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Prescription Benefits for Statewide Schools

Prescription Drug Option Cottonwood School District 242 Effective Date September 1st, 2015		**Prescription Benefits for Statewide Schools**
Retail (90 day supply with multiple copays)	**Generic**	You pay $10 copayment
	Preferred Brand Name	You pay $25 copayment
	Non-Preferred Brand Name	You pay $40 copayment
Mail Order (90 day supply with multiple copays)	**Copayment**	Matches Retail
Prescribed Contraceptives	You pay nothing for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Web site, www.bcidaho.com; Deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one (1) time, as applicable to the specific contraceptive drug or supply.	
Out-of-Pocket Limit	**Individual:** You pay $1,000 in Copayments and/or Coinsurance per Benefit Period for a combination of all Prescription Drug charges incurred. **Family:** You pay a combination of $2,000 in Copayments and/or Coinsurance per Benefit Period for a combination of all Prescription Drug charges incurred. *When the Prescription Drug Out-of-Pocket Limit is met, the Prescription Drug Benefits payable will increase to 100% of the Allowed Charge or the Usual Charge for the remainder of the Benefit Period.*	

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Preferred Blue® Dental PPO Plan for Statewide Schools

Summary of Benefits Cottonwood School District 242 Effective Date September 1st, 2015	Preferred Blue® Dental PPO Plan for Statewide Schools Option 1	
Individual/Family Deductible (Deductible applies to In-Network basic, major services, and all Out-of-network services.)	$50/$150	
Individual Benefit Period Maximum	$1,250	
In/Out-of-Network	**In-Network**	**Out-of-Network.**
	By choosing an In-Network provider you pay only coinsurance amounts for allowed charges.	By choosing an Out-of-Network provider you pay your deductible, coinsurance, and are responsible for the difference between what Blue Cross allows and what the Out-of-Network provider charges*
Preventive Services		
Oral Examinations One examination every six months.	You pay nothing of the allowed amount	By choosing an Out-of-Network provider you pay 20% of the allowed amount*
Fluoride One application per benefit period for enrolled eligible dependent children.		
Sealants: Limited to permanent posterior unrestored dentition of eligible dependent children under age 16 and limited to one time per tooth in any three consecutive benefit periods.		
X-rays, Bitewings Once per benefit period.		
X-rays, Complete Mouth Series or Panoramic x-ray One time in any five consecutive benefit periods.		
Prophylaxis (Cleaning) Once every six months. (Regardless of type)		
Basic Services		
Fillings Restorations involving multiple surfaces will be combined and paid according to the number of surfaces treated; same tooth surface restoration is covered once in two benefit periods.	You pay 20% of the allowed amount	By choosing an Out-of-Network provider you pay 30% of the allowed amount*
Extractions		
Root Canal Therapy		
Periodontal Maintenance Once every six months. (Regardless of type)		
Scaling and Root planing Once per quadrant of the mouth every three benefit periods.		
Occlusal Guard One appliance every two benefit periods.		
Osseous Surgery Once per area of the mouth every three years.		
Space Maintainers For enrolled eligible dependent children under age 16.		
Major Services Preauthorization required on all major services		
Bridges, Inlays, Onlays, Crowns, Veneers, and Full or Partial Dentures Five year replacement.	You pay 50% of the allowed amount	By choosing an Out-of-Network provider you pay 60% of the allowed amount*
Dental Implants Including the implant body, implant abutment and implant crown – benefits may be available up to the Maximum Allowance of a standard complete or partial denture, or bridge. Implant body and abutment-limited to once per tooth per lifetime. Implant crown –five year replacement.		

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Preferred Blue® Dental PPO Plan for Statewide Schools

***By choosing an Out-of-Network provider you pay your coinsurance, deductible, and any difference between what Blue Cross of Idaho allows and what the Out-of-Network provider charges.**

This summary describes the general features of this program; it is not a contract. All provisions of the Group Master Plan apply to this program.

