

# Group Policy

# ENROLLEE CERTIFICATE

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**Coldwater Creek  
PPO**

***Effective Date: July 1, 2009***

***Benefit Period: January 1 through December 31***



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

# ASC PREFERRED BLUE MASTER GROUP PLAN BENEFITS OUTLINE

This Benefits Outline describes the benefits of this Plan in general terms. It is important to read the Plan in full for specific and detailed information that includes additional exclusions and limitations on benefits. Your manager of employee benefits should be able to help if you have questions.

Throughout this Plan, Blue Cross of Idaho may be referred to as BCI. For Covered Services under the terms of this Plan, 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.

To locate a Contracting Provider in your area, please visit the BCI Web site at [www.bcidaho.com](http://www.bcidaho.com). Click on "Find a Provider" under "TOOLS" and you will be taken to our searchable Directory. You may also call our Customer Services Department at 208-331-7347 or 800-627-1188 for assistance in locating a Provider.

## ELIGIBILITY AND ENROLLMENT

EE1c asclg/01/04

To qualify as an Eligible Person under this Plan, a person must be and remain a full-time employee, sole proprietor, or partner of the Group who regularly works at least 32 hours per week and is paid on a regular, periodic basis through the Group's payroll system. (see the Plan for additional Eligibility and Enrollment provisions)

## PROBATIONARY PERIOD

PP1c asc /01/04

The Group will determine if there are certain probationary periods that must be satisfied before a new Eligible Person can qualify for coverage under this Plan. Please contact your manager of employee benefits for the probationary period applicable to you.

**Note: In order to receive maximum benefits, some covered services require Emergency Admission Notification, NonEmergency Preadmission Notification, and/or Prior Authorization. Please review the Inpatient Admission Notification Section and/or the Prior Authorization Section of your Plan and Attachment A to this Benefits Outline for specific details.**

Insureds should check with BCI to determine if the treatment or service being considered requires Prior Authorization. All Inpatient Admissions and Emergency Admissions require Inpatient Notification Review or Emergency Admission Review, as appropriate.

If an Insured chooses a Noncontracting or a nonparticipating Provider, the Insured may be responsible for any charges that exceed the Maximum Allowance.

**COMPREHENSIVE MAJOR MEDICAL BENEFITS**

<p><b>Deductibles:</b> Individual</p>	<p><b>Hourly</b> Insured pays first \$250 of eligible expenses per Benefit Period, except for In-Network Physician Office Visits</p> <p><b>Salary</b> Insured pays first \$500 of eligible expenses per Benefit Period, except for In-Network Physician Office Visits</p>
<p>Family</p>	<p><b>Hourly</b> Insureds pay a combination of \$500 of eligible expenses for all Insureds under same Family Coverage per Benefit Period, except for In-Network Physician Office Visits (<i>No Insured may contribute more than the Individual Deductible amount toward the Family Deductible</i>)</p> <p><b>Salary</b> Insureds pay a combination of \$1,000 of eligible expenses for all Insureds under same Family Coverage per Benefit Period, except for In-Network Physician Office Visits (<i>No Insured may contribute more than the Individual Deductible amount toward the Family Deductible</i>)</p>
<p><b>Out-of-pocket Limit</b> (see Plan for services that do not apply to the limit)</p>	<p><b>In-Network and Out-of-Network Combined</b></p> <p><b>Hourly</b> Individual pays \$2,250 of eligible expenses per Benefit Period Family pays \$4,500 of eligible expenses per Benefit Period <b>(includes Deductible and Coinsurance)</b></p> <p><i>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 In-Network Covered Services that require a Copayment, dental care, vision care, and Prescription Drug Covered Services.</i></p> <p><b>Salary</b> Individual pays \$2,500 of eligible expenses per Benefit Period Family pays \$5,000 of eligible expenses per Benefit Period <b>(includes Deductible and Coinsurance)</b></p> <p><i>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 In-Network Covered Services that require a Copayment, dental care, vision care, and Prescription Drug Covered Services.</i></p>
<p><b>Comprehensive Lifetime Benefit Limit</b></p>	<p>Plan pays up to \$1,000,000 on behalf of an Insured for all combined Covered Services. Payments applied toward specific Lifetime Benefit Limits also apply toward the all-inclusive Comprehensive Lifetime Benefit Limit.</p>

<b>SERVICES BCI COVERS</b>	<b>AMOUNT OF PAYMENT</b>	
	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Allergy Injections</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Insured pays \$5 Copayment per visit if this is the only service provided during the visit	Plan pays 70% of Maximum Allowance after Deductible
<b>Ambulance Transportation Service</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible
<b>Chiropractic Care Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible
	(up to a combined total of \$800 per Insured, per Benefit Period)	
<b>Dental Services Related to Accidental Injury</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible
<b>Diabetes Self-Management Education Services</b> (Only for Providers approved by BCI)	<b>In-Network</b>	<b>Out-of-Network</b>
	Insured pays \$25 Copayment per visit  (Plan pays up to \$500 per Insured, per Benefit Period)	No benefits
<b>Diagnostic Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible
<b>Durable Medical Equipment</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible

	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Emergency Services</b> <i>(see the Plan for services and conditions that affect continuing benefit payments)</i>	Plan pays 80% of Maximum Allowance after Deductible (Contracting and Noncontracting Facility Providers and Facility-based Professional Providers Only)	Plan pays 70% of Maximum Allowance after Deductible
<b>Home Health Skilled Nursing Care Services</b>	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible
	(up to a combined total of \$5,000 per Insured, per Benefit Period)	
<b>Home Intravenous Therapy</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	No benefits
<b>Hospice Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 100% of Maximum Allowance (Deductible does not apply)  (Lifetime Benefit Limit is \$10,000 per Insured)	No benefits
<b>Hospital Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible
<b>Inpatient Physical Rehabilitation Care</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible  (Lifetime Benefit Limit is \$150,000 per Insured)	No benefits
<b>Maternity Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible
<b>Orthotic Devices</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible

<b>Outpatient Rehabilitation Therapy Services</b> <ul style="list-style-type: none"> <li>• Outpatient Occupational Therapy</li> <li>• Outpatient Physical Therapy</li> <li>• Outpatient Speech Therapy</li> </ul>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 50% of Maximum Allowance after Deductible  (up to \$2,000 per Insured, per Benefit Period)	No benefits
<b>Physician Office Visits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	\$25 Copayment per visit (any additional services, such as treatment and diagnosis of Mental/Nervous Conditions, or lab, x-ray, and other Diagnostic Services are subject to Deductible and Coinsurance)	Plan pays 70% of Maximum Allowance after Deductible
<b>Post-Mastectomy/Lumpectomy Reconstructive Surgery</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible
<b>Prosthetic Appliances</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible
<b>Psychiatric Inpatient Services</b> <i>(Facility and Professional Services)</i>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible  (up to 10 days per Insured, per Benefit Period)	No benefits
<b>Psychiatric Outpatient Services</b> <i>(Facility and Professional Services)</i>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 50% of Maximum Allowance after Deductible  (up to 18 visits per Insured, per Benefit Period)	No benefits
<b>Skilled Nursing Facility</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible
	(up to 30 days per Insured, per Benefit Period)	

<b>Selected Therapy Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible
<b>Surgical/Medical (Professional Services)</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible
<b>Transplant Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible

### PREVENTIVE CARE BENEFITS

	<b>In-Network</b>	<b>Out-of-Network</b>
<p><b>For specifically listed Covered Services</b>  <i>Annual adult physical examinations; routine or scheduled well-baby and well-child examinations; Bone Density; Chemistry Panels; Cholesterol Screening; Colorectal Cancer Screening (Colonoscopy, Sigmoidoscopy, Fecal Occult Blood Test); Complete Blood Count (CBC); Diabetes Screening; Pap Test; PKU; PSA Test; Rubella; Screening EKG; Screening Mammogram; Thyroid Stimulating Hormone (TSH); Transmittable Diseases Screening (Chlamydia, Gonorrhea, HIV, Syphilis, Tuberculosis (TB)); Urinalysis (UA)</i></p>	<p><b>BCI pays 100% of the Maximum Allowance</b>                      (up to \$500 per Insured, per Benefit Period)  <i>(for services in excess of the above limit, Deductible and Coinsurance apply)</i></p>	No benefits
<p><b>For services not specifically listed</b></p>	BCI pays 80% of Maximum Allowance after Deductible	No benefits
	<b>In-Network</b>	<b>Out-of-Network</b>
<p><b>Immunizations</b>  <i>Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rotavirus, Rubella, Tetanus, Varicella (Chicken Pox)</i></p> <p>Other immunizations not specifically listed may be covered at the discretion of BCI when Medically Necessary.</p> <p>There are no benefits for travel vaccines</p>	<p>Listed immunizations require no Copayment, Deductible, or Coinsurance</p> <p>BCI pays 80% of Maximum Allowance after Deductible</p>	No benefits

