Notice of Ten-Day Right to Examine Policy
If, after examining this Policy, you are not satisfied with it and the contract as a whole for any reason, you may return it to any office of Blue Cross of Idaho, or to the licensed agent who enrolled you, within ten days of its delivery or reasonable availability to you. If you return the Policy within ten days whereupon, a full refund of your payment will be made, and the Policy will be deemed rescinded and never to have been in effect.
READ THE POLICY CAREFULLY
This Outline of Coverage provides a very brief description of some of the important features of the Policy. It is not a contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and Blue Cross of Idaho. Therefore, it is important that you read the Policy carefully. Throughout this Outline of Coverage and the Policy, Blue Cross of Idaho may be referred to as BCI.

SHORT DURATION MEDICAL BENEFIT HEALTH COVERAGE
Policies of this category are designed to provide short duration medical benefit health coverage to enrolled individuals.

For Covered Services under the terms of the Policy, Maximum Allowance is the amount established as the highest level of compensation for a Covered Service. There is more detailed information on how Maximum Allowance is determined and how it affects out-of-state coverage in the Definitions Section of the Policy. If you choose a Noncontracting Provider, you may be responsible for any charges that exceed the Maximum Allowance.

SHORT TERM PPO BENEFITS
After the applicable Deductibles shown in the Outline of Coverage Table are met, Short Term PPO will pay eighty percent (80%) of the Maximum Allowance for In-Network Services or fifty percent (50%) of the Maximum Allowance for Out-of-Network Services, unless stated otherwise, for the Covered Services listed below in the Outline of Coverage Table. All Contracting Providers, including Physicians, hospitals, and other medical facilities and Providers, recognize the Maximum Allowance as their fee for service under this program.

To locate a Contracting Provider in your area, please visit the BCI Web site at www.bcidualo.com. You may also call the Customer Service Department at 208-331-7347 or 800-627-1188 for assistance in locating a Provider.
INPATIENT NOTIFICATION SECTION

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

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

I. NON-EMERGENCY PREADMISSION NOTIFICATION

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

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

II. EMERGENCY OR MATERNITY ADMISSION NOTIFICATION

When an Emergency Admission occurs for Emergency Medical Conditions, an unscheduled cesarean section delivery, or (if covered under this Policy) maternity delivery services, and notification cannot be completed prior to admission due to the Insured’s condition, the Insured, or his or her representative, should notify BCI within twenty-four (24) hours of the admission. If the admission is on a weekend or legal holiday, BCI should be notified by the end of the next working day after the admission. If the Emergency Medical Condition, unscheduled cesarean section delivery or (if covered under this Policy) maternity delivery services, renders it medically impossible for the Insured to provide such notice, the Insured should immediately notify BCI of the admission when it is no longer medically impossible to do so.

This notification alerts BCI to the emergency stay.

III. CONTINUED STAY REVIEW

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

IV. DISCHARGE PLANNING

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

NOTICE: The Medical Necessity of Covered Services listed below should be determined to be eligible for benefits under the terms of this Policy. If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in this decision to deny must be resolved by use of the Blue Cross of Idaho appeal process as outlined in the General Provisions Section.

If Non-Medically Necessary services are performed by Contracting Providers, without the Prior Authorization by Blue Cross of Idaho, and benefits are denied, the cost of said services are not the financial responsibility of the Insured.

The Insured is financially responsible for Non-Medically Necessary services provided by a Noncontracting Provider.

Prior Authorization is a request by the Insured’s Contracting Provider to BCI, or delegated entity, for authorization of an Insured’s proposed treatment. BCI may review medical records, test results and other sources of information to ensure that it is a Covered Service and determine whether the proposed treatment meets the standard of Medical Necessity as defined in this Policy.

The Insured is responsible for obtaining Prior Authorization when seeking treatment from a Noncontracting Provider.

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

The Insured is responsible for notifying BCI if the proposed treatment will be provided by a Noncontracting Provider.

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

Covered Services include:

### MEDICAL SERVICES

<table>
<thead>
<tr>
<th>Deductible:</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured</td>
<td>Insured pays the first $2,000 of combined In-Network and Out-of-Network Services of eligible expenses per Benefit Period</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>(The Individual Deductible only applies to the Medical Benefits Section and does not apply to Covered Services, Deductibles or Coinsurance under any other benefit section of the Policy. Covered Services, Deductibles or Coinsurance under any other benefit section do not apply to this benefit section’s Deductible.)</em></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-Pocket Limit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(see Policy for services that do not apply to the limit)</em></td>
<td>Insured pays first $4,000 of eligible expenses per Benefit Period <em>(includes Deductibles and Coinsurance)</em></td>
<td>Insured pays first $4,000 of eligible expenses per Benefit Period <em>(includes Deductibles and Coinsurance)</em></td>
</tr>
<tr>
<td></td>
<td><em>(When the Out-of-Pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for Prescription Drug Covered Services)</em></td>
<td><em>(When the Out-of-Pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for Prescription Drug Covered Services)</em></td>
</tr>
</tbody>
</table>

### SERVICES BCI COVERS

<table>
<thead>
<tr>
<th>AMOUNT OF PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td>Ambulance Transportation Service</td>
</tr>
<tr>
<td>Dental Services Related to Accidental Injury <em>(treatment of injuries to a Sound Natural Tooth that occur during the Insured’s Benefit Period)</em></td>
</tr>
<tr>
<td>SERVICES BCI COVERS</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Diabetes Self-Management Education Services (only for Providers approved by BCI)</td>
</tr>
<tr>
<td>Diagnostic Services (Laboratory and X-ray)</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>Home Health Skilled Nursing Care Services (only for Providers approved by BCI)</td>
</tr>
<tr>
<td>Home Intravenous Therapy</td>
</tr>
<tr>
<td>Hospital Services (two-bed room, including a special care or a nursery unit) and related services and supplies; emergency room services and related supplies; blood transfusion and cost of commercial blood)</td>
</tr>
<tr>
<td>Involuntary Complications of Pregnancy (available only for the Insured and enrolled Eligible Dependents)</td>
</tr>
<tr>
<td>Orthotic Devices</td>
</tr>
<tr>
<td>Outpatient Physical Therapy Services</td>
</tr>
<tr>
<td>Physician Services (Includes Physician Office Visits)</td>
</tr>
<tr>
<td>Prosthetic Appliances</td>
</tr>
<tr>
<td>SERVICES BCI COVERS</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
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<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td><em>(two-bed room and related charges)</em></td>
</tr>
<tr>
<td>Surgical/Medical (Professional Services)</td>
</tr>
<tr>
<td><em>(including anesthesia services)</em></td>
</tr>
<tr>
<td>Therapy Services</td>
</tr>
<tr>
<td><em>(such as radiation, chemotherapy, renal dialysis, respiration, Inpatient physical, Inpatient occupational, Inpatient speech, enterostomal, growth hormone)</em></td>
</tr>
<tr>
<td>Autotransplant Services</td>
</tr>
<tr>
<td><em>(see Policy for listed Autotransplant Covered Services.)</em></td>
</tr>
</tbody>
</table>

**PRESCRIPTION DRUG BENEFITS**

<table>
<thead>
<tr>
<th>Deductible:</th>
<th>Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insured pays the first $100 in eligible Prescription Drug expenses per Benefit Period</td>
</tr>
<tr>
<td></td>
<td><em>(Prescription Drug Deductible is a separate Deductible and shall not apply to the Medical Benefits Deductible for eligible medical benefits.)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Generic Drugs and Brand Name Drugs</th>
<th>BCI pays 80% of the cost of the covered Prescription Drugs after the Prescription Drug Deductible is met</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(requiring a written prescription and that are listed and accepted in the United States Pharmacopoeia, National Formulary, or AMA Drug Evaluations published by the American Medical Association)</em></td>
<td><em>(Each prescription shall not exceed a ninety (90) day supply at one (1) time)</em></td>
</tr>
</tbody>
</table>

**BENEFIT MAXIMUM**

The greatest aggregate amount payable by BCI is $1,000,000 for an Insured. When an Insured has reached his or her Benefit Maximum, no further benefits shall be owed or paid to the Insured under the Policy.
PREEXISTING CONDITION WAITING PERIOD
There are no benefits available under the Policy for services, supplies, drugs or other charges related to any symptoms or conditions that existed before you enrolled in Short Term PPO. No credit is given under the Policy for any prior coverage, including prior Short Term PPO or Short Term Blue coverage or its successor.

A Preexisting Condition is the existence of:
1. A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the Effective Date of coverage under this Policy; or
2. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the Effective Date of coverage under this Policy; or
3. A pregnancy existing on the Effective Date of coverage under this Policy.

GENERAL EXCLUSIONS AND LIMITATIONS SECTION
In addition to the exclusions and limitations listed elsewhere in the Policy, the following exclusions and limitations apply to the entire Policy, unless otherwise specified:

You are not covered for services, supplies, drugs or other charges that are:

A. Not Medically Necessary. If services requiring Prior Authorization by Blue Cross of Idaho are performed by a Contracting Provider and benefits are denied as not Medically Necessary, the cost of said services are not the financial responsibility of the Insured. However, the Insured could be financially responsible for services found to be not Medically Necessary when provided by a Noncontracting Provider.

B. In excess of the Maximum Allowance.

C. For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an Accidental Injury or unless an attending Physician certifies in writing that the Insured has a non-dental, life-endangering condition which makes hospitalization necessary to safeguard the Insured's health and life.

D. Not prescribed by or upon the direction of a Physician or other Professional Provider; or which are furnished by any individuals or facilities other than Licensed General Hospitals, Physicians, and other Providers.

E. Investigational in nature.

F. Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Insured is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts or under Employer Liability Acts, or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Insured claims such benefits or compensation or recovers losses from a third party.

G. Provided or paid for by any federal governmental entity except when payment under the Policy is expressly required by federal law, or provided or paid for by any state or local governmental entity where its charges therefore would vary, or are or would be affected by the existence of coverage under the Policy, or for which payment has been made under Medicare Part A and/or Medicare Part B, or would have been made if an Insured had applied for such payment except when payment under the Policy is expressly required by federal law.

H. Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.

I. Furnished by a Provider who is related to the Insured by blood or marriage and who ordinarily dwells in the Insured's household.
J. Received from a dental, vision, or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.

K. For Surgery intended mainly to improve appearance or for complications arising from Surgery intended mainly to improve appearance, except for:
   1. Reconstructive Surgery necessary to treat an Accidental Injury, infection or other Disease of the involved part; or
   2. Reconstructive Surgery to correct Congenital Anomalies in an Insured who is a dependent child.

L. Rendered prior to the Insured's Effective Date; or during an Inpatient admission commencing prior to the Insured's Effective Date.

M. For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance), or convenience items or services even if prescribed by a Physician, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs, spas, hot tubs, whirlpool baths, waterbeds or swimming pools and therapies, including but not limited to, educational, recreational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, homeopathic or naturopathic, massage, or music.

N. For telephone consultations, and all computer or Internet communications; for failure to keep a scheduled visit or appointment; for completion of a claim form; or for personal mileage, transportation, food or lodging expenses or for mileage, transportation, food or lodging expenses billed by a Physician or other Professional Provider.

O. For Outpatient Occupational Therapy; Outpatient Speech Therapy, Inpatient or Outpatient Custodial Care; or for Inpatient or Outpatient services consisting mainly of educational therapy, behavior modification, self-care or self-help training, except as specified as a Covered Service in the Policy.

P. For Inpatient admissions that are primarily for Diagnostic Services, Therapy Services, or Physical Rehabilitation, except as specified in the Policy; or for Inpatient admissions when the Insured is ambulatory and/or confined primarily for bed rest, a special diet, behavioral problems, environmental change or for treatment not requiring continuous bed care or when skilled nursing is not required.

Q. For any cosmetic foot care, including but not limited to, treatment of corns, calluses and toenails (except for surgical care of ingrown or Diseased toenails).

R. Related to Dentistry or Dental Treatment, even when Medically Necessary, including but not limited to, dental implants, appliances, or prosthetics, or treatment related to Orthodontia and orthognathic Surgery and any surgical or other treatment of temporomandibular joint syndrome.

S. For hearing aids or examinations for the prescription or fitting of hearing aids.

T. For any treatment of either gender leading to or in connection with transsexual Surgery, gender transformation, sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence, even if related to a medical condition.

U. For orthoptics, eyeglasses or contact lenses or the vision examination for prescribing or fitting eyeglasses or contact lenses.

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

W. Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury, except as specified as a Covered Service in the Policy.
X. Furnished by a facility that is primarily a place for treatment of the aged or that is primarily a nursing home, a convalescent home, or a rest home.

Y. For Acute Care, rehabilitative care, diagnostic testing, evaluation or treatment of Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, or for Pain Rehabilitation.