Exclusions and Limitations

In addition to any other exclusions and limitations of this Plan, the exclusions and limitations listed below apply to this particular section and throughout the entire Plan, unless otherwise specified. No benefits are available under this Plan for the following:

- Procedures that are not included in the Closed List of Dental Covered Services; or that are not Medically Necessary for the care of a Participant's covered dental condition; or that do not have uniform professional endorsement; or that are Investigative in nature.
- Charges for services that were started prior to the Participant's Effective Date. The following guidelines are used to determine the date when a service is deemed to have been started:
  - For full dentures or partial dentures: the date the final impression is taken.
  - For fixed bridges, crowns, inlays or onlays: the date the teeth are first prepared.
  - For root canal therapy: the later of the date the pulp chamber is opened or the date canals are explored to the apex.
  - For periodontal Surgery: the date the Surgery is actually performed.
  - For all other services: the date the service is performed.
  - For orthodontic services, if benefits are available under this Plan: the date any bands or other appliances are first inserted.
- Cast restorations (crowns, inlays or onlays) for teeth that are restorable by other means (i.e., by amalgam or composite fillings).
- Replacement of an existing crown, inlay or onlay that was installed within the preceding five (5) years or replacement of an existing crown, inlay or onlay that can be repaired.
- Appliances, restorations, or other services provided or performed solely to change, maintain, or restore vertical dimension or occlusion.
- A service for cosmetic purposes, unless necessitated as a result of Accidental Injuries received while the Participant was covered by BCI.
- Services or supplies required to correct a Congenital Anomaly or developmental malformation unless the Participant is a dependent child.
- A partial or full removable denture or fixed bridgework, or the addition of teeth thereto, if involving a replacement or modification of a denture or bridgework that was installed during the preceding five (5) years.
- Orthodontic services and supplies unless otherwise specifically listed in the Closed List of Dental Covered Services.
- Replacement of lost or stolen appliances.
- Ridge augmentation procedures.
- Any procedure, service, or supply other than alveoloplasty or alveolectomy required to prepare the alveolus, maxilla, or mandible for a prosthetic appliance. Excluded services, include but are not limited to, vestibuloplasty, stomatoplasty, and bone grafts (either synthetic or autogenous) to the alveolars, maxilla, or mandible.
- Any procedure, service, or supply required directly or indirectly to treat a muscular, neural, orthopedic or skeletal disorder, dysfunction or Disease of the temporomandibular joint (jaw hinge) and its associated structures, including but not limited to, myofacial pain dysfunction syndrome.
- Orthognathic Surgery, including but not limited to, osteotomy, ostectomy and other services or supplies to augment or reduce the upper or lower jaw.
- Temporary dental services. Charges for temporary services are considered an integral part of the final dental services and are not separately payable.
- Any service, procedure, or supply for which the prognosis for success is not reasonably favorable as determined by BCI.
- Myofunctional therapy; biofeedback procedures; athletic mouth guards; precision of semi-precision attachments; denture duplication; oral hygiene instruction; treatment of jaw fractures; charges for acid etching; or charges for oral cancer screenings which are included in a regular oral examination.
- Diagnostic casts.
- Occlusal adjustments.

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Cottonwood School District 242 Effective Date September 1st, 2015	VISION CARE BENEFITS (VSP) for Statewide Schools - Plan III
For Covered Providers and Services	
Copayment	You pay $0 per eye exam and/or $25 per Frame and Lenses or Medically Necessary Contact Lenses.
Service Frequency Limitations	
Elective—includes basic eye exam and an allowance of $130 in place of benefits for Prescribed Lenses and Frames	You may receive one (1) eye exam and/or one (1) pair of Lenses and/or one (1) Frame or one (1) pair of Medically Necessary Contact Lenses (in lieu of eyeglasses) every twelve (12) months.
Payment for Services Rendered	
Participating VSP Doctor	BCI pays 100% of Maximum Allowance after Copayment
Nonparticipating VSP Doctor **Professional Fees** Eye Exam **Materials—lenses per pair** Single Vision Bifocals, up to Trifocals, up to Frame, up to **Contact Lenses— per pair** (evaluation, materials, and fittings only) **Medically Necessary, up to**	 $45 $48 $65 $90 $45 $120 $250

*The Participating VSP Doctor is responsible for verifying benefits with VSP prior to rendering services. A participant must provide the VCSV Participating Provider sufficient information to verify eligibility. Failure of the participant to provide sufficient information may delay services and may affect benefit payment under the plan.