**PRESCRIPTION DRUG BENEFITS**

<p><b>Tier 1: Generic Drugs</b></p> <p><b>Tier 2: Formulary Brand Name Drugs</b></p> <p><b>Tier 3: Non-Formulary Brand Name Drugs</b></p> <p><b>Note:</b> Certain prescription drugs have generic equivalents. If the Member requests a Brand Name Drug, the Member is responsible for the difference between the price of the Generic Drug and the Brand Name Drug, regardless of the Formulary or Non-Formulary status.</p>	<p>Insured pays \$0 per prescription</p> <p>Insured pays \$30 per prescription</p> <p>Insured pays \$50 per prescription</p>
<p><b>BCI Approved Mail Order Participating Pharmacy</b></p> <p><b>Tier 1: Generic Drugs</b></p> <p><b>Tier 2:Formulary Brand Name Drugs</b></p> <p><b>Tier 3: Non-Formulary Brand Name Drugs</b></p> <p><b>Note:</b> Certain prescription drugs have generic equivalents. If the Member requests a Brand Name Drug, the Member is responsible for the difference between the price of the Generic Drug and the Brand Name Drug, regardless of the Formulary or Non-Formulary status.</p>	<p>Insured pays \$8 per prescription</p> <p>Insured pays \$30per prescription</p> <p>Insured pays \$50 per prescription</p>
<p><b>Smoking Cessation</b></p>	<p>BCI pays up to \$600 per Insured, per Benefit Period (benefits are limited to a 30-day supply at one time)</p>

**DENTAL CARE BENEFITS**

Please Note: The Member will receive maximum benefits for Covered Services from a dental PPO Contracting Provider

<p><b>For Covered Providers and Services</b></p> <p><b>Benefit Limit</b></p> <p><b>Orthodontic Lifetime Limit</b></p> <p><b>Deductible:</b></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	<p>\$1,500 per Insured, per Benefit Period</p> <p>\$1,000 per Insured</p> <p>Insured pays \$50 per Benefit Period</p> <p>The Family Deductible is satisfied after three (3) Insureds of the same family have met their Individual Deductible (No Insured may contribute more than the Individual Deductible amount toward the Family Deductible)</p>
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<b>Preventive Services</b>	BCI pays 100% of Maximum Allowance
<b>Basic Services</b>	BCI pays 80% of Maximum Allowance after Deductible
<b>Major Services</b>	BCI pays 50% of Maximum Allowance after Deductible
<b>Orthodontic Services</b> (for eligible dependent children)	Plan pays 50% of Maximum Allowance

**Attachment A:**  
**NON-EMERGENCY SERVICES REQUIRING PRIOR AUTHORIZATION ANNUAL NOTICE**  
**EFFECTIVE: January 1, 2009**

**NOTICE:** *The Medical Necessity of Covered Services listed below should be determined to be eligible for benefits under the terms of this Plan. 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](http://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 in our outside the state of Idaho: (not applicable for inpatient services)
  - Magnetic Resonance Imaging (MRI)
  - Magnetic Resonance Angiography (MRA)
  - Computed Tomography Scans (CT Scan)
  - Positron Emission Tomography (PET)

**Other Services**

- Inpatient stays that originate from an Outpatient service.
- Diabetes self management education
- Home intravenous therapy
- Non-emergent ambulance
- Certain prescription drugs (including drugs that cost five hundred dollars (\$500) or more)
- Restorative dental services following accidental injury to sound natural teeth
- Hospice services
- 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

**ASC Preferred Blue Master  
Group Plan  
And  
Enrollee Certificate**

GROUP PLAN

FOR

Coldwater Creek

Group #10030052

Effective Date: July 1, 2009

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## HOW TO SUBMIT CLAIMS

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

1. The health care Provider (hospital, doctor, or other facility or specialist) can file the claims for the Insured. Most Providers will submit a claim on an Insured's behalf if the Insured shows them a BCI identification card and asks them to send BCI the claim, or submit the claim to the local Blue Cross/Blue Shield plan in the area where services were received.
2. The Insured can send BCI the claim or submit the claim to the local Blue Cross/Blue Shield plan in the area where services were received.

### To File An Insured's Own Claim

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

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

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

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

### How Blue Cross Of Idaho Notifies The Insured

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

**BLUE CROSS OF IDAHO DISTRICT OFFICE LOCATIONS**

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

**Boise Office**

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

*Mailing Address*

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

**Coeur d'Alene Office**

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

**Idaho Falls Office**

Blue Cross of Idaho  
2116 East 25<sup>th</sup> Street  
Idaho Falls, ID 83404

*Mailing Address*

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

**Lewiston Office**

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

*Mailing Address*

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

**Pocatello Office**

Blue Cross of Idaho  
275 South 5<sup>th</sup> Ave., Suite 150  
Pocatello, ID 83201

*Mailing Address*

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

**Twin Falls Office**

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

*Mailing Address*

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

## INPATIENT NOTIFICATION SECTION

This section describes procedures that must 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 must notify BCI of all proposed Inpatient admissions as soon as he or she knows they will be admitted as an Inpatient. The notification must 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 Plan.

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 Plan) maternity delivery services, and notification cannot be completed prior to admission due to the Insured's condition, the Insured, or his or her representative, must notify BCI within twenty-four (24) hours of the admission. If the admission is on a weekend or legal holiday, BCI must 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 Plan) maternity delivery services, renders it medically impossible for the Insured to provide such notice, the Insured must 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 Plan.

### **IV. Discharge Planning**

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

## PRIOR AUTHORIZATION SECTION

### I. Prior Authorization

**NOTICE:** *The Medical Necessity of Covered Services listed below should be determined to be eligible for benefits under the terms of this Plan. 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 make a determination as to Medical Necessity or alternative treatments.

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

Please refer to Attachment A of the Benefits Outline, check the BCI Web site at [www.bcidaho.com](http://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 Plan 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.

## COMPREHENSIVE MAJOR MEDICAL BENEFITS SECTION

This section specifies the benefits an Insured is entitled to receive for the Covered Services described, subject to the other provisions of this Plan.

**Note:** *It is important to remember that when the term 'Contracting' is designated in front of the specific Covered Provider, all Major Medical Covered Services for that type of Provider must be furnished by Contracting Providers. There are no benefits when Covered Services are provided by Noncontracting Providers in the state of Idaho. (See item VI.B. of this section for services provided outside the state of Idaho.)*

### I. Benefit Period

The Benefit Period is the specified period of time during which an Insured accumulates annual benefit limits, Deductible amounts and Out-of-pocket Limits. Please see the Quick View information on the cover page of this Plan for the group's specific Benefit Period. If the Insured's Effective Date is after the Plan Date, the initial Benefit Period for that Insured may be less than twelve (12) months.

The Benefit Period for Hospice Home Care Covered Services is a continuous six (6) month period that begins when a Hospice Plan of Treatment is approved by Blue Cross of Idaho (BCI). The Insured may apply to BCI for an extension of the Hospice Home Care Benefit Period if Hospice benefits have not otherwise been exhausted.

### II. Deductible

#### A. Individual

The Individual Deductible is shown in the Benefits Outline.

#### B. Family

The Family Deductible is shown in the Benefits Outline.

#### C. Hospice

Deductibles do not apply to expenses for services and supplies provided as part of a Hospice Plan of Treatment preauthorized by BCI.

### III. Out-Of-Pocket Limit

The Out-of-pocket Limit is shown in the Benefits Outline. Eligible Out-of-pocket expenses include only the Insured's Deductible and Coinsurance for eligible Covered Services. If an Insured is admitted as an Inpatient at the end of a Benefit Period and the hospitalization continues uninterrupted into the succeeding Benefit Period, all eligible Out-of-pocket expenses incurred for Inpatient Hospital Services are considered part of the Benefit Period in which the date of admission occurred. Out-of-pocket expenses associated with the following are not included in the Out-of-pocket Limit:

- A. Amounts that exceed the Maximum Allowance.
- B. In-Network Copayments.
- C. Amounts that exceed benefit limits.
- D. Dental Covered Services.
- E. Vision care Covered Services.
- F. Prescription Drug Covered Services.
- G. Noncovered services or supplies.

