crisis** 24/7 -1-800-833-3031. For online services go to **www.EAPHelplink.com** (University code: UI1), and for networked providers and company information go to **www.qualitycareforme.com**.

When you call the EAP, you should identify yourself as a University of Idaho employee. If you have a straightforward issue or just need information, such as the name and location of a support group, your issue may be resolved during the phone call. However, if you have a more complex issue, the counselor will help you determine the "next steps" to find a solution. You'll receive an authorization number and the name of an EAP counselor. Call the counselor to schedule your appointment — be sure to provide your authorization number to ensure cost-free service.

Next steps may include:

- **Assessment:** Employees, retirees, or immediate family members who contact the EAP can meet with a counselor for an assessment to accurately identify their problem. Upon completion of the assessment, the counselor will make specific recommendations.
- **Short-term Counseling:** Employees, retirees, or immediate family members may be offered short-term counseling (up to eight sessions per situation) with a counselor.
- **Referral Services:** Sometimes it may be necessary to refer you or your family member to services or treatment beyond what is offered by the EAP.
- **Legal Care:** You will be able to consult with an attorney at no cost for any non-work-related legal concern. Consultation services are available during business hours, Monday through Friday, and also during "off hours" for emergencies. Common legal concerns may include: divorce, wills, child custody, estate planning, civil disputes, criminal issues, taxes, consumer rights, etc. To meet with a lawyer, you will receive a referral to a law firm in your area. Referral lawyers have agreed to provide the initial half-hour consultation at no cost to you. If you decide to retain the lawyer for further services, the lawyer will charge a special 25% reduced rate because you were referred through the EAP.
- **Financial Care:** You can also access a financial consultant who will discuss your concerns and provide suggestions regarding a course of action. The telephone consultation is provided free of charge to you and your dependent family members. When appropriate, the EAP can provide a local community referral for a specific concern, such as: taxes, housing, mortgage, retirement planning, wage garnishment/liens, bankruptcy, credit problems, budgeting and cash flow, and credit restoration.

Internet Self-Help

This service provides self-help resources and referral for a variety of community-based services such as elder and child care, assisted transportation and home meal delivery services. Information to help prepare for life events and other resources that may help as you face life challenges are available. Many of these same services are also offered through the 24-hour helpline. These services are unlimited.

Contacting the EAP

You can contact the EAP at **1-800-999-1077**, 24 hours a day, 365 days a year. For online services, go to **www.EAPHelplink.com** (University code: UI1) and for network providers and company information, go to **www.qualitycareforme.com**.

Health Savings Account

A Health Savings Account (HSA) is a self-funded account permitted under federal tax law that allows you to save money for eligible healthcare expenses on a tax-favored basis.

An HSA is an individual account that belongs to you and is not part of the University's medical plan. It is portable, which means it is not tied to your University employment. HSAs may earn interest or investment returns, based on the terms. Because the HSA has a special tax-favored status under law, it is governed by numerous mandatory tax rules and regulations.

If you have an HSA balance, you can continue to withdraw contributions to pay for eligible healthcare expenses. However, only participants in a qualifying high deductible health plan, such as Plan B, who are not eligible for Medicare, may contribute to an HSA.

Who Is Eligible to Contribute to the University Sponsored HSA

To contribute to the University HSA, you must meet certain criteria:

- Be enrolled in a the University "high deductible health plan," such as Plan B.
- Not be covered by another health plan (unless it qualifies as a high deductible health plan) or enrolled in Medicare Part A or B;
- Not be claimed as a dependent on another person's tax return; and
- Not enrolled in a general purpose FSA. Note that if your spouse participates in his/her employer's general purpose FSA, unless reimbursements are limited only to your spouse, you cannot contribute to the University's HSA.

Medicare Part A

You are enrolled in Medicare Part A automatically when you apply for Social Security benefits. Medicare Part A enrollment is retroactive to the first day of the month in which you attain age 65 and you cannot contribute to an HSA during these months.

Opening an HSA

If you do not already have an HSA Account, you may open one with any provider of your choice. Once your enrollment is complete and a deposit is made, your account will be established and available to use for eligible health care expenses.