This summary describes the general features of this program; it is not a contract. All provisions of the Group Master Plan apply to this program.

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Preferred Blue® PPO for Statewide Schools

Summary of Benefits Cottonwood School District 242 Effective September 1, 2015		Preferred Blue® PPO for Statewide Schools	
		In-Network	Out-of-Network
Benefit Period* Deductible (Individual/Family)		$5,000/$10,000	
Coinsurance		You pay 20% of the allowed amount	You pay 40% of the allowed amount
Individual Out-of-Pocket Limit *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)*		$5,500	$8,000
Family Out-of-Pocket Limit *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)*		$11,000	$16,000
COVERED SERVICES *By choosing a non-contracting provider you may be responsible for the difference between what Blue Cross allows and what the non-contracting provider charges. Some services may require prior authorization.*	**In-Network deductible and/or coinsurance payment required before insurance pays?**	**In-Network**	**Out-of-Network**
		The amount you pay	
Allergy Injections	No	You pay a $5 copayment *(if this is the only service provided during the visit)*	You pay 40% of the allowed amount
Ambulance Transportation Services	Yes	You pay 20% of the allowed amount	
Breastfeeding Support and Supply Services (Limited to one (1) breast pump purchase per participant, per benefit period.)	No	You pay nothing of the allowed amount	
Chiropractic Care (Limited to 18 visits combined per participant, per benefit period.)	Yes	You pay 20% of the allowed amount	You pay 50% of the allowed amount
Dental Services Related to Accidental Injury			You pay 40% of the allowed amount
Diabetes Self-Management Education Services (Only for accredited Providers approved by BCI.)	No	You pay a $20 copayment per visit	
Diagnostic Services (Including diagnostic mammogram.)	Yes/No	You pay nothing up to $100 for services in excess of the $100 you pay deductible and coinsurance	
Durable Medical Equipment/ Prosthetic Appliances/ Orthotic Devices	Yes	You pay 20% of the allowed amount	
Emergency Services – Facility Services** (Copayment waived if admitted)	Yes	You pay $100 copayment per hospital outpatient emergency room visit, then you pay 20% of the allowed amount	You pay $100 copayment per hospital outpatient emergency room visit, then you pay 40% of the allowed amount
Emergency Services – Professional Services**	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Home Health Skilled Nursing			
Home Intravenous Therapy	Yes		You pay 80% of the allowed amount

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Preferred Blue® PPO for Statewide Schools

COVERED SERVICES *By choosing a non-contracting provider you may be responsible for the difference between what Blue Cross allows and what the non-contracting provider charges. Some services may require prior authorization.*		In-Network deductible and/or coinsurance payment required before insurance pays?	In-Network	Out-of-Network
			The amount you pay	
Hospice Services		No	You pay nothing of the allowed amount	You pay 40% of the allowed amount
Hospital Services (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)		Yes	You pay 20% of the allowed amount	
Inpatient Physical Rehabilitation		Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Maternity Services and/or Involuntary Complications of Pregnancy		Yes		
Mental Health– Inpatient (Facility and Professional Services)				
Mental Health– Outpatient	**Psychotherapy Services**	No	You pay a $20 copayment per visit	
	Facility and other Professional Services	Yes	You pay 20% of the allowed amount	
Morbid Obesity ($5,000 combined lifetime benefit limit, per participant.)				
Outpatient Rehabilitation and Habilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per participant, per benefit period.)		Yes		
Physician Office Visit (Other services rendered during a physician office visit will be subject to deductible and coinsurance.)		No	You pay a $20 copayment per visit	
Post Mastectomy Reconstructive Surgery		Yes	You pay 20% of the allowed amount	
Skilled Nursing Facility (Limited to 30 days combined per participant, per benefit period)				
Surgical/Medical (Professional Services)				
Therapy Services (Including chemotherapy, enterostomal therapy, growth hormone therapy, radiation, renal dialysis, respiratory therapy, and inpatient occupational therapy.)				
Transplant Services				
Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)		No	You pay nothing of the allowed amount	
Preventive Care Benefits (See Plan for specifically listed preventive care services)		Yes/No	You pay nothing for services specifically listed. For services not specifically listed, you pay deductible and coinsurance	
Immunizations (See Plan for specifically listed immunizations)		No	You pay nothing for listed immunizations	

*The specified period of time during which charges for covered services must be incurred in order to accumulate toward annual benefit limits, deductible amounts and out-of-pocket limits.

