

City of Idaho Falls
Retiree

Effective Date: October 1, 2010

Benefit Period: January 1 through December 31

SUMMARY OF BENEFITS

GRANDFATHERED HEALTH PLAN NOTICE:

Blue Cross of Idaho believes this Policy is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Policy may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Group Administrator. For ERISA plans, You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

OBSTETRIC OR GYNECOLOGICAL CARE NOTICE:

You do not need prior authorization from Blue Cross of Idaho or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please visit our Web site at www.bcidaho.com. You may also call our Customer Services Department at 208-331-7347 or 800-627-1188 for assistance in locating a Provider.

EMERGENCY SERVICES

For the treatment of emergency medical conditions or accidental injuries of sufficient severity to necessitate immediate medical care by, or that require ambulance transportation service to, the nearest appropriate facility provider, BCI will provide In-Network benefits for Covered Services provided by either a participating or nonparticipating facility provider and facility-based professional providers only. If the nearest facility provider is nonparticipating, once the Insured is stabilized and is no longer receiving emergency care the Insured (at BCI's option) may transfer to the nearest appropriate participating facility provider for further care in order to continue to receive In-Network benefits for Covered Services. If the Insured is required to transfer, transportation to the participating facility provider will be a Covered Service under the ambulance transportation service provision of this Policy.

This summary provides a brief description of certain benefits and terms of your health care plan. Throughout this Policy, Blue Cross of Idaho may be referred to as BCI. Please review this entire booklet for a complete explanation of benefits, limitations, exclusions, and general provisions.

Deductible: \$500 per Insured. No family shall be obligated to meet more than two (2) deductibles in any calendar year; however, at least one (1) family member must meet the individual \$500 deductible. Benefits are payable after the deductible has been met.

Stop-Loss Coverage: \$2,000 (plus deductible) per Insured. Each family member must meet the Stop-Loss amount; however, no family shall be charged for more than three (3) Stop-Loss amounts in any calendar year.

Annual Maximum Benefit Limit: \$1,250,000 per Insured, per calendar year. All covered services apply towards the Annual Maximum Benefit Limit except for chiropractic care services, diabetes self-management education services, hospice services, transplant travel benefits, foot orthotics and hearing services. .

Benefits—subject to the deductible and then coinsurance	Your Responsibility
Ambulance Services (prior review required for air ambulance)	20% coinsurance
Blood and Blood Plasma	20% coinsurance

Chemical Dependency and Mental Health <ul style="list-style-type: none"> • Outpatient chemical dependency and mental health services • Inpatient chemical dependency services • Inpatient mental health services 	20% coinsurance 20% coinsurance 20% coinsurance
Chiropractic Services (\$500 calendar year maximum)	20% coinsurance
Contraceptives (Retiree, spouse and dependents) <ul style="list-style-type: none"> • Oral contraceptive prescription drugs (34 day supply) • Diaphragms and intrauterine devices • Injectable contraceptives (Depo Provera) • Norplant insertion 	See prescription drug section \$25 copayment per device \$20 copayment per injection \$100 copayment per implant
Durable Medical Equipment; Orthotics; and Prosthetic Devices	20% coinsurance
Home Health Care (17 visit maximum per calendar year)	20% coinsurance
Home Infusion Therapy	20% coinsurance for participating 80% for nonparticipating
Hospice Care (limited to a combined \$5,000 and a maximum of six months from the initial date covered care is provided)	20% coinsurance
Hospital Care <ul style="list-style-type: none"> • Outpatient services (surgery, diagnostic laboratory and x-ray charges) • Emergency room (medical emergencies, treatment of injury within 72 hours of injury) • Inpatient services (room and board and general nursing care, cardiac or intensive care units, ancillary services and supplies) 	20% coinsurance 20% coinsurance 20% coinsurance
Human Growth Hormone Therapy	20% coinsurance
Injury to Sound Natural Tooth (12 months from date of accident)	20% coinsurance
Mental Health (see Chemical Dependency)	
Physician/Provider Services (office, home and outpatient hospital calls, inpatient hospital calls, surgical services and 2 nd and 3 rd surgical opinions)	20% coinsurance
Prescription Drugs	20% coinsurance
Rehabilitation <ul style="list-style-type: none"> • Inpatient services (25 day maximum per calendar year) • Outpatient services 	20% coinsurance 20% coinsurance
Skilled Nursing Facility (30 days calendar year maximum)	20% coinsurance

<p>Preventive Care Services Specifically listed Services include: Annual adult physical examinations; routine or scheduled well-baby and well-child 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 EKG; Thyroid Stimulating Hormone (TSH); Transmittable Diseases Screening (Chlamydia, Gonorrhea, HIV, Syphilis, Tuberculosis (TB)); Urinalysis (UA); Screening Mammograms, Aortic Aneurysm Ultrasound; Alcohol Misuse Assessment; Genetic Counseling 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 Insured, per Benefit Period); Urine Culture for Pregnant Women; Hepatitis B Virus Screening for Pregnant Women; Iron Deficiency Screening for Pregnant Women; Rh (D) Incompatibility Screening for Pregnant Women.</p> <p>The specifically listed Preventive Care Services may be adjusted accordingly to coincide with federal government changes, updates, and revisions.</p>	<p>You pay nothing for specifically listed services.</p> <p>20% coinsurance for services not specifically listed.</p>
<p>Immunizations –Specifically listed Immunizations include: 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.</p> <p><i>The specifically listed Immunizations may be adjusted accordingly to coincide with federal government changes, updates, and revisions.</i></p>	<p>You pay nothing for specifically listed immunizations.</p> <p>20% coinsurance for services not specifically listed.</p>

Unless specifically listed in the benefit summary, the coinsurance amount for Participating Providers and Nonparticipating Providers is the same amount.

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INTRODUCTION

Blue Cross of Idaho values every opportunity we have to demonstrate we are the premier choice for health insurance in Idaho. Quality services and products enable BCI of Idaho to deliver the security and confidence in health insurance that you demand.

BCI of Idaho's employees are committed to our customers. That includes having knowledgeable customer service representatives available who can answer any questions you may have about benefits, providers, charges, or deductibles.

This booklet will describe the benefits provided to you and your enrolled dependents under the group policy provided by your employer. Please take the time to familiarize yourself with waiting periods, exclusions, limitations, and other provisions of your health insurance policy.

BCI of Idaho urges you to use your health care plan wisely. Monthly premiums are based on actual cost and utilization. Intelligent use of the plan will benefit you and your family.

As we strive for continued excellence, our commitment to providing you with the outstanding customer service you've come to expect from BCI of Idaho remains our top priority.

BLUE CROSS OF IDAHO DISTRICT OFFICE LOCATIONS

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

Boise Office

Blue Cross of Idaho
Customer Services Department
3000 East Pine Avenue
Meridian, ID 83642

Mailing Address

P.O. Box 7408
Boise, ID 83707
(208) 331-7699 (Boise Area)
1-800-627-1006

Coeur d'Alene Office

Blue Cross of Idaho
2100 Northwest Blvd., Suite 120
Coeur d'Alene, ID 83814
(208) 666-1495

Idaho Falls Office

Blue Cross of Idaho
2116 E. 25th St.
Idaho Falls, ID 83401

Mailing Address

P.O. Box 2287
Idaho Falls, ID 83403
(208) 522-8813

Lewiston Office

Blue Cross of Idaho
1010 17th Street
Lewiston, ID 83501

Mailing Address

P.O. Box 1468
Lewiston, ID 83501
(208) 746-0531

Pocatello Office

Blue Cross of Idaho
275 S. 5th Ave., Suite 150
Pocatello, ID 83201

Mailing Address

P.O. Box 2578
Pocatello, ID 83206
(208) 232-6206

Twin Falls Office

Blue Cross of Idaho
1431 N. Fillmore St., Suite 200
Twin Falls, ID 83301

Mailing Address

P.O. Box 5025
Twin Falls, ID 83303
(208) 733-7258

Web Site Address: www.bcidaho.com

IDAHO DEPARTMENT OF INSURANCE CONTACT INFORMATION

Idaho Department of Insurance

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

HOW TO SUBMIT CLAIMS

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

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

To File An Insured's Own Claims

If a doctor or hospital prefers that an Insured file the claim, here is the procedure to follow:

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

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

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

How Blue Cross Of Idaho Notifies The Insured

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

HOSPITAL ADMISSION REVIEW

WHAT IS HOSPITAL ADMISSION REVIEW?

Hospital admission review is BCI's program to make certain your benefit plan pays only for Medically Necessary care and helps employers contain health care costs. Hospital admission review is prior authorization for Medical Necessity of inpatient stays in a hospital, skilled nursing facility, or psychiatric/chemical dependency treatment facility.

If your condition requires additional days for further treatment exceeding the days originally scheduled, BCI will authorize additional days based on information provided by the hospital or your doctor.

HOSPITAL ADMISSION REVIEW OFFERS SEVERAL BENEFITS:

- It insures you know the health care alternatives available to you;
- It assures you in advance that you meet the requirements for benefits; and
- It gives you the opportunity to receive care in the most appropriate setting.

HOW DOES HOSPITAL ADMISSION REVIEW WORK?

When your doctor recommends a stay in a hospital of 24 hours or longer, simply call BCI's toll-free number, 1-800-743-1871. This telephone line is available 24 hours a day, 7 days a week. If an answering system receives your call, you will be asked to leave your name, identification number from your BCI identification card, daytime telephone number, and any other helpful information.

BCI should be notified within two (2) business days of the admission. For scheduled admissions, please call as soon as you know the admission date. For a maternity stay, call when you know your expected delivery date. For emergency admissions, you should notify BCI when you are stabilized and physically able. All admissions should be reviewed by BCI. Review of an admission does not guarantee benefit payments. Benefit payments will be made based upon the Policy provisions and eligibility criteria.

BCI will accept calls from anyone; however, it is ultimately the patient's and/or family's responsibility to initiate prior review. The final medical decision regarding your care is between you and your doctor.

Rising health care costs affect us all. **Remember, it's your health care dollar; please spend it wisely.**

NON-EMERGENCY SERVICES REQUIRING PRIOR AUTHORIZATION

NOTICE: The Medical Necessity of Covered Services listed below should be determined to be eligible for benefits under the terms of this Policy.

- Advanced Imaging Services: (not applicable for inpatient services)
 - Magnetic Resonance Imaging (MRI)
 - Magnetic Resonance Angiography (MRA)
 - Computed Tomography Scans (CT Scan)
 - Positron Emission Tomography (PET)
 - Nuclear Cardiology
- Air Ambulance
- Durable Medical Equipment when the expected charge exceeds three hundred dollars (\$300)
- Growth Hormone Therapy
- Home Health Skilled Nursing Services
- Home Infusions Therapy
- Human Organ and Tissue Transplants
- Hospice Services

- Inpatient Psychiatric/Chemical Dependency Treatment Facilities
- Mental Health and Substance Abuse Services:
 - Outpatient Psychotherapy services after the tenth (10th) visit (does not include medication management services).
 - Intensive Outpatient Program (IOP)
 - Partial Hospitalization Program(PHP)
 - Residential Treatment Program
 - Psychological testing/neuropsychological evaluation testing
 - Electroconvulsive Therapy (ECT)
- Inpatient Physical Rehabilitation Therapy
- Skilled Nursing Facilities

GENERAL PROVISIONS

1. DEFINITIONS

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

Allowable Charge means the lesser of the submitted charge, the allowance established by BCI, or if services were rendered outside the state of Idaho, the allowance established by a Blue Cross Blue Shield Association affiliate in the area where the service was rendered, for all such services covered under the terms of this Policy. This allowance is determined based upon many factors, including: the charge(s) of the Provider; the charge(s) of Providers with similar training and experience within a particular geographic area; pre-negotiated payment amounts; diagnostic related groupings (DRG); relative value scales; and/or the cost of providing the service or supply.

Assisted Reproductive Technology (ART) means any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART, include but are not limited to donor sperm utilized for artificial insemination or extraordinary procedures to induce fertilization with professional or technical assistance, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, and pronuclear stage tubal transfer.

Chemical Dependency means an illness, other than a Mental or Neuropsychiatric Condition, characterized by physiological or psychological dependency, or both, on any chemical substance, including alcohol. It is further characterized by a frequent or intense pattern of pathological use to the extent the individual exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the substance is reduced or discontinued; and the individual's health is substantially impaired or endangered.

Chiropractor means a doctor of chiropractic licensed to practice as such by the state where the service was rendered.

Coinsurance means the sharing of health care expenses for Covered Services between BCI and its enrolled Insureds. The Coinsurance payable by BCI after the Insured's Deductible requirement is satisfied is expressed as a percentage amount in the Schedule of Benefits. The remaining percentage, determined by subtracting the percentage paid by BCI from one hundred percent (100%), is the responsibility of the Insured.

Copayment means that portion of the cost of a Covered Service for which an Insured is financially responsible. Copayment amounts cannot be applied to an Insured's Deductible nor be paid under any benefit provision of this Policy.

Cosmetic means any surgical procedure that primarily improves or changes appearance and does not primarily improve physical bodily function. Cosmetic Surgery does not include procedures done to correct deformities resulting from disease, trauma, previous therapeutic process, or congenital anomalies. For the purposes of this definition, "congenital anomaly" shall mean an abnormality present at birth.

Covered Service means a treatment, commodity, or supply specified in this Policy for which benefits will be provided when rendered by a Physician or Provider.

Custodial Care means care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-

administration of medications not requiring constant attention of trained medical personnel.

Deductible means the amount of charges, up to the Allowable Charge, for Covered Services payable by an Insured to an appropriately licensed health care Provider who is recognized for payment under this Policy before BCI will assume any liability for all or part of the remaining Covered Services.

Dentist means a person who has received a degree in Dentistry and is duly licensed to practice Dentistry by governmental authority having jurisdiction over the licensing and practice of Dentistry where said Dentist practices his or her profession.