Please note: Expenses incurred before the account is established are not eligible for reimbursement by your HSA.

Contributing to an HSA

HSA contributions to your account are exempt from federal and most states' income taxes.

The table below shows the 2019 contribution amounts.

If you enroll for …	2019 HSA Contribution Amount You may save up to …
Retiree Only coverage	$3,500
Family coverage in one of the following coverage tiers: – Retiree+ Spouse – Retiree + Child – Retiree + Children – Retiree + Spouse + Child(ren)	$ 7,000
If you are age 55 or over in 2019, you can save an additional $1,000 in catch-up contributions.	

How to Contribute to Your HSA

You may make your annual contributions to your HSA by personal check and then deduct the after-tax HSA contribution on your income tax return. Contact your HSA provider to learn more about making contributions.

Spending Your HSA Dollars

You may use your HSA funds tax-free to pay for qualified healthcare expenses for you, your spouse and certain other individuals who qualify as your dependent for health care purposes under federal law *. Because you own your HSA, you are responsible for ensuring your tax-free withdrawals are spent on qualified healthcare expenses.

Additionally, you can use your HSA funds tax-free to pay qualified healthcare expenses only if you incurred the expenses *after* you established the HSA and only if the expenses are not reimbursed from another source (such as your spouse's health plan).

* For this purpose, the individual must meet the IRS definition of a "qualifying child" or "qualifying relative." Generally, a qualifying child is a child who is under age 19 (24 if a full-time student) who lives with you for more than half the year and provides less than half of his/her own support), A "qualifying relative" is a family member (or someone who lives with you in your household) who can't be claimed as another individual's qualifying child and who receives more than ½ of his or her support from you. You should consult with your tax adviser for more information.

Qualified Healthcare Expenses

Here is a general list of qualified healthcare expenses:

- Any medical expenses used to meet your deductible;
- Any portion of the cost of covered services (yourcost-sharing) you pay after meeting the deductible;
- Any expenses the IRS considers qualified healthcare expenses for tax purposes. This category includes expenses such as dental treatment, vision care, hearing aids and over-the-counter supplies used to treat illness or injury (such as bandages, crutches and blood-sugar test kits).
- Over-the-counter medications, other than insulin, are qualified health care expenses only when prescribed. Procedures not covered by traditional medical plans, such as laser eye

surgery and alternative medicine treatments;

- The cost of your monthly contributions for coverage (such as COBRA coverage) while you are unemployed;
- Long-term care insurance contributions; and
- Once you reach age 65, Medicare contributions.

To learn more about eligible expenses refer to the IRS Publication 502, which can be found at **www.irs.gov**.

What if ... I use my HSA money for an ineligible expense?

If you are under age 65 and you spend your HSA funds on an ineligible expense, the amount will be subject to regular income taxes, plus a 20% tax penalty. However, once you are age 65 and older, you may spend your HSA funds for any purpose. You will pay regular income taxes on your distribution for ineligible expenses, but the 20% penalty tax will not apply.

What if ... I accidentally use my HSA money for an ineligible expense? How can I avoid tax penalties?

If you accidentally use your HSA funds for an ineligible expense, you can avoid paying taxes and penalties by redepositing the amount of money you used from your HSA by April 15 of the following year. Please note: You must be able to show by clear and convincing evidence that the HSA distribution resulted from a reasonable mistake (for example, you reasonably — but mistakenly — believed you had an eligible medical expense). To avoid paying tax penalties in addition to ordinary income tax, you will need to complete this deposit before April 15 of the following year (the annual tax filing deadline). And, you must inform your provider that the re-deposited funds are a reimbursement to the account.

Filing Your Taxes

In return for an HSA's tax-free privileges, the IRS requires documentation. Because you own your HSA, the IRS holds you accountable for monitoring the eligibility of your expenses and maintaining good records. As a result, it is recommended that you retain all covered healthcare receipts for three years.

To help you in filing your taxes your HSA provider should send you the following IRS forms:

- In January, Form 1099-SA detailing your HSA withdrawals; and
- In May, Form 5498-SA detailing HSA contributions.