### IV. Covered Providers

**Note:** *It is important to remember that when the term 'Contracting' is designated in front of the specific Covered Provider, all Major Medical Covered Services for that type of Provider must be furnished by Contracting Providers. There are no benefits when Covered Services are provided by Noncontracting Providers in the state of Idaho. (See item VI.B. of this section for services provided outside the state of Idaho.)*

The following are Covered Providers under this section:

- Ambulance Transportation Service

- Ambulatory Surgical Facility (Surgery Center)
- Certified Nurse-Midwife
- Certified Registered Nurse Anesthetist
- Chiropractic Physician
- Clinical Nurse Specialist
- Contracting Alcoholism or Substance Abuse Treatment Facility
- Contracting Certified Speech Therapist
- Contracting Clinical Psychologist
- Contracting Electroencephalogram (EEG) Provider
- Contracting Home Intravenous Therapy Company
- Contracting Hospice
- Contracting Licensed Clinical Professional Counselor (LCPC)
- Contracting Licensed Clinical Social Worker (LCSW)
- Contracting Licensed Marriage and Family Therapist (LMFT)
- Contracting Licensed Occupational Therapist
- Contracting Licensed Physical Therapist
- Contracting Licensed Rehabilitation Hospital
- Contracting Lithotripsy Provider
- Contracting Psychiatric Hospital
- Dentist/Denturist
- Diagnostic Imaging Provider
- Durable Medical Equipment Supplier
- Freestanding Diabetes Facility
- Freestanding Dialysis Facility
- Home Health Agency
- Independent Laboratory
- Licensed General Hospital
- Nurse Practitioner
- Optometrist/Optician
- Physician
- Physician Assistant
- Podiatrist
- Prosthetic and Orthotic Supplier
- Radiation Therapy Center
- Skilled Nursing Facility

**V. Covered Services**

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

Only the following are eligible Major Medical expenses:

**A. 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 Plan 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 in place 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 Covered Services 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**

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 the admission to the Licensed General Hospital as an Inpatient. If the Licensed General Hospital or Physician cancels or postpones the admission then benefits are provided.

- 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 uncontrollable bleeding.
  - (4) Severe bronchial asthma.
  - (5) Children under ten (10) years of age who require general anesthetic.
  - (6) Other non-dental life-endangering conditions that require hospitalization, subject to approval by BCI, on behalf of the Plan Administrator.

**B. 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 annual maximum stay (the number of days for a maximum stay is shown in the Benefits Outline). If the Insured is receiving care at a Skilled Nursing Facility at the end of a Benefit Period, this annual maximum stay benefit shall not renew the following Benefit Period until the Insured is discharged. However, no benefits are provided when the care received consists primarily of:

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

**C. 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 C.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.

For purposes of this section, Ambulance means a specially designed and equipped vehicle used only for transporting the sick and injured.

**D. Psychiatric Care Services**

**1. Inpatient Psychiatric Care**

The In-Network benefits provided for Inpatient hospital services and Inpatient medical services in this section are also provided for the care of Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, or any combination of these, up to the annual maximum stay as stated in the Benefits Outline. If the Insured is receiving Inpatient Psychiatric care at the end of a Benefit Period, this annual maximum stay benefit shall not renew the following Benefit Period until the Insured is discharged.

## 2. **Outpatient Psychiatric Care**

The In-Network benefits provided for Outpatient Hospital Services and Outpatient Medical Services in this section are also provided for Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, or for Pain Rehabilitation, or any combination of these. The use of Hypnosis to treat an Insured's Mental or Nervous Condition is a Covered Service.

For In-Network Inpatient Facility and Inpatient Professional Covered Services, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance up to the annual day benefit limit as shown in the Benefits Outline. These payments apply to covered Inpatient facility services furnished by any of the following:

- Contracting Licensed General Hospital
- Contracting Alcoholism or Substance Abuse Treatment Facility
- Contracting Psychiatric Hospital
- Contracting Licensed Clinical Social Worker (LCSW)
- Contracting Licensed Clinical Professional Counselor (LCPC)
- Contracting Licensed Marriage and Family Therapist (LMFT)
- Contracting Clinical Psychologist
- Contracting Physician

For In-Network Outpatient Facility and Outpatient Professional Covered Services, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance up to the annual visits benefit limit as shown in the Benefits Outline. These payments apply to Covered Services furnished by any of the following:

- Contracting Licensed General Hospital
- Contracting Alcoholism or Substance Abuse Treatment Facility
- Contracting Psychiatric Hospital
- Contracting Licensed Clinical Social Worker (LCSW)
- Contracting Licensed Clinical Professional Counselor (LCPC)
- Contracting Licensed Marriage and Family Therapist (LMFT)
- Contracting Clinical Psychologist
- Contracting Physician

No benefits are provided for Out-of-Network Psychiatric Covered Services.

## E. **Maternity Services**

The benefits provided for Licensed General Hospital Services and Surgical/Medical Services are also provided for the maternity services listed below when rendered by a Licensed General Hospital or Physician to the Enrollee or the Enrollee's spouse (if an Insured). Nursery care of a newborn infant is not a maternity service.

Benefits for any hospital 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) or ninety-six (96) hours. For stays in excess of forty-eight (48) or ninety-six (96) hours, additional benefits may be available under the terms of Item III, Continued Stay Review in the Inpatient Notification Section. Diagnostic x-ray and laboratory services related to pregnancy, childbirth, or miscarriage are covered.

No benefits are provided for any Normal Pregnancy or Involuntary Complications of Pregnancy for enrolled Eligible Dependent children. However, tests to determine pregnancy are covered. All other diagnostic x-ray and laboratory services related to pregnancy, childbirth, or miscarriage are not covered.

### 1. **Normal Pregnancy**

Normal Pregnancy includes all conditions arising from pregnancy or delivery, including any condition usually associated with the management of a difficult pregnancy that is not defined below as an Involuntary Complication of Pregnancy.

2. **Involuntary Complications Of Pregnancy**
  - a) Involuntary Complications of Pregnancy include, but are not limited to:
    - (1) Cesarean section delivery, ectopic pregnancy that is terminated, spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible (miscarriage), puerperal infection, and eclampsia.
    - (2) Conditions requiring Inpatient confinement (when the pregnancy is not terminated), the diagnoses of which are distinct from pregnancy but are adversely affected or are caused by pregnancy. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but do not include false labor, occasional spotting, Physician-prescribed bed rest during 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) A life-endangering condition. Benefits for termination of pregnancy are provided only if the Enrollee or Enrollee's Eligible Dependent spouse suffers a life-endangering condition and the Enrollee or Enrollee's Eligible Dependent spouse is eligible for maternity services.

## F. **Transplant Services**

1. **Transplants Or Autotransplants**

Transplants or Autotransplants of arteries, veins, blood, ear bones, cartilage, muscles, skin and tendons; heart valves, regardless of their source; implanting of artificial or mechanical pacemakers; and Autotransplanting of teeth or tooth buds.

  - a) The applicable benefits provided for hospital and Surgical/Medical Services are also provided only for a recipient of Medically Necessary Transplant services.
  - b) No benefits are available for services, expenses, or other obligations of or for a donor (even if the donor is an Insured).
2. **Transplants**

Transplants of corneas, kidneys, bone marrow, livers, hearts, lungs, heart/lung and pancreas/kidney combinations.

  - a) The applicable benefits provided for Hospital and Surgical/Medical Services are also provided for a recipient of Medically Necessary Transplant services.
  - b) Benefits for a recipient of a bone marrow, liver, heart, lung, heart/lung or pancreas/kidney combination Transplant(s) are subject to the following conditions:
    - (1) The Transplant must be preauthorized by BCI.
    - (2) The recipient must have the Transplant performed at an appropriate Recognized Transplant Center. If the recipient is eligible for Medicare, the recipient must have the Transplant performed at a Recognized Transplant Center that is approved by the Medicare program for the requested Transplant Covered Services.
  - c) If the recipient is eligible to receive benefits for these transplant services, Organ Procurement charges are paid for the donor (even if the donor is not an Insured). Benefits for the donor will be charged to the recipient's coverage.
3. **Exclusions And Limitations**

In addition to any other exclusions and limitations of this Plan, the following exclusions and limitations apply to Transplant services. No benefits are available under this Plan for the following:

  - a) Transplants of 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 unless the recipient is an Insured who is eligible to receive benefits for Transplant services.
- 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.
- e) Living expenses for the recipient, donor, or family members.
- f) 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.
- g) Any complication to the donor arising from a donor's Transplant Surgery is not a covered benefit under the Insured Transplant recipient's Plan. If the donor is a BCI Insured, eligible to receive benefits for Covered Services, benefits for medical complications to the donor arising from Transplant Surgery will be allowed under the donor's policy.
- h) Costs related to the search for a suitable donor.