Z. Incurred by an Insured for care or treatment of any condition arising from or related to pregnancy, childbirth, or delivery, except as specified as a Covered Service in the Policy.

AA. For weight control or treatment of obesity or morbid obesity, including but not limited to Surgery for obesity, except when Surgery for obesity is Medically Necessary to control other medical conditions that are eligible for Covered Services under the Policy, and nonsurgical methods have been unsuccessful in treating the obesity. For reversals or revisions of Surgery for obesity, except when required to correct an immediately life-endangering condition.

AB. For use of operating, cast, examination, or treatment rooms or for equipment located in a Contracting or Noncontracting Provider’s office or facility, except for emergency room facility charges in a Licensed General Hospital, unless specified as a Covered Service in the Policy.

AC. For an elective abortion unless to preserve the life of the female upon whom the abortion is performed.

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

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

AF. For Transplant Services and Artificial Organs, except as specified as a Covered Service in the Policy.

AG. For Chiropractic Care.

AH. For acupuncture.

AI. For surgical procedures that alter the refractive character of the eye, including but not limited to, radial keratotomy, myopic keratomileusis, Laser-In-Situ Keratomileusis (LASIK), and other surgical procedures of the refractive-keratoplasty type, to cure or reduce myopia or astigmatism, even if Medically Necessary. Additionally, reversals, revisions, and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.

AJ. For pastoral, spiritual, and bereavement counseling.

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

AL. For Hospice Home Care.

AM. For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation.

AN. Any services or supplies for which an Insured would have no legal obligation to pay in the absence of coverage under the Policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage, unless such injuries are a result of a medical condition or domestic violence.
AO. For a routine or periodic mental or physical examination that is not connected with the care and treatment of an actual Illness, Disease or Accidental Injury or for an examination required on account of employment; or related to an occupational injury; for a marriage license; or for insurance, school or camp application; or for sports participation physical; or a screening examination including routine hearing examinations.

AP. For routine or preventive immunizations.

AQ. For breast reduction Surgery or Surgery for gynecomastia.

AR. For nutritional supplements.

AS. For replacements or nutritional formulas, except when administered enterally due to impairment in digestion and absorption of an oral diet and is the sole source of caloric need or nutrition in an Insured.

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

AU. Any services or supplies furnished by a facility that is primarily a health resort, sanatorium, residential treatment facility, transitional living center, or primarily a place for Outpatient treatment or residential facility care of Mental or Nervous Conditions.

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

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

AX. Provided to a person enrolled as an Eligible Dependent, but who no longer qualifies as an Eligible Dependent due to a change in eligibility status that occurred after enrollment.

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

AZ. Furnished by a Provider or caregiver that is not listed as a Covered Provider, including but not limited to, naturopaths and homeopaths.

AAA. For Outpatient pulmonary and/or cardiac rehabilitation.

AAB. For complications arising from the acceptance or utilization of noncovered services.

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

AAD. For arch supports, orthopedic shoes, and other foot devices.

AAE. For well-baby or well-child care furnished by a Physician or other Professional Provider to an Insured who is not a patient at a Licensed General Hospital or Ambulatory Surgical Facility.

AAF. Contraceptives, oral or other, whether medication or device, except as specified as a Covered Service.

AAG. For wigs and cranial molding helmets.

AAH. For surgical removal of excess skin that is the result of weight loss or gain, including but not limited to association with prior weight reduction (obesity) surgery.

AAI. For the purchase of Therapy or Service Dogs/Animals and the cost of training/maintaining said animals.
TERM OF POLICY
The Policy is in effect for a specific Benefit Period and may not be renewed.

We may terminate the Policy, but only if we do so for everyone in your enrollment category and give thirty (30) days advance notice. We may terminate or rescind your coverage for fraud or false information or intentional misrepresentation of a material fact, that affected BCI’s decision to accept you for enrollment as an Insured, or if you no longer meet our eligibility requirements as specified in the Policy. We may terminate the Policy if premiums are not paid or a payer financial institution returns or refuses to honor a check or ACH draft when presented for payment, constituting nonpayment of premiums.

This Outline of Coverage describes only the general features of the Short Term PPO Policy; it is not all-inclusive and is not a contract. Please see the Policy for a full explanation of all provisions.
Attachment A:

NON-EMERGENCY SERVICES REQUIRING PRIOR AUTHORIZATION ANNUAL NOTICE
EFFECTIVE: May 1, 2011

NOTICE: The Medical Necessity of Covered Services listed below should be determined to be eligible for benefits under the terms of this Policy. If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in this decision to deny must be resolved by use of the Blue Cross of Idaho appeal process.

If Non-Medically Necessary services are performed by Contracting Providers, without the Prior Authorization by Blue Cross of Idaho, and benefits are denied, the cost of said services are not the financial responsibility of the Insured.

The Insured is financially responsible for Non-Medically Necessary services provided by a Noncontracting Provider.

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

Surgical Services – Inpatient or Outpatient
- Organ and tissue Transplants
- Gallbladder Surgery
- Arthroscopic Surgery of the knee, hip, shoulder, wrist, or jaw
- Nasal and sinus procedures
- Eyelid Surgery
- Spinal Surgery
- Hysterectomy
- Gastric reflux procedures
- Plastic and reconstructive Surgery
- Surgery for snoring or sleep problems
- Invasive treatment of lower extremity veins (including but not limited to varicose veins)
- 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

Other Services
- Inpatient stays including those that originate from an Outpatient service
- Home intravenous therapy
- Non-emergent ambulance
- Certain Prescription Drugs as listed on the BCI Web site, www.bcidaho.com
- Restorative dental services following Accidental Injury to a Sound Natural Tooth
- Growth hormone therapy
- Genetic testing services
- Home health skilled nursing services

The following services require Prior Authorization when the expected charges exceed three hundred dollars ($300):
- Rental or purchase of Durable Medical Equipment
- Prosthetic Appliances
- Orthotic Devices
MAJOR MEDICAL BENEFIT OPTION
INDIVIDUAL POLICY

SHORT TERM PPO
Short Duration Medical Benefit Health Coverage

BLUE CROSS OF IDAHO
HEALTH SERVICE, INC.

QUICK VIEW

$1,000 Individual Benefit Period Deductible
$100 Individual Benefit Period Prescription Deductible
$3,000 Out-of-Pocket Limit
(Prescription Drug Services Deductible and Coinsurance do not apply to the Out-of-Pocket Limit)

The benefit period of this policy is selected at the time of purchase and may extend to no longer than 10 months. Please check the effective dates of coverage provided on your identification card.

Notice of Ten (10)-Day Right to Examine Policy
If, after examining this Policy, you are not satisfied with it and the contract as a whole for any reason, you may return it to any office of Blue Cross of Idaho, or to the licensed agent who enrolled you, within ten (10) days of its delivery or reasonable availability to you. If you return the Policy within ten (10) days whereupon, a full refund of your payment will be made, and the Policy will be deemed rescinded and never to have been in effect.
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AGREEMENT

In consideration of the Enrollee’s enrollment application and the payment of required premiums when due, and subject to all the terms of this Policy, Blue Cross of Idaho Health Service, Inc. agrees to provide to the person named as the applicant on the enrollment application (referred to as the Enrollee) and any enrolled Eligible Dependents, the benefits of this Policy beginning on the Enrollee’s Effective Date. Blue Cross of Idaho accepts the Enrollee’s enrollment application at its home office in Meridian, Idaho (the state of issue). Throughout this Policy, Blue Cross of Idaho Health Service, Inc. may be referred to as BCI.

EFFECTIVE DATE AND TERM

BCI’s Short Term PPO Policy is issued subject to the statements made on the Enrollee’s enrollment application and advance receipt of the Enrollee’s premium. The full amount of the premium, for the first month of coverage, must be paid at the time of application. The Enrollee agrees to pay the premiums as established by BCI for the subsequent months of coverage (not to exceed an additional nine (9) months) in full at the time of enrollment or by authorizing BCI to debit his or her account at a cooperating financial institution for each subsequent month for which premiums are due. The Enrollee’s premium will be refunded in full if coverage is denied because the Enrollee or any enrolled Eligible Dependents do not meet the eligibility requirements for enrollment under this Policy. Once coverage is effective, however, the Enrollee cannot enroll any additional dependents, except as provided in this Policy.

If an Enrollee, Enrollee’s estate or entity cancels this Policy for any reason, BCI shall refund the pro rata portion of the unused collected premium to the beginning of the next monthly billing cycle. As used in this paragraph “unused collected premium” shall mean that portion of any premium collected which is not used, on a pro rata basis to the beginning of the next monthly billing cycle at the time of cancellation, by BCI to insure against loss as there is no risk of loss from the Enrollee or that portion of any collected premium which would have not been collected had the Enrollee paid monthly.

The Enrollee’s coverage under this Policy starts on the Effective Date specified by BCI on the Enrollee’s identification card and is valid for the Benefit Period specified by BCI on the Enrollee’s identification card, as long as premiums have been paid.

NONRENEWABLE

This Policy is issued for a specific Benefit Period and cannot be renewed.
HOW TO SUBMIT CLAIMS

We must receive a claim in order to pay benefits for Covered Services. There are two (2) ways for you to submit claims for medical expenses:

1. Your health care Provider (hospital, doctor, or other facility or specialist) can file them for you. Most Providers will submit claims to us on your behalf if you show them your BCI identification card and ask them to send us your claims, or
2. You can send us your claims yourself.
3. For prescription drug claims, attach your pharmacy receipts to a Member Claim Form and mail them to the address below.

TO FILE YOUR OWN CLAIMS

If your Covered Provider prefers that you file your own claim, here is what you need to do:

1. Ask the Covered Provider for an itemized billing. The itemized billing should show each service received, its procedure code and its diagnosis code, the date it was furnished, the charge for each service, the Insured’s name, address, and date of birth, and the Insured’s BCI identification number. **We cannot accept billings that only say “Balance Due,” “Payment Received” or some similar statement.**
2. Obtain a Member Claim Form from your Covered Provider or any of our offices and follow the instructions. Use a separate billing and Member Claim Form for each patient.
3. Attach your billing to the Member Claim Form and send it to:
   Blue Cross of Idaho Claims Control
   Blue Cross of Idaho
   P.O. Box 7408
   Boise, ID 83707

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

HOW WE NOTIFY YOU

We will send you an Explanation of Benefits (EOB) as soon as we process your claim. The explanation will show all the payments we made and to whom the payments were sent. It will also explain any charges we did not pay in full. Keep this EOB for your records.
BLUE CROSS OF IDAHO DISTRICT OFFICE LOCATIONS

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

**Meridian Office**
Blue Cross of Idaho
Customer Services Department
3000 E. Pine Avenue
Meridian, ID 83642

*Mailing Address*
P.O. Box 7408
Boise, ID 83707
(208) 331-7347 (Boise Area)
1-800-627-1188

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

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

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

**Pocatello Office**
Blue Cross of Idaho
275 S. 5th Avenue, Suite 150
Pocatello, ID 83201

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

**Idaho Falls Office**
Blue Cross of Idaho
2116 E. 25th Street
Idaho Falls, ID 83404

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

**Twin Falls Office**
Blue Cross of Idaho
1431 N. Fillmore Street, Suite 200
Twin Falls, ID 83301

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

IDAHO DEPARTMENT OF INSURANCE CONTACT INFORMATION

**Idaho Department of Insurance**
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise ID 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov
INPATIENT NOTIFICATION SECTION

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

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

I. NON-EMERGENCY PREADMISSION NOTIFICATION

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

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

II. EMERGENCY OR MATERNITY ADMISSION NOTIFICATION

When an Emergency Admission occurs for Emergency Medical Conditions, an unscheduled cesarean section delivery, or (if covered under this Policy) maternity delivery services, and notification cannot be completed prior to admission due to the Insured’s condition, the Insured, or his or her representative, should notify BCI within twenty-four (24) hours of the admission. If the admission is on a weekend or legal holiday, BCI should be notified by the end of the next working day after the admission. If the Emergency Medical Condition, unscheduled cesarean section delivery or (if covered under this Policy) maternity delivery services, renders it medically impossible for the Insured to provide such notice, the Insured should immediately notify BCI of the admission when it is no longer medically impossible to do so.

This notification alerts BCI to the emergency stay.

III. CONTINUED STAY REVIEW

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

IV. DISCHARGE PLANNING

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

NOTICE: The Medical Necessity of Covered Services listed below should be determined to be eligible for benefits under the terms of this Policy. If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in this decision to deny must be resolved by use of the Blue Cross of Idaho appeal process as outlined in the General Provisions Section.

If Non-Medically Necessary services are performed by Contracting Providers, without the Prior Authorization by Blue Cross of Idaho, and benefits are denied, the cost of said services are not the financial responsibility of the Insured.