Denturist means a person licensed in the state where service is rendered to engage in the practice of denturism. For BCI to provide benefits, the Denturist must be performing within the scope of his/her license.

Dependent means: (1) The legal spouse of the Enrolled Employee and/or (2) the child of an Enrolled Employee or Enrolled Employee's spouse, up to his or her twenty-sixth (26th) birthday regardless of financial or marital status. The term "children" is limited to natural children, step-children, adopted children, children in the process of adoption from the time placed with the Insured, or children legally dependent upon the Enrolled Employee or Enrolled Employee's spouse for support where a normal parent-child relationship exists with the expectation that the Enrolled Employee will continue to rear that child to adulthood. However, if one or both of that child's natural parents live in the same household with the Enrolled Employee, a parent-child relationship shall not be deemed to exist, even though the Enrolled Employee or the Enrolled Employee's spouse provides support.

Durable Medical Equipment means an item or items which are primarily used to serve a medical purpose, ordered by the attending Physician, can withstand repeated use, are generally not useful to a person in the absence of Illness or Injury, and are appropriate for use by an Insured who is not confined as an Inpatient.

Effective Date means the first day of the Insured's coverage under this Policy, or if the Enrolled Employee must satisfy a probationary period before coverage is effective under this Policy, the Effective Date for the Enrolled Employee and Dependents is the first day of the Enrolled Employee's probationary period. The Effective Date of a Late Enrollee is always the first day of the Insured's coverage under this Policy.

Elective Surgical Procedure means a Surgery that is not emergency Surgery or Surgery which, if not performed expeditiously, might endanger the health or life of an Insured.

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

Enrolled Employee means an eligible person who applied for coverage, satisfied the Enrollment Qualifications, is accepted and enrolled for coverage, and in whose name the identification card is issued.

Family means two (2) or more persons related by blood, marriage, or law who are enrolled under the same identification number.

Hospital means: (1) a facility duly licensed as such in the state where located which provides service primarily for Inpatient surgical and medical diagnosis, treatment, and care of injured and ill persons by or under the supervision of a staff of licensed Physicians, or (2) a specialized Inpatient facility licensed and approved as such by the state where located for mental or neuropsychiatric treatment. A Hospital under this definition is not, other than incidentally, a place for rest, a nursing home, or a facility for convalescence.

Illness means a bodily disorder or disease other than an Injury. All such bodily disorders existing concurrently, which are due to the same cause or pathologically related causes, shall be considered to be one (1) Illness. Successive Illnesses resulting from the same cause, or from treatment or complications thereof, shall be considered as the same Illness, provided not more than 180 days has elapsed between treatments for such Illness.

Injury means physical Injury caused by an unexpected or unintended occurrence, independent of disease or bodily infirmity, or caused by unintended ingestion of toxic substances and occurs while this Policy is in force. All bodily disorders sustained in the same mishap or accident or from treatment or complications thereof or pathologically related thereto shall be considered as one (1) Injury. Bodily disorders resulting from allergies shall not be considered as Injuries.

Inpatient means an Insured who is admitted to a Hospital for treatment and who is so confined in such Hospital for a period of twenty-four (24) hours or more and/or for whom a room charge is made.

Insured means any person who satisfies the Enrollment Qualifications and is enrolled for coverage under this Policy.

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

Investigative Treatment means the use of any treatment, procedure, facility, equipment, drug, device, or commodity, regardless of its Medical Necessity, deemed by BCI to be either investigative; experimental; or in the early developmental stage of medical technology. The determination by BCI will be based on objective data and information obtained by BCI and reviewed, by competent medical personnel, according to the following criteria:

- 1) The technology must have final approval from the appropriate government regulatory bodies.
- 2) The scientific data and data obtained through actual medical experience regarding the technology must be sufficiently comprehensive to permit BCI medical personnel to reach well-substantiated conclusions concerning the effect of the technology or health outcomes.
- 3) The technology's overall beneficial effects on health outweigh the overall harmful effects on health.
- 4) The technology must be as beneficial as any established alternative.
- 5) When used under the usual conditions of medical practice, the technology should be reasonably expected to satisfy the criteria of sections (3) and (4).

The determination referred to herein will be within the exclusive discretion of BCI and may or may not be in accord with some medical experts' opinions on the acceptance of the technology as established medical practice.

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

Late Enrollee means an eligible retiree or Dependent who requests enrollment in this Policy following the initial enrollment period during which the individual was entitled to enroll under the terms of this Policy, provided that the initial enrollment period is a period of at least thirty (30) days. However, an eligible retiree or Dependent shall not be considered a Late Enrollee if:

- 1) The individual meets each of the following:
 - a) The individual was covered under Qualifying Previous Coverage at the time of the initial enrollment period;
 - b) The individual lost coverage under Qualifying Previous Coverage as a result of termination of

- employment or eligibility, the involuntary termination of the Qualifying Previous Coverage; and
- c) The individual requests enrollment within thirty (30) days after termination of the Qualifying Previous Coverage.
 - 2) The Group offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;
 - 3) A court has ordered coverage be provided for a spouse or Dependent child under this Policy and request for enrollment is made within thirty (30) days after issuance of the court order; or
 - 4) The individual first becomes eligible.

Medical Emergency means the sudden onset, not sudden discovery, of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical care (within twenty-four [24] hours of onset) would result in permanently placing the Insured's life in jeopardy or serious and permanent impairment or dysfunction of any bodily parts, functions, or organs.

Medically Necessary or Medical Necessity shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Medicare means Parts A, B, and D of Title XVIII of the Social Security Act of 1965, including amendments thereto, providing certain Physician, Hospital, and other benefits to qualifying individuals. Reference to such act is hereby made, and said act, including amendments thereto, is by reference made a part hereof as if specifically set forth herein. Part A of such act means Hospital Insurance Benefits, Part B means Supplementary Medical Insurance Benefits, and Part D means Voluntary Prescription Drug Benefit Program as set forth in the act.

Mental or Neuropsychiatric Condition means an illness, disorder, or condition, regardless of whether organic or nonorganic, biological, nonbiological, genetic, irrespective of cause, basis, or inducement, classified as a mental disorder in the current edition of the International Classification of Disease, Clinical Modification (ICD-CM), or the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Mental or Neuropsychiatric Condition, includes but is not limited to psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, impulsive control disorders, developmental delays, etc. Mental or Neuropsychiatric Condition does not include Chemical Dependency.

Newborn Children means a child or children born during the term of this Policy to a parent who is an Enrolled Employee or spouse of an Enrolled Employee. Newborn Children shall also include adopted newborn infants who are placed with the Enrolled Employee within sixty (60) days of the adopted child's date of birth. For the purposes of this Policy, "placed" shall mean physical placement in the care of the adoptive Enrolled Employee. In those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive Enrolled Employee signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. A child will no longer be a Newborn Child if he or she has a break in coverage of sixty-three (63) or more days.

Newly Adopted Children means a child or children under the age of eighteen (18) who is placed for adoption with an Enrolled Employee more than sixty (60) days after the child's date of birth. A child will no longer be a Newly Adopted Child if he or she has a break in coverage of sixty-three (63) or more days after placement for adoption with the Enrolled Employee. For the purposes of this Policy, "placed" shall mean physical placement in the care of the adoptive Enrolled Employee. In those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive Enrolled Employee signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child.

Nonparticipating Hospital means: (1) a Hospital, as herein defined, which has not contracted with BCI, or (2) a Hospital located outside the state of Idaho which is not participating with a local Blue Cross and/or Blue Shield plan in the state where the Hospital is located. No benefit payment shall be made directly to a Nonparticipating Hospital. Any balances remaining after an Insured's Copayment and/or Coinsurance amounts and BCI's payment shall be the financial responsibility of the Insured.

Nonparticipating Physician/Provider means: (1) a Physician/Provider as herein defined located in the state of Idaho who is not participating with BCI, or (2) a Physician/Provider located outside the state of Idaho who is not participating with a local Blue Cross and/or Blue Shield plan in the state where the Physician/Provider practices or is located. Any balances remaining after an Insured's Copayment and/or Coinsurance amounts and BCI's payment shall be the financial responsibility of the Insured.

Outpatient means services rendered in the Provider's office, or at the Hospital or other facility when the Insured is not admitted to the Hospital or facility for a period of more than twenty-four (24) hours.

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

Participating Hospital means: (1) a Hospital as herein defined that has contracted with BCI, or (2) a Hospital located outside the state of Idaho which has contracted with a local Blue Cross and/or Blue Shield plan in the state where the Hospital is located. A Participating Hospital has agreed to provide Covered Services as set forth in this Policy to Insureds and to accept the Insured's Deductible, Coinsurance, and/or Copayment plus BCI's benefit payment as payment in full.

Participating Physician/Provider means: (1) a Physician/Provider as herein defined who has contracted with BCI, or (2) a Physician/Provider located outside the state of Idaho who has contracted with a local Blue Cross and/or Blue Shield plan in the state where the Physician/Provider practices or is located. A Participating Physician/Provider has contracted with the local Blue Cross and/or Blue Shield plan to provide Covered Services to Insureds and to accept the Insured's Deductible, Coinsurance, and/or Copayment plus BCI's benefit payment as payment in full.

Physical Therapy means the treatment of disability or dysfunction by physical agents and methods (i.e., therapeutic exercise, hydrotherapy, various forms of energy) to assist in rehabilitation and restoration of normal body function after disease or Injury.

Physician means a doctor of medicine and Surgery and/or osteopathy duly licensed to practice as such in the state where he or she practices.

Policy means the written agreement between BCI and the Policyholder identifying the terms and conditions of such agreement, including general provisions, exclusions, limitations, schedule of benefits, any endorsements thereto, and application form(s). No oral statements or representations by any person, including employers, agents, or representatives of BCI, can change, alter, delete, add, or otherwise modify the express written terms

of this Policy or a validly executed endorsement to this Policy.

Policyholder means the employer, corporation, partnership, sole proprietor, association, trust, or other legal entity which has entered into this written agreement with BCI to provide health care benefits to its Enrolled Employees and their respective eligible Dependents.

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

Preexisting Condition means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within a six (6) month period immediately preceding the Effective Date of coverage. Genetic information shall not be considered a Preexisting Condition in the absence of a diagnosis of the condition related to such information. A pregnancy existing on the Effective Date of coverage will not be considered a Preexisting Condition.

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

Provider means a person or entity recognized as a covered Provider by BCI and duly licensed or certified under applicable state law to provide Covered Services as set forth in this Policy.

Qualifying Previous Coverage means, with respect to an individual, health benefits or coverage provided under any of the following;

- 1) Group health benefit plan;
- 2) Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market or otherwise;
- 3) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
- 4) Title XIX of the Social Security Act (Medicaid);
- 5) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents). For purposes of 55 Title 10, United States Code, "uniformed services" means the armed forces, the Commissioned Corps of the National Oceanic and Atmospheric Administration and the Public Health Service;
- 6) A medical care program of the Indian Health Services or of a tribal organization;
- 7) A state health benefits risk pool;
- 8) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP)); \
- 9) A public health plan, which for purposes of this act, means a plan established or maintained by a state, a foreign country, the U.S. government, or other political subdivision of a state, the U.S. government or foreign country that provides health insurance coverage to individuals enrolled in the plan; or
- 10) A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C. 2504 (e)).

A State Children's Health Insurance Program (CHIP), under Title XXI of the Social Security Act, is creditable coverage, whether it is a stand-alone separate program, a CHIP Medicaid expansion program, or a combination program, and whether it is provided through a group health plan, health insurance, or any other mechanism.

CMS Insurance Standards Bulletin, Transmittal No. 05-01 clarified that:

"Any public health plan, including a plan established or maintained by the U. S. government, or a foreign country, is creditable coverage for purposes of identifying eligible individuals under Part B of Title XXVII of the Public Health Service Act (PHS Act)".

Rehabilitation/Occupational Therapy means the treatment of disabled persons due to Injury, disease, or

developmental delay by means of training in self-care; upper extremity/hand rehabilitation (i.e., strengthening, coordination, range-of-motion, splinting, fluído-therapy), cognitive/perceptual training, and developmental training to promote the restoration of a person's ability to satisfactorily accomplish the necessary tasks of daily living and those required by the person's particular occupational role.

Respiratory Therapy means introduction of dry or moist gasses into the lungs for treatment purposes.

Retired Employee means an employee who fully retired from active employment after the effective date hereof and who on the date of his or her retirement was eligible for early retirement under the Public Employees Retirement System of Idaho or who was eligible for early retirement as a result of his or her participation under any other retirement plan previously established by Employer.

Registered Dietitian means professional trained in foods and the management of diets (dietetics) who is credentialed by the Commission on Dietetic Registration of the American Dietetic Association.

Residential Treatment Program means a twenty-four (24) hour level of care that provides Insureds with long-term or severe mental disorders or substance abuse-related disorders with residential care. Care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs.

Service Extender means a person who provides services to treat Mental or Neuropsychiatric Conditions under the supervision of a licensed psychologist in conformance with the guidelines for use of Service Extenders contained in the rules and regulations of the Idaho State Board of Psychologist Examiners and who is: (1) a licensed professional counselor with a current license issued by the Idaho State Counselor Licensing Board pursuant to Section 54-3405 of the Idaho Code, or (2) a Certified Social Worker licensed by the Idaho State Board of Social Work Examiners pursuant to Section 54-3206 of the Idaho Code.

Sound Natural Tooth means a healthy tooth or one that has been restored to a sound condition or replaced by a fixed or removable partial denture or bridge.

Speech Therapy means treatment for the correction of a speech impairment resulting from disease; Surgery; Injury; congenital, psychological, and developmental anomalies; or previous therapeutic processes.

Surgery means operative procedures involving cutting, suturing, or incision through the true skin; care of fractures and dislocations; visualization of the hollow organs of the body when accomplished or accompanied by cutting incision or for removal of a foreign body; scoping procedures (entry by endoscope into the hollow organs of body cavities) for excision; treatment of burns; manipulations under general anesthesia; aspirations for drainage; destruction of tissue by electrical, mechanical, or chemical methods; and x-ray and radium therapy, including use of isotopes, when used in lieu of cutting procedures.