## G. 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 20% for a Physician assistant and 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. The use of Hypnosis as anesthesia is not a Covered Service. General anesthesia administered by the surgeon or assistant surgeon is not a Covered Service.
- 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 include Acute Care of Mental or Nervous Conditions rendered by a Physician or other Professional Provider to an Insured, who is receiving Covered Services in a Licensed General Hospital, Skilled Nursing Facility, Contracting Alcoholism or Substance Abuse Treatment Facility, or Contracting Psychiatric Hospital.

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, or Pain Rehabilitation, except as specified elsewhere in this section:

- a) **Emergency Care**—medical care for the treatment of an Accidental Injury, Disease, Emergency Medical Condition, or Illness.
- b) **Special Therapy Services**—deep radiation therapy or chemotherapy for a malignancy when such therapy is performed in the Physician’s office.
- c) **Home And Other Outpatient Services**—medical care for the diagnosis or treatment of an Accidental Injury, Disease, condition or Illness.
- d) **Preventive Care Services**

The Plan will pay or otherwise satisfy a percentage of the Maximum Allowance up to the annual benefit limit as shown in the Benefits Outline.

Benefits are provided for:

- (1) Well-Baby Care and Well-Child care—routine or scheduled well-baby and well-child examinations, including specifically listed preventive care Covered Services.
- (2) Adult Examinations—annual physical examinations, including specifically listed preventive care Covered Services.
- (3) Preventive Care Covered Services—see Benefits Outline for complete list.
- (4) Immunizations—see Benefits Outline for complete list.

No benefits are provided for Out-of-Network Covered Services.

- e) **Physician Office Visit**— Physician office medical visits and consultations, including visits for wellness and preventive health services.

Additional services, such as treatment and diagnosis of Mental/Nervous Conditions, or laboratory, x-ray, and other Diagnostic Services are not included in the Office Visit. Benefits for these services may be available under other areas in this Comprehensive Major Medical Section, subject to Deductible and Coinsurance

Benefits for In-Network and Out-of-Network Covered Services are shown in the Benefits Outline.

- f) **Allergy Injections**—For In-Network Services, benefits for Covered Services for allergy injections may require a Copayment as shown in the Benefits Outline if no other Copayment is required for other Covered Services provided during the same visit.

For Out-of-Network Services, benefits are paid at a percentage of the Maximum Allowance as shown in the Benefits Outline for eligible covered expenses that exceed the Deductible.

**H. Diagnostic Services**

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

**I. Therapy Services**

- 1. **Radiation Therapy**
- 2. **Chemotherapy**
- 3. **Renal Dialysis**
- 4. **Physical Therapy**

- a) Payment is limited to Physical Therapy Services related to developmental and rehabilitative care, with reasonable expectation that the services will produce significant improvement in the Insured's condition in a reasonable period of time. Physical Therapy Services are covered when performed by:
  - (1) A Physician.
  - (2) A Contracting 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 Contracting Licensed Physical Therapist are not required:
    - (a) Repetitive exercise(s) to improve gait and maintain strength and endurance.
    - (b) 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.
    - (c) 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 Contracting Licensed Physical Therapist.

5. **Respiratory Therapy**

6. **Occupational Therapy**

- a) Payment is limited to Occupational Therapy Services related to developmental and rehabilitative care, with reasonable expectation that the services will produce significant improvement in the Insured's condition in a reasonable period of time. Occupational Therapy Services are covered when performed by:
  - (1) A Physician.
  - (2) A Contracting Licensed Occupational Therapist, provided the Covered Services are directly related to a written treatment regimen prepared by a Contracting Licensed Occupational Therapist and approved by a Physician.
- b) No benefits are provided for:
  - (1) Facility-related charges for Outpatient Occupational Therapy Services, health club dues or charges, or Occupational Therapy Services provided in a health club, fitness facility, or similar setting.
  - (2) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Contracting Licensed Occupational Therapist.

7. **Speech Therapy**

Benefits are limited to Speech Therapy Services related to developmental and rehabilitative care, with reasonable expectation that the services will produce significant 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 Contracting Certified 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 are only available as preauthorized and approved by BCI, on behalf of the Plan Administrator, when Medically Necessary.

10. **Home Intravenous Therapy (Home Infusion Therapy)**

In-Network 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 available as preauthorized and approved by BCI, on behalf of the Plan Administrator, when Medically Necessary.

There are no Out-of-Network Benefits for Home Infusion Therapy medications, services, and/or supplies.

**J. 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. The services must be Medically Necessary and preauthorized by BCI, on behalf of the Plan Administrator, 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, on behalf of the Plan Administrator, will pay or otherwise satisfy for In-Network and Out-of-Network Covered Home Health Skilled Nursing Care Services and the benefit limit for such services are shown in the Benefits Outline.

**K. Hospice Home Care Services**

For In-Network Hospice Covered Services rendered by a Contracting Hospice, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance up to the Lifetime Benefit Limit as shown in the Benefits Outline.

No benefits are provided for Out-of-Network Hospice Covered Services.

**1. Conditions**

Benefits are provided only for Hospice Covered Services included in a Hospice Plan of Treatment that has been preauthorized by BCI, on behalf of the Plan Administrator.

An Insured must specifically request Hospice benefits and must meet the following conditions to be eligible:

- a) The attending or primary Physician must certify that the Insured is a terminally ill patient with a life expectancy of six (6) months or less.
- b) The Insured must live within the Contracting Hospice's local geographical area.
- c) The Insured must be formally accepted by the Contracting Hospice.
- d) The Insured must have a designated volunteer Primary Care Giver at all times.
- e) Services and supplies must be prescribed by the attending Physician and included in a Hospice Plan of Treatment approved in advance by BCI. The Hospice must notify BCI within one (1) working day of any change in the Insured's condition or Plan of Treatment that may affect the Insured's eligibility for Hospice Benefits.
- f) Palliative care (which controls pain and relieves symptoms but does not provide a cure) must be appropriate to the Insured's Illness.

**2. Exclusions And Limitations**

No benefits are provided for:

- a) Hospice Services not included in a Hospice Plan of Treatment and not provided or arranged and billed through a Contracting Hospice.
- b) Continuous Skilled Nursing Care except as specifically provided as a part of Respite Care or Continuous Crisis Care.
- c) Hospice benefits provided during any period of time in which an Insured is receiving Home Health Skilled Nursing Care benefits.

**L. Chiropractic Care Services**

Services rendered, referred, or prescribed by a Chiropractic Physician licensed by the state where services are rendered. For BCI to provide benefits, the individual must be practicing within the scope of license.

The percentage of the Maximum Allowance that BCI will pay or otherwise satisfy for In-Network and Out-of-Network Covered Chiropractic Care Services and the benefit limit for such services are shown in the Benefits Outline.

**M. 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 Plan). Benefits shall not exceed the cost of the standard, most economical Durable Medical Equipment that is consistent, according to generally accepted medical treatment practices, with the 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. 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).

**N. Prosthetic Appliances**

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. The Prosthetic Appliance must be approved by BCI before the Insured purchases it.
2. 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. No benefits are provided for dental appliances or major Artificial Organs, including but not limited to, artificial hearts and pancreases.
4. Following cataract Surgery, benefits for a required contact lens or a pair of eyeglasses are limited to the first contact lens or pair of eyeglasses, which must be purchased within ninety (90) days.
5. No benefits are provided for the rental or purchase of any synthesized, artificial speech or communications output device or system or any similar device, appliance or computer system designed to provide speech output or to aid an inoperative or unintelligible voice, except for voice boxes to replace all or part of a surgically removed larynx.

**O. 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, Contracting Licensed Physical Therapist or Contracting 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.

**P. 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 teeth, mouth, or face. Such services are covered only for the twelve (12) month period immediately following the date of injury providing the Plan remains in effect during the twelve (12) month period. 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 natural teeth, 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 natural teeth which are abutting the bridge or denture.

**Q. Inpatient Physical Rehabilitation Only**

Benefits are provided for Inpatient Physical Rehabilitation subject to the following:

1. Admission for Inpatient Physical Rehabilitation must occur within one hundred twenty (120) days of discharge from an Acute Care Licensed General Hospital.
2. Continuation of benefits is contingent upon approval by BCI of a Physical Rehabilitation Plan of Treatment and documented evidence of patient progress submitted to BCI at least twice each month.

For In-Network Covered Services rendered by a Contracting Licensed General Hospital or a Contracting Licensed Rehabilitation Hospital, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance up to the Lifetime Benefit Limit as shown in the Benefits Outline.