Use Form 1099-SA to complete IRS tax Form 8889 and file it with your federal tax return.

You should learn the many tax rules that govern the use of HSAs and monitor your contributions and qualified expenses. For more information about HSAs and the tax rules that apply to them, review the material in Publication 969 at **www.irs.gov**.

COBRA Continuation of Coverage

Your covered dependents may be offered COBRA continuation coverage when their coverage under the medical, prescription drug and dental plans would otherwise end because of a life event known as a "qualifying event."

COBRA continuation coverage generally consists of the coverage under the plan that your family members had immediately before the qualifying event.

When COBRA Continuation of Coverage Is Available

Your covered spouse and/or dependents may continue their coverage for up to 36 months if they lose coverage under the terms of the plan because of one of the following qualifying events:

- You (the retiree) and your spouse become divorced, legally separated or your marriage is annulled; or
- Your covered dependent child no longer meets the plan's definition of a dependent (for example, if a dependent child reaches the maximum age limit for coverage).
- You die, and within 36 months of your death, your spouse or dependent child loses coverage because he or she becomes eligible for coverage under another employer's health plan.

You Must Give Notice of Some Qualifying Events

You or your covered dependents must notify the COBRA Administrator, in writing, of the qualifying event within 60 days of the latest of:

- The date of the qualifying event;
- The date coverage would be lost because of the qualifying event; or
- The date on which the qualifying beneficiary was informed of the responsibility to provide notice and the procedure for doing so.

This notice should be sent to the COBRA Administrator at the address specified in the section *How to Contact the COBRA Administrator.* A notice mailed to the COBRA Administrator will be considered provided on the date of mailing.

The notice must include the qualified beneficiary's name, the nature of the qualifying event (e.g., divorce, legal separation or a child's loss of dependent status) and the date the qualifying event occurred (e.g., date of divorce or legal separation or the date the dependent child reached the plan's limiting age or gets married).

If notice is not provided during this 60-day notice period, the spouse or dependent child who loses coverage will not be offered the opportunity to elect COBRA continuation coverage.

Once notification has taken place, the qualified beneficiary will receive a notification package. This package will contain details about continuing coverage, such as the deadline for electing continued coverage, monthly costs, and how to pay for coverage.

Notice of any right to continued coverage to a covered spouse will be deemed notice to any covered dependent children who reside with your spouse.

Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage. The duration of the coverage depends on the nature of the qualifying event that causes the loss of coverage:

Continued coverage is available if coverage would otherwise be lost because:	For up to:
Your dependent child(ren) is no longer eligible under the plan.	36 months for your dependent child(ren) from the date the child becomes ineligible under the terms of the plan.
You divorce or legally separate from your spouse.	36 months for your spouse and eligible dependent child(ren) from the date of the divorce or legal separation.
You die and your spouse or child(ren) becomes eligible for coverage under another employer's plan.	36 months for your spouse and eligible dependent child(ren) from the date of your death.

Electing COBRA Continuation of Coverage

COBRA election forms are mailed from the University of Idaho Benefits Center, the COBRA Plan Administrator, to the home address on file as soon as they receive notice of the qualifying event. To elect continuation coverage, your covered dependents must send the University of Idaho Benefits Center a completed election form within 60 days of receipt.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, continuation coverage may be elected for only one, several or all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children.

Paying for COBRA Continuation of Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in your COBRA notice.

First payment for continuation coverage: Payment for COBRA coverage does not have to be sent with the election. However, the first payment must be made no later than 45 days after the date of the election. (This is the date the election notice is post-marked, if mailed.) The qualified beneficiary is responsible for making sure that the amount of the first payment is correct. The COBRA Administrator should be contacted to confirm the correct amount of the first payment. Coverage will not become effective until payment in full is received.

IMPORTANT!
Failure to make the first payment for continuation coverage in full within 45 days after the date of the election will result in the loss of all continuation coverage rights under the plan. Once COBRA continuation rights are terminated, they cannot be reinstated.