The Insured is financially responsible for Non-Medically Necessary services provided by a Noncontracting Provider.

Prior Authorization is a request by the Insured’s Contracting Provider to BCI, or delegated entity, for authorization of an Insured’s proposed treatment. BCI may review medical records, test results and other sources of information to ensure that it is a Covered Service and determine whether the proposed treatment meets the standard of Medical Necessity as defined in this Policy.

The Insured is responsible for obtaining Prior Authorization when seeking treatment from a Noncontracting Provider.

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

The Insured is responsible for notifying BCI if the proposed treatment will be provided by a Noncontracting Provider.

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

MEDICAL BENEFITS SECTION

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

I. BENEFIT PERIOD

The Benefit Period is the specified period of time during which an Insured’s benefits for incurred Covered Services accumulate toward benefit limits, Deductible amounts and Out-of-pocket Limits.

II. DEDUCTIBLE

The individual Insured’s Deductible is shown in the Outline of Coverage. The Deductible does not apply to Covered Services, Deductibles or Coinsurance under any other benefit section of this Policy, and Covered Services, Deductibles or Coinsurance under any other benefit section do not apply to this benefit section’s Deductible.

III. OUT-OF-POCKET LIMIT

The Out-of-pocket Limit shall be based upon the Insured’s eligible out-of-pocket expenses incurred during one Benefit Period. Eligible out-of-pocket expenses shall include only the Insured’s Deductible and Coinsurance for eligible Covered Services. Out-of-pocket expenses associated with the following are not eligible for inclusion in the Out-of-pocket Limit:

A. Amounts that exceed the Maximum Allowance;
B. Prescription Drug Covered Services; or

C. Noncovered services or supplies.

The Out-of-pocket Limit is shown in the Outline of Coverage. When an Insured has met the Out-of-pocket Limit, the benefits payable on behalf of the Insured for Covered Services shall increase to one hundred percent (100%) of the Maximum Allowance, during the remainder of the Benefit Period, except for Prescription Drug Covered Services.

IV. COVERED PROVIDERS

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

The following are Covered Providers from whom an Insured must receive Covered Services in order to be entitled to receive benefits under this section:

- Ambulance Transportation Service
- Ambulatory Surgical Facility (Surgery Center)
- Audiologist
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Clinical Nurse Specialist
- Electroencephalogram (EEG) Provider
- Home Intravenous Therapy Company
- Licensed Rehabilitation Hospital
- Lithotripsy Provider
- Dentist/Denturist
- Diagnostic Imaging Provider
- Durable Medical Equipment Supplier
- Freestanding Diabetes Facility
- Freestanding Dialysis Facility
- Home Health Agency
- Independent Laboratory
- Licensed General Hospital
- Licensed Physical Therapist
- Nurse Practitioner
- Optometrist/Optician
- Physician
- Physician Assistant
- Podiatrist
- Prosthetic and Orthotic Supplier
- Radiation Therapy Center
- Skilled Nursing Facility

V. MEDICAL COVERED SERVICES

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

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

Only the following are eligible medical expenses:
A. **AMBULANCE TRANSPORTATION SERVICE**

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

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

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

B. **DENTAL SERVICES RELATED TO ACCIDENTAL INJURY**

Dental services which are rendered by a Physician or Dentist and required as a result of Accidental Injury to the jaw, Sound Natural Tooth, mouth or face. Injuries as a result of chewing or biting and Temporomandibular Joint (TMJ) Disorder are not considered Accidental Injuries. No benefits are available under this section for Orthodontia or orthognathic services.

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

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

C. **DIABETES SELF-MANAGEMENT EDUCATION SERVICES**

The maximum benefit for covered Diabetes Self-Management Education Services is shown in the Outline of Coverage.

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

Approved programs must meet the standards of the ADA; or are supervised by a certified diabetes educator.

D. **DIAGNOSTIC SERVICES**

Diagnostic Services are covered provided such services are not related to Chiropractic Care. Diagnostic Services include mammograms. Pap tests are covered regardless of results. Benefits for Medically Necessary genetic testing are only available when Prior Authorization has been completed.

E. **DURABLE MEDICAL EQUIPMENT**

The lesser of the Maximum Allowance or billed charge for rental (but not to exceed the lesser of the Maximum Allowance or billed charge for the total purchase price) or, at the option of BCI, the purchase of Medically Necessary Durable Medical Equipment required for therapeutic use. The Durable Medical Equipment must be prescribed by an attending Physician or other Professional Provider within the scope of license. No benefits are available for the replacement of any item of Durable Medical Equipment that has been used by an Insured for less than five (5) years (whether or not the item being replaced was covered under this Policy). Benefits shall not exceed the cost of the standard, most economical Durable Medical Equipment that is consistent, according to generally accepted medical treatment practices, with the Insured’s condition. If the Insured and his or her
Provider has chosen a more expensive treatment than is determined to be the standard and most economical by BCI, the excess charge is solely the responsibility of the Insured. Equipment items considered to be common household items are not covered.

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

F. **HOME HEALTH SKILLED NURSING CARE SERVICES**

Services must be Medically Necessary, preauthorized by BCI and the patient’s Physician, and must not constitute Custodial Care. Services must be provided by a Medicare Certified Home Health Agency and limited to intermittent Skilled Nursing Care. The patient’s Physician must review the care at least every thirty (30) days. No benefits are provided during any period of time in which the Insured is receiving Hospice Covered Services.

The percentage of the Maximum Allowance that BCI will pay or otherwise satisfy for Home Health Skilled Nursing Care Covered Services and the benefit limit for such services is shown in the Outline of Coverage.

G. **HOSPITAL SERVICES**

1. **INPATIENT HOSPITAL SERVICES**

   a) **ROOM AND BOARD, AND GENERAL NURSING SERVICE**

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

   (1) A room with two (2) or more beds is covered. If a private room is used, the benefit provided in this section for a room with two (2) or more beds will be applied toward the charge for the private room. Any difference between the charges is a noncovered expense under this Policy and is the sole responsibility of the Insured.

   (2) If isolation of the Insured is: (a) required by the law of a political jurisdiction, or (b) required to prevent contamination of either the Insured or another patient by the Insured, then payment for approved private room isolation charges shall be in place of the benefits for the daily room charge stated in paragraph one (1).

   (3) Benefits for a bed in a Special Care Unit shall be instead of the benefits for the daily room charge stated in paragraph one (1).

   (4) A bed in a nursery unit is covered.

   b) **ANCILLARY SERVICES**

   Licensed General Hospital services and supplies including:

   (1) Use of operating, delivery, cast, and treatment rooms and equipment.

   (2) Prescribed drugs administered while the Insured is an Inpatient.

   (3) Administration and processing of whole blood and blood products when the whole blood or blood products are actually used in a transfusion for an Insured; whole blood or blood plasma that is not donated on behalf of the Insured or replaced through contributions on behalf of the Insured.

   (4) Anesthesia, anesthesia supplies and services rendered by the Licensed General Hospital as a regular hospital service and billed by the same hospital in conjunction with a procedure that is a Covered Service.

   (5) All medical and surgical dressings, supplies, casts, and splints that have been ordered by a Physician and furnished by a Licensed General Hospital. Specially constructed braces and supports are not a Covered Service under this section.

   (6) Oxygen and administration of oxygen.

   (7) Patient convenience items essential for the maintenance of hygiene provided by a Licensed General Hospital as a regular hospital service in connection
with a covered hospital stay. Patient convenience items include, but are not limited to, an admission kit, disposable washbasin, bedpan or urinal, shampoo, toothpaste, toothbrush, and deodorant.

(8) Diagnostic Services and Therapy Services.

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

2. OUTPATIENT HOSPITAL SERVICES
   a) EMERGENCY CARE—Licensed General Hospital services and supplies for the treatment of Accidental Injuries and Emergency Medical Conditions.
   b) SURGERY—Licensed General Hospital or Ambulatory Surgical Facility services and supplies including removal of sutures, anesthesia, anesthesia supplies and services. The furnished supplies and services must be in conjunction with a Covered Service rendered by an employee of one (1) of the above facilities who is not the surgeon or surgical assistant.
   c) THERAPY SERVICES—except for Outpatient Speech Therapy and Outpatient Occupational Therapy.

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

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

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

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

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

H. INVOLUNTARY COMPLICATIONS OF PREGNANCY
Benefits are provided for Covered Services for Involuntary Complications of Pregnancy for the Enrollee or enrolled Eligible Dependent.

1. Cesarean Section Delivery
   Benefits are provided for Covered Hospital and Surgical/Medical Services for cesarean section delivery for the Enrollee or an enrolled Eligible Dependent, subject to the Individual Deductible as shown in the Outline of Coverage for each cesarean section delivery.
2. Subject to the annual Individual Deductible (as shown in the Outline of Coverage), benefits are provided for Covered Services for other Involuntary Complications of Pregnancy for the Enrollee or enrolled Eligible Dependent.

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

a) Ectopic pregnancy that is terminated, spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible (miscarriage), puerperal infection and eclampsia.

b) 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. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Involuntary Complications of Pregnancy does not include false labor, occasional spotting, Physician-prescribed bed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

3. If you have a birth, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child will include forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a cesarean section delivery. Federal law generally does not prohibit the mother’s or newborn’s attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours or ninety-six (96) hours as applicable. For stays in excess of forty-eight (48) hours or ninety-six (96) hours, additional benefits may be available under the terms of Item III., Continued Stay Review, in the Inpatient Notification Section.

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

J. OUTPATIENT PHYSICAL THERAPY SERVICES
For Outpatient Physical Therapy Covered Services rendered by a Covered Provider, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance up to the benefit limit as shown in the Outline of Coverage.

K. POST-MASTECTOMY/LUMPECTOMY RECONSTRUCTIVE SURGERY
Reconstructive Surgery in connection with a Disease related mastectomy/lumpectomy, in a manner determined in consultation with the attending Physician and the Insured, including:

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

L. PRESCRIPTION DRUGS
See the Prescription Drug Benefits Section and the Outline of Coverage regarding Covered Services for Prescription Drugs.

M. PROSTHETIC APPLIANCES
Benefits are provided for the purchase, fitting, necessary adjustment, repair and replacement of Prosthetic Appliances including post-mastectomy prostheses.
Benefits for Prosthetic Appliances are subject to the following limitations:
1. To be eligible for benefits, the Prosthetic Appliance must be preauthorized before the Insured purchases it.
2. In all cases, benefits shall not exceed the cost of the standard, most economical Prosthetic Appliance that is consistent, according to generally accepted medical treatment practices, with the Insured’s condition. If the Insured and his or her Provider have chosen a more expensive treatment than is determined to be the standard and most economical by BCI, the excess charge is solely the responsibility of the Insured.
3. Benefits shall not be provided for dental appliances or major Artificial Organs, including but not limited to, artificial hearts and pancreases.
4. Benefits for a required contact lens or pair of eyeglasses following cataract Surgery shall be limited to the first contact lens or eyeglasses, which must be purchased within ninety (90) days after cataract Surgery.
5. No benefits are provided for the rental or purchase of any synthesized or artificial speech or communication output device or system or any similar device, appliance or computer system designed to provide speech output or to aid an inoperative or unintelligible voice, except for voice boxes used to replace all or part of a surgically removed larynx.

N. SKILLED NURSING FACILITY
Benefits provided to an Inpatient of a Licensed General Hospital are also provided for services and supplies customarily rendered to an Inpatient of a Skilled Nursing Facility. Benefits are provided up to the maximum stay (the number of days for a maximum stay is shown in the Outline of Coverage).

However, no benefits are provided when the care received consists primarily of:
1. Room and board, routine nursing care, training, supervisory, or Custodial Care.
2. Care for senile deterioration, mental deficiency, or mental retardation.
3. Care for Mental or Nervous Conditions, Alcoholism or Substance Abuse or Addiction.

O. SURGICAL/MEDICAL SERVICES
1. SURGICAL SERVICES
   a) SURGERY—Surgery performed by a Physician or other Professional Provider.
   b) MULTIPLE SURGICAL PROCEDURES—benefits for multiple surgical procedures performed during the same operative session by one (1) or more Physicians or other Professional Providers are calculated based upon the Maximum Allowance and payment guidelines.
   c) SURGICAL SUPPLIES—when a Physician or other Professional Provider performs covered Surgery in the office, benefits are available for a sterile suture or Surgery tray normally required for minor surgical procedures.
   d) SURGICAL ASSISTANT—Medically Necessary services rendered by a Physician or other appropriately qualified surgical assistant who actively assists the operating surgeon in the performance of covered Surgery where an assistant is required. The percentage of the Maximum Allowance that is used as the actual Maximum Allowance to calculate the amount of payment under this section for Covered Services rendered by a surgical assistant is twenty percent (20%) for a Physician assistant and ten percent (10%) for other appropriately qualified surgical assistants.
   e) ANESTHESIA—in conjunction with a covered procedure, the administration of anesthesia ordered by the attending Physician and rendered by a Physician or other Professional Provider. General anesthesia administered by the surgeon or assistant surgeon is not a Covered Service. The use of Hypnosis as anesthesia is not a Covered Service.
   f) SECOND AND THIRD SURGICAL OPINION—
      (1) Services consist of a Physician's consultative opinion to verify the need for elective Surgery as first recommended by another Physician.
      (2) Specifications:
(a) Elective Surgery is covered Surgery that may be deferred and is not an emergency.
(b) Use of a second consultant is at the Insured's option.
(c) If the first recommendation for elective Surgery conflicts with the second consultant's opinion, then a third consultant's opinion is a Covered Service.
(d) The third consultant must be a Physician other than the Physician who first recommended elective Surgery or the Physician who was the second consultant.