No benefits are provided for Out-of-Network Inpatient Physical Rehabilitation Care Covered Services.

**R. Diabetes Self-Management Education Services**

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

For In-Network Services benefits for Diabetes Self-Management Education may require a Copayment as shown in the Benefits Outline.

No benefits will be paid for Out-of-Network Services.

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.

Coverage for Diabetes Self-Management Education is contingent upon Prior Authorization by BCI—approved programs must meet the standards of the ADA; or are supervised by a certified diabetes educator.

**S. Outpatient Rehabilitation Therapy Services**

For In-Network Outpatient Rehabilitation Therapy Services consisting of Outpatient Physical Therapy, Outpatient Speech Therapy, and Outpatient Occupational Therapy Covered Services rendered by a Covered Provider, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance as shown in the Benefits Outline.

Benefits for all Outpatient Rehabilitation Therapy Covered Services combined per Insured, per Benefit Period are shown in the Benefits Outline. If Outpatient Rehabilitation Therapy Covered Services are provided under any other Benefit Section of this Plan, the amount paid under that Benefit Section shall also apply to this benefit limit.

No Benefits are provided for Out-of-Network Outpatient Rehabilitation Therapy Covered Services.

**T. Post-Mastectomy/Lumpectomy Reconstructive Surgery**

Reconstructive Surgery in connection with a Disease related mastectomy/lumpectomy, 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;

in a manner determined in consultation with the attending Physician and the Insured.

**U. Prescribed Contraceptive Services**

Covered Services include prescribed devices, injectable and insertable methods of temporary contraception, such as diaphragms, IUDs, Depo-Provera.

There are no benefits for:

1. Over-the-counter items including, but not limited to condoms, spermicides, and sponges.
2. Implantable contraceptive hormone methods, including but not limited to Norplant.
3. Prescribed contraceptives that could otherwise be purchased over-the-counter.
4. Oral contraceptive prescription drugs and other prescription hormonal contraceptives, such as Ortho Evra patch and NuvaRing. See Prescription Drug Benefit Section for oral contraceptive benefits.

**VI. Additional Amount Of Payment Provisions**

Any amounts remaining unpaid for Covered Services under any other benefit section of this Plan (except the Supplemental Accident Benefit Section and Dental Benefit sections if applicable), are not eligible for payment under this Comprehensive Major Medical Benefits section. Except as specified elsewhere in this Plan, BCI, on behalf of the Plan Administrator, will provide the following benefits for Covered Services after an Insured has satisfied his or her individual Deductible or, if applicable, the family Deductible has been satisfied:

- A.** For In-Network Services: Unless stated otherwise, for Major Medical Covered Services rendered in the state of Idaho, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance (shown in the Benefits Outline) if the Covered Services were rendered by any of the Providers listed in this section either 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 Benefits Outline.

For Out-of-Network Services: Unless stated otherwise, for Major Medical Covered Services rendered in the state of Idaho, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance (shown in the Benefits Outline) if the Covered Services were rendered by any of the Providers listed in this section either 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 Benefits Outline.

- B.** For Major Medical Covered Services furnished outside the state of Idaho by a Covered Provider, Blue Cross of Idaho shall provide the benefit payment levels specified in this section according to the following:
1. If the Provider has a 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 Preferred Provider Organization 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 nor the Plan Administrator are responsible for the difference, if any, between BCI's payment and the actual charge.

- 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 nor the Plan Administrator are 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, on behalf of the Plan Administrator, 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 it is medically safe to do so, the Insured (at BCI's option, on behalf of the Plan Administrator) may be required to 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 Plan.

## DENTAL BENEFITS SECTION

*Please Note: To receive maximum benefits the Member must receive Covered Services from a dental PPO Contracting Provider*

This section specifies the benefits an Insured is entitled to receive for the Dental Covered Services described, subject to the other provisions of this Plan.

### **I. Benefit Period And Benefit Limit For Covered Services**

The Benefit Period and the Benefit limits are shown in the Benefits Outline.

### **II. Covered Providers**

The following are Covered Providers under this section:

- Dentist
- Denturist

### **III. Deductibles**

The individual and family Deductible amounts are shown in the Benefits Outline.

### **IV. Predetermination Of Benefits**

A recommended Dental Treatment Plan must be submitted to Blue Cross of Idaho (BCI) for a Predetermination of Benefits before treatment begins if this Plan includes one (1) or more of the following procedures:

- |                                    |  |
|------------------------------------|--|
| <b>A.</b> Bonding Procedures       | <b>E.</b> Inlays/Onlays                      |
| <b>B.</b> Bridgework               | <b>F.</b> Laminate Veneers                   |
| <b>C.</b> Crowns                   | <b>G.</b> Periodontal Surgery                |
| <b>D.</b> Full or Partial Dentures | <b>H.</b> Surgical Removal of Impacted Teeth |

The Dental Treatment Plan must be accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials requested by BCI or its dental consultant(s).

BCI will notify the Insured and his or her Dentist of the benefits available based upon the Dental Treatment Plan. In determining the amount of benefits available, BCI, on behalf of the Plan Administrator, considers whether alternate procedures would accomplish a professionally satisfactory result. If the charges or fees for the treatment chosen by the Insured and his or her Dentist exceed the charges or fees for the treatment BCI has determined will accomplish a professionally satisfactory result, then BCI, on behalf of the Plan Administrator, will only provide benefits based on the charges or fees for the less costly treatment.

If an Insured submits a claim for completed treatment that includes services in the above listed categories, and benefits have not been predetermined by BCI, the claim is reviewed in the same manner as if it were being submitted for a Predetermination of Benefits. BCI, on behalf of the Plan Administrator, will consider whether alternate procedures would have accomplished a professionally satisfactory result. If the Insured and his or her Dentist have chosen a more expensive method of treatment than is determined professionally satisfactory by BCI, the excess charge is solely the responsibility of the Insured.

A Predetermination of Benefits is valid for six (6) months from the date it is issued. After six (6) months, a Dental Treatment Plan must be resubmitted for a new Predetermination of Benefits before treatment begins.

### **V. Amount Of Payment For Services Rendered By A Contracting Dentist**

Except as stated elsewhere in this Plan, BCI, on behalf of the Plan Administrator, pays benefits for Preventive, Basic, and Major Dental Covered Services after an Insured has satisfied his or her Deductible, if applicable. The reimbursement schedule is shown in the Benefits Outline.

Unless stated otherwise, if Dental Covered Services are rendered by a Dentist outside the state of Idaho, BCI will provide the same benefits as described for an in-state Contracting Dentist.

Except as stated elsewhere, BCI will pay benefits for Orthodontic Dental Covered Services after an Insured has

satisfied his or her Deductible, if applicable. BCI will pay benefits for Covered Services rendered to an Insured by a Contracting Dentist according to the Orthodontic rates shown in the Benefits Outline. If applicable, BCI will pay benefits for Covered Services rendered to an Insured by a Noncontracting Dentist according to the Orthodontic rates shown in the Benefits Outline.

BCI will pay benefits for Covered Services rendered to an Insured by a Contracting Dentist according to the Orthodontic rates shown in the Benefits Outline.

Benefits for Orthodontic Services are paid as follows:

1. BCI will pay benefits on the patient's initial banding.
2. Thereafter, BCI will pay benefits up to the Orthodontic Lifetime Benefit Limit in monthly installments so long as the Insured continues orthodontic treatment and remains covered under this Plan.

A Contracting Dentist rendering Covered Services shall not make an additional charge to an Insured for amounts in excess, if any, of BCI's payment except for Deductibles, Coinsurance, and noncovered services.

#### **VI. Amount Of Payment For Services Rendered By A Noncontracting Dentist**

A Noncontracting Dentist is not obligated to accept BCI's Maximum Allowance as payment in full, and BCI is not responsible for the difference, if any, between BCI's payment and the actual charge, unless otherwise specified in this Plan. Insureds are responsible for any such difference, including Deductibles, Coinsurance, Copayments, charges for noncovered services and the amount charged by the Noncontracting Dentist that is in excess of BCI's Maximum Allowance.

#### **VII. Closed List Of Dental Covered Services**

The following is a complete list of Dental Covered Services for which benefits are available. Only those services included on this list are eligible for payment.