Periodic payments for continuation coverage: After the first payment for continuation coverage is made, a qualified beneficiary will be required to make monthly payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary will be billed monthly and the the payments can be made on a monthly basis. Under the plan, each of these monthly payments for continuation coverage is due on the date shown in the notice. If a monthly payment is made on or before the first day of the coverage period to which it applies, coverage under the plan will continue for that coverage period without any break.

Grace periods for monthly payments: Although monthly payments are due on the required date, a qualified beneficiary will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Continuation coverage will be provided for each coverage period as long as payment for that coverage period is made on or before the date that the grace period for that payment ends.

However, if a monthly payment is made later than the first day of the coverage period to which it applies, but before or on the date that the grace period ends for the coverage period, coverage under the plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the monthly payment is received. This means that any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

Failure to make a monthly payment before the end of the grace period for that coverage period will result in the loss of all rights to continuation coverage under the plan.

The first payment and all monthly payments for continuation coverage should be sent to the COBRA Administrator listed in the *Plan Administration and Contact Information* section at the end of this document.

When COBRA Coverage Ends

A qualified beneficiary's COBRA continuation coverage will end before the expiration of the maximum coverage period if any of the following events occurs:

- The contribution for coverage is not paid in a timely manner;
- After electing COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition that the individual may have;
- After electing COBRA continuation coverage, the qualified beneficiary enrolls for Medicare;
- If coverage is extended on account of disability, the Social Security Administration makes a determination that the individual is no longer disabled; and/or
- The University no longer provides group health coverage to any of its employees or retirees.

Keep the Plan Informed of Address Changes

To protect your and your family's rights, you should keep the COBRA Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

How to Contact the COBRA Administrator

All required notices should be mailed to the COBRA Administrator at the following address:

University of Idaho Benefits Center
P.O. Box 25406
Pittsburgh, PA 15264-5406
Phone: **1-855-360-5479**

Plan Administration and Contact Information

This section provides some additional details on the benefits described in this booklet.

Plan	Administered by	Contact Information	Insured by	Funded by
Medical Plan	Blue Cross of Idaho Contract #: 10030497	3000 East Pine Avenue Meridian, ID 83642 **1-866-685-2258** **www.bcidaho.com**	Self-insured	University and retiree contributions
Prescription Drug Plan (Pre-Medicare Eligible)	CVS Caremark	**1-888-202-1654** **www.caremark.com**	Self-insured	University and retiree contributions
Prescription Drug Plan (Medicare - Eligible)	Silverscript	**1-855-539-4715**		
Behavioral Health Plan	Blue Cross of Idaho Contract #: 10030497	3000 East Pine Avenue Meridian, ID 83642 **1-866-685-2258** **www.bcidaho.com**	Self-insured	University and retiree contributions
Dental Plan	Delta Dental of Idaho, Inc. Contract #: 1530	P.O. Box 2870 Boise, ID 83701 **1-800-356-7586** **www.deltadentalid.com**	Self-insured	University and retiree contributions
Employee Assistance Plan	KEPRO	44 South Broadway Suite 1200 White Plains, NY 10601 **1-800-999-1077** **www.EAPHelplink.com (code UI1)** **www.qualitycareforme.com** to find providers	Self-insured	University contributions

Plan Administrator

University of Idaho
875 Perimeter Drive MS 4332
Moscow, ID 83844-4332

www.uidaho.edu/benefits
1-208-885-3697

Plan Year

The plan records are administered on a contract year basis beginning January 1 and ending December 31 of each year.

Agent for Service of Legal Process

University of Idaho (Physical Address)
415 West 6th Street

Moscow, ID 83844-4332

Employer Identification Number

82-6000945

Changes to the Program

While the University expects to continue the program indefinitely, it reserves the right to amend, modify, suspend or terminate the program or any of the plans at any time in its sole discretion for active or former employees, as well as for COBRA participants. The University also reserves the right to change the amount of required retiree contributions for coverages under the benefit programs described in this document.

An amendment or termination of the program may affect not only the coverage of active employees (and their covered dependents) but also of COBRA participants and former employees, who retired, died or otherwise terminated employment.

A plan change may transfer plan assets and debt to another plan or split the plan into two or more parts. If the University does change or end a plan, it may decide to set up a different plan.