Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

HSA Blue℠ PPO for Statewide Schools Economy Option

Summary of Benefits Lapwai School District #341 **Effective Date September 1, 2017**		**HSA Blue℠ PPO for Statewide Schools**	
		In-Network	**Out-of-Network**
Benefit Period* Aggregate Deductible (The Individual/Family, applies to benefits below unless noted.)		$3,000/$6,000	
Coinsurance (Applies to benefits below unless noted.)		You pay 30% of the allowed amount	You pay 50% of the allowed amount
Out-of-Pocket Limit *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)*		$5,800/$11,600	
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	
Ambulance Transportation Services	Yes	You pay 30% of the allowed amount	You pay 50% 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	You pay 50% of the allowed amount
Chiropractic Care (Limited to 18 visits combined per participant, per benefit period.)	Yes	You pay 30% of the allowed amount	You pay 50% of the allowed amount
Dental Services Related to Accidental Injury			
Diabetes Self-Management Education Services (Only for accredited Providers approved by BCI.)			
Diagnostic Services (Including diagnostic mammogram.)			
Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances			
Emergency Services– Facility Services** (Copayment waived if admitted)	Yes	You pay $100 copayment per hospital Outpatient emergency room visit, then you pay 30% of the allowed amount	You pay $100 copayment per hospital Outpatient emergency room visit, then you pay 50% of the allowed amount
Emergency Services – Professional Services**	Yes	You pay 30% of the allowed amount	You pay 50% of the allowed amount
Home Health Skilled Nursing			
Home Intravenous Therapy			You pay 80% of the allowed amount
Hospice Services	Yes	You pay nothing of allowed amount	You pay 50% of the allowed amount
Hospital Services (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)	Yes	You pay 30% of the allowed amount	
Immunizations (See Plan for specifically listed immunizations.)	No	You pay nothing for listed immunizations	
Maternity Services and/or Involuntary Complications of Pregnancy	Yes	You pay 30% of the allowed amount	You pay 50% of the allowed amount
Medical Services (Inpatient and outpatient)			
Mental Health– Inpatient and Outpatient (Facility and Professional Services)			

Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

HSA Blue℠ PPO for Statewide Schools Economy Option

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	
Outpatient Habilitation Therapy Services (Includes physical, speech & occupational therapies. Limited to 20 visits combined per participant, per benefit period.)	Yes	You pay 50% of the allowed amount	You pay 80% of the allowed amount
Outpatient Rehabilitation Therapy Services (Includes physical, speech & occupational therapies. Limited to 20 visits combined per participant, per benefit period.)			
Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)	No	You pay nothing of the allowed amount	You pay 50% of the allowed amount
Physician Office Visits	Yes	You pay 30% of the allowed amount	You pay 50% of the allowed amount
Post Mastectomy Reconstructive Surgery			
Preventive Care Services (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	
Rehabilitation or Habilitation Services	Yes	You pay 30% of the allowed amount	
Skilled Nursing Facility (Limited to 30 days combined per participant, per benefit period.)			
Surgical Services			
Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.)			
Transplant Services			

*One family member will not accumulate more than the individual deductible or out-of-pocket maximum toward the family deductible or out-of-pocket maximum. After one family member has met the individual deductible, benefits begin for that person. After the family deductible has been met, benefits begin for all family members.

****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.

PRESCRIPTION DRUG BENEFITS *(Prescription Drug Services apply to the Out-of-Pocket Limits.)*	
RETAIL OR BCI MAIL ORDER PHARMACIES	
Generic Prescription Drugs **Preferred Brand Name Prescription Drugs** **Non-Preferred Brand Name Prescription Drugs**	You pay 30% of Maximum Allowance after the In-Network Individual/Family Deductible is met
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.

Note: Certain Prescription Drugs have generic equivalents. If the Insured requests a Brand Name Drug, the Insured is responsible for the difference between the price of the Generic Drug and the Brand Name Drug, regardless of the Preferred or Non-Preferred status.

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. For reversals or revisions of surgery for obesity, except when required to correct a life-endangering condition, except as specifically listed 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.