There are no waiting periods for benefits for treatment of Preexisting Conditions except as stated in the following list of Dental Covered Services or in the Exclusions and Limitations Section:

##### **A. Type I: Preventative Dental Services**

1. Oral examination—limited to two examinations per Benefit Period.
2. Emergency oral examination.
3. Complete mouth series or panoramic x-ray—limited to one (1) time in any five (5) consecutive Benefit Periods, unless requested by BCI for verification of treatment claimed.
4. Individual periapical x-rays—limited to the same benefit as a complete mouth series or panoramic x-ray. Individual periapical x-rays are not covered when performed during root canal therapy as an intra-operative procedure.
5. Occlusal x-rays—limited to two films per Benefit Period.
6. Extraoral x-rays—limited to two films per Benefit Period.
7. Bitewing x-rays—limited to twice per Benefit Period.
8. Other x-rays.
9. Dental prophylaxis—limited to twice per Benefit Period.
10. Fluoride treatments—limited to two applications per Benefit Period and limited to Insureds who are Eligible Dependent children under age 23.
11. Space maintainers—limited to Insureds who are Eligible Dependent children under age 16. Includes all adjustments made within 6 months of installation.
12. Palliative treatment—paid as a separate benefit only if no other service is rendered during the visit (except x-rays).
13. Topical application of sealants per tooth—limited to molars and bicuspid and lingual pits on upper anterior laterals of Eligible Dependent children under age 16. Limited to permanent teeth except for retained deciduous teeth where no permanent tooth exists. Also limited to one time per tooth in any two consecutive Benefit Periods.
14. Biopsy of soft or hard oral tissue.

**B. Type II: Basic Dental Services**

1. Diagnostic casts—limited to one time in any three consecutive calendar year period. Working models taken in conjunction with a prosthetic or other appliance are not considered to be diagnostic casts.
2. Amalgam restorations—restorations involving multiple surfaces will be combined for benefit purposes and paid according to the number of surfaces treated.
3. Pin retention.
4. Silicate restorations.
5. Plastic restorations.
6. Composite restorations.
7. Simple extractions.
8. Surgical removal of an erupted or partially erupted tooth or mucoperiosteal flap or incision of soft tissue.
9. Impaction that requires incision of overlying soft tissue, elevation of a flap and either removal of bone and tooth or sectioning and removal of the tooth (extraction of tooth, partial bony impaction).
10. Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, and sectioning of the tooth for removal (extraction of tooth, complete bony extraction).
11. Impaction that requires incision of overlying tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and/or presents unusual difficulties and circumstances (including report).
12. Root recovery.
13. Excision of pericoronal tissues.
14. Tooth reimplantation.
15. Tooth transplantation—separate benefits are not payable for donor site charges.
16. Alveoloplasty and alveolectomy—not separately payable if performed on the same date as extraction.
17. Removal of exostosis.
18. Frenectomy (frenulectomy).
19. Excision of hyperplastic tissue.
20. Incision and drainage.
21. Radical excision (lesion diameter up to 1.25 cm)—not payable in addition to extraction performed in same site on same date.
22. Radical excision (lesion diameter more than 1.25 cm)—not payable in addition to extraction performed in same site on same date.
23. Excision pericoronal gingiva (operculectomy).
24. Excision of benign tumor (lesion diameter up to 1.25 cm)—not payable in addition to extraction performed in same site on same date.
25. Excision of benign tumor (lesion diameter more than 1.25 cm)—not payable in addition to extraction performed in same site on same date.
26. Removal of odontogenic cyst or tumor (diameter up to 1.25 cm)—not payable in addition to extraction performed in same site on same date.
27. Removal of odontogenic cyst or tumor (diameter more than 1.25 cm)—not payable in addition to extraction performed in same site on same date.
28. Suture of small wounds.
29. General anesthesia—covered as a separate benefit only if Blue Cross of Idaho reasonably determines that it is required for complex oral surgical procedures covered under this Plan.
30. I.V. sedation—covered as a separate benefit only if Blue Cross of Idaho determines that it is reasonably required for complex oral surgical procedures covered under this Plan.
31. Pulp cap (direct or indirect).
32. Pulpotomy.
33. Root canal therapy.
34. Apicoectomy and retrograde filling—paid as a separate benefit only if performed more than 12 months after the root canal therapy is completed.
35. Hemisection.
36. Occlusal adjustment (per quadrant)—limited to one time in any 12 consecutive month period.
37. Occlusal adjustment (full mouth)—limited to one time in any 12 consecutive month period.

38. Scaling and root planing (periodontal therapy)—limited to two times per quadrant of the mouth, per Benefit Period.
39. Periodontal maintenance—limited to four times per Benefit Period. To be eligible, at least three months must have elapsed since the last periodontal therapy was performed. Periodontal therapy is defined as any of the following procedures: gingivectomy, gingival curettage, mucogingival surgery, osseous surgery, osseous grafts, scaling and root planing.
40. Gingivectomy—one such surgical procedure per area of the mouth, per Benefit Period.
41. Gingival curettage—one such surgical procedure per area of the mouth, per Benefit Period.
42. Mucogingival surgery—one such surgical procedure per area of the mouth, per Benefit Period.
43. Osseous surgery—one such surgical procedure per area of the mouth, per Benefit Period.
44. Osseous grafts—only autogenous grafts are covered. Synthetic grafting techniques are not covered.
45. Pedicle grafts.
46. Free soft tissue grafts.
47. Bruxism appliance—limited to one appliance per Benefit Period.

**C. Type III: Major Dental Services**

All benefits for the services listed below include an allowance for all temporary restorations and appliances and for one year follow-up care:

1. Synthetic bone grafting procedures.
2. Periodontal splinting procedures.
3. Recement inlays.
4. Recement crowns.
5. Recement bridges.
6. Crown build-up—covered only for endodontically treated teeth that require crowns and only if reasonably necessary.
7. Tissue conditioning—limited to repairs or adjustments performed more than 12 months after the initial insertion of prosthesis.
8. Repairs to full dentures—limited to repairs performed more than 12 months after the initial insertion of prosthesis.
9. Repairs to partial dentures—limited to repairs performed more than 12 months after the initial insertion.
10. Repairs to bridges—limited to repairs or adjustments performed more than 12 months after the initial insertion.
11. Repairs to crowns.
12. Gold inlays and onlays—covered only when the teeth cannot be restored by a filling, and only if more than five years have elapsed since the last placement.
13. Cast porcelain restoration—covered only when the teeth cannot be restored by a filling, and only if more than five years have elapsed since the last placement.
14. Crowns and laminate veneers—covered only when the tooth cannot be restored by a filling, and only if more than five years have elapsed since the last placement; for Insureds under age 16, benefits are limited to plastic or stainless steel crowns.
15. Stainless steel crowns—covered only when the tooth cannot be restored by a filling material.
16. Post and core.
17. Full dentures—includes all adjustments within six months of installation. Replacement of a denture is covered only if the existing denture is more than five years old and cannot be repaired. There are no additional benefits for overdentures or customized dentures.
18. Partial dentures—includes two clasps and rests, all teeth, and all adjustments within six months of installation. Replacement of a partial denture with another denture or fixed bridgework is eligible for benefits only if the existing denture is more than five years old and cannot be repaired. There are no additional benefits for precision or semiprecision attachments.
19. Each additional clasp and rest (beyond two).
20. Denture adjustments—one adjustment per Benefit Period and only if performed more than six months after the insertion of the denture.

21. Relining dentures—initial placement of dentures — may be relined once within 6 months of insertion. Subsequent relines must be performed 12 months after initial placement and no more than once in a 24 month period.
22. Fixed bridges—upgrading from a partial denture to fixed bridgework is covered only if the patient's arch cannot be adequately restored with a partial denture. Replacement of an existing fixed bridge or partial denture is eligible only if the existing appliance is more than five years old and cannot be repaired.
23. Maryland bridge—upgrading from a partial denture to fixed bridgework is covered only if the patient's arch cannot be adequately restored with a partial denture. Replacement of an existing fixed bridge or partial denture is eligible only if the existing appliance is more than five years old and cannot be repaired.

**D. Type IV: Orthodontic Services**

1. Orthodontia or Orthodontic Treatment.

**VIII. Conditions**

**A. Right To Review Dental Work**

Before providing benefits for Covered Services, BCI, on behalf of the Plan Administrator, has the right to refer the Insured to a Dentist of its choice and at its expense to verify the need, quantity, and quality of dental work claimed as a benefit.

**B. Care Rendered By More Than One (1) Dentist**

If an Insured transfers from the care of one (1) Dentist during a Dental Treatment Plan, or if more than one (1) Dentist renders services for one (1) dental procedure, BCI, on behalf of the Plan Administrator, will pay no more than the amount that it would have paid if only one (1) Dentist had rendered the service.

**C. Alternate Treatment Plan**

If a Dentist and Insured select a Dental Treatment Plan other than one customarily provided by the dental profession, the benefits available under this section are limited to the Dental Treatment Plan that is least expensive.