2. **INPATIENT MEDICAL SERVICES**
Inpatient medical services rendered by a Physician or other Professional Provider to an Insured who is receiving Covered Services in a Licensed General Hospital or Skilled Nursing Facility, provided such services are not related to Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, or Pain Rehabilitation.

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

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

a) **EMERGENCY CARE**—medical care for the treatment of an Accidental Injury or Emergency Medical Condition.

b) **SPECIAL THERAPY SERVICES**—radiation therapy or chemotherapy for a malignancy when such therapy is performed in the Physician's office.

c) **HOME AND OTHER OUTPATIENT VISITS**—medical care for the examination, diagnosis, or treatment of an Accidental Injury, Disease, condition or Illness.

d) **PHYSICIAN OFFICE VISIT**—Physician office medical visits and consultations.

**P. THERAPY SERVICES**
1. **RADIATION THERAPY**
2. **CHEMOTHERAPY**
3. **RENAL DIALYSIS**
4. **RESPIRATORY THERAPY**
5. **PHYSICAL THERAPY**

a) Payment is limited to Physical Therapy Services related to developmental and rehabilitative care, with reasonable expectation that the services will produce measurable improvement in the Insured’s condition in a reasonable period of time. Physical Therapy Services are covered when performed by any of the following:

   (1) A Physician.

   (2) A Licensed Physical Therapist, provided the Covered Services are directly related to a written treatment regimen prepared by the therapist.

   (3) A Podiatrist.

b) No benefits are provided for:

   (1) The following Physical Therapy Services when the specialized skills of a Licensed Physical Therapist are not required:

      (a) Range of motion and passive exercises that are not related to restoration of a specific loss of function but are useful in maintaining range of motion in paralyzed extremities.

      (b) Assistance in walking, such as that provided in support for feeble or unstable patients.
(2) Facility-related charges for Outpatient Physical Therapy Services, health club dues or charges, or Physical Therapy Services provided in a health club, fitness facility or similar setting.

(3) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Physical Therapist.

c) Outpatient Occupational Therapy Services may be eligible for coverage if performed on the hand(s) and/or wrist(s), following Surgery, by a Licensed Occupational Therapist in place of Physical Therapy.

6. INPATIENT OCCUPATIONAL THERAPY ONLY

7. INPATIENT SPEECH THERAPY ONLY
Benefits are limited to Inpatient Speech Therapy services related to developmental and rehabilitation care, where there is a reasonable expectation that the services will produce measurable improvement in the Insured’s condition in a reasonable period of time. Speech Therapy services are covered when performed by either of the following:

a) A Physician.
b) A speech therapist, provided the services are directly related to a written treatment regimen designed by the therapist.

8. ENTEROSTOMAL THERAPY

9. GROWTH HORMONE THERAPY
Benefits for this Therapy Service are only available as preauthorized and approved where Medically Necessary.

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

Benefits for this Therapy are only subject to Prior Authorization and are available when Medically Necessary.

Q. AUTOTRANSPLANT SERVICES

1. AUTOTRANSPLANTS
Benefits are limited to Autotransplants of arteries, veins, ear bones (ossicles), cartilage, muscles, skin and tendons; teeth or tooth buds. The applicable benefits provided for hospital and Surgical/Medical Services are also provided only for a recipient of Medically Necessary Autotransplant Services. Autologous blood transfusion, heart valves, regardless of their source; and implanting of artificial or mechanical pacemakers are not considered Transplants and are a Covered Service if Medically Necessary.

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

a) Transplants of bone marrow, liver, heart, heart/lung combinations, lung, corneas, kidneys, pancreas/kidney combinations, brain tissue or brain membrane, islet tissue, pancreas, intestine, pituitary and adrenal glands, hair Transplants, or any other Transplant not specifically named as a Covered Service in this section; or for Artificial Organs including but not limited to, artificial hearts or pancreases.

b) Any eligible expenses of a donor related to donating or transplanting an organ or tissue, even if the donor is an Insured.

c) The cost of a human organ or tissue that is sold rather than donated to the recipient.

d) Transportation costs including but not limited to, Ambulance Transportation Service or air service for the donor, or to transport a donated organ or tissue.
Living expenses for the recipient, donor, or family members, except as specifically listed as a Covered Service in this Policy.

Costs covered or funded by governmental, foundation or charitable grants or programs; or Physician fees or other charges, if no charge is generally made in the absence of insurance coverage.

Costs related to the search for a suitable donor.

VI. ADDITIONAL AMOUNT OF PAYMENT PROVISIONS
Any amounts remaining unpaid for Covered Services under any other benefit section of this Policy are not eligible for payment under this Medical Benefits Section. Except as specified elsewhere in this Policy, BCI will provide the following benefits for Covered Services after an Insured has satisfied his or her Deductible.

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

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

B. For Covered Services furnished outside the state of Idaho by a Covered Provider, BCI shall provide the benefit payment levels specified in this section according to the following:
1. If the Provider has a Preferred Provider Organization (PPO) agreement for claims payment with the Blue Cross and/or Blue Shield plan in the area where the Covered Services were rendered, BCI will base the payment on the local plan's PPO payment arrangement and allow In-Network benefits. The Provider shall not make an additional charge to an Insured for amounts in excess of BCI’s payment except for Deductibles, Coinsurance, Copayments, and noncovered services.
2. If the Provider does not have a PPO agreement for claims payment with the Blue Cross and/or Blue Shield plan in the area where the Covered Services are rendered, BCI will base payment on the Maximum Allowance and allow out-of-network benefits. The Provider is not obligated to accept BCI’s payment as payment in full. BCI is not responsible for the difference, if any, between BCI’s payment and the actual charge, except as stated elsewhere in this Policy.

C. A contracting Covered Provider rendering Covered Services shall not make an additional charge to an Insured for amounts in excess of BCI’s payment except for Deductibles, Coinsurance, Copayments, and noncovered services.

D. A noncontracting Covered Provider inside or outside the state of Idaho is not obligated to accept BCI’s payment as payment in full. BCI is not responsible for the difference, if any, between BCI’s payment and the actual charge, unless otherwise specified. Insureds are responsible for any such difference, including Deductibles, Coinsurance, Copayments, charges for noncovered services and the amount charged by the noncontracting Covered Provider that is in excess of the Maximum Allowance.

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

VII. BENEFIT MAXIMUM FOR THIS POLICY
The greatest aggregate amount payable by BCI is $1,000,000 for an Insured. When an Insured has reached his or her Benefit Maximum, no further benefits shall be owed or paid to the Insured under this Policy.

PRESCRIPTION DRUG BENEFITS SECTION
This section specifies the benefits an Insured is entitled to receive for Covered Services described in this section, subject to all of the other provisions of this Policy.

I. PRESCRIPTION DRUG DEDUCTIBLE
The Deductible is shown in the Outline of Coverage.

II. COVERED PROVIDERS
The following are Covered Providers under this section:
• Licensed Pharmacist
• Physician

III. DISPENSING LIMITATIONS
Each prescription shall not exceed a ninety (90) day supply at one (1) time. However, prescriptions and Prescription Drugs may be subject to more restrictive quantity limits.

IV. COVERED SERVICES
Prescription Drugs, approved by the Pharmacy and Therapeutics Committee including compounded medications of which at least one (1) ingredient is a Prescription Drug, insulin, and any other drug that, under applicable state law, may be dispensed only upon the written prescription of a Physician. The drugs or medicines must be directly related to the treatment of an Illness, Disease, medical condition or Accidental Injury and must be dispensed by a Licensed Pharmacist or Physician on or after the Insured’s Effective Date. Benefits for Prescription Drugs are available up to the limits stated in Item III. of this section.

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

VI. PREAUTHORIZATION
Certain Prescription Drugs may require preauthorization. If the Insured’s Physician or other Provider prescribes a drug which requires preauthorization, either the Provider or the Pharmacist will inform the Insured that preauthorization is required. To obtain preauthorization the Insured or the Insured’s Physician must notify Blue Cross of Idaho or its designated agent, describing the Medical Necessity for the prescription. Within a reasonable period of time, but not later than fifteen (15) days after BCI or its designated agent, receives a request for preauthorization, BCI or its designated agent, will notify the Insured and/or the attending Provider(s) of its determination, or BCI or its designated agent, may request additional information necessary to make an informed determination.
VII. DEFINITIONS
A. **PHARMACY AND THERAPEUTICS COMMITTEE**—a committee of Physicians and Licensed Pharmacists established by BCI that recommends policy regarding the evaluation, selection, and therapeutic use of various drugs. The Committee also decides which drugs are eligible for benefits under this Policy.

B. **PRESCRIPTION DRUGS**—drugs, biologicals and compounded prescriptions that can be dispensed only according to a written prescription given by a Physician, that are listed and accepted in the *United States Pharmacopeia, National Formulary*, or *AMA Drug Evaluations* published by the American Medical Association (AMA), that are prescribed for human consumption, and that are required by law to bear the legend: “Caution—Federal Law prohibits dispensing without prescription.”

VIII. PHARMACY EXCLUSIONS AND LIMITATIONS
In addition to any other exclusions and limitations of this Policy, the following exclusions and limitations apply to this particular benefit section and throughout the entire Policy, unless otherwise specified.

If an Insured also has a Prescription Drug discount through a manufacturer, coupon, store or discount card program, that Prescription Drug discount will be applied prior to applying the benefit available under this Policy. Prescription Drug benefits are limited to the Insured’s out-of-pocket expenses under the discount Drug program, up to the Prescription Drug benefits available under this Policy.

No benefits are provided for the following:
A. Contraceptives, oral or other, whether medication or device, and regardless of intended use—except for contraceptives that are clearly Medically Necessary for the treatment of a medical condition which requires the use of hormone therapy.

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

C. Over-the-counter drugs other than insulin, even if prescribed by a Physician. Notwithstanding this exclusion, BCI, through the determination of the BCI Pharmacy and Therapeutics Committee may choose to cover certain over-the-counter medications when Prescription Drug benefits are provided under this Policy. Such approved over-the-counter medications must be identified by BCI in writing and will specify the procedures for obtaining benefits for such approved over-the-counter medications. Please note that the fact a particular over-the-counter drug or medication is covered does not require BCI to cover or otherwise pay or reimburse the Insured for any other over-the-counter drug or medication.

D. Charges for the administration or injection of any drug, except influenza and pneumonia vaccinations.

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

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

G. Immunization agents, except influenza and pneumonia vaccinations, biological sera, blood or blood plasma. Benefits may be available under the Medical Benefits Section of this Policy.

H. Medication that is to be taken by or administered to an Insured, in whole or in part, while the Insured is an Inpatient in a Licensed General Hospital, rest home, sanatorium, Skilled Nursing Facility, extended care facility, convalescent hospital, nursing home, or similar institution which operates or allows to operate on its premises, a facility for dispensing pharmaceuticals.
I. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician’s original order.

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

K. Any Prescription Drug, biological or other agent which is:
   1. Prescribed primarily to aid or assist the Insured in the cessation of the use of tobacco.
   2. Prescribed primarily to aid or assist the Insured in weight loss, including all anorectics, whether amphetamine or nonamphetamine.
   3. Prescribed primarily to retard the rate of hair loss or to aid in the replacement of lost hair.
   4. Prescribed primarily to increase fertility, including but not limited to, drugs which induce or enhance ovulation.
   5. Prescribed primarily for personal hygiene, comfort, beautification, or for the purpose of improving appearance.
   6. Prescribed primarily to increase growth, including but not limited to, growth hormone. Benefits are available for this Therapy Service under the Medical Benefits section of this Policy only as preauthorized and when Medically Necessary.
   7. Provided by or under the direction of a Home Intravenous Therapy Company, Home Health Agency or other Provider approved by BCI. Benefits are available for this Therapy Service under the Medical Benefits Section of this Policy only as preauthorized and when Medically Necessary.