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 Participant is stabilized and is no longer receiving emergency care the Participant (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 Participant is required to transfer, transportation to the Contracting Facility Provider will be a Covered Service under the Ambulance Transportation Service provision of this Plan.

This summary describes the general features of this program; it is not a contract.
All provisions of the Group Master Plan apply to this program
Noncontracting providers may bill you for amounts over the maximum allowance.

SUMMARY OF GENERAL EXCLUSIONS AND LIMITATIONS

No benefits will be provided for services, supplies, drugs or other charges that are:

- Not medically necessary. If services requiring prior authorization by Blue Cross of Idaho are performed by a contracting provider and benefits are denied as not medically necessary, the cost of said services are not the financial responsibility of the participant. However, the participant could be financially responsible for services found to be not medically necessary when provided by a noncontracting provider.
- In excess of the maximum allowance.
- For hospital inpatient or outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an accidental injury or unless an attending physician certifies in writing that the participant has a non-dental, life-endangering condition which makes hospitalization necessary to safeguard the participant's health and life.
- 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.
- Investigational in nature.
- Provided for any condition, disease, illness or accidental injury to the extent that the participant is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal workers' compensation acts, or under employer liability acts, or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the participant claims such benefits or compensation, or recovers losses from a third party.
- Provided or paid for by any federal governmental entity except when payment under the Plan is expressly required by federal law, or provided or paid for by any state or local governmental entity where its charges therefore would vary, or would be affected by the existence of coverage under the Plan.
- Provided for any condition, accidental injury, disease or illness suffered as a result of any act of war or any war, declared or undeclared.
- Furnished by a provider who is related to the participant by blood or marriage and who ordinarily dwells in the participant's household.
- Received from a dental, vision, or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- For surgery intended mainly to improve appearance or for complications arising from surgery intended mainly to improve appearance, except for:
    - Reconstructive surgery necessary to treat an accidental injury, infection, or other disease of the involved part; or
    - Reconstructive surgery to correct congenital anomalies in a participant who is a dependent child.
    - Benefits for reconstructive surgery to correct an accidental injury are available even though the accident occurred while the participant was covered under a prior insurer's coverage.
- Rendered prior to the participant's effective date.
- 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.
- For telephone consultations; and all computer or internet communications, except as specified as a Covered Service in this Plan.
- For failure to keep a scheduled visit or appointment; 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.
- For inpatient admissions that are primarily for diagnostic services or therapy services; or for inpatient admissions when the participant is ambulatory and/or confined primarily for bed rest, special diet, behavioral problems, environmental change, or for treatment not requiring continuous bed care.
- For inpatient or outpatient custodial care; or for inpatient or outpatient services consisting mainly of educational therapy, behavioral modification, self-care or self-help training, except as specified as a covered service in the Plan.
- For any cosmetic foot care, including but not limited to, treatment of corns, calluses, and toenails (except for surgical care of ingrown or diseased toenails).
- Related to dentistry or dental treatment, even if related to a medical condition; or orthoptics, eyeglasses or contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses, unless specified as a covered service in the Plan.
- For hearing aids or examinations for the prescription or fitting of hearing aids.
- 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.
- Made by a licensed general hospital for the participant's failure to vacate a room on or before the licensed general hospital's established discharge hour.
- Not directly related to the care and treatment of an actual condition, illness, disease or accidental injury.
- Furnished by a facility that is primarily a place for treatment of the aged or that is primarily a nursing home, a convalescent home, or a rest home.
- For acute care, rehabilitative care, diagnostic testing except as specified as a covered service in this Plan; for mental or nervous conditions and substance abuse or addiction services not recognized by the American Psychiatric and American Psychological Associations.
- For any of the following:
    - For appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a covered service in this Plan;
    - For orthognathic Surgery, including services and supplies to augment or reduce the upper or lower jaw;
    - For implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies;