Terminal Illness means an illness or condition in which it is medically probable that the patient has less than six (6) months to live, provided such illness or condition continues its normal course. The patient's condition must be certified as terminally ill by his or her attending Physician.

Totally Disabled means a condition resulting from illness or injury in which, as certified by a Physician:

- 1) An Enrolled Employee or spouse is completely unable to perform the substantial duties of any occupation or business for which qualified by reason of education, training, or experience and is not in fact engaged in any occupation for wage or profit; or
- 2) A retiree or Dependent is completely unable to engage in normal duties or activities of a person in good health who is the same gender and age.

2. WAITING PERIODS

Benefits set forth in this Policy shall be provided for the conditions set forth below only after completion of minimum continuous periods of coverage under this Policy immediately preceding treatment as follows:

- A.** For Insureds age nineteen (19) and over, benefits for Preexisting Conditions will only be provided for services received at least twelve (12) months after the Insured's Effective Date under this Policy. There are no waiting periods for Insureds under the age of nineteen (19). This waiting period shall not apply to Newborn Children, who shall be covered from the moment of birth. This waiting period also shall not apply to Newly Adopted Children, who shall be covered from the date of placement with the Enrolled Employee for adoption. A pregnancy existing on the Effective Date of coverage will not be considered a Preexisting Condition.
- B.** BCI shall waive any time period applicable to a Preexisting Condition exclusion or limitation period for the period of time an individual was previously covered by Qualifying Previous Coverage, provided that the Qualifying Previous Coverage was continuous to a date not more than sixty-three (63) days prior to the Effective Date of coverage under this Policy.
- C.** Benefits for Preexisting Conditions shall be denied until a Late Enrollee age nineteen (19) and over has been enrolled for coverage on this Policy for a continuous twelve (12) month period. There are no waiting periods for Insureds under the age of nineteen (19).
- D.** Benefits for sterilization will only be provided after six (6) months of continuous coverage under this Policy. This waiting period shall apply to all adopted children placed with the Enrolled Employee more than six (6) months after the date of birth but shall not apply to Newborn Children who shall be covered from the moment of their birth.

3. EXCLUSIONS

Benefits will not be provided in any of the following circumstances or for any of the following conditions under the terms of this Policy:

- A.** To the extent benefits are provided or covered by any governmental agency, except as otherwise provided by law.
- B.** Expenses for services incurred as a result of any work related Injury or Illness, including any claims that are resolved pursuant to a disputed claim. The only exception would be if the Insured is exempt from state or federal Workers' Compensation Law. See the Right of Reimbursement and Subrogation section of these General Provisions.
- C.** Any Injury or Illness resulting from any act of war or from explosion of atomic or similar fissionable materials in war (declared or undeclared) or any Illness or Injury contracted or incurred during military service, including any complications or recurrences thereof, or national disaster.
- D.** Physical examinations unless made in connection with a covered Injury or Illness, unless specifically listed in this Policy.
- E.** Any situation in which no specific medical treatment plan or psychiatric plan is furnished, including but not limited to rest cure, detoxification setup, Custodial Care, etc.
- F.** Hospital benefits when hospitalization is primarily for diagnostic studies or Physical Therapy when such procedures could have been done adequately and safely on an Outpatient basis.
- G.** Pregnancy tests unless provided by a Physician, Physician Assistant or Nurse Practitioner and administered in the Physician's office or in the Hospital.

- H.** Immunizations, unless specifically listed in this Policy.
- I.** Routine well baby care, unless specifically listed in this Policy.
- J.** Routine newborn care, including nursery room charges, is not payable, unless specifically listed in this Policy.
- K.** Maternity benefits for Dependent children.
- L.** Laetrile (amygdalin); acupuncture; Chelation therapy (except for lead poisoning); homeopathic services; naturopathic services; thermography.
- M.** Routine eye refractions, eye glasses; visual therapy or training.
- N.** Radial keratotomy (refractive keratoplasty or other surgical procedures to correct refractive errors/ astigmatism).
- O.** Routine hearing examinations; hearing aids.
- P.** Humidifiers; vaporizers; air conditioners; or any other air filtration or purification unit or system.
- Q.** Physical fitness or Physical Therapy equipment, including but not limited to whirlpools, spas, hot tubs; weight lifting equipment; charges in or by health spas; weight reduction programs.
- R.** Heating pads, contour chairs, and therapeutic beds (not including certified, standard model hospital beds which will be paid under the Other Services section of this Policy).
- S.** Investigative Treatment as determined by BCI pursuant to the Definitions section of these General Provisions.
- T.** Cosmetic or reconstructive procedures and attendant hospitalization, except for Newborn Children or due to trauma or disease, done for aesthetic purposes and not to restore an impaired function of the body. Cosmetic procedures will not be covered regardless of the fact that the lack of correction causes emotional or psychological effects. Complications or subsequent Surgery related in any way to any previous Cosmetic procedure shall not be covered, even if the procedure is a Necessary Medical, Surgical, and Hospital Service.
- U.** Routine foot care (including removal of corns or calluses or trimming of nails), foot impression casting, including x-rays incidental to casting, orthopedic shoes, arch supports, and other supportive devices for the feet, unless specifically listed in this Policy.
- V.** Benefits which are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to or makes benefits available to the Insured, whether or not application is duly made therefore, unless benefits are payable under a defined Plan in the Coordination of Benefits section of this Policy and such benefits will be coordinated with the benefits under this Policy.
- W.** Procedures related to sex transformations or reversal of sterilization.
- X.** Charges for services related to surrogate pregnancy.
- Y.** Any Assisted Reproductive Technology (ART) procedure including associated services and supplies.
- Z.** Vasectomies (male sterilization) will be covered for Physician services only.

- AA.** Speech, occupational, rehabilitation, or neurodevelopmental therapy, except as provided under rehabilitation benefits.
- AB.** Medical or surgical treatment for obesity and manifestations thereof, or for reversal or revisions of Surgery for obesity.
- AC.** Benefits in connection with transplants, except as specifically provided in the Schedule of Benefits for Preauthorized Human Organ and Tissue Transplants and Bone Marrow Reinfusion.
- AD.** Benefits in connection with harvesting and reinfusion of bone marrow for the treatment of any illness, except as set forth in the Schedule of Benefits for Preauthorized Human Organ and Tissue Transplants and Bone Marrow Reinfusion.
- AE.** Any services, chemotherapy, radiation therapy (or any therapy that damages the bone marrow), supplies, drugs and aftercare for or related to bone marrow transplant, stem cell support or peripheral stem cell support procedures for a condition not specifically provided in the Schedule of Benefits for Preauthorized Human Organ and Tissue Transplants and Bone Marrow Reinfusion.
- AF.** Fertility drugs (Pergonal, etc.).
- AG.** Maternity and/or conditions due to pregnancy.
- AH.** Services connected with nonemergency, nonmaternity Hospital admissions on Fridays or Saturdays, unless Surgery is performed the day of admission or the day following admission.
- AI.** Elective abortions, except to preserve the life of the female Enrolled Employee or spouse upon whom the abortion is performed.
- AJ.** Treatment to correct malocclusion (bad closure of the jaw); to correct vertical dimension (the distance between two [2] points on the face, one [1] above and one [1] below the mouth); to restore occlusion (including splinting, orthodontic treatment, or dental appliances); and for Dentistry, oral Surgery, or dental implants whether resulting from accident, disease, or dental treatment. Dental implants, including related procedures and oral surgery in preparation for dental implants, may be payable for correction of a congenital anomaly or developmental malformation for Dependent children.
- AK.** Treatment of temporomandibular joint (TMJ) disorders and/or orthognathic conditions.
- AL.** Benefits for counseling in the absence of illness or injury, including but not limited to pre-marital or marital counseling; family counseling; educational, social, behavioral, or recreational therapy; bereavement counseling; sex or interpersonal relationship counseling; or counseling with the Insured's friends, employer, school counselor, or school teacher.
- AM.** Charges for services and supplies: (1) for which an Insured is not required to make payment, (2) that are made only because benefits are available under this Policy, or (3) for which an Insured would have no legal obligation to pay in the absence of this or any similar coverage.
- AN.** Charges for telephone or internet consultations; missed appointments; claim form completion; interest charges; legal services; obtaining medical records; setup and delivery of Durable Medical Equipment; or Provider travel and/or lodging expenses.
- AO.** Convenience items such as telephones; television; guest trays or meals; personal hygiene items or services; or homemaker or housekeeping services, except by home health aides as ordered in a hospice treatment plan.
- AP.** Drugs and supplies not requiring a prescription order, including but not limited to aspirin, antacid, benzyl

peroxide preparations, cosmetics, medicated soaps, food supplements, syringes, and bandages; Antabuse, Methadone, Minoxidil, or Rogaine hair preparations; experimental drugs, including those labeled "Caution- Limited by Federal Law to Investigational Use"; and prescription medications related to health care services which are not covered under this Policy.

- AQ.** Diet and weight monitoring and educational services.
- AR.** Special foods or diets, vitamins, minerals, dietary and nutritional supplements, and nutritional therapy.
- AS.** Any services, supplies, or charges which result from the treatment of any direct or indirect complication of any illness or condition for which coverage is not or was not provided.

4. LIMITATIONS

- A.** Claims submitted to BCI more than twelve (12) months after the last day on which Covered Services were rendered shall be ineligible for payment, unless it can be shown to the satisfaction of BCI that there was unusual and justifiable cause for such late submission.
- B.** Total benefits paid for Inpatient rehabilitation services shall be limited to a maximum of 25 days per Insured each calendar year.
- C.** Total benefits paid for services of a Chiropractor shall be limited to a maximum of \$500 per Insured each calendar year.
- D.** Total benefits paid for home health care visits shall be limited to a maximum of 17 visits per Insured each calendar year.
- E.** Total benefits paid for hospice care services shall be limited to a combined \$5,000 lifetime maximum per Insured and a maximum of six (6) months from the initial date covered hospice care is provided.
- F.** Total benefit paid for extended care facility services shall be limited to a maximum of thirty (30) days per Insured each calendar year.

5. INDIVIDUAL CASE MANAGEMENT

BCI may authorize benefits in an individual case for specific services which would not ordinarily be Covered Services if it appears to BCI that use of such Services will reduce costs without compromising the quality of care. BCI shall advise the Insured and the Providers in writing when, and to what extent, such benefits will be provided. Providing such benefits shall not constitute an amendment to this Policy.

6. ENROLLMENT QUALIFICATIONS

- A.** Eligibility: All Retired Employees and their Dependents as of the date of retirement are eligible for enrollment under this Policy. An Insured shall cease to be eligible for coverage when he or she reaches age sixty-five (65) years or ceases to be an eligible Dependent. If a Retired Employee and his or her Dependents apply for and are enrolled under this Policy, coverage will become effective on the day following the Enrolled Employee's retirement, provided such retirement occurs after the effective date of this Policy.
- B.** Enrolled Employees and Dependents have thirty (30) days from the Enrolled Employee's date of retirement to submit an enrollment form. An Enrolled Employee or Dependent who does not enroll on this Policy within thirty (30) days from the Enrolled Employee's date of retirement may be a Late Enrollee. Coverage will be effective the first day of the month following the qualifying event. If the Enrolled Employee elects COBRA coverage in lieu of this Policy, the Enrolled Employee may not apply for

coverage by this Policy after the expiration of the maximum coverage under COBRA.

- C.** Enrollment forms for enrollment of Dependents must be duly submitted by the Enrolled Employee and accepted by BCI. Enrollment forms and commitments made hereunder by such Enrolled Employee on behalf of any such Dependents shall be fully effective as to and binding upon such Enrolled Employee and upon such Dependents. Newborn Children's enrollment shall be effective from moment of birth for sixty (60) days, but shall continue thereafter only if a completed enrollment form and payment of required premium is received within sixty (60) days following date of birth. Enrollment for Newly Adopted Children shall be effective from the date of placement with the Enrolled Employee and for sixty (60) days, but shall continue thereafter only if a completed enrollment form and payment of required premium is received within sixty (60) days following date of placement with the Enrolled Employee. Coverage provided in accordance with this section of these Enrollment Qualifications shall include, but not be limited to coverage for congenital anomalies for an individual who has not attained age eighteen (18) as of the date of the adoption or placement for adoption. If the date of birth for the Newborn Child or date of placement for the Newly Adopted Child is on or before the fifteenth (15th) of the month, the premium will be billed for the entire month. If date of birth or date of placement is after the fifteenth (15th), the premium will commence with the first day of the month following birth or placement.
- D.** Prior to legal finalization of an adoption, the coverage provided herein shall continue until the first of the following events occurs: (1) the date the child is removed permanently from placement, or (2) the date the Enrolled Employee rescinds, in writing, the agreement of adoption and the agreement assuming financial responsibility. If one of the foregoing events occurs, coverage shall terminate on the last day of the calendar month in which such event occurs.
- E.** In the absence of fraud, all statements made by applicants, Policyholders, or by an Insured shall be deemed representations and not warranties. No statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless such statement is contained in a written instrument signed by the Policyholder or the Insured.
- F.** When an Enrolled Employee or Dependent has been covered by this Policy for at least thirty (30) days and subsequently terminates coverage under this Policy, the Enrolled Employee or Dependent may transfer to an BCI individual plan with continuous coverage if written application to transfer is made within thirty-one (31) days after termination from the Policy. When an Insured reaches age sixty-five (65) or becomes eligible for Medicare, an Insured must transfer to a Medicare Supplement plan with continuous coverage if such written application to transfer is made within six (6) months after the Enrolled Employee becomes eligible for Medicare. Credit for the period during which Insureds were continuously covered under this Policy will be applied to the waiting periods of the new Policy.
- G.** Any enrolled child, who is or becomes incapable of self-sustaining employment by reason of developmental disability or physical handicap prior to reaching his or her twenty-sixth (26th) birthday and who is chiefly dependent upon the Enrolled Employee for support and maintenance, shall not be terminated so long as this Policy remains in force and the Dependent remains in such condition, provided the Enrolled Employee maintains coverage under this Policy and the Enrolled Employee has, within thirty-one (31) days of such Dependent's reaching age twenty-six (26), submitted proof of such Dependent's incapacity as herein described. BCI may require subsequent proof of the Dependent's disability and dependency but not more frequently than once each year.
- H.** BCI must receive and accept payment in advance of the full proper charge, as provided in the premium endorsement hereafter set forth, for the calendar month during which such services are to commence.
- I.** Coverage for any Insured will terminate on the last day of the calendar month in which the Insured ceases to be eligible for coverage.