DEFINITIONS SECTION

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

ACCIDENTAL INJURY—an objectively demonstrable impairment of bodily function or damage to part of the body caused by trauma sustained by the Insured and occurring at a reasonably identifiable time and place, and without an Insured’s foresight or expectation, which may require medical attention at the time of the accident. The injury may be the result of the injured party’s actions, but must not be intentionally self-inflicted

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

ADVERSE BENEFIT DETERMINATION—any denial, reduction or termination of, or the failure to provide payment for, a benefit for services or ongoing treatment under this Policy.

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

ALCOHOLISM OR SUBSTANCE ABUSE TREATMENT FACILITY—a JCAHO or CARF accredited Facility Provider that is primarily engaged in providing detoxification and rehabilitative care for Alcoholism, or Substance Abuse, or Addiction.

AMBULANCE—a specially designed and equipped vehicle used only for transporting the sick and/or injured.
AMBULATORY SURGICAL FACILITY (Surgery Center)—a Medicare Certified Facility Provider, with a staff of Physicians, which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis.
2. Provides treatment by or under the supervision of Physicians and provides Skilled Nursing Care while the Insured is in the facility.
3. Does not provide Inpatient accommodations appropriate for a stay of longer than twelve (12) hours.
4. Is not primarily a facility used as an office or clinic for the private practice of a Physician or other Professional Provider.

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

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

BENEFIT MAXIMUM—the greatest amount payable by Blue Cross of Idaho, for an Insured under this Policy.

BENEFIT PERIOD—the period of time during which an Insured may receive Covered Services.

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

BLUE CROSS OF IDAHO HEALTH SERVICE, INC. (Blue Cross of Idaho or BCI)—a nonprofit mutual insurance company.

CERTIFIED NURSE MIDWIFE—an individual licensed to practice as a Certified Nurse Midwife.

CERTIFIED REGISTERED NURSE ANESTHETIST—a licensed individual registered as a Certified Registered Nurse Anesthetist.

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

CHIROPRACTIC PHYSICIAN—an individual licensed to practice Chiropractic Care.

CLINICAL NURSE SPECIALIST—an individual licensed to practice as a Clinical Nurse Specialist.

COINSURANCE—the percentage of the Maximum Allowance or the actual charge, whichever is less, an Insured is responsible to pay out-of-pocket for Covered Services after satisfaction of any applicable Deductibles.

COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES (CARF)—an independent, not-for-profit organization, governed by a board that issues accreditation to providers in areas such as behavioral health.

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

CONTRACTING PROVIDER—a Provider that has entered into a written agreement with BCI regarding payment for Covered Services rendered to an Insured under a Preferred Provider Organization (PPO) program.

COPAYMENT—a designated dollar and/or percentage amount separate from Coinsurance that an Insured is financially responsible for and must pay to a Provider at the time certain Covered Services are rendered.
COST EFFECTIVE—A requested or provided medical service or supply that is Medically Necessary in order to identify or treat an Insured’s health condition, illness or injury and that is:

1. Provided in the most cost-appropriate setting consistent with the Insured’s clinical condition and the Covered Provider’s expertise. For example, when applied to services that can be provided in either an Inpatient hospital setting or Outpatient hospital setting, the Cost Effective setting will generally be the outpatient setting. When applied to services that can be provided in a hospital setting or in a physician office setting, the Cost Effective setting will generally be the physician office setting.

2. Not more costly than an alternative service or supply, including no treatment, and at least as likely to produce an equivalent result for the Insured’s condition, disease, illness or injury.

COVERED PROVIDER—a Provider specified in this Policy from whom an Insured must receive Covered Services in order to be eligible to receive benefits.

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

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

DEDUCTIBLE—the amount an Insured is responsible to pay out-of-pocket before BCI begins to pay benefits for Covered Services. The amount credited to the Deductible is based on the Maximum Allowance or the actual charge, whichever is less.

DENTIST—an individual licensed to practice Dentistry.

DENTISTRY OR DENTAL TREATMENT—the treatment of teeth and supporting structures, including but not limited to, the replacement of teeth.

DIAGNOSTIC IMAGING PROVIDER—a Medicare Certified person or entity that is licensed, where required, to render Covered Services.

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

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

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

DURABLE MEDICAL EQUIPMENT—items which can withstand repeated use, are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of Accidental Injury, Disease or Illness, and are appropriate for use in the Insured’s home.

DURABLE MEDICAL EQUIPMENT SUPPLIER—a business that is Medicare Certified and licensed, where required to sell or rent Durable Medical Equipment.

EFFECTIVE DATE—the date when coverage for an Insured begins under this Policy, as specified by BCI on the Enrollee’s identification card.
ELECTROENCEPHALOGRAM (EEG) PROVIDER—a Facility Provider that participates with Medicare and has technologists certified by the American Board of Registration of Electroencephalographic and Evoked Potential Technologies to render Covered Services.

ELIGIBLE DEPENDENT—a dependent who is actually enrolled under the Enrollee’s Policy. Eligibility for enrollment as a dependent is limited to:
1. The Enrollee’s spouse under a legally valid marriage.
2. The Enrollee’s natural child, stepchild, legally adopted child, child placed with the Enrollee for adoption or child for whom the Enrollee or the Enrollee’s spouse has court-appointed guardianship or custody. The child must be:
   a) Under the age of twenty-six (26); or
   b) Medically certified as disabled due to mental handicap or retardation or physical handicap and financially dependent upon the Enrollee for support, regardless of age.

ELIGIBLE INDIVIDUAL—an Idaho resident, individual or dependent of an Idaho resident who is under the age of sixty-five (65) years, is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (Medicare), or a state plan under Title XIX of the Social Security Act (Medicaid) or any successor program, and who does not have other health insurance coverage; or who is a federally eligible individual (one who meets the eligibility criteria set forth in the federal Health Insurance Portability and Accountability Act of 1996 Public Law 104-191, Sec. 2741(b) (HIPAA)). An “Eligible Individual” can be the dependent of an eligible employee, which eligible employee is receiving health insurance benefits subject to the regulation of Title 41, Idaho Code, provided that no Insurer shall be required to issue a Basic, Standard, Catastrophic, or HSA compatible Health Benefit Plan to any individual who is covered under other health insurance coverage.

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

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

EMERGENCY OR MATERNITY ADMISSION NOTIFICATION—notification to BCI of an Emergency Inpatient Admission or an unscheduled maternity admission. See Inpatient Notification Section II.

ENROLLEE—an Eligible Individual whose application has been approved by BCI and who is enrolled for coverage under this Policy and is the Policyholder.

ENROLLMENT CLASS—consists of all individually enrolled Insureds within a specific age or gender category who have the same Policy benefits and provisions, and the same premiums.

FAMILY COVERAGE—the enrollment of an Enrollee and two (2) or more Eligible Dependents under this Policy.

FREESTANDING DIABETES FACILITY—a person or entity that is recognized by the American Diabetes Association to render Covered Services.

FREESTANDING DIALYSIS FACILITY—a Medicare Certified or JCAHO certified Facility Provider that is primarily engaged in providing dialysis treatment, maintenance, or training to patients on an Outpatient or home care basis.

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

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

**HOME HEALTH AGENCY**—any agency or organization that provides Skilled Nursing Care services and other therapeutic services.

**HOME HEALTH SKILLED NURSING CARE SERVICES**—professional nursing services provided to a Homebound Insured that can only be rendered by a licensed registered nurse (R.N.) or a licensed practical nurse (L.P.N.), provided such nurse does not ordinarily reside in the Insured’s household or is not related to the Insured by blood or marriage.

**HOME INTRAVENOUS THERAPY COMPANY**—a Medicare Certified and licensed, where required, pharmacy or other entity that is principally engaged in providing services, medical supplies, and equipment for certain home infusion Therapy Covered Services, to Insureds in their homes or other locations outside of a Licensed General Hospital.

**HOSPICE**—a Medicare Certified public agency or private organization designated specifically to provide services for care and management of terminally ill patients, primarily in the home.

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

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

**IN-NETWORK SERVICES**—Covered Services provided by a Contracting Provider that are generally reimbursed at a higher rate than Out-of-Network Services.

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

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

**INVESTIGATIONAL**—any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes such as length of life, quality of life, and functional ability. A technology is considered investigational if it fails to meet any one (1) of the following criteria:

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

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

**JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO)**—an independent, not-for-profit organization, governed by a board that includes Physicians, nurses, and consumers. JCAHO sets the standards by which health care quality is measured. As a condition of their contract with Blue Cross of Idaho, certain Contracting Providers must be certified by JCAHO.

**LICENSED GENERAL HOSPITAL**—a short term, Acute Care, general hospital that:

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

**LICENSED REHABILITATION HOSPITAL**—a Facility Provider principally engaged in providing diagnostic, therapeutic, and Physical Rehabilitation Services to Insureds on an Inpatient basis.

**LICENSED PHARMACIST**—an individual licensed to practice pharmacy.

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

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

In addition, Maximum Allowance for Covered Services provided by Contracting or Noncontracting Dentists is determined using many factors, including pre-negotiated payment amounts, a calculation of charges submitted by Contracting Idaho Dentists, and/or a calculation of the average charges submitted by all Idaho Dentists.
MEDICALLY NECESSARY (or Medical Necessity)—the Covered Service or supply recommended by the treating Covered Provider to identify or treat an Insured’s condition, Disease, Illness or Accidental Injury and which is determined to be:

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

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

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

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

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

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

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

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

NONCONTRACTING PROVIDER—a Professional Provider or Facility Provider that has not entered into a written agreement with BCI regarding payment for Covered Services rendered to an Insured under a Preferred Provider Organization (PPO) program.

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

OCcupational therapist—an individual licensed to practice occupational therapy.

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

OPTOMETRIST—a person who is licensed and specializes in optometry to examine, measure and treat certain visual defects by means of corrective lenses or other methods that do not require a license as a physician.
ORTHOTIC DEVICES—an rigid or semi-rigid supportive device that restricts or eliminates motion of a weak or diseased body part.

ORTHODONTIA OR ORTHODONTIC TREATMENT—the movement of teeth through bone by means of active orthodontic appliances in order to correct a patient’s malocclusion (misalignment of the teeth).

OUT-OF-NETWORK SERVICES—any Covered Services rendered by a Noncontracting Provider that are generally reimbursed at a lower rate than In-Network Services.

OUT-OF-POCKET LIMIT—the amount of out-of-pocket expenses incurred during one Benefit Period that an Insured is responsible for paying. Eligible out-of-pocket expenses include only the Insured's Deductible and Coinsurance for eligible Covered Services.

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

PAIN REHABILITATION—an intensive Inpatient program administered by qualified health care professionals, under the orders of an attending Physician, to an Insured who is suffering chronic, intractable pain (regardless of its origin) which has failed to respond to medical or surgical treatment. Pain Rehabilitation is intended to teach the Insured how to control and cope with pain and regain normal function.

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

PHYSICAL REHABILITATION PLAN OF TREATMENT—a written plan which describes the services and supplies for the Physical Rehabilitation care and treatment to be provided to an Insured. The written plan must be established and periodically reviewed by an attending Physician.

PHYSICAL THERAPIST—an individual licensed to practice physical therapy.

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

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

PODIATRIST—an individual licensed to practice podiatry.

POLICY—this Policy, which includes only the Outline of Coverage, the enrollee’s enrollment application and identification card, individual enrollment applications, Insured identification cards, any written endorsements, riders, and amendments.

POST-SERVICE CLAIM—any claim for a benefit under this Policy that does not require prior approval or preauthorization before services are rendered.

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

PREEXISTING CONDITION—the existence of:

1. A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the Effective Date of coverage under this Policy; or
2. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the Effective Date of coverage under this Policy; or
3. A pregnancy existing on the Effective Date of coverage under this Policy.

**PREFERRED PROVIDER ORGANIZATION (PPO)**—a health benefit program in which the highest level of benefits is received when the Insured obtains Covered Services from a PPO Provider.

**PRESCRIPTION DRUGS**—drugs, biologicals, and compounded prescriptions that can be dispensed only according to a written prescription given by a Physician, that are listed with approval in the *United States Pharmacopeia, National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that are prescribed for human consumption, and that are required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription."

**PRE-SERVICE CLAIM**—any claim for a benefit under this Policy that requires Prior Authorization before services are rendered.

**PRIOR AUTHORIZATION**—the Provider’s or the Insured’s request to BCI, or delegated entity, for a Medical Necessity determination of an Insured’s proposed treatment. BCI or the delegated entity may review medical records, test results and other sources of information to make the determination. Prior Authorization is not a determination of benefit coverage. Benefit coverage and eligibility for payment is determined by the provisions of this Policy.

**PROSTHETIC AND ORTHOTIC SUPPLIER**—a person or entity that is Medicare Certified and licensed, where required, to render Covered Services.