    - For alveolectomy or alveoloplasty when related to tooth extraction
- For weight control or treatment of obesity or morbid obesity, even if medically necessary, including but not limited to surgery for obesity, except as specifically provided as a covered service in this plan.
- 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 Plan.
- For the reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties.
- Treatment for infertility and fertilization procedures, including but not limited to, ovulation induction procedures and pharmaceuticals, artificial insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance a participant's reproductive ability, including but not limited to laboratory services, radiology services or similar services related to treatment for fertility or fertilization procedures.
- For transplant services and artificial organs, except as specified as a covered service under the Plan.
- For acupuncture.
- For surgical procedures that alter the refractive character of the eye, including but not limited to, radial keratotomy, myopic keratomileusis, laser-in-situ keratomileusis (lasik), and other surgical procedures of the refractive-keratoplasty type, to cure or reduce myopia or astigmatism, even if medically necessary, unless specified as a covered service in a vision benefits section of the Plan, if any. Additionally, reversals, revisions, and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.
- For hospice, except as specified as a covered service in the Plan.
- For pastoral, spiritual, bereavement, or marriage counseling.
- For homemaker and housekeeping services or home-delivered meals.
- For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation unless such injuries are a result of a medical condition or domestic violence.
- For treatment or other health care of any participant in connection with an illness, disease, accidental injury or other condition which would otherwise entitle the participant to covered services under the Plan, if and to the extent those benefits are payable to or due the participant under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's, or other similar Plan of insurance, contract, or underwriting plan.
- In the event Blue Cross of Idaho (BCI) for any reason makes payment for or otherwise provides benefits excluded by the above provisions, it shall succeed to the rights of payment or reimbursement of the compensated provider, the participant, and the participant's heirs and personal representative against all insurers, underwriters, self-insurers, or other such obligors contractually liable or obliged to the participant, or his or her estate for such services, supplies, drugs or other charges so provided by BCI in connection with such illness, disease, accidental injury or other condition.
- Any services or supplies for which a participant would have no legal obligation to pay in the absence of coverage under the Plan or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage of for which reimbursement or payment is contemplated under an agreement entered into with a third party.
- For a routine or periodic mental or physical examination that is not connected with the care and treatment of an actual illness, disease or accidental injury or for an examination required on account of employment; or related to an occupational injury; for a marriage license; or for insurance, school or camp application; or for sports participation physicals; or a screening examination including routine hearing examinations, unless specified as a covered service under the Plan.
- For immunizations except as provided as a covered service in the Plan.
- For breast reduction surgery or surgery for gynecomastia.
- For nutritional supplements.
- For replacements or nutritional formulas except, when administered enterally due to impairment in digestion and absorption of an oral diet and is the sole source of caloric need or nutrition in a participant.
- For vitamins and minerals, unless required through a written prescription and cannot be purchased over the counter.
- For an elective abortion, except to preserve the life of the female upon whom the abortion is performed, unless benefits for an elective abortion are specifically provided by a separate endorsement to the Plan.
- For alterations or modifications to a home or vehicle.
- For special clothing, including shoes (unless permanently attached to a brace).
- Provided to a person enrolled as an eligible dependent, but who no longer qualifies as an eligible dependent due to a change in eligibility status that occurred after enrollment.
- Provided outside the United States, which if had been provided in the United States, would not be a covered service under the Plan.
- For outpatient pulmonary and/or cardiac rehabilitation.
- For complications arising from the acceptance or utilization of noncovered services.
- For the use of hypnosis, as anesthesia or other treatment, except as specified as a covered service.
- For dental implants, appliances, (with the exception of sleep apnea devices) and/or prosthetics, and/or treatment related to orthodontia, even when medically necessary, unless specified as a covered service in the Plan.
- For arch supports, orthopedic shoes, and other foot devices.
- For wigs.
- For cranial molding helmets, unless used to protect post cranial vault surgery.
- For surgical removal of excess skin that is the result of weight loss or gain, including but not limited to association with prior weight reduction (obesity) surgery.
- For the purchase of therapy or service dogs/animals and the cost of training/maintaining said animals.