- J. Once an Enrolled Employee or Dependent has terminated coverage, he or she will not be allowed to re-enroll under this Policy.
- K. In the event the Enrolled Employee enrollment under this retiree plan exceeds forty (40) Enrolled Employees, BCI shall reserve the right to modify premium rates upon thirty (30) days' written notice to the Group prior to the effective date of the adjustment in premium.

7. GROUP QUALIFICATION

The employer shall certify that those Enrolled Employees showing on the eligibility list are eligible for coverage under the terms of the Policy. Failure to certify such Enrolled Employees as being eligible or deliberately certifying ineligible persons as being eligible shall, at BCI's option, be cause for cancellation of the entire Policy.

8. PREMIUM PAYMENTS

- A. The Group agrees to pay BCI in advance for each and every month hereafter while this Policy is in effect a sum in accordance with the rates established for each enrolled Insured.
- B. The Enrolled Employee shall authorize the Group to (1) withhold, deduct, or collect from the Enrolled Employee the monthly payment contracted to be made, and (2) remit such monthly payments to BCI in accordance with the application form submitted by each employee. Such application and its contents thereof is hereby made a part of this Policy.
- C. Receipt by BCI of any sum on account for any individual not entitled to be an Insured during the period for which such premium has been paid shall not constitute an acceptance thereof by BCI.
- D. Benefits set forth in this Policy are contingent upon receipt of premium as provided herein. No benefits shall be provided for cases under treatment or otherwise beyond the last day for which premium is received by BCI, except as provided in Extended Benefits Upon Termination of this Policy.
- E. If for any reason the Group cancels coverage under this Policy, BCI shall be notified upon thirty (30) days' written notice by the Group. Provided that no benefits were paid during the interim, BCI will refund to the Group any unused premium received on the Insured's behalf for the period of ineligibility.

9. COORDINATION OF BENEFITS, OTHER INSURANCE

If an Insured is covered under any other Plan (as defined below), the benefits under this Policy and those of the other Plan will be coordinated in accordance with the provisions of this section of these General Provisions.

In addition to the definitions section of the Policy, the following are definitions specific to this Coordination of Benefits, Other Insurance provision:

- A. **Allowable Expense** means any health care expense, including Coinsurance or Copayments and without reduction for any applicable Deductible, that is covered in full or in part by any Plan. An expense or portion of an expense that is not covered by any Plan covering the Insured is not an Allowable Expense. In no event shall benefits payable by BCI and another Plan exceed the allowable charges for such benefits.
- B. **Birthday** means only the month and day in a Calendar Year and does not include the year in which the Insured is born.
- C. **Closed Panel Plan** means a Plan that provides health benefits to Insureds primarily in the form of services through a panel of providers that have contract with or are employed by the Plan and that excludes benefits for services provided by other providers, except in the cases of emergency or referral

by a panel member. If the Primary Plan is a Closed Panel Plan and the Secondary Plan is not a Closed Panel Plan, the Secondary Plan shall provide benefits as if it were the Primary Plan when an Insured uses a non-panel provider, except for emergency services or authorized referrals that are provided by the Primary Plan.

D. Plan means this coverage and any other similar plan, contract, or policy which provides benefits for an Illness or Injury by or through any of the following:

- 1) Group and non-group insurance contracts and subscriber contracts;
- 2) Uninsured group or group-type coverage arrangements;
- 3) Group and non-group coverage through Closed Panel Plans;
- 4) Group-type contracts;
- 5) Medical care components of long-term care contracts, such as skilled nursing care;
- 6) Medicare or other governmental benefits, except as provided below;
- 7) Medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts.

Plan **shall not** include any of the following:

- 1) Hospital indemnity coverage or other fixed indemnity coverage;
- 2) School accident-type coverage such as contracts that cover students for accidents only, including athletic injuries, either on a twenty-four (24) hour basis or on a "to and from school" basis;
- 3) Specified disease or specified accident coverage;
- 4) Accident only coverage;
- 5) Benefits provided in long-term care insurance policies for non-medical services; for example, personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care, and Custodial Care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- 6) Limited benefit health coverage;
- 7) Medicare supplement policies;
- 8) Medicaid;
- 9) A governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or non-governmental plan.

E. Primary Plan means a Plan whose benefits for an Insured's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is primary if: 1) the Plan either has no order of benefit payment determination, or its provision differs from the one detailed here (see below); or 2) all Plans that cover the Insured use the same order of benefit payment determination, and under this provision, the Plan determines its benefits first.

F. Secondary Plan means a Plan that is not a Primary Plan. In the event an Insured is covered under more than one Secondary Plan, the order of benefit determination provision (see below) decides the order in which the Secondary Plans' benefits are determined in relation to each other.

Order of benefit determination: If another Plan contains a provision coordinating its benefits with the benefits of this Policy, the following rules shall apply to establish the order of benefit payment under this Policy and the other Plan:

A. The benefits of a Plan that covers the Insured other than as a Dependent shall be primary to the benefits of a Plan that covers that Insured as a Dependent (except where this order of benefits would cause a violation of federal law concerning coordination of benefits with Medicare).

- B.** Where a Dependent child is covered by more than one Plan, the following rules shall apply:
- 1) For a Dependent child whose parents are married or living together, whether or not they have ever been married, the benefits of the Plan of the parent whose Birthday falls earlier in a year are determined before those of the parent whose Birthday falls later in that year. If both parents have the same Birthday, the benefits of the Plan that has covered the parent for the longer period of time shall be the Primary Plan.
 - 2) For a Dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - a) If a court decree specifies that one of the parents is responsible for the child's health care expenses (or coverage) and the Plan of that parent has actual knowledge of those terms, that parent's Plan is the Primary Plan. If the parent with responsibility has no health care coverage for the child, but that parent's spouse does, that parent's spouse's Plan shall be the Primary Plan (if that Plan has actual knowledge of the terms of the court decree).
 - b) If a court decree states that both parents are responsible for the child's health care expenses (or coverage), the benefits of the Plan of the parent whose Birthday falls earlier in a year are determined before those of the parent whose Birthday falls later in that year. If both parents have the same Birthday, the benefits of the Plan which has covered the parent for the longer period of time shall be the Primary Plan.
 - c) If a court decree states that the parents have joint custody without specifying that a particular parent has responsibility for the health care expenses (or coverage) of the child, the benefits of the Plan of the parent whose Birthday falls earlier in a year are determined before those of the parent whose Birthday falls later in that year. If both parents have the same Birthday, the benefits of the Plan which has covered the parent for the longer period of time shall be the Primary Plan.
 - d) If there is no court decree allocating responsibility for the child's health care expenses (or coverage), the order of benefit determination among the Plans for the child is:
 - (1) The Plan covering the custodial parent;
 - (2) The Plan covering custodial parent's spouse;
 - (3) The Plan covering the noncustodial parent; and then
 - (4) The Plan covering the noncustodial parent's spouse.
 - 3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the order of benefits shall be determined as per B. 1) or B. 2) above as if those individuals were parents of the child.
- C. Active employee or retired laid-off employee:** The Plan that covers the individual as an active employee; that is, an employee who is neither laid off nor retired (or as that active employee's Dependent) is the Primary Plan. The Plan covering that same person as a retired or laid-off employee (or as that retired or laid-off employee's Dependent) is the Secondary Plan. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
- D. Continuation coverage:** The Plan which covers the individual as an employee or retired employee, or as that employee's Dependent, will be the Primary Plan over the Plan that is providing continuation

coverage under federal or state law, which shall be the Secondary Plan. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

E. Longer/shorter length of coverage: If none of the above rules determines the order of benefits, the Plan that covered the Insured for a longer period of time is the Primary Plan and the Plan covering the Insured for the shorter period of time is the Secondary Plan.

- 1) To determine the length of time a person has been covered under a Plan, two (2) Plans shall be treated as one (1) if the person was eligible under the second within twenty-four (24) hours after the first ended.
- 2) The start of a new Plan does not include:
 - a) A change in the amount of scope of a Plan's benefits;
 - b) A change in the entity that pays, provides, or administers the Plan's benefits;
 - c) A change from one type of Plan to another (such as from a single employer plan to that of a multiple employer plan).
- 3) The person's length of time covered under a Plan is measured from the person's first date of coverage under that Plan. If that date is not readily available for a group Plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present Plan has been in force.

F. If the above rules do not establish an order of benefit priority, the Allowable Expenses of each Plan shall be shared equally.

If BCI shall have made payment under this Policy in excess of the amount required by this provision, then upon such excess being established, BCI shall be entitled to recover from the patient, the patient's assignee or beneficiary, or from the other Plan on request.

10. MEDICARE

In certain situations, this Policy is primary to Medicare. This means that when an Insured is enrolled in Medicare and this Policy at the same time, BCI will pay benefits for Covered Services first and Medicare pays second. Those situations are:

- A.** When the Enrolled Employee or spouse is age sixty-five (65) or over and by law Medicare is secondary to the employer group health plan;
- B.** When the Insured incurs Covered Services for kidney transplant or kidney dialysis and by law Medicare is secondary to this Policy; and
- C.** When the Insured is entitled to benefits under Medicare disability and by law Medicare is secondary to this Policy.

11. COMPLIANCE WITH LAW AND COURT ORDERS

BCI administers all health insurance policies in compliance with applicable Idaho and federal law. In the event a court of competent jurisdiction enters a Qualified Medical Child Support Order (QMCSO) or other order regarding enrollment of or payment of medical expenses for a Dependent child or alternate recipient, a copy of such order must be provided to BCI. BCI shall comply with any such order to the extent possible.

12. MODIFICATION REQUIRED BY CHANGE IN LAW

In the event of a change in federal or state law, BCI will administer this Policy according to the change in law at the time such law becomes effective. Unless a prior notice is otherwise required by such change in federal or state law, BCI may choose to incorporate the change in law by amendment to this Policy or reissue a policy to the Group as modified by such change, upon the Group's renewal date. Should such change in law mandate that BCI modify benefits under the policy, BCI may reasonably adjust the premium to cover the increased cost of the benefit modifications.

13. RIGHTS OF REIMBURSEMENT AND SUBROGATION

This Policy excludes any medical, prescription drug, or time loss benefits for any Injury or Illness, if the costs associated with the Injury or Illness may be recoverable from a third party or through worker's compensation or from any other source. This includes first party payer payments for any automobile Personal Injury Protection or Medical Payments and Uninsured or Underinsured Motorist coverages. BCI may choose, at its discretion, reimbursement or subrogation as a means of recovery.

If the Insured has a potential right of recovery for an Illness or Injury for which a third party may have legal responsibility, BCI may advance benefits pending the resolution of the claim upon the following condition:

By accepting or claiming benefits, the Insured agrees that BCI is entitled to reimbursement of the full amount of benefits that BCI has paid, out of any settlement or recovery from any source, including any judgment, settlement, disputed claim settlement, uninsured motorist payment, or any other recovery related to the Injury or Illness for which BCI has provided benefits.

This right applies without regard to the characterization as payment for medical expenses, or other designation of the recovery by the affected Insured and/or any third party or the recovery source. Regence BCI's right to reimbursement, however, will not exceed the amount of recovery.

BCI may require the Insured to sign and deliver all legal papers and take any other actions BCI may ask to secure the rights of BCI, including an assignment of rights to pursue the Insured's claim if the Insured fails to pursue his or her claim. If BCI asks the Insured to sign a trust agreement or other document to reimburse BCI from the proceeds of any recovery, the Insured may be required to do so as a condition to advancement of any benefits. If benefits were paid before the agreement is signed, the Insured agrees to reimburse BCI upon receipt of recovery in any form from or on behalf of a third party.

The Insured agrees that he or she will do nothing to prejudice BCI rights and will cooperate fully with BCI, including signing any documents and providing prompt notice of any settlement. The Insured shall notify BCI of any facts which may impact BCI's right to reimbursement or subrogation. This shall include but not necessarily be limited to the following:

- 1) The filing of a lawsuit, or;
- 2) Timely advance notification of settlement negotiations, including but not necessarily limited to a minimum of twenty one (21) days advance notice of the date, time, location, and participants to be involved in any settlement conference or mediations, or;
- 3) A minimum of five (5) business days prior notification of the intent of a third party to make payment of any kind to the benefit of or on behalf of an Insured which is in any manner related to the Injury or Illness which gives rise to Regence BCI's right to reimbursement or subrogation.

The Insured acknowledges that BCI is authorized but not obligated to recover directly from any third party any benefits paid from any party liable to the Insured upon mailing of a written notice to the potential payer and affected Insured or his or her representative.

BCI is entitled to reimbursement from the first dollars received from any recovery. BCI will not reduce the

reimbursement or subrogation right due to the Insured not being made whole. BCI shall not be liable for any expenses or fees incurred by the Insured in connection with obtaining a recovery. An Insured, however, may request BCI to pay a proportional share of attorney's fees and costs at the time of any settlement or recovery or to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid by BCI. BCI has discretion whether to grant such requests.

Advancement of payment for otherwise excluded benefits or review of a request for attorney fees are conditioned upon the retention by the Insured's attorney of funds sufficient to satisfy BCI's asserted lien in a client trust account, until such lien is satisfied or released.