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

**PROVIDER**—a person or entity that is licensed, where required, to render Covered Services. For the purposes of this Policy, Providers include only the following:

1. **Facility Providers**
   a. Ambulatory Surgical Facility (Surgery Center)
   b. Electroencephalogram (EEG) Provider
   c. Home Intravenous Therapy Company
   d. Licensed Rehabilitation Hospital
   e. Lithotripsy Provider
   f. Diagnostic Imaging Provider
   g. Freestanding Diabetes Facility
   h. Freestanding Dialysis Facility
   i. Home Health Agency
   j. Independent Laboratory
   k. Licensed General Hospital
   l. Prosthetic and Orthotic Supplier
   m. Radiation Therapy Center
   n. Skilled Nursing Facility

2. **Professional Providers**
   a. Ambulance Transportation Service
   b. Audiologist
   c. Certified Nurse Midwife
   d. Certified Registered Nurse Anesthetist
   e. Clinical Nurse Specialist
   f. Dentist/Denturist
   g. Durable Medical Equipment Supplier
   h. Licensed Pharmacist
   i. Licensed Physical Therapist
j. Nurse Practitioner
k. Optometrist
l. Physician
m. Physician Assistant
n. Podiatrist

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

RECOGNIZED TRANSPLANT CENTER—a Licensed General Hospital that meets any of the following criteria:
1. Is approved by the Medicare program for the requested Transplant Covered Services.
2. Is included in the Blue Cross and Blue Shield System's National Transplant Networks.
3. Has arrangements with another Blue Cross and/or Blue Shield Plan for the delivery of the requested Transplant Covered Services, based on appropriate approval criteria established by that Plan.
4. Is approved by BCI based on the recommendation of BCI’s Medical Director.

SINGLE COVERAGE—the enrollment of only the Enrollee under this Policy.

SKILLED NURSING CARE—nursing service that must be furnished by or under the direct supervision of a licensed registered nurse (R.N.) to maximize the safety of an Insured and to achieve the medically desired result according to the orders and direction of an attending Physician. The following components of Skilled Nursing Care distinguish it from Custodial Care, which does not require professional health training:
1. The observation and assessment of the total medical needs of the Insured.
2. The planning, organization, and management of a treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired result.
3. Rendering to the Insured, direct nursing services that require specialized training.

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

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

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

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

SUBSTANCE ABUSE OR ADDICTION—a behavioral or physical disorder manifested by repeated excessive use of a drug or alcohol to the extent that it interferes with an Insured's health, social, or economic functioning.

SURGERY—within the scope of a Provider's license, the performance of:
1. Generally accepted operative and cutting procedures.
2. Endoscopic examinations and other invasive procedures using specialized instruments.
3. The correction of fractures and dislocations.

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

TOTALLY DISABLED (or Total Disability)—as certified in writing by an attending Physician, a condition resulting from Disease, Illness or Accidental Injury causing:
1. An Enrollee’s inability to perform the principal duties of the regular employment or occupation for which the Enrollee is or becomes qualified through education, training, or experience; and the Enrollee is not in fact engaged in any work, profession, or avocation for fees, gain, or profit; or
2. An enrolled Eligible Dependent to be so disabled and impaired as to be unable to engage in the normal activities of an individual of the same age and gender.

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

TWO-PARTY COVERAGE—the enrollment of the Enrollee and one (1) Eligible Dependent under this Policy.

EXCLUSIONS AND LIMITATIONS SECTION

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

I. PREEXISTING CONDITION WAITING PERIOD
No benefits are available under this Policy for services, supplies, drugs, or other charges that are for any Preexisting Condition. If this Policy replaces a prior Blue Cross of Idaho agreement, policy, certificate, or contract, the Insured’s prior continuous membership will not be credited to this Policy’s waiting periods and Deductibles. In addition, the Insured must satisfy all other terms and requirements of this Policy. If an Insured becomes covered under any other agreement, policy, certificate or contract after termination or expiration of this Policy, the Insured must fully satisfy all the terms and requirements of the new agreement, policy, certificate or contract.

II. GENERAL EXCLUSIONS AND LIMITATIONS
There are no benefits provided for services, supplies, drugs, or other charges that are:
A. Not Medically Necessary. If services requiring Prior Authorization by Blue Cross of Idaho are performed by a Contracting Provider and benefits are denied as not Medically Necessary, the cost of
said services are not the financial responsibility of the Insured. However, the Insured could be financially responsible for services found to be not Medically Necessary when provided by a Noncontracting Provider.

B. In excess of the Maximum Allowance.

C. For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an Accidental Injury or unless an attending Physician certifies in writing that the Insured has a non-dental, life-endangering condition which makes hospitalization necessary to safeguard the Insured's health and life.

D. Not prescribed by or upon the direction of a Physician or other Professional Provider; or which are furnished by any individuals or facilities other than Licensed General Hospitals, Physicians, and other Providers.

E. Investigational in nature.

F. Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Insured is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts or under Employer Liability Acts, or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Insured claims such benefits or compensation or recovers losses from a third party.

G. Provided or paid for by any federal governmental entity except when payment under the Policy is expressly required by federal law, or provided or paid for by any state or local governmental entity where its charges therefore would vary, or would be affected by the existence of coverage under the Policy, or for which payment has been made under Medicare Part A and/or Medicare Part B, or would have been made if an Insured had applied for such payment except when payment under this Policy is expressly required by federal law.

H. Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.

I. Furnished by a Provider who is related to the Insured by blood or marriage and who ordinarily dwells in the Insured's household.

J. Received from a dental, vision, or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.

K. For Surgery intended mainly to improve appearance or for complications arising from Surgery intended mainly to improve appearance, except for:
   1. Reconstructive Surgery necessary to treat an Accidental Injury, infection or other Disease of the involved part; or
   2. Reconstructive Surgery to correct Congenital Anomalies in an Insured who is a dependent child.

L. Rendered prior to the Insured's Effective Date; or during an Inpatient admission commencing prior to the Insured's Effective Date.

M. For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance), or convenience items or services even if prescribed by a Physician, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs, spas, hot tubs, whirlpool baths, waterbeds or swimming pools and therapies, including but not limited to, educational, recreational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, homeopathic or naturopathic, massage, or music.
N. For telephone consultations, and all computer or Internet communications; for failure to keep a scheduled visit or appointment; for completion of a claim form; or for personal mileage, transportation, food or lodging expenses or for mileage, transportation, food or lodging expenses billed by a Physician or other Professional Provider.

O. For Outpatient Occupational Therapy, Outpatient Speech Therapy, Inpatient or Outpatient Custodial Care; or for Inpatient or Outpatient services consisting mainly of educational therapy, behavior modification, self-care or self-help training, except as specified as a Covered Service in this Policy.

P. For Inpatient admissions that are primarily for Diagnostic Services, Therapy Services, or Physical Rehabilitation, except as specified in this Policy; or for Inpatient admissions when the Insured is ambulatory and/or confined primarily for bed rest, a special diet, behavioral problems, environmental change or for treatment not requiring continuous bed care or when skilled nursing is not required.

Q. For any cosmetic foot care, including but not limited to, treatment of corns, calluses and toenails (except for surgical care of ingrown or diseased toenails).

R. Related to Dentistry or Dental Treatment, even when Medically Necessary, including but not limited to, dental implants, appliances, or prosthetics, or treatment related to Orthodontia and orthognathic Surgery and any surgical or other treatment of temporomandibular joint syndrome.

S. For hearing aids or examinations for the prescription or fitting of hearing aids.

T. For any treatment of either gender leading to or in connection with transsexual Surgery, gender transformation, sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence, even if related to a medical condition.

U. For orthoptics, eyeglasses or contact lenses or the vision examination for prescribing or fitting eyeglasses or contact lenses.

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

W. Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury, except as specified as a Covered service in this Policy.

X. Furnished by a facility that is primarily a place for treatment of the aged or that is primarily a nursing home, a convalescent home, or a rest home.

Y. For Acute Care, rehabilitative care, diagnostic testing, evaluation or treatment of Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, or for Pain Rehabilitation.

Z. Incurred by an Insured for care or treatment of any condition arising from or related to pregnancy, childbirth, or delivery, except as specified as a Covered Service in this Policy.

AA. For weight control or treatment of obesity or morbid obesity, including but not limited to Surgery for obesity, except when Surgery for obesity is Medically Necessary to control other medical conditions that are eligible for Covered Services under this Policy, and nonsurgical methods have been unsuccessful in treating the obesity. For reversals or revisions of Surgery for obesity, except when required to correct an immediately life-endangering condition.

AB. For use of operating, cast, examination, or treatment rooms or for equipment located in a Contracting or Noncontracting Provider’s office or facility, except for emergency room facility charges in a Licensed General Hospital, unless specified as a Covered Service in this Policy.
AC. For an elective abortion, unless to preserve the life of the female upon whom the abortion is performed.

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

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

AF. For Transplant Services and Artificial Organs, except as specified as a Covered Service in this Policy.

AG. For Chiropractic Care.

AH. For acupuncture.

AI. For surgical procedures that alter the refractive character of the eye, including but not limited to, radial keratotomy, myopic keratomileusis, Laser-In-Situ Keratomileusis (LASIK), and other surgical procedures of the refractive-keratoplasty type, to cure or reduce myopia or astigmatism, even if Medically Necessary. Additionally, reversals, revisions, and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.

AJ. For pastoral, spiritual, and bereavement counseling.

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

AL. For Hospice Home Care.

AM. For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.

AN. Any services or supplies for which an Insured would have no legal obligation to pay in the absence of coverage under this Policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage.

AO. For a routine or periodic mental or physical examination that is not connected with the care and treatment of an actual Illness, Disease or Accidental Injury or for an examination required on account of employment; or related to an occupational injury; for a marriage license; or for insurance, school or camp application; or for sports participation physical; or a screening examination including routine hearing examinations.

AP. For routine or preventive immunizations.

AQ. For breast reduction Surgery or Surgery for gynecomastia.

AR. For nutritional supplements.

AS. For replacements or nutritional formulas, except when administered enterally due to impairment in digestion and absorption of an oral diet and is the sole source of caloric need or nutrition in an Insured.
AT. For vitamins and minerals, unless required through a written prescription and cannot be purchased over the counter.

AU. Any services or supplies furnished by a facility that is primarily a health resort, sanatorium, residential treatment facility, transitional living center, or primarily a place for Outpatient treatment or residential facility care of Mental or Nervous Conditions.

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

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

AX. Provided to a person enrolled as an Eligible Dependent, but who no longer qualifies as an Eligible Dependent due to a change in eligibility status that occurred after enrollment.

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

AZ. Furnished by a Provider or caregiver that is not listed as a Covered Provider, including but not limited to, naturopaths and homeopaths.

AAA. For Outpatient pulmonary and/or cardiac rehabilitation.

AAB. For complications arising from the acceptance or utilization of noncovered services.

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

AAD. For arch supports, orthopedic shoes, and other foot devices.

AAE. For well-baby or well-child care furnished by a Physician or other Professional Provider to an Insured who is not a patient at a Licensed General Hospital or Ambulatory Surgical Facility.

AAF. Contraceptives, oral or other, whether medication or device, except as specified as a Covered Service.

AAG. For wigs and cranial molding helmets.

AAH. For surgical removal of excess skin that is the result of weight loss or gain, including but not limited to association with prior weight reduction (obesity) surgery.

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

GENERAL PROVISIONS SECTION

I. ENTIRE POLICY—CHANGES
This Policy, which includes only the Outline of Coverage, the Enrollee’s application, individual enrollment applications, Insured identification cards, and any written endorsements, riders, amendments, or other written agreements approved in writing by an authorized Blue Cross of Idaho (BCI) officer, is the entire Policy of insurance. No insurance agent, independent producer, or any agent, employee or representative of BCI, other than a BCI officer, may change this Policy or waive any of its provisions. This Policy supplants and replaces any and all previous oral or written agreements, certificates, contracts, policies or representations, which shall have no further force and effect.

II. EFFECTIVE DATE AND EXPIRATION DATE
This Policy is effective at 12:01 a.m., Mountain Time, on the Effective Date specified on the Enrollee’s identification card, provided premiums are paid in accordance with the requirements of this Policy.

This Policy expires at 12:00 midnight, Mountain Time, on the day specified by Blue Cross of Idaho on the Enrollee’s identification card.

III. **ENROLLMENT OF ELIGIBLE DEPENDENTS**

A. An Enrollee’s newborn Dependent, including adopted newborn children who are placed with the adoptive Enrollee within sixty (60) days of the adopted child’s date of birth, are covered under this Policy from and after the date of birth for 60 days.