## PRESCRIPTION DRUG BENEFITS SECTION

This Prescription Drug 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 Plan.

### I. Prescription Drug Copayment

For the types and levels of benefits coverage regarding Prescription Drug Copayments and/or Coinsurance, see the Benefits Outline.

#### Retail Prescription Drugs:

For a thirty (30)-day or less supply of a Prescription Drug, the Insured is responsible for paying one (1) Copayment amount.

For a thirty-one (31)-day to sixty (60)-day supply of a Prescription Drug, the Insured is responsible for paying two (2) Copayment amounts.

For a sixty-one (61)-day to ninety (90)-day supply of a Prescription Drug, the Insured is responsible for paying three (3) Copayment amounts.

#### Mail Order Prescription Drugs:

For Mail Order Prescription Drugs the Insured is responsible for paying one (1) Copayment amount for each covered prescription.

#### Diabetic Supplies

Insulin syringes/needles and supplies have no additional copayment if purchased within thirty (30) days of insulin purchase.

### II. Covered Providers

The following are Covered Providers under this section:

- Licensed Pharmacist
- Participating Pharmacy/Pharmacist
- Physician

### III. Dispensing Limitations

Retail:

Each covered prescription for a Prescription Drug is limited to no more than a ninety (90)-day supply. However, prescriptions and Prescription Drugs may be subject to more restrictive quantity limits.

Mail Order:

Each covered prescription for a Prescription Drug is limited to no more than a ninety (90)-day supply. However, prescriptions and Prescription Drugs may be subject to more restrictive quantity limits. Unless the doctor states on the prescription "dispense as written" (DAW), the mail order Participating Pharmacy will automatically substitute an approved generic drug when available and permissible by law.

Smoking Cessation:

In addition to the benefit limit shown in the Benefits Outline, each covered Prescription Drug prescribed primarily to aid or assist the Insured in the cessation of the use of tobacco is limited to no more than a thirty (30)-day supply at one time.

### IV. Amount Of Payment

**A.** The amount of payment for a covered Prescription Drug dispensed by a Participating Pharmacist is the balance remaining after subtracting the Prescription Drug Copayment from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

**B.** For a covered Prescription Drug dispensed by a Physician or a Licensed Pharmacist who is not a Participating Pharmacist, the Insured is responsible for paying for the Prescription Drug at the time of purchase and must submit a claim to BCI or one (1) of its designated claims processing vendors. The

amount of payment for a covered Prescription Drug is the balance remaining after subtracting the Prescription Drug Copayment from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

- C. The amount of payment for a covered Prescription Drug dispensed by an approved mail order Participating Pharmacy is the balance remaining after subtracting the Prescription Drug Copayment from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

**V. Generic Drugs**

Certain Prescription Drugs are restricted to Generics for payment by BCI. Even if the Insured, the Physician or other duly licensed Provider requests the Brand Name Drug, the Insured is responsible for the difference between the price of the Generic and Brand Name Drug, plus any applicable Brand Name Drug Copayment/Coinsurance.

**VI. 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.

**VII. Preauthorization**

Certain Prescription Drugs may require preauthorization. If the Insured's Physician or other Provider prescribes a drug, which requires preauthorization, the Insured will be informed by the Provider or Pharmacist. To obtain preauthorization the Insured's Physician must write a letter to BCI or its designated agent, describing the Medical Necessity for the prescription. Within a reasonable period of time, but no 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.

**VIII. Covered Services**

Prescription Drugs approved by the Pharmacy and Therapeutics Committee, compounded medication 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 written prescription of a Physician, when the drugs or medicines are directly related to the treatment of an Illness, Disease, medical condition or Accidental Injury and are 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.

Covered Prescription Drugs prescribed for the cessation of the use of tobacco are limited to Chantix and/or Bupropion SR (generic equivalent of Zyban).

Covered prescription drugs include oral contraceptives and other prescription hormonal contraceptives, such as Ortho Evra patch and NuvaRing.

**IX. Definitions**

- A. **Allowed Charge**—the amount payable for a Prescription Drug as determined by the reimbursement formula agreed upon between the Participating Pharmacist and one (1) or more of BCI's designated claims processing vendors.
- B. **Brand Name Drug**—a Prescription Drug, approved by the FDA, that is protected by a patent and is marketed and supplied under the manufacturer's brand name.
- C. **Diabetic Supplies**—supplies that can be purchased at a Participating Pharmacy using the Insured's pharmacy benefit. Includes: insulin syringes, insulin pen needles, control solution, alcohol swabs, cotton swabs, lancets, test strips (blood glucose and urine), and insulin pump supplies (reservoirs and syringes, administration sets, and access sets).
- D. **Generic Drug**—a Prescription Drug, approved by the FDA, that has the same active ingredients, strength, and dosage form as its Brand Name Drug counterpart.
- E. **Participating Pharmacy/Pharmacist**—a Licensed Pharmacist or retail pharmacy that has a contract with one (1) or more of BCI's designated claims processing vendors for the purpose of providing Prescription Drug Covered Services to Insureds under this Plan.

- F. 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 Plan.
- G. 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 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.”
- H. Usual Charge**—the lowest retail price being charged by a Licensed Pharmacist for a Prescription Drug at the time of purchase by an Insured.

**X. Exclusions And Limitations**

In addition to any other exclusions and limitations of this Plan, the following exclusions and limitations apply to this particular section and throughout the entire Plan, unless otherwise specified.

If an Insured also has a Prescription Drug benefit under a stand-alone Prescription Drug program, Prescription Drug benefits under this Plan are limited to the Insured’s Out-of-pocket expenses under the stand-alone Prescription Drug program, up to the Prescription Drug benefit available under this Plan.

- A.** No benefits are provided for the following:
  1. Contraceptive devices.
  2. Drugs used for the termination of early pregnancy, and complications arising therefrom, except when required to correct an immediately life-endangering condition.
  3. 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 Plan. 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.
  4. Charges for the administration or injection of any drug.
  5. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, and other non-medicinal substances except for diabetic supplies, regardless of intended use.
  6. Drugs labeled “Caution—Limited by Federal Law to Investigational Use,” or experimental drugs, even though a charge is made to the Insured.
  7. Immunization agents, biological sera, blood or blood plasma. Benefits may be available under the Major Medical Benefits Section of this Plan.
  8. 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.
  9. 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.
  10. 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.
  11. Any Prescription Drug, biological or other agent, which is:
    - a) Prescribed primarily to aid or assist the Insured in weight loss, including all anorectics, whether amphetamine or nonamphetamine.
    - b) Prescribed primarily to retard the rate of hair loss or to aid in the replacement of lost hair.
    - c) Prescribed primarily to increase fertility, including but not limited to, drugs which induce or enhance ovulation.
    - d) Prescribed primarily for personal hygiene, comfort, beautification, or for the purpose of improving appearance.

- e) Prescribed primarily to increase growth, including but no limited to, growth hormone. Benefits are available for this Therapy Service under the Major Medical Benefits Section of this Plan only as preauthorized and approved when Medically Necessary.
- f) Provided by or under the direction of a Contracting Home Intravenous Therapy Company, Home Health Agency or other Provider approved by BCI. Benefits are available for this Therapy Service under the Major Medical Benefits Section of this Plan only as preauthorized and approved when Medically Necessary.

## ELIGIBILITY AND ENROLLMENT SECTION

### I. Eligibility And Enrollment

All Eligible Persons will have the opportunity to apply for coverage under this Plan. All applications submitted to Blue Cross of Idaho (BCI) by the Group now or in the future, will be for Eligible Persons or Eligible Dependents only.

#### A. Eligible Person

##### 1. *Eligible Full-time Employees – Medical/Dental Coverage*

A. To Qualify as an Eligible Person Under this Plan, a person must be actively at work and remain a regular, full-time employee, proprietor, partner or corporate officer of the Group and regularly work at least 32 hours per week and be paid therefore on a regular, periodic basis through the Group's payroll system.

1. An Eligible Person who is paid on a salaried basis becomes eligible to apply for coverage under this Plan on the first day of the calendar month following the date of regular full-time employment.

2. An Eligible Person who is paid on an hourly basis becomes eligible to apply for coverage under this Plan on the first day of the calendar month following completion of any probationary period imposed by the Employer and the employee has been granted status as a regular, full-time employee by the Employer in writing.

2. *Eligible Part-time Employees – Dental coverage only.* The Plan is only available to Part-time Employees who were eligible and enrolled in the Plan prior to April 1, 2002. The Plan is closed to any Part-time Employee who did not enroll prior to April 1, 2002.