In the event that an Insured and/or his/her agent or attorney fails to comply with the terms of these provisions, BCI may recover through legal action, any benefits advanced for any Illness or Injury resulting from the action or omission of a third party.

Any benefits provided by this Policy contrary to the exclusion are provided solely to assist the Insured, and are subject to all clauses herein related to the Insured's obligations regarding reimbursement and subrogation rights of this Policy.

By paying for such benefits BCI is not acting as a volunteer and is not waiving BCI's right to reimbursement or subrogation.

14. RIGHT TO RECOVERY

If for any reason BCI has paid any amount to or on behalf of an Insured in any of the following circumstances:

- 1) For services, supplies or accommodations not covered under this Policy;
- 2) Payments made for or on behalf of a person who is not covered under this Policy;
- 3) Payments which exceed amounts to be paid as benefits under this Policy;
- 4) Duplicate payments; or
- 5) For benefits received from BCI for treatment of an Illness or Injury of an Insured where another person, entity, firm or corporation is legally responsible for payment for the treatment of the Insured,

the Insured agrees to reimburse BCI for any and all above described amounts. BCI shall have three (3) years from the date of loss or in the case of third party responsibility as described in paragraph 5, shall have three (3) years from discovery of the payment to Insured or on the Insured's behalf by the third party through contract, settlement, judgment or any other means, to request reimbursement from the Insured. In the event BCI uses a third party collection agency or attorney to collect the overpayment, the Insured shall be responsible for payment of collection fees incurred, including but not limited to any court costs and attorney fees. BCI's right to recovery includes the right to deduct the amount paid in error from future benefits BCI would provide for the Insured, even if the payment error was not made originally on that Insured's behalf.

This Right to Recovery provision in no way reduces rights to reimbursement or subrogation. Please reference other sections of this Policy specific to third party liability.

15. CHOICE OF LAW

This Policy shall be governed by and construed and enforced in accordance with the laws of the State of Idaho. Venue:

Any legal action arising out of this Policy must be filed in either state or federal court in Idaho. Venue of any cause of action arising out of this Policy resulting in legal action in state court or in arbitration or mediation shall be in Bonneville County, Idaho.

Merger:

This Policy contains the entire agreement binding the parties. It is expressly agreed that neither party is bound by any stipulation, representation, or agreements (verbal or otherwise), which is not printed or written in the Policy.

16. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that health information about an Insured may be requested or disclosed by BCI. The information requested or disclosed will be used for the purpose of facilitating health care treatment, payment of claims, or business operations necessary to administer health care benefits; or as required by law.

The information requested or disclosed may be related to treatment or services received from:

- A.** A Physician, Dentist, pharmacist or other physical or behavioral health care practitioner;
- B.** A clinic, hospital, long-term care or other medical facility;
- C.** Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or
- D.** An insurance carrier or group health plan.

Health information requested or disclosed by BCI may include, but is not limited to claim records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

NOTE: This provision does not apply to information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services, and genetic testing. A specific authorization will be obtained from the Insured in order for BCI to receive information related to these health conditions

17. TERM, TERMINATION, AND MODIFICATION PROVISIONS

This Policy shall be in full force and effect for a period of twelve (12) months from the date first hereinabove mentioned and from month to month thereafter, unless terminated in accordance with the following provisions:

- A.** This Policy may be terminated by the Group without cause at any time upon thirty (30) days' written notice to BCI.
- B.** In the event of nonpayment of premium by the Group on or before the due date as prescribed by BCI, or in the event the Group fails to meet the Group Qualifications, the Policy shall be considered as having been terminated by the Group. Such termination shall be effective as of the end of the month for which premium was received, unless reinstated to the satisfaction of BCI.

This Policy may be modified by BCI as to benefits, premium rates, and/or other provisions upon four (4) months written notice to the Group prior to the anniversary date.

18. EXTENDED BENEFITS UPON TERMINATION OF THIS POLICY

In accordance with Sections 41-2213 and 41-2214 of the Idaho Code, the following provisions apply:

- A.** If an Insured covered under this Policy at the time of termination of the Policy is Totally Disabled, BCI shall continue to provide benefits for such Insured for covered expenses incurred as a result of the disabling condition(s) beyond the date of termination of the Policy for a period not exceeding twelve (12) months, until the Insured is no longer Totally Disabled, or until the maximum benefits of this Policy have been paid, whichever occurs first.
- B.** If this Policy provided for maternity benefits and a covered Enrolled Employee or Dependent spouse is pregnant at the time of discontinuance of this Policy and is not eligible for any replacement group coverage

within sixty (60) days of the discontinuance of this Policy, BCI will provide maternity benefits as defined in this Policy for a period not to exceed twelve (12) months beyond the date of termination for the Enrolled Employee or Dependent spouse.

19. REPLACEMENT

In the event this Policy replaces within sixty (60) days another group contract or Policy which has been terminated, credit will be given for previous employment and waiting periods completed with the employer according to the provisions of Section 41-2215 of the Idaho Code.

20. INDEPENDENT CONTRACTORS

It is expressly understood and agreed that Physicians and Providers hereunder are, as to BCI, solely independent contractors and are not agents of BCI for any purpose hereunder and that BCI shall have no liability whatsoever for any negligence, act, or failure to act on the part of any such Physician or Provider.

21. LIMITATIONS OF LIABILITY

In no case shall BCI be liable for the negligence or other wrongful act or omission of any Physician or Provider or his or her employees or any other person. BCI shall not be liable to any person or entity for the inability or failure to procure or provide the benefits of this Policy by reason of epidemic, disaster, or other cause or condition beyond the control of BCI.

22. VESTING OF POLICIES

Under no circumstances does an Insured acquire a vested interest in continued receipt of a particular benefit or level of benefits. If benefits for a service or supply are eliminated or modified for a new Policy year, benefits will not be provided for those services or supplies rendered after the effective date of the elimination or modification. No oral statements or representations by any person, including employers, agents, or representatives of BCI, can change, alter, delete, add, or otherwise modify the express written terms of this Policy or a validly executed endorsement to this Policy.

23. NONASSIGNABILITY

The benefits hereunder shall not, by the Insured or any person entitled thereto, be pledged, hypothecated, encumbered, or assigned without the expressed written consent of BCI.

24. NONASSIGNABILITY OF VOTING RIGHTS

A Policyholder entitled to vote on any matter of corporation business may not assign or in any way delegate such voting right to any other person, or entity, other than by a validly executed written proxy filed with BCI in compliance with its bylaws.

25. CLAIMS APPEALS PROCESS

A. INFORMAL INQUIRY

For any initial questions concerning a claim, an Insured should call or write BCI's Customer Services Department. BCI's phone numbers and addresses are listed on the Explanation of Benefits (EOB) form and in the District Office Locations section of this Policy.

B. FORMAL APPEAL

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

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and the documents in support of such appeals may be submitted by phone or facsimile. The appeal should set forth the reasons why the Insured contends BCI's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.
2. After receipt of the appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed. For non-urgent claim appeals, BCI will mail a written reply to the Insured within fifteen (15) days after receipt of the written appeal. Urgent claim appeals will be notified orally within seventy-two (72) hours. If the original decision is upheld, the reply will state the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible taking into account the medical exigencies of each claim.
3. Furthermore, the Insured or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.
4. If the original, non-urgent claim decision is upheld upon reconsideration, the Insured may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within thirty (30) days of BCI's mailing of the initial reconsideration decision. The Appeals and Grievance Coordinator will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt.

C. An Insured who wishes to formally appeal a Post-Service Claims decision by BCI may do so through the following process:

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. This written appeal should set forth the reasons why the Insured contends BCI's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.
2. After receipt of the written appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed. BCI shall mail a written reply to the Insured within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will list the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible.
3. Furthermore, the Insured or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.
4. If the original decision is upheld upon reconsideration, the Insured may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within sixty (60) days of BCI's mailing of the initial reconsideration decision. The Appeals and Grievance Coordinator will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within thirty (30) days of its receipt.

D. Insured's Rights to an Independent External Review

Please read this carefully. It describes a procedure for review of a disputed health claim by a

qualified professional who has no affiliation with BCI. If an Insured or their authorized representative requests an independent external review of a claim, the decision made by the independent reviewer will be binding and final. Except in limited circumstances, the Insured or their authorized representative will have no further right to have the claim reviewed by a court, arbitrator, mediator or other dispute resolution entity.

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

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

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

An Insured may submit a written request for an external review to:

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

For more information and for an external review request form:

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

An Insured may act as their own representative in a request or an Insured may name another person, including an Insured's treating health care provider, to act as an authorized representative for a request. If an Insured wants someone else to represent them, an Insured must include a signed "Appointment of an Authorized Representative" form with the request. An Insured's written external review request to the Department of Insurance must include a completed form authorizing the release of any medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without an Insured's completed authorization form. If the request qualifies for external review, BCI's final adverse benefit determination will be reviewed by an independent review organization selected by the Department of Insurance. BCI will pay the costs of the review.

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

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

and to the Department of Insurance within forty-two (42) days after receipt of an external review request.

Expedited External Review Request: An Insured may file a written “urgent care request” with the Department of Insurance for an expedited external review of a pre-service or concurrent service denial.

“Urgent care request” means any Pre-Service Claim or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

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

The Department of Insurance will send your request to us. BCI will determine, no later than the second (2nd) full business day, if the request is eligible for review. BCI will notify the Insured and the Department of Insurance no later than one (1) business day after BCI’s decision if the request is eligible. If BCI denies the eligibility for review, the Insured may appeal that determination to the Department of Insurance. If the request is eligible for review, the Department of Insurance will assign an independent review organization to the review upon receipt of BCI’s notice. The Department of Insurance will also notify the Insured. The independent review organization must provide notice of its decision to the Insured, BCI and to the Department of Insurance within seventy-two (72) hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within forty-eight (48) hours of notice of its decision. If the decision reverses BCI’s denial, BCI will notify the Insured and the Department of Insurance of the approval of coverage as soon as reasonably practicable, but not later than one (1) business day after making the determination.

Binding Nature of the External Review Decision:

If the Group is subject to the federal Employee Retirement Income Security Act (ERISA) laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on BCI. The Insured may have additional review rights provided under federal ERISA laws.

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

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

26. BLUECARD PAYMENT CALCULATIONS

A. EMPLOYER INFORMATION

Like all Blue Cross and Blue Shield Licensees, BCI participates in a program called “BlueCard.” Whenever Enrollees access health care services outside the geographic area BCI serves, the claim for those services may be processed through BlueCard and presented to BCI for payment in conformity with network access rules of the BlueCard Policies then in effect (“Policies”). Under BlueCard, when Enrollees receive Covered Services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee (“Host Blue”), BCI will remain responsible to the Group for fulfilling BCI contract obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing services such as contracting with its participating Providers and handling all interaction with its participating

Providers. The financial terms of BlueCard are described generally below.

1. LIABILITY CALCULATION METHOD PER CLAIM

The calculation of Enrollee liability on claims for Covered Services incurred outside the geographic area BCI serves and processed through BlueCard, if not covered by a flat dollar copayment, will be based on the lower of the Provider's billed charges or the negotiated price BCI pays the Host Blue. The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's Provider contracts. The negotiated price paid to a Host Blue by BCI on a claim for health care services processed through BlueCard may represent:

- a) the actual price paid on the claim by the Host Blue to the health care Provider ("Actual Price"); or
- b) an estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care Providers or one or more particular Providers ("Estimated Price"); or
- c) an average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its Providers or for a specified group of Providers ("Average Price").

An Average Price may result in greater variation to the Enrollee and the Group from the Actual Price than would an Estimated Price. Host Blues using either the Estimated Price or an Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Enrollee is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either (1) to use a basis for calculating Enrollee liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) to add a surcharge. If any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, BCI would then calculate Enrollee liability for any Covered Services consistent with the applicable Host Blue state statute in effect at the time the Enrollee received those services; or

- d) the billed charge, at BCI's sole discretion, when Covered Services are received outside the geographic area.

2. RETURN OF OVERPAYMENTS

Under BlueCard, recoveries from a Host Blue or from participating Providers of a Host Blue can arise in several ways, including but not limited to anti-fraud and abuse audits, Provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.

B. EMPLOYEE INFORMATION

Under BlueCard, when you obtain health care services outside the geographic area BCI serves, if not covered by a flat dollar copayment, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Enrollee liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. If any state statutes mandate Enrollee liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, BCI will then calculate your liability for any Covered Services in accordance with the applicable Host Blue state statute in effect at the time you received your care.

SCHEDULE OF BENEFITS ELIGIBILITY FOR BENEFITS

27. DEDUCTIBLE ACCUMULATION

From and after the effective date of this Policy, the benefits of this Policy shall apply commencing with the first day of an Illness, Injury, or physical disability for which Covered Services are provided hereunder, after the following conditions have been fulfilled:

- A.** Before an Insured shall qualify for the benefits of this Policy, such Insured must have paid, subsequent to the Effective Date of coverage under this Policy, the Deductible amount of \$500 for each calendar year in which the benefits of this Policy apply. In calculating whether the Deductible requirements have been fulfilled, only amounts, up to the Allowable Charge, of Covered Services actually paid by the Insured for medical, surgical, and Hospital care during the current calendar year shall be considered.
- B.** No Family shall be obligated to meet more than two (2) Deductibles in any calendar year; however, at least one (1) Family member must meet the individual \$500 Deductible.
- C.** If charges for Covered Services are paid during the last three (3) months of a calendar year, the amounts applied to the Deductible during these months may be accumulated in satisfying the Deductible for the following year.
- D.** Charges for services payable by the Insured due to a reduction of benefits, denial of benefits, or amounts charged in excess of Allowable Charges are the financial responsibility of the Insured and shall not be considered as an eligible expense for application towards the Deductible amount.
- E.** If an Insured is hospitalized on the last day of the calendar year for which the Deductible requirement has been fulfilled and such hospitalization continues uninterrupted into the succeeding calendar year, such period of continuous hospitalization shall be considered a part of the calendar year in which it originated, and the Deductible requirement for the succeeding calendar year shall not apply until the day following the Insured's discharge from the Hospital.
- F.** To qualify for the benefits of this Policy, the Insured shall submit proof to BCI that the applicable Deductible amount for the calendar year involved has been incurred including name of Provider, diagnosis, and itemized statements.
- G.** If two (2) or more in a Family are injured in the same accident, only one (1) Deductible will apply.