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

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

B. If the date of adoption or the date of placement for adoption of a child is more than sixty (60) days after the child’s date of birth, the Effective Date of coverage will be the date of adoption or the date of placement for adoption. In this Policy, ‘child’ means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. In this Policy, “placed for adoption” means physical placement in the care of the adoptive Enrollee, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Enrollee signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

In the event that Blue Cross of Idaho cancels this Policy for reasons other than nonpayment of premium or an act of fraud or intentional misrepresentation of a material fact by the Enrollee, pregnancy benefits shall be provided as an extension of benefits as to pregnancy commencing while this Policy is in force and for which benefits would have been payable had this Policy remained in force.

C. **NOTIFICATION OF CHANGE IN ELIGIBILITY STATUS**

An Enrollee must notify BCI in writing within thirty (30) days when an enrolled dependent no longer qualifies as an Eligible Dependent. Coverage for the former enrolled dependent will terminate on the last day of the Benefit Period in which the change in eligibility status occurred.

IV. **TERMINATION OR MODIFICATION OF THIS POLICY**

A. The Enrollee may terminate this Policy with or without cause by sending written notice to BCI. Upon receiving such notice, BCI will cancel this Policy effective on the first day of the next month and issue any applicable refunds.

B. BCI may modify this Policy or its premiums by giving written notice to the Enrollee at least thirty (30) days in advance of the date the modification is effective. Modifications to this Policy must first be approved by the Department of Insurance. Any such modification shall apply to all Policies included in this Enrollment Class. The Enrollee’s payment of the revised premium constitutes acceptance of the modification.

C. BCI may unilaterally terminate this Policy for the Enrollee’s fraud or intentional misrepresentation of a material fact. If this Policy is terminated because of the Enrollee’s fraud or intentional misrepresentation of a material fact, the Enrollee shall not be deemed to be an Eligible Individual for a period of twelve (12) months from the Effective Date of the termination of this Policy and shall not be deemed to have Qualifying Previous Coverage under the Small Employer Health Insurance Availability Act or the Individual Health Insurance Availability Act.
D. BCI may terminate this Policy if premiums are not paid or a payer financial institution returns or refuses to honor a check or ACH draft when presented for payment, constituting nonpayment of premiums.

E. Prior to legal finalization of an adoption, the coverage provided in this Policy for a child placed for adoption with an Enrollee shall continue as it would for a naturally born child of the Enrollee until the first of the following events occurs:
   1. The date the child is removed permanently from placement and the legal obligation terminates; or
   2. The date the Enrollee rescinds, in writing, the agreement of adoption or the agreement assuming financial responsibility.

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

F. Coverage for an Eligible Dependent will terminate on the last day of the Benefit Period in which the Eligible Dependent experiences a change in eligibility status that causes him or her to no longer qualify as an Eligible Dependent.

G. If an Enrollee, Enrollee’s estate or entity cancels this Policy for any reason, BCI shall refund the pro rata portion of the unused collected premium to the beginning of the next monthly billing cycle. As used in this paragraph “unused collected premium” shall mean that portion of any premium collected which is not used, on a pro rata basis to the beginning of the next monthly billing cycle at the time of cancellation, by BCI to insure against loss as there is no risk of loss from the Enrollee or that portion of any collected premium which would not have been collected had the Enrollee paid monthly.

V. BENEFITS AFTER TERMINATION OR EXPIRATION OF THIS CERTIFICATE

A. Termination or expiration of this Policy cancels all of an Insured’s rights hereunder, except as otherwise provided in this section.

B. If all policies in the same Enrollment Class are terminated, an Insured who is Totally Disabled on the day termination is effective shall be entitled to benefits after termination for Covered Services, but only so long as the Insured remains continuously Totally Disabled, or until the end of the Benefit Period in which termination was effective, or until benefits are exhausted, whichever occurs first.

The term Totally Disabled (or Total Disability) means a condition resulting from Disease, Illness or Accidental Injury by reason of which, and as certified in writing by an attending Physician, the Insured is unable to perform the principal duties of any employment or occupation for which the Insured is or becomes qualified by reason of education, training or experience; and the Insured is not in fact engaged in any work, profession or avocation for fees, gain or profit. An Insured is considered Totally Disabled while confined as an Inpatient in a Licensed General Hospital.

C. After the expiration of this Policy, benefits for Covered Services are only available for a limited period of time to an Insured who is being treated as an Inpatient in a Licensed General Hospital, at the time of the expiration of this Policy, for a condition, Accidental Injury, Disease or Illness which commenced during the Benefit Period of this Policy. Benefits for Covered Services are limited to the Inpatient treatment of the condition, Accidental Injury, Disease or Illness causing the hospital confinement. Such benefits shall be available after the expiration date of this Policy for the number of days equal to the Benefit Period of the expired Policy, or until benefits are exhausted, or until the Insured is discharged from the Licensed General Hospital, whichever occurs first.

VI. TERMINATION OF COVERAGE

Termination of this Policy cancels all of an Insured’s rights hereunder.
VII. APPLICABLE LAW
This Policy shall be governed by and interpreted according to the laws of the state of Idaho.

VIII. INQUIRY AND APPEALS PROCEDURES
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 and 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 shall 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 and eighty (180) days after receipt of the Explanation of Benefits. 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:**

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.

IX. REIMBURSEMENT OF BENEFITS PAID BY MISTAKE
If BCI mistakenly pays benefits on behalf of an Enrollee or his or her Eligible Dependent(s) that the Enrollee or his or her Eligible Dependent(s) is not entitled to under this Policy, the Enrollee must reimburse the erroneous benefits to BCI.

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

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

X. SUBROGATION AND REIMBURSEMENT RIGHTS OF BLUE CROSS OF IDAHO
The benefits of this Policy will be available to an Insured when he or she is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereinafter referred to as “third party”). To the extent that such benefits for Covered Services are provided or paid for by Blue Cross of Idaho under this Policy or any other Blue Cross of Idaho plan, agreement, certificate, contract or policy, Blue Cross of Idaho shall be subrogated and succeed to the rights of the Insured or, in the event of the Insured’s death, to the rights of his or her heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Services in such an event, the Insured or his or her personal representative shall furnish Blue Cross of Idaho in writing with the names and addresses of the third party or parties that caused or are responsible, or may have caused or may be responsible for such injury, harm or loss, and all facts and information known to the Insured or his or her personal representative concerning the injury, harm or loss.

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

Subrogation is taking over the Insured’s right to receive payments from other parties. The Insured or his or her legal representative will transfer to Blue Cross of Idaho any rights he or she may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Insured. Thus, Blue Cross of Idaho may initiate litigation at its sole discretion, in the name of the Insured, against any third party or parties. Furthermore, the Insured shall fully cooperate with Blue Cross of Idaho in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice Blue Cross of Idaho’s subrogation rights and efforts. Blue Cross of Idaho will be reimbursed in full for all benefits paid even if the Insured is not made whole or fully compensated by the recovery.

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

The Insured shall pay Blue Cross of Idaho as the first priority, and Blue Cross of Idaho shall have a constructive trust and an equitable lien on, all amounts from any recovery by suit, settlement or otherwise from any third party or parties or from any third party’s or parties’ insurer(s), indemnitor(s) or underwriter(s), to the extent of benefits provided by Blue Cross of Idaho under this Policy, regardless of how the recovery is
allocated (i.e., pain and suffering) and whether the recovery makes the Insured whole. Thus, Blue Cross of Idaho will be reimbursed by the Insured, or his or her legal representative, from monies recovered as a result of the injury, harm or loss or all benefits paid even if the Insured is not made whole or fully compensated by the recovery.

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

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

Blue Cross of Idaho’s subrogation and reimbursement rights shall take priority over the Insured’s rights both for expenses already incurred and paid by Blue Cross of Idaho for Covered Services, and for benefits to be provided or payments to be made by Blue Cross of Idaho in the future on account of the injury, harm or loss giving rise to Blue Cross of Idaho’s subrogation and reimbursement rights. Further, Blue Cross of Idaho’s subrogation and reimbursement rights for incurred expenses and/or future expenses yet to be incurred are primary and take precedence over the rights of the Insured, even if there are deficiencies in any recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Insured and Blue Cross of Idaho.

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

XI. NOTICE
Any notice required under this Policy must be in writing. Notice given to an Enrollee will be sent to the Enrollee’s address as it appears on the records of BCI. Notice given to BCI must be sent to BCI’s address contained in this Policy. BCI or the Enrollee shall give written notice of any change of address.

XII. BENEFITS TO WHICH INSUREDS ARE ENTITLED
A. Subject to all of the terms of this Policy, an Insured is entitled to benefits for Covered Services in the amounts specified in the benefit sections and/or in the Outline of Coverage.

B. Benefits will be provided only when the Insured receives Covered Services while covered under this Policy. Inpatient Covered Services rendered to an Insured by a Licensed General Hospital or other Facility Provider are eligible for benefits only if the Insured’s admission to the Licensed General Hospital or other Facility Provider occurred on or after the Insured’s Effective Date.

C. Benefits will be provided only if Covered Services are prescribed by or performed by or under the direction of a Physician or other Professional Provider.

D. Benefits will be provided only for Covered Services that are furnished by the Covered Providers specified in the benefit sections of this Policy and that are regularly and customarily included in such Covered Providers’ charges.

E. Covered Services are subject to the availability of Licensed General Hospitals and other Facility Providers and the ability of the employees of such Providers and of available Physicians to provide such services. BCI shall not assume nor have any liability for conditions beyond its control, which affect the Insured’s ability to obtain Covered Services.
XIII. NOTICE OF CLAIM
BCI will not be liable under this Policy to provide benefits unless a proper claim is furnished to BCI that shows Covered Services have been rendered to an Insured. A claim must be provided within one (1) year from the date a Covered Service is rendered. The claim must include all the data necessary for BCI to determine benefits.

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

B. As a condition of coverage under this Policy, each Insured authorizes Providers to testify at BCI’s request as to any information regarding the Insured’s medical history, services rendered and treatment received. Any and all provisions of law or professional ethics forbidding such disclosures or testimony are waived by and in behalf of each Insured.

XV. EXCLUSION OF GENERAL DAMAGES
Liability under this Policy or benefits conferred hereunder, including recovery under any claim or breach of this Policy, shall be limited to the actual benefits for Covered Services as provided herein and shall specifically exclude any claim for general damages, including but not limited to, alleged pain, suffering or mental anguish or for economic loss or consequential loss or damages.

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

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

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

XVII. PAYMENT OF BENEFITS
A. BCI is authorized by the Insured to make payments directly to Providers furnishing Covered Services to the Insured for which benefits are provided under this Policy. Notwithstanding this authorization, BCI reserves and shall have the right to make payments directly to the Insured. Except as provided by law, BCI’s right to pay an Insured directly is not assignable by an Insured nor can it be waived without the concurrence of BCI, nor may the right to receive benefits for Covered Services under this Policy be transferred or assigned, either before or after Covered Services are rendered.

B. Once Covered Services are rendered by a Provider, BCI shall not be obliged to honor an Insured’s request not to pay claims submitted by such Provider, and BCI shall have no liability to any person because of its rejection of such request.

XVIII. INSURED/PROVIDER RELATIONSHIP
A. The choice of a Provider is solely the Insured’s.

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

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

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

XX. COORDINATION WITH MEDICARE
Benefits under this Policy will be reduced to the extent such benefits are provided under the provisions of the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended (Medicare).

XXI. DUPLICATE BLUE CROSS AND/OR BLUE SHIELD MEMBERSHIP
If an Insured is enrolled or becomes eligible to enroll under two (2) or more Individual (nongroup) Blue Cross and/or Blue Shield Policies, BCI reserves the right to limit enrollment to one (1) such Individual Policy. The Insured may choose the Individual Policy under which he or she wishes to enroll or remain enrolled.

XXII. MEMBERSHIP, VOTING, ANNUAL MEETING AND PARTICIPATION
The Enrollee, as the policyholder, is a member of BCI and is entitled to vote in person or by proxy at meetings of policyholders. The annual meeting of policyholders of BCI shall be held on the last Friday of April of each year at 2 P.M., at the corporation’s registered office, 3000 East Pine Avenue, Meridian, Idaho. This notice shall be sufficient as to notification of such annual meetings. If any dividends are distributed, the policyholders shall share in them according to the articles of incorporation and bylaws of BCI and under the conditions set by the board of directors of BCI.

XXIII. TIME LIMIT ON CERTAIN DEFENSES
After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred or disability, as defined in the Policy, commencing after the expiration of such two (2) year period.

No claim for loss incurred or disability, as defined in the Policy, commencing after one (1) year from the date of issue of this Policy shall be reduced or denied on the ground that a Disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of coverage of this Policy.