#### B. Eligible Dependent

To qualify as an Eligible Dependent under this Plan, a person must be and remain one of the following:

1. The Enrollee's spouse under a legally valid marriage.

2. The Enrollee's Domestic Partner under a valid Affidavit of Domestic Partnership.

3. The Enrollee's or the Enrollee's Domestic Partner's never married natural child, stepchild, legally adopted child, child placed with the Enrollee or the Enrollee's Domestic Partner for adoption or child for whom the Enrollee, the Enrollee's spouse or the Enrollee's Domestic Partner has court-appointed guardianship or custody. The child must be primarily dependent on the Enrollee or the Enrollee's Domestic Partner for financial support. A child shall be an Eligible Dependent until the end of the month in which the child reaches age 23, until the child provides a majority of his or her financial support, or until the child marries, whichever occurs first.

4. An Enrollee must notify Coldwater Creek within 30 days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate the last day of the month in which the change in eligibility status took place.

### II. Leave Of Absence

During an employer-approved, temporary leave of absence, and subject to the payment by the Group of the amount paid in benefits plus the administrative fee provided in the Administrative Services Agreement and payment of the monthly Excess Loss Premium, if any, submitted with the regular Group billing, coverage under this Plan shall continue for no more than three calendar months.

On its regular billing, the Group shall notify Blue Cross of Idaho of the Enrollee's date of departure for the leave of absence, and shall continue its regular contribution for the Enrollee's coverage during the leave of absence.

**III. Group Contribution**

The Group agrees it will pay one hundred percent (100%) of the amount paid in benefits for all Insureds under this Plan, except as modified by the Administrative Services Agreement.

**IV. Miscellaneous Eligibility And Enrollment Provisions**

**A.** All eligible Persons will have the opportunity to apply for coverage. All applications submitted to BCI now or in the future, are for Eligible Persons or Eligible Dependents only.

The Group agrees to be responsible for and make the total required payment to BCI as provided in the Administrative Services Agreement. The Group further agrees that no other hospital, medical or surgical group coverage will be offered to employees during the term of this Plan, unless required by State or Federal law.

**B.** Before the effective date of the change, the Group must submit all eligibility changes for Enrollees and Eligible Dependents on BCI's usual forms. It is the Group's responsibility to verify that all Insureds are eligible for coverage as specified in this Plan. BCI will have the right to audit the Group's employment, payroll, and eligibility records to verify that all Insureds are eligible and properly enrolled and to ensure that the Group meets enrollment requirements.

**C.** This Plan is issued to the Group upon the express condition that a pre-established required percentage of the Eligible Persons specified in the Application for Group Coverage who meet the underwriting criteria of BCI are and continue to be Enrollees. This Plan is issued under the express condition that the Group continues to make the employer contribution specified in the Application for Group Coverage and this Plan. BCI may terminate this Plan if the percentage of Eligible Persons as Enrollees or the percentage of the employer contribution drops below the required level.

**D.** 1. For an Eligible Person to enroll himself or herself and any Eligible Dependents for coverage (or for an Enrollee to enroll Eligible Dependents for coverage) the Eligible Person or Enrollee must complete a BCI application and submit it and any required premiums to BCI in a manner approved by both BCI and the Employer.

2. Except as provided otherwise in this section, the Effective Date of coverage for an Eligible Person or an Eligible Dependent is the first day of the month following the month of enrollment.

3. The Effective Date of coverage for an Eligible Person and Eligible Dependents listed on the Eligible Person's application is the Group's Plan Date, if the application is submitted to BCI by the Group on or before the Plan Date.

**E.** BCI, on behalf of the Plan Administrator, will waive the time period applicable to the Preexisting Condition waiting period (set forth in this Plan's Exclusions and Limitations Section) with respect to particular Covered Services for the period of time an Insured was previously covered by Creditable Coverage that provided benefits with respect to such Covered Services, provided that the Creditable Coverage was continuous to a date not more than sixty-three (63) days prior to the Enrollment Date under this Plan. This paragraph does not preclude the application of a probationary period applicable to all new employees.

**F.** 1. Except as stated otherwise in subparagraphs F.2. and 3. below, the initial enrollment period is thirty (30) days for Eligible Persons and Eligible Dependents. The initial enrollment period begins on the date the Eligible Persons or Eligible Dependent first becomes eligible for coverage.

2. 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 Plan from and after the date of birth for 60 days. The Preexisting Condition waiting period (set forth in this Plan’s Exclusions and Limitations Section) does not apply to such Eligible newborn Dependent.

Premium for the first sixty (60) days of coverage is due within ninety (90) days of the date of birth. To continue coverage beyond the sixty (60) days outlined above, the Enrollee must complete an enrollment application and submit the required premium within ninety (90) days of the date of birth.

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.

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 Plan, ‘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 Plan, “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.

3. The initial enrollment period is thirty (30) days for an Eligible Dependent who becomes eligible because of marriage. The initial enrollment period begins on the date of such marriage. The Effective Date of coverage is the first day of the month following the month of enrollment.

**G. Late Enrollee**

If an Eligible Person or Eligible Dependent does not enroll during the initial enrollment period described in Paragraph F. of this section or during a special enrollment period described in Paragraph H. of this section, the Eligible Person or Eligible Dependent is a Late Enrollee who is subject to the 12-month Preexisting Condition waiting period set forth in the Exclusions and Limitations Section of this Plan. Following the receipt and acceptance of a completed enrollment application, the Effective Date of coverage for a Late Enrollee will be the date of the Group’s next Plan Date.

**H. Special Enrollment Periods**

1. Individuals Losing Other Coverage — An Eligible Enrollee or Eligible Dependent losing other coverage may enroll for coverage under this Plan if each of the following conditions is met:
  - a) The Eligible Enrollee or Eligible Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the Eligible Person or Eligible Dependent.
  - b) The Eligible Enrollee’s or Eligible Dependent’s coverage described in subparagraph a):
    - (1) was under a COBRA continuation provision and the coverage under such provision was exhausted; or
    - (2) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of a Domestic Partnership, termination of employment or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.
  - c) Under the terms of this Plan, the Eligible Enrollee requests such enrollment no later than 30 days after the date of exhaustion of coverage described in subparagraph b)(1) or termination of coverage or employer contribution described in subparagraph b)(2).
2. For Dependent Beneficiaries —

- a) If a person becomes an Eligible Dependent of an Enrollee (or of an Eligible Person who failed to enroll during a previous enrollment period) through marriage, commencement of a Domestic Partnership, birth, adoption before age 18 or placement for adoption before age 18, the Eligible Dependent (or, if not otherwise enrolled, the Eligible Person) may enroll, and in the case of the birth or adoption of a child, the spouse of the Enrollee or Eligible Person may enroll as an Eligible Dependent if such spouse is otherwise eligible for coverage.
- b) The dependent special enrollment period under this subparagraph 2 shall be a period of sixty (60) days and shall begin on the date of the marriage, commencement of a Domestic Partnership, birth, adoption or placement for adoption (as the case may be).
- c) If an Enrollee enrolls an Eligible Dependent during the dependent special enrollment period described in this subparagraph 2, the Effective Date of coverage shall be:
  - (1) in the case of marriage or commencement of domestic partnership, the first day of the month following the date Coldwater Creek is notified. Such notification must be provided during the special enrollment period;
  - (2) in the case of an Eligible Dependent's birth, as of the date of such birth; or
  - (3) in the case of an Eligible Dependent's adoption or placement for adoption, the date of birth for an Eligible Dependent adopted or placed for adoption within 60 days of the Eligible Dependent's date of birth; and the date of such adoption or placement for adoption for an Eligible Dependent adopted or placed for adoption more than 60 days after the Eligible Dependent's date of birth.

For the purposes of this Plan, "placed for adoption" means the assumption and retention by the adoptive Enrollee of a legal obligation for total or partial support of a child in anticipation of adoption of such child. The child's placement with the Enrollee terminates upon termination of such legal obligation.

## V. **Qualified Medical Child Support Order**

- A. If this Plan provides Family Coverage BCI, on behalf of the Plan Administrator, will comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of Section 609 of ERISA and any other applicable federal or state laws. A medical child support order is any judgement, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:
  - 1. Provides for child support with respect to a child of an Enrollee or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under this Plan, or
  - 2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.
- B. A medical child support order meets the requirements of a QMCSO if such order clearly specifies:
  - 1. The name and the last known mailing address (if any) of the Enrollee and the name and mailing address of each child covered by the order.
  - 2. A reasonable description of the type of coverage to be provided by this Plan to each such child, or the manner in which such type of coverage is to be determined.
  - 3. The period to which such order applies.
- C.
  - 1. Within fifteen (15) days of receipt of a medical child support order, BCI will