SCHEDULE OF BENEFITS (CONT.)

MEDICAL, SURGICAL AND HOSPITAL BENEFITS

After an Insured has otherwise qualified and fulfilled the Deductible requirement above, BCI will provide such Insured with benefits for Medically Necessary medical, surgical, and Hospital services actually incurred subject to the maximum lifetime benefit limits and the terms, waiting periods, exclusions, limitations, and general provisions set forth in this Policy, as follows:

28. PARTICIPATING PHYSICIAN/PROVIDER

Benefits of this Participating Physician/Provider section shall apply to all office, home, and Hospital services provided by and billed by a Participating Physician/Provider.

Laboratory testing and x-ray examination services provided at a Hospital or other facility, regardless of whether the Insured was referred to the Hospital or facility by a Participating Physician/Provider, will be paid under the applicable section of this Schedule of Benefits depending upon the person, entity, or facility providing the service.

See the section of this Schedule of Benefits entitled Mental and Neuropsychiatric Conditions and Chemical Dependency, for benefits for services and treatment for such conditions.

Benefits for services of a Participating Physician/Provider as outlined below shall be provided at eighty percent (80%) of the Allowable Charge unless specifically listed:

- A.** Office, home, and Outpatient Hospital visits for treatment of Illness, Injury, or Surgery either in the Physician/Provider's office or as an Outpatient in the Hospital.
- B.** Hospital calls for Illness or Injury while necessarily hospitalized as an Inpatient.
- C.** Surgical services, including services of assistant surgeon, and anesthesiologist.
- D.** Laboratory testing and x-ray services.
- E.** Second and third surgical consultative opinions to confirm the need for Elective Surgical Procedures as first recommended by the attending Physician. A second opinion consultant shall not be the same Physician who recommended elective Surgery and a third opinion consultant shall not be the same Physician who recommended elective Surgery or rendered the second opinion. Use of a second opinion is at the Insured's option. If the second opinion conflicts with the first, then a third opinion is a Covered Service.
- F.** Specifically listed preventive care services are provided at one hundred percent (100%) of the Allowable Charge and are not subject to deductible.
- G.** Specifically listed immunizations are provided at one hundred percent (100%) of the Allowable Charge and are not subject to deductible.

29. NONPARTICIPATING PHYSICIAN/PROVIDER

In the event services described in the Participating Physician/Provider section above are provided by a Nonparticipating Physician/Provider, BCI will pay to the Insured or to the Nonparticipating Physician/Provider, at the election of BCI, eighty percent (80%) of the Allowable Charge for such services.

EMERGENCY SERVICES

For the treatment of emergency medical conditions or accidental injuries of sufficient severity to necessitate immediate medical care by, or that require ambulance transportation service to, the nearest appropriate facility

provider, BCI will provide In-Network benefits for Covered Services provided by either a participating or nonparticipating facility provider and facility-based professional providers only. If the nearest facility provider is nonparticipating, once the Insured is stabilized and is no longer receiving emergency care the Insured (at BCI's option) may transfer to the nearest appropriate participating facility provider for further care in order to continue to receive In-Network benefits for Covered Services. If the Insured is required to transfer, transportation to the participating facility provider will be a Covered Service under the ambulance transportation service provision of this Policy.

30. HOSPITAL ADMISSION REVIEW

An Insured, his or her representative, or the facility should notify BCI of all Inpatient Hospital and skilled nursing facility admissions, including Inpatient admission for cochlear implant, within two (2) business days of admission. For emergency admissions, the Insured should notify BCI when stabilized and physically able. All admissions should be reviewed by BCI. Review of an admission does not guarantee benefit payments. Benefit payments will be made based upon Policy provisions and eligibility criteria.

31. HOSPITAL SERVICES

- A.** Benefits will be provided at eighty percent (80%) of the Allowable Charge for room and board and general nursing care in a Hospital room of two (2) or more beds. Allowance shall be made for the day of admission or the day of discharge but not for both.
- B.** Benefits will be provided at eighty percent (80%) of the Allowable Charge for Hospital cardiac or intensive care units.
- C.** Benefits will be provided at eighty percent (80%) of the Allowable Charge for Hospital ancillary services and supplies.
- D.** Benefits will be provided at eighty percent (80%) of the Allowable Charge for BCI-approved Outpatient Hospital services, including but not limited to Surgery, diagnostic laboratory, and x-ray.
- E.** Benefits will be provided at eighty percent (80%) of the Allowable Charge for the use of the emergency room for the following circumstances or conditions:
 - 1) Medical emergencies having sudden and unexpected onset requiring immediate care to safeguard the life of the patient. Medical emergencies include, but are not limited to, heart attacks, strokes, poisonings, loss of consciousness or respiration, and convulsions. Similar acute conditions may also be determined to be medical emergencies by BCI.
 - 2) Treatment for Injuries within seventy-two (72) hours after such Injury has occurred.
- F.** Hospital benefits as set forth above for cases of dental Surgery when performed by a Dentist and upon certification by a Physician that hospitalization is necessary because of nondental health impairment such as hemophilia, heart disease, etc.

32. MENTAL OR NEUROPSYCHIATRIC CONDITIONS AND CHEMICAL DEPENDENCY

- A.** Benefits shall be provided at eighty percent (80%) of the Allowable Charge for services for the treatment of Mental or Neuropsychiatric Conditions or Chemical Dependency while the Insured is necessarily hospitalized as an Inpatient in an approved Hospital or nonfederal institution specializing in the treatment of such Illnesses when such services are provided by a Participating Physician/Provider.
- B.** Benefits shall be provided at eighty percent (80%) of the Allowable Charge for services for the treatment of Mental or Neuropsychiatric Conditions or Chemical Dependency, while necessarily hospitalized as an Inpatient in an approved Hospital or nonfederal institution specializing in the treatment

of such Illnesses when such services are provided by a Nonparticipating Physician/Provider.

- C. Benefits shall be provided at eighty percent (80%) of the Allowable Charge for room and board, general nursing care, and ancillary services in a Hospital room of two (2) or more beds for the treatment of Mental or Neuropsychiatric Conditions or Chemical Dependency. Allowance shall be made for the day of admission or the day of discharge, but not for both.
- D. Benefits shall be provided at eighty percent (80%) of the Allowable Charge for Outpatient Physician services for medical and surgical treatment of Mental or Neuropsychiatric Conditions or Chemical Dependency when such services are provided by a Participating Physician/Provider.
- E. Benefits shall be provided at eighty percent (80%) of the Allowable Charge for Outpatient Physician services for medical and surgical treatment of Mental or Neuropsychiatric Conditions or Chemical Dependency when such services are provided by a Nonparticipating Physician/Provider.
- F. Benefits shall be provided at eighty percent (80%) of the Allowable Charge, for Outpatient Hospital services for medical and surgical treatment of Mental or Neuropsychiatric Conditions or Chemical Dependency.

33. MAMMOGRAPHY SERVICES

Benefits shall be provided for diagnostic mammography services at the appropriate percentage as outlined in Participating Physician/Provider Services, Nonparticipating Physician/Provider Services, Hospital Services, or Other Services sections of the Schedule of Benefits.

34. OTHER SERVICES

Benefits will be provided at eighty percent (80%) of the Allowable Charge for the following:

- A. Blood and blood plasma, if not replaced by donors.
- B. Subject to prior authorization by BCI, the rental (but not to exceed the total cost of purchase) or, at the option of BCI, the purchase of Durable Medical Equipment when prescribed by a Physician or Provider and required for therapeutic use. BCI shall reserve the right to contract with Providers as necessary to provide covered Durable Medical Equipment for its Insureds. Items secured under the provisions of this paragraph shall be limited to the standard model of such appliance or medical equipment (no benefits for electronic or cosmetic appliances). Repairs or maintenance costs will be covered. Replacement costs will be covered only if the equipment was used by the Insured in the manner and for the purpose for which the equipment was intended, and the replacement costs are necessarily incurred due to normal wear and tear of the equipment. See the Exclusions section of the General Provisions for other items not covered.
- C. Purchase, fitting, necessary adjustment, repairs, and replacements of prosthetic devices and supplies which 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 (excluding artificial hearts, dental appliances, and the replacement of cataract lenses, except when new cataract lenses are needed because of prescription change). Replacement costs will be covered only if the prosthetic appliance was used by the Insured in the manner and for the purpose for which such appliance was intended, and the replacement costs are necessarily incurred due to normal wear and tear of the appliance. BCI shall reserve the right to contract with Providers as necessary to provide covered prosthetic appliances for its Insureds.
- D. Benefits shall be provided for the purchase of an ankle-foot orthotics, and/or a knee-ankle-foot orthotic used to support, align, prevent, or correct deformities or improve function of movable parts of the body when

required for therapeutic use for treatment of neurological or circulatory conditions. BCI shall reserve the right to contract with Providers as necessary to provide covered orthotics for its Insureds. Items secured under the provisions of this paragraph shall be limited to the standard and/or most cost effective model of such orthotic (no benefits for electronic or cosmetic devices). Maintenance costs will not be covered. Repairs and replacement costs will be covered only if the orthotic was used by the Insured in the manner and for the purpose for which the orthotic was intended, and the replacement costs are necessarily incurred due to normal wear and tear of the orthotic.

- E.** Ambulance service within the local community by means of a specially designed and equipped vehicle used primarily for transporting the sick and injured:
- 1) From an Insured's home or scene of Injury or Medical Emergency to an approved Hospital, or
 - 2) Between approved Hospitals or
 - 3) Between an approved Hospital and skilled nursing facility, if such facility is the closest institution that can provide Covered Services appropriate to the Insured's condition. If there is no facility in the local community that can provide Covered Services appropriate to the Insured's condition, ambulance service will extend to the closest facility outside the local community that can provide the necessary service.

Air ambulance will be provided only when ground transportation is not feasible. Prior approval must be obtained from BCI to be eligible for this benefit unless an emergency situation existed which precluded obtaining prior approval.

- F.** Extended care in an approved skilled nursing facility for charges covering room and board and ancillary services, up to thirty (30) days per Insured each calendar year. To be eligible for this benefit the following qualifications must be met: (1) the patient's admittance to the skilled nursing facility must be ordered by the attending Physician; (2) the Illness or Injury must require skilled nursing care on a continuing basis; and (3) skilled nursing facility confinement must be for circumstances reflecting the need for convalescence from an Illness, treatment of a terminal condition, or a long term Illness and must not be for Custodial Care.
- G.** Professional services rendered by a Physician or Dentist for the treatment of a fractured jaw or for Injury to a Sound Natural Tooth for up to twelve (12) months from date of accident. Services needed as a result of chewing or biting shall not be considered services required as a result of an Injury.
- H.** Professional services rendered by a Chiropractor, practicing within the scope of his or her license, when such services would constitute benefits of this Policy if rendered by a Physician. See the Limitations section of the General Provisions. Chiropractic benefits shall not be provided under the Stop-Loss Coverage or for the treatment of orthognathic conditions or temporomandibular joint (TMJ) disorders.
- I.** Charges for services of BCI-approved diagnostic laboratory and x-ray facilities.
- J.** Prescription drugs and medicines properly identified and ordered in writing by a Physician and dispensed by a licensed pharmacist or Physician for the specific and direct treatment of a covered Illness or Injury, including prescription medications newly approved by the Federal Food and Drug Administration (FDA). Insulin, diabetic supplies, and allergy antigens are also covered under this provision.

35. CONTRACEPTIVES

- A.** Benefits provided for covered oral contraceptive prescription drugs for the Insured shall be subject to the prescription drug benefits and dispensing limit.
- B.** Benefits shall be provided for diaphragms and intrauterine devices for the Insured at one hundred percent

(100%) of the Allowable Charge, subject to a \$25 Copayment per device.

- C. Benefits shall be provided for injectable contraceptives (Depo Provera, etc.) for the Insured at one hundred percent (100%) of the Allowable Charge, subject to a \$20 Copayment per injection.
- D. Benefits shall be provided for Norplant insertion for the purpose of contraception for the Insured at one hundred percent (100%) of the Allowable Charge, subject to a \$100 Copayment per implant.

Removal for conception and reinsertion following delivery is not covered.

Coverage for implants will be limited to once each five (5) years.

36. HUMAN GROWTH HORMONE THERAPY

Benefits shall be provided at eighty percent (80%) of the Allowable Charge (Participating and Non-participating Providers) for human growth hormone therapy for: (1) growth hormone deficiency in children, (2) growth failure in children secondary to chronic renal insufficiency, (3) Turner's Syndrome, or (4) the promotion of wound healing for patients with severe, acute burns. Human growth hormone therapy for the above listed conditions will only be provided when authorized by BCI in advance.

37. PREAUTHORIZED HUMAN ORGAN AND TISSUE TRANSPLANTS AND BONE MARROW REINFUSION

A. Covered Services related to human organ and tissue transplants and bone marrow transplants shall be paid as set forth in Physician/Provider Services, Hospital Services, and Other Services. In addition to the exclusions and limitations set forth in the General Provisions of the Policy, human organ and tissue transplants shall be further subject to all of the conditions and limitations set forth below:

- 1) Organ or tissue transplants must be given by one human being to another (except in the case of autologous bone marrow reinfusion). No benefits will be paid for artificial, nonhuman, or mechanical transplants regardless of whether implantation is a temporary measure while awaiting an available human organ.
- 2) No benefits will be paid for donor or organ procurement services and costs incurred outside the United States, unless specifically approved by BCI.
- 3) Benefits are not provided for selection, transportation or storage costs when donor or organ procurement benefits are available through other group coverage, when government funding is available, or if funds are available from any other source.
- 4) No benefits will be paid for the purchase of any organ or tissue.
- 5) No benefits will be provided for any services or supplies related to transplant procedures other than those specifically listed as covered.
- 6) No benefits will be provided for any services, chemotherapy, radiation therapy supplies, drugs and aftercare for or related to bone marrow transplant, stem cell support or peripheral stem cell support procedures for a condition not specifically listed below as covered.

B. In addition to the provisions listed in paragraph A above, benefit payments related to the expenses incurred by the donor and the recipient of any organ or tissue transplant are also subject to the following additional provisions:

- 1) Organ procurement services means those diagnostic or medical services to evaluate, select, store, identify, or test that organ or tissue which is actually used in a transplant. It also means

the donor's surgical and hospital services directly related to the removal of an organ or tissue which is actually used in a transplant. Organ procurement costs also include those expenses incurred by recipients in the medical process to locate a compatible donor. Transportation of the donor or for the donated organ or tissue is not an organ procurement service.

- 2) When both the donor and recipient are covered by this Policy, benefits for the recipient's expenses will be paid according to the terms of this Policy.
- 3) When both the donor and recipient are covered by this Policy, benefits for the donor's expenses are limited to the payment of organ procurement services subject to the following:
 - a) No donor expenses will be paid unless the donor's organ is actually used in the transplant.
 - b) Medical complications and unforeseen medical effects of the donation will be covered as any other illness regardless of whether the organ is actually used in the transplant.
- 4) When only the recipient is an Insured under this health care Policy, only the recipient receives the benefits listed herein. No expenses incurred by the noninsured donor will be paid, except as otherwise permitted by the payment of organ procurement services under the recipient's health care Policy. No benefits whatsoever are available to a noninsured recipient.
- 5) When only the donor is an Insured of this group health, Policy benefits for the donor's expenses are limited to the payment of organ procurement services subject to the following:
 - a) No donor expenses will be paid unless the donor's organ is actually used in the transplant.
 - b) Medical complications and unforeseen medical effects of the donation will be covered as any other illness regardless of whether the organ is actually used in the transplant.

C. There shall be a benefit of up to \$5,000 in maximum lifetime benefits payable for the transportation, lodging, meals, and other incidental expenses incurred as a direct result of the transplant. The benefit will be paid upon the following terms and conditions:

- 1) The benefits will be paid only for the listed expenses incurred by the recipient or the recipient's immediate Family members.
- 2) The benefits will be reimbursed upon the submission to BCI of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service provider.
- 3) The listed expenses will not be reimbursed unless such expenses are incurred between the time period of five (5) days prior to the transplant to one hundred twenty (120) days after the transplant.
- 4) BCI 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.

D. Human organ and tissue transplants covered under this Policy are limited to:

- 1) Heart
- 2) Single/bilateral/lobar lung
- 3) Lung in conjunction with heart transplant

- 4) Cornea
- 5) Kidney
- 6) Liver
- 7) Pancreas
- 8) Islet cell autotransplantation when undergoing total pancreatectomy for chronic pancreatitis
- 9) Small bowel
- 10) Small bowel/liver
- 11) Small bowel/liver/multivisceral
- 12) Autologous bone marrow transplant and/or autologous peripheral stem cell transplant only for the treatment of the following conditions:
 - a) Lymphoma
 - b) Hodgkin's disease
 - c) Neuroblastoma
 - d) Acute leukemia
 - (1) Lymphocytic
 - (2) Myelogenous
 - e) Germ cell tumor
 - f) Ewing's sarcoma, recurrent or refractory
 - g) Medulloblastoma, recurrent or refractory
 - h) Wilm's tumor, high risk or recurrent
 - i) Primitive neuroectodermal tumor
 - j) Multiple myeloma
- 13) Allogeneic bone marrow transplant only for the treatment of the following conditions:
 - a) Aplastic anemia
 - b) Acute leukemia
 - (1) Lymphocytic
 - (2) Myelogenous
 - c) Severe combined immunodeficiency (not AIDS)
 - d) Infantile malignant osteopetrosis
 - (1) Albers - Schonberg syndrome
 - (2) Marble bone disease

- e) Chronic myelogenous leukemia
 - f) Lymphoma
 - g) Wiskott-Aldrich Syndrome
 - h) Neuroblastoma
 - i) Homozygous beta-thalassemia (thalassemia major)
 - j) Hodgkin's disease
 - k) Myelodysplastic syndrome
 - l) Mucopolysaccharidoses
 - m) Mucopolipidoses
 - n) Myeloproliferative disorders
 - o) Sickle cell anemia
 - p) Kostmann's syndrome
 - q) Leukocyte adhesion deficiencies
 - r) X-linked lymphoproliferative syndrome
 - s) Wilm's tumor, high risk or recurrent
 - t) Ewing's sarcoma, recurrent or refractory
- 14) and other transplants determined by BCI to be a covered transplant since this Policy was issued.

E. If preauthorization is not obtained from BCI prior to covered transplant-related services, services may be subject to denial. If non-Medically Necessary services are performed by participating provider, without the preauthorization by Blue Cross of Idaho, and benefits are denied, the cost of said services are not the financial responsibility of the Insured. The Insured is financially responsible for non-Medically Necessary services provided by a nonparticipating provider. The Insured is responsible for obtaining Prior Authorization when seeking treatment from a Noncontracting Provider. . BCI will determine whether to preauthorize a proposed transplant based on: (1) the Insured's medical condition, (2) medical appropriateness of the proposed transplant, (3) the Physician who will perform the transplant procedure, (4) the facility in which the transplant procedure will be performed, and (5) the terms and conditions of this transplant provision. BCI reserves the right, at its sole option, to contract with specific facilities to perform these transplant services and to base benefit payments upon the terms and conditions of such third party contracts.

38. HOME INFUSION THERAPY

Benefits for participating home infusion therapy providers shall be provided at eighty percent (80%) of the Allowable Charge for Medically Necessary services and supplies when provided by a BCI-approved home infusion therapy provider. Benefits for nonparticipating home infusion therapy providers shall be provided at twenty percent (20%) of the Allowable Charge for Medically Necessary services. Covered Services shall include the following:

A. Professional skilled nursing services of a nurse (RN or LPN) required for: (1) training the Insured

and/or alternative caregiver; (2) the administration of therapy; and (3) monitoring the intravenous therapy treatment.

- B. Medical and surgical supplies, and equipment, which are customarily furnished by the home infusion therapy agency and which are Medically Necessary to administer the home infusion therapy treatment.
- C. Prescribed drugs furnished by the home infusion therapy agency, which is a part of the home infusion therapy treatment. The administration of such drugs must require the professional skills of a nurse (RN or LPN) at the time the Insured is receiving nursing services as set forth above. This does not include prescribed drugs that are self-administered or administered by a non-professional caregiver.

No benefits will be provided unless the Insured obtains preauthorization from BCI prior to receiving home infusion therapy treatment. BCI must receive information sufficient for its determination of medical necessity.

39. HOME HEALTH CARE

Benefits shall be provided eighty percent (80%) of the Allowable Charge (Participating and Non-Participating Providers) for home health care services when provided by a BCI-approved home health care agency. All of the following conditions must be met to qualify for this benefit:

- A. Services are provided in lieu of in-hospital or necessary skilled nursing facility services.
- B. The services are prescribed by a Physician.
- C. The services are provided by a R.N. or L.P.N. on a part-time visiting basis of no more than four (4) hours in duration per visit.
- D. The services are provided by a Hospital or state-licensed community health care agency approved by BCI.
- E. Notification to BCI of treatment and plan of care is required.

No benefits will be paid for services provided where no specific medical treatment is furnished. Services provided by a relative, volunteer, or by a person who normally resides with the patient also will not be covered.

Total benefits paid for home health care visits shall be limited to a maximum of 17 visits per Insured each calendar year.

40. HOSPICE CARE

Benefits will be provided at eighty percent (80%) of the Allowable Charge (Participating and Non-Participating Providers) for hospice services and supplies listed below, when such services and supplies are included in the hospice treatment plan, provided and billed by a hospice licensed by the Department of Health and Welfare, and provided to an Insured who is terminally ill and homebound. Notification of the Physician's treatment and plan of care must be provided to BCI.

Benefits are available for six (6) months from the initial date covered hospice care is provided, subject to a maximum of \$5,000 in benefits paid. BCI may, in its sole discretion, grant limited extensions if it is determined that continued hospice care is appropriate.

Home Care Visits - Visits by a registered or licensed practical nurse; a physical, occupational, or speech therapist; MSW (Masters of Social Works); or a home health aide. A visit must be for intermittent, Medically Necessary, or palliative care of not more than four (4) hours in duration.

Hospice Inpatient Care - Up to twelve (12) days in the six (6) month benefit period. Benefits shall be subject to the

\$5,000 benefit maximum. Prior approval by BCI is required.

Respite Care - Up to 120 hours of care per three-month period in most appropriate setting.

Limitations and Exclusions - Hospice benefits do not cover the following:

- 1) Services provided to other than the terminally ill Insured, including bereavement counseling for Family members.
- 2) Pastoral and spiritual counseling.
- 3) Services performed by Family members or volunteer workers.
- 4) Homemaker or housekeeping services, except by home health aides, as ordered in the hospice treatment plan.
- 5) Supportive environmental materials, including but not limited to handrails, ramps, air conditioners, and telephones.
- 6) Normal necessities of living, including but not limited to food, clothing, and household supplies.
- 7) Food service, such as "Meals on Wheels."
- 8) Separate charges for reports, records, or transportation.
- 9) Legal and financial counseling services.
- 10) Services and supplies not included in the hospice treatment plan or not specifically set forth as a hospice benefit.
- 11) Services and supplies in excess of the stated limitations or services and supplies provided more than six (6) months after the initial date of covered hospice care, unless specifically approved by BCI.

41. INPATIENT REHABILITATION

Benefits shall be provided at eighty percent (80%) of the Allowable Charge (Participating and Non-Participating Providers) for Inpatient rehabilitation services and supplies, cardiac and pulmonary rehabilitation, provided and billed by a licensed acute rehabilitation Hospital with accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facility (CARF), or a Medicare-approved rehabilitation facility. Benefits are provided to restore an Insured who was Totally Disabled as the result of a covered Illness, Injury, condition, or disease, as outlined below to a level of function which allows that Insured to live as independently as possible.

All of the applicable requirements below must be met to qualify for this benefit:

- A.** The rehabilitation facility's program must be closely supervised by a physiatrist or Physician with experience in rehabilitation. The facility must provide twenty-four (24) hour rehabilitative nursing care and rehabilitative therapy with the availability of a registered nurse having specialized training or experience in rehabilitation.
- B.** The facility must provide a plan of treatment to BCI including current evaluations showing potential for improvement of the Insured's function.
- C.** Conditions for inpatient rehabilitation services covered under this Policy must be acute in nature. The benefits of this section will not be payable if the Insured has been previously treated for the same condition or received any multi-level rehabilitative treatment in a medical rehabilitation center for the same condition. Covered conditions are limited to the following:

- 1) Extensive intracranial Injury
 - a) Cerebral laceration and contusions
 - b) Subarachnoid, subdural extradural hemorrhage following Injury
 - c) Intracranial bleeding following Injury
 - d) Other intracranial Injury
- 2) Extensive spinal cord Injury
- 3) Extensive crushing Injury involving multiple fractures
 - a) Lower extremity amputation due to trauma or new amputation due to illness
- 4) Inflammatory diseases of the central nervous system resulting in marked neurological/neuromuscular deficiency limited to the following:
 - a) Meningitis
 - b) Encephalitis
 - c) Intracranial and intraspinal abscess
- 5) Disorders of the central nervous system limited to the following:
 - a) Hemiplegia
 - b) Paraplegia
- 6) Acute cerebrovascular accidents
- 7) Neoplasms resulting in marked neurological and/or neuromuscular deficit limited to the following:
 - a) Spinal cord compression due to neoplasm
 - b) Intracranial neoplasm

Diagnosis alone does not justify benefit application for Inpatient rehabilitation.

D. The medical condition of the Insured must meet the following criteria for benefit consideration. This information must be documented in writing:

- 1) The Insured must be considered medically stable to tolerate rehabilitative therapy.
- 2) Physical Therapy and cognitive therapy (upon approval following review) must be the main focus of rehabilitation.
- 3) The Insured must be able to tolerate at least three (3) hours of therapy per day.
- 4) Severe physical, neuromuscular, neurological impairment necessitating the need for twenty-four (24) hour nursing care must be present.
- 5) The Insured must be responsive to verbal and visual stimuli.
- 6) No other medical, surgical, or psychological impairing condition shall be present which may limit rehabilitation progress.

7) The Insured must show potential for rehabilitation.

E. If preauthorization is not obtained from BCI prior to Inpatient admission for rehabilitation, services may be subject to denial. If non-Medically Necessary services are performed by participating provider, without the preauthorization by Blue Cross of Idaho, and benefits are denied, the cost of said services are not the financial responsibility of the Insured. The Insured is financially responsible for non-Medically Necessary services provided by a nonparticipating provider. The Insured is responsible for obtaining Prior Authorization when seeking treatment from a Noncontracting Provider. BCI reserves the right to review all requests for prior approval based on: (1) the Insured's medical condition, (2) the Physician who will supervise the treatment, and (3) the facility in which the rehabilitation will be performed. BCI must receive information sufficient for its determination of Policy and benefit application. BCI reserves the right, at its sole option, to contract with specific facilities to perform rehabilitation services and to base benefit payments upon the terms and conditions of such third party contracts.

Total benefits paid for Inpatient rehabilitation services shall be limited to a maximum of 25 days per Insured each calendar year.

Limitations and Exclusions - Inpatient rehabilitation benefits do not cover the following:

- 1) Custodial Care
- 2) Maintenance care
- 3) Vocational rehabilitation
- 4) Driver's education
- 5) Communication devices
- 6) Services to reduce or training to reduce debilitating chronic pain
- 7) Pain management/clinics
- 8) Rehabilitation for post Inpatient Hospital stays for orthopaedic or reconstructive surgeries
- 9) Sensory stimulation for coma patients
- 10) Services for polyarthritis (including rheumatoid), neurological disorders, and/or deconditioning due to long illness
- 11) Prosthetic devices
- 12) Educational materials
- 13) Services, supplies, medication, or care of any kind, other than those directly related to rehabilitation care
- 14) Charges from a transitional care/subacute rehabilitation unit

42. OUTPATIENT REHABILITATION

Benefits shall be provided at eighty percent (80%) of the Allowable Charge (Participating and Non-Participating Providers) for Medically Necessary Outpatient rehabilitation services and supplies provided and billed by a licensed or certified physical, occupational, respiratory, cardiac, pulmonary, or speech therapist to improve or

restore lost bodily function.

Limitations and Exclusions - Outpatient rehabilitation benefits do not cover the following:

- 1) Inpatient care and services.
- 2) Diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, whether or not that service is provided by a licensed or registered Provider.
- 3) Treatment primarily for Mental or Neuropsychiatric Conditions or Chemical Dependency .
- 4) Services, supplies, medications, or care of any kind, other than those directly related to rehabilitation care.
- 5) Biofeedback, unless rendered as neuromuscular electrical stimulation.

43. WORLD-WIDE COVERAGE

Benefits of this Policy shall be available on a world-wide basis.

44. STOP-LOSS COVERAGE

In the event total benefits paid by BCI at eighty percent (80%) of the Allowable Charge for one Insured exceed \$8,000 in one calendar year (\$2,000 out-of-pocket plus Deductible), all further benefits payable under this Policy on behalf of that Insured shall be provided at one hundred percent (100%) of the Allowable Charge for the remainder of the calendar year in which the excess charges were incurred. Each Family member must meet the Stop-Loss amount; however, no Family shall be charged for more than three Stop-Loss amounts in any calendar year. Charges for services of a Chiropractor or services provided at any percentage other than eighty percent (80%) are not subject to this provision.

45. ANNUAL MAXIMUM BENEFIT LIMIT

Total benefits paid under this Policy shall not exceed \$1,250,000 per Insured, per calendar year. All covered services apply towards the Annual Maximum Benefit Limit except for chiropractic care services, diabetes self-management education Services, hospice services, transplant travel benefits, foot orthotics and hearing services. .

NOTICE TO INSUREDS

WOMEN'S HEALTH AND CANCER RIGHTS

An Insured who is receiving medical and surgical benefits under this Policy in connection with a covered mastectomy and who elects breast reconstruction in connection with such mastectomy and in a manner determined in consultation with the attending physician shall be entitled to receive benefits for:

- Reconstruction of the breast on which the mastectomy 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, including lymphedemas.

Coverage provided shall be consistent with the benefits of this Policy and may be subject to the applicable Deductible and/or Coinsurance provisions of this Policy.

COBRA CONTINUATION

This COBRA CONTINUATION OF COVERAGE Section applies only when the Group is subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA. Under certain circumstances, called qualifying events, Insureds may have the right to continue coverage beyond the time coverage would ordinarily have ended. The following rights and obligations regarding continuation of coverage are governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. In the event of any conflict between this continuation of coverage provision and COBRA, the minimum requirements of COBRA will govern. This provision will automatically cease to be effective when federal law requiring continuation of eligibility for coverage no longer applies to the Group. This section does not provide a full description of COBRA and more complete information is available from the Group.

WHO IS ELIGIBLE FOR COBRA CONTINUATION AND HOW LONG IT LASTS

If the Enrolled Employee's health coverage terminates due to either of the following qualifying events, the Enrolled Employee may elect COBRA continuation coverage for a maximum of 18 months following the date that the Enrolled Employee's coverage normally would have been lost:

- termination of employment for reasons other than gross misconduct;
- loss of coverage due to position elimination and eligibility for the Trade Adjustment Act; or
- reduction in hours of employment.

The Enrolled Employee's Dependents whose health coverage terminates due to either of these qualifying events may also elect this COBRA Continuation Coverage for a maximum of 18 months.

If health coverage for any of the Enrolled Employee's Dependents terminates due to any of the following qualifying events, that Dependent may elect COBRA Continuation Coverage for a maximum of 36 months following the date his or her coverage would have normally been lost:

- the Enrolled Employee's death;
- the Enrolled Employee and Enrolled Employee's spouse dissolve their marriage (divorce) or legally separate;
- the Enrolled Employee becomes entitled to Medicare benefits; or
- the Dependent is a child and loses eligibility as a dependent under this Policy.

By electing COBRA continuation coverage, unless the Enrolled Employee specifies to the contrary, The Enrolled Employee will automatically be maintaining benefits for the Enrolled Employee and Dependents. If COBRA continuation coverage is not desired for the Enrolled Employee or any of the Enrolled Employee's Dependents, each Insured may independently elect such coverage on behalf of him or herself. Any election by the Enrolled Employee's spouse will automatically continue coverage of the Enrolled Employee's Dependent children, unless specified to the contrary.

COBRA coverage following a termination of employment/reduction in hours qualifying event can be extended to a maximum of up to 29 total months if the Enrolled Employee and the Enrolled Employee's Dependent is determined to have been disabled for purposes of Title II or Title XVI of the Social Security Act at the time of the initial qualifying event or within the first 60 days of COBRA continuation coverage. To be eligible for the extension, the Enrolled Employee and the Enrolled Employee's Dependent must provide the Group documentation of the Social Security disability determination within 60 days of the date it is made and while still within the 18-month continuation period. The disability extension extends to the Enrolled Employee and the Enrolled Employee's Dependents, even if only one person is disabled.

An 18-month period of COBRA continuation coverage following a termination of employment/reduction in hours qualifying event (or a 29-month COBRA Continuation period involving such a termination/reduction followed by a disability extension) may be extended to a total period of up to 36 months for the Enrolled Employee's Dependent who would otherwise lose health coverage by virtue of any of the following "second" qualifying events occurring within the first 18-month (or, if there has been a disability extension, 29-month) period:

- the Enrolled Employee's death;
- the Enrolled Employee and the Enrolled Employee's spouse dissolve their marriage (divorce) or legally separate;
- the Enrolled Employee becomes entitled to Medicare benefits; or
- the Enrolled Employee's Dependent is a child and loses eligibility as a dependent under this Policy.

However (except with regard to employer Chapter 11 bankruptcy as described below), in no event will COBRA continuation coverage extend beyond 36 months from the date coverage was first lost due to the termination of employment/reduction in hours qualifying event. The Enrolled Employee and the Enrolled Employee's Dependent must provide the Group notice of the occurrence of one of these qualifying events.

IF THE ENROLLED EMPLOYEE IS RETIRED AND THE GROUP FILES CHAPTER 11 BANKRUPTCY

COBRA also allows continuation of coverage if the Enrolled Employee is retired, the Group files a Chapter 11 bankruptcy petition, and the Enrolled Employee and the Enrolled Employee's Dependent experiences a loss of plan coverage (or substantial reduction in coverage) within one year before or after the bankruptcy filing. Retired employees, and widows or widowers of retired employees who died before the bankruptcy, may continue coverage for the remainder of their lifetimes. If the Enrolled Employee is retired and die after the bankruptcy, and the Enrolled Employee's Dependents may continue coverage for up to 36 months after the Enrolled Employee death.

IF THE ENROLLED EMPLOYEE BECOMES ENTITLED TO MEDICARE BEFORE ELECTING COBRA

If the Enrolled Employee becomes entitled to Medicare before electing COBRA in connection with a termination of employment or reduction in hours qualifying event, the Enrolled Employee may maintain both Medicare and up to 18 months of COBRA coverage and the Enrolled Employee's Dependents will be allowed to continue their COBRA coverage until the later of:

- up to 18 months from the date coverage otherwise would be lost due to the termination of employment/reduction in hours, or
- up to 36 months from the date the Enrolled Employee became entitled to Medicare.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA continuation under this Policy will end for the Enrolled Employee and the Enrolled Employee's Dependents as of the last day of the monthly premium payment period in which any of the following occurs:

- failure to make premium payments necessary to bring premiums current within 45 days of electing COBRA;
- failure to make the monthly premium payment within 30 days of the premium due date;
- the date, after election of COBRA, that the Enrolled Employee and the Enrolled Employee's Dependents become covered under another group health plan (which does not limit or exclude any Preexisting Condition the person might have, either because of no applicable Preexisting Condition or sufficient creditable coverage to eliminate any Preexisting Condition limitation) or become entitled to Medicare benefits;
- the date the lifetime maximum benefit under this Policy is met for an Insured;
- the date this Policy terminates; or
- the applicable period of COBRA continuation ends.

COBRA Continuation under this Policy will end for the Enrolled Employee and the Enrolled Employee's Dependents:

- when there is final determination that the Enrolled Employee and the Enrolled Employee's Dependent are no longer disabled for the purposes of Title II or Title XVI of the Social Security Act, as of the later of:
 - the last day of 18 months of continuation coverage; or
 - the first day of the month that is more than 30 days following the date of the final determination of the nondisability.

This event will terminate the continuation of all Insureds who had qualified to extend by virtue of the Insured's disability and it is the Enrolled Employee and the Enrolled Employee's Dependent's responsibility to notify the Group of such a final determination within 30 days of the day it is made.

WHEN THE ENROLLED EMPLOYEE ACQUIRES A NEW DEPENDENT CHILD WHILE THE ENROLLED EMPLOYEE IS ON COBRA

Children born to the Enrolled Employee or placed with the Enrolled Employee for adoption while the Enrolled Employee is on COBRA may be added to COBRA coverage and have all the rights extended to the Enrolled Employee and the Enrolled Employee's Dependents who have elected COBRA. Addition of such children must occur in accordance with the terms of the Enrollment Qualifications of this Policy.

NOTIFICATION RESPONSIBILITIES

In order to preserve rights under COBRA, Insureds and the Group must meet certain notification, election and payment deadline requirements.

Under COBRA, the Enrolled Employee and the Enrolled Employee's Dependents must inform the Group in writing within 60 days of the Enrolled Employee's divorce or legal separation, or a loss of dependent status. The Group is responsible for notifying the Enrolled Employee and the Enrolled Employee's Dependents of the right to elect COBRA continuation due to any of the other qualifying events (for example, employee's death, termination of employment or reduction in hours, or Medicare entitlement).

Once the Group is notified or aware of a qualifying event, it will send the Enrolled Employee and the Enrolled Employee's Dependents information concerning continuation options, including the necessary COBRA continuation election forms. The Enrolled Employee and the Enrolled Employee's Dependents will have 60 days from the later of the date of the qualifying event or the date of the Group notice to the Enrolled Employee and the Enrolled Employee's Dependent in which to make an election.

As mentioned above, to be eligible for disability extension, the Enrolled Employee and the Enrolled Employee's Dependent must provide the Group documentation of a Social Security disability determination within 60 days of the date it is made and while still within the 18-month COBRA Continuation period following a termination or reduction of hours qualifying event. The determination must reflect that the Enrolled Employee and the Enrolled Employee's Dependent was disabled for Social Security purposes at the time of the initial qualifying event or within the first 60 days of COBRA continuation. If a final determination is subsequently made that the Enrolled Employee and the Enrolled Employee's Dependent is no longer disabled for Social Security purposes, the Enrolled Employee and the Enrolled Employee's Dependent must provide the Group notice of that determination within 30 days of the date it is made.

To be eligible for an extension of the 18-month continuation following a termination of employment/reduction in hours qualifying event (or a 29 month COBRA Continuation period involving such a termination/reduction followed by a disability extension), the Enrolled Employee and the Enrolled Employee's Dependent must notify the Group within 30 days of the occurrence of any of the following "second" qualifying events causing a loss of coverage within that 18-month (or 29-month) period:

- the Enrolled Employee's death;
- the Enrolled Employee and the Enrolled Employee's spouse dissolve their marriage (divorce) or legally separate;
- the Enrolled Employee becomes entitled to Medicare benefits; or

. the Enrolled Employee's Dependent is a child and loses eligibility as a dependent under this Policy.

However (except with regard to employer Chapter 11 bankruptcy as described above), in no event will COBRA continuation coverage extend beyond 36 months from the date coverage was first lost due to the termination of employment/reduction in hours qualifying event. The Enrolled Employee and the Enrolled Employee's Dependent must provide the Group notice of the occurrence of one of these "second" qualifying events.

PAYING CONTINUATION PREMIUM

If Insureds wish to continue coverage, they must pay for it. The premium will reflect the total cost of the group health care coverage and up to a 2% administration fee. For those Insureds who receive COBRA Continuation Coverage due to a Social Security disability determination, the premium and administration fees will be up to 150% of the total cost for coverage for the period of the disability extension (provided the disabled individual is among those continuing coverage). Coverage will cease if timely premium payments are not made. Insureds have a maximum of 45 days from the date that the election form is mailed to the Group to submit the first payment. This first payment must retroactively cover any period of time after the date coverage was terminated. All subsequent payments are due on the first day of the month for which coverage is to be provided or within a 30-day grace period thereafter.

IF INSUREDS DO NOT ELECT COBRA CONTINUATION

If Insureds do not elect COBRA continuation coverage, coverage under this Policy will end according to the terms of this Policy and BCI will not pay claims for services provided on and after the date coverage ends. If Insureds elect and exhaust COBRA continuation coverage, they may be eligible for an individual conversion-type plan.

IMPORTANCE OF KEEPING INFORMATION CURRENT

It is very important that the Enrolled Employee keep the Group informed of the current address of all Insureds who are or may become qualified beneficiaries.