XXIV. INDEPENDENT BLUE CROSS AND BLUE SHIELD PLAN
The Enrollee hereby expressly acknowledges his or her understanding this Policy constitutes a contract solely between the Enrollee and BCI, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the “Association”), permitting BCI to use the Blue Cross and Blue Shield Service Marks in the state of Idaho, and that BCI is not contracting as the agent of the Association. The Enrollee further acknowledges and agrees that he or she has not entered into this Policy based upon representations by any person, entity or organization other than BCI and that no person, entity or organization other than BCI shall be held accountable or liable to the Enrollee for any of BCI’s obligations to the Enrollee created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of BCI other than those obligations created under other provisions of this Policy.
XXV. STATEMENTS
In the absence of fraud, all statements made by an applicant or the policyholder or by an enrolled person shall be deemed representations and not warranties, and no statement made for the purpose of acquiring insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the enrolled person.

XXVI. BLUECARD PAYMENT CALCULATIONS
Under BlueCard, when you obtain health care services outside the geographic area BCI serves, if not covered by a flat Copayment, the amount you pay for Covered Services is calculated on the lower of:
1. The billed charges for your Covered Services, or
2. 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, withholdings, 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 state statute in effect at the time you received your care.

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

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

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

Finally, there are no benefits for services, supplies, drugs or other charges that are provided outside the United States, which if had been provided in the United States, would not be a Covered Service under this Policy.
XXIX. COORDINATION OF THIS POLICY’S BENEFITS WITH OTHER BENEFITS

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

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

A. DEFINITIONS

1. A Contract is any of the following that provides benefits or services for medical or dental care or treatment. If separate Contracts are used to provide coordinated coverage for members of a group, the separate Contracts are considered parts of the same Contract and there is no COB among those separate contracts.
   a) Contract includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
   b) Contract does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefit for non-medical components of long-term care policies; Medicare supplement policies; Medicare or any other federal governmental plans, unless permitted by law.

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

2. This Contract means, in a COB provision, the part of the Contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Contracts. Any other part of the Contract providing health care benefits is separate from this plan. A Contract may apply one (1) COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, any may apply under COB provision to coordinate other benefits.

3. The Order of Benefit Determination Rules determine whether This Contract is a Primary Contract or Secondary Contract when the Insured has health care coverage under more than one (1) Contract. When This Contract is primary, it determines payment for its benefits first before those of any other Contract without considering any other Contract’s benefits. When This Contract is secondary, it determines its benefits after those of another Contract and may reduce the benefits it pays so that all Contract benefits do not exceed One hundred percent (100%) of the total Allowable Expense.

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

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

a) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Contracts provides coverage for private hospital room expenses.

b) If an Insured is covered by two (2) or more Contracts that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

c) If an Insured is covered by two (2) or more Contracts that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees it not an Allowable Expense.

d) If an Insured is covered by one (1) Contract that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Contract that provides its benefits or services on the basis of negotiated fees, the Primary Contract’s payment arrangement shall be the Allowable Expense for all Contracts. However, if the provider has contracted with the Secondary Contract to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Contract’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Contract to determine its benefits.

e) The amount of any benefit reduction by the Primary Contract because a covered person has failed to comply with the Contract provisions is not an Allowable Expense. Examples of these types of Contract provisions include second surgical opinions, pre-certificate of admissions, and preferred provider arrangements.

5. Closed Panel Plan is a Contract that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by BCI, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

6. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

B. ORDER OF BENEFIT DETERMINATION RULES

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

1. The Primary Contract pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Contract.

2. a) Except as provided in Paragraph 2.b) below, a Contract that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Contracts state that the complying Contract is primary.
b) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Contract provided by the Contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

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

4. Each Contract determines its order of benefits using the first of the following rules that apply:
   a) Non-Dependent or Dependent. The Contract that covers the Insured other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Contract and the Contract that covers the Insured as a dependent is the Secondary Contract. However, if the Insured is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Contract covering the Insured as a dependent; and primary to the Contract covering the Insured as other than a dependent (e.g. a retired employee); then the order of benefits between the two Contracts is reversed so that the Contract covering the Insured as an employee, member, policyholder, subscriber or retiree is the Secondary Contract and the other Contract is the Primary Contract.
   b) Dependent Child Covered Under More Than One Contract. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Contract the order of benefits is determined as follows:
      (1) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Contract of the parent whose birthday falls earlier in the calendar year is the Primary Contract; or If both parents have the same birthday, the Contract that has covered the parent the longest is the Primary Contract.
      (2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Contract of that parent has actual knowledge of those terms, that Contract is primary. This rule applies to Contract year commencing after the Contract is given notice of the court decree;
         ii. If a court decree states that both parents are responsible for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) shall determine the order of benefits;
         iii. If a court decree states both parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
         iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            1. The Contract covering the Custodial Parent;
            2. The Contract covering the spouse of the Custodial Parent;
            3. The Contract covering the non-Custodial Parent; and then
For a dependent child covered under more than one Contract of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

c) Active Employee or Retired or Laid-off Employee. The Contract that covers an Insured as an active employee, that is, an employee who is neither laid-off nor retired, is the Primary Contract. The Contract covering that same Insured as a retired or laid-off employee is the Secondary Contract. The same would hold true if an Insured is a dependent of an active employee and that same Insured is a dependent of a retired or laid-off employee. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

d) COBRA or State Continuation Coverage. If an Insured whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Contract, the Contract covering the Insured as an employee, member, subscriber or retiree or covering the Insured as a dependent of an employee, member, subscriber or retiree is the Primary Contract and the COBRA or state or other federal continuation coverage is the Secondary Contract. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

e) Longer or Shorter Length of Coverage. The Contract that covered the Insured as an employee, member, policyholder, subscriber, or retiree longer is the Primary Contract and the Contract that covered the Insured the shorter period of time is the Secondary Contract.

f) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Contracts meeting the definition of Contract. In addition, This Contract will not pay more than it would have paid had it been the Primary Contract.

C. EFFECT ON THE BENEFITS OF THIS CONTRACT

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

2. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Contract and other Closed Panel Plans.

D. FACILITY OF PAYMENT

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

E. **RIGHT OF RECOVERY**

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

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

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

\[Signature\]
Dennis C. Warren
*Vice President*
Account Management
AMENDMENT TO THE BLUE CROSS OF IDAHO INDIVIDUAL POLICIES

On the Policy effective date, the following Blue Cross of Idaho Individual Outline of Coverages and Policies shall be amended as follows:

- Short Term PPO Policy Form No. 3-420 (05/11)
- Short Term PPO Outline of Coverage Form No. 3-419 (05/11)

The OUTLINE OF COVERAGE shall be amended to reflect the following revisions:

1. The following language shall be added to the Outline of Coverage:

   SPANISH (Español): Para obtener asistencia en Español, llame al (208) 331-7347 or (800) 627-1188.
   TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (208) 331-7347 or (800) 627-1188.
   CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (208) 331-7347 or (800) 627-1188.
   NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninissingo, kwiijigo holne' (208) 331-7347 or (800) 627-1188.

The PRIOR AUTHORIZATION SECTION shall be amended as follows:

1. The Prior Authorization Section shall read as follows:

   NOTICE: Prior Authorization is required to determine if the services listed in the Attachment A are Medically Necessary and a Covered Service. If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in Blue Cross of Idaho’s Medical Necessity decision must be resolved by use of the Blue Cross of Idaho appeal process.

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

   Prior Authorization is a request by the Insured’s Contracting Provider to BCI, or delegated entity, for authorization of an Insured’s proposed treatment. BCI may review medical records, test results and other sources of information to ensure that it is a Covered Service and determine whether the proposed treatment meets the standard of Medical Necessity as defined in this Policy.

   The Insured is responsible for obtaining Prior Authorization when seeking treatment from a Noncontracting Provider.

   Please refer to Attachment A of the Outline of Coverage, check the BCI website at www.bcoidaho.com, or call Customer Service at the telephone number listed on the back of the Insured’s Identification Card to determine if the Insured’s proposed services require Prior Authorization. To request Prior Authorization, the Contracting Provider must notify BCI of the Insured’s intent to receive services that require Prior Authorization.

   The Insured is responsible for notifying BCI if the proposed treatment will be provided by a Noncontracting Provider.

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

   Prior Authorization is not a guarantee of payment. It is a pre-service determination of Medical Necessity based on information provided to Blue Cross of Idaho at the time the Prior Authorization request is made. Blue Cross of Idaho retains the right to review the Medical Necessity of services, eligibility of services and benefit limitations and exclusions after services are received.

The MEDICAL BENEFITS SECTION shall be amended as follows:

1. Item V. M. 4. in the Covered Services Section shall read as follows:

   M. PROSTHETIC APPLIANCES
4. Following cataract Surgery or for the treatment of Keratoconsus, benefits for a required contact lens or a pair of eyeglasses are limited to the first contact lens or pair of eyeglasses, which must be purchased within ninety (90) days.

2. Item VI. in the Additional Amount of Payment Provisions shall read as follows:

VI. ADDITIONAL AMOUNT OF PAYMENT PROVISIONS

Any amounts remaining unpaid for Covered Services under any other benefit section of this Policy are not eligible for payment under this Medical Benefits Section. For Covered Services eligible for benefits under more than one benefit section of this Policy, the amount paid for Covered Services may be applied to any benefit limit(s) in each benefit section. Except as specified elsewhere in this Policy, BCI will provide the following benefits for Covered Services after an Insured has satisfied his or her Deductible.

The PRESCRIPTION DRUG BENEFITS SECTION shall be amended as follows:

1. The following language shall be added to the VIII. PHARMACY EXCLUSIONS AND LIMITATIONS section:

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

2. Item VII. B. of the Definitions section shall be amended to read:

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

Wherever the above terms are used in the Policy, the new Definition will apply.

The DEFINITIONS SECTION shall be amended as follows:

1. The following term shall be added:

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

2. The following terms shall be amended to read:

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

• The technology must have final approval from the appropriate government regulatory body. This applies to drugs, biological products, devices, and other products/procedures that must have approval from the U.S. Food and Drug Administration (FDA) or another federal authority before they can be marketed. Interim approval is not sufficient. The condition for which the technology is approved must be the same as that BCI is evaluating.

• The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of current published medical literature and investigations published in peer-reviewed journals. The quality of the studies and consistency of results will be considered. The evidence should demonstrate that the technology can measure or alter physiological changes related to a Disease, injury, Illness, or condition. In addition, there should be evidence that such measurement or alteration affects health outcomes.

• The technology must improve the net health outcome. The technology’s beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.

• The technology must be as beneficial as any established alternatives.

• The technology must show improvement that is attainable outside the investigational setting. Improvements must be demonstrated when used under the usual conditions of medical practice.
If a technology is determined to be investigational, all services specifically associated with the technology, including but not limited to associated procedures, treatments, supplies, devices, equipment, facilities or drugs will also be considered investigational.

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

MEDICALLY NECESSARY (or Medical Necessity)—the Covered Service or supply recommended by the treating Covered Provider to identify or treat an Insured’s condition, Disease, Illness or Accidental Injury and which is determined to be:

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

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

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

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

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

Wherever the above terms are used in the Policy, the new Definition will apply.

The EXCLUSIONS AND LIMITATIONS SECTION shall be amended as follows:

1. The following items in the II. GENERAL EXCLUSIONS AND LIMITATIONS SECTION shall be amended to read:
   AAG. For wigs.
   AAH. For cranial molding helmets, unless used to protect post cranial vault surgery.
   The remaining General Exclusions and Limitations will be re-lettered accordingly – i.e. "AAH" will become "AAG", etc.

The GENERAL PROVISIONS SECTION shall be amended as follows:

1. Items VIII. B. and C. of the INQUIRY AND APPEALS PROCEDURES section shall now read:
   VIII. INQUIRY AND APPEALS PROCEDURES
   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 and eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and the documents in support of such appeals may be submitted by phone or facsimile. The appeal should set forth the reasons why the Insured contends BCI's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

2. After receipt of the appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by a BCI Medical Director, or physician designee. For non-urgent claim appeals, BCI shall 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. A BCI Medical Director who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt.

C. An Insured who wishes to formally appeal a Post-Service 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 and eighty (180) days after receipt of the Explanation of Benefits. 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 by a BCI Medical Director, or physician designee if the appeal requires medical judgment. BCI shall mail a written reply to the Insured within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will list the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible.

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. A BCI Medical Director who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will issue a final decision after consideration of all relevant information, if the appeal requires medical judgment. A final decision on the appeal will be made within thirty (30) days of its receipt. If the appeal does not require medical judgment, a BCI Vice President who did not decide the initial appeal will issue the decision.

Except as amended, the policy shall remain unchanged. This amendment is attached to and forms part of the policy issued to the Enrollees.

In witness whereof, BLUE CROSS OF IDAHO HEALTH SERVICE, INC., by its duly authorized officer, has executed this amendment.
Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID  83707

Dennis C. Warren
Vice President
Account Management

Dennis C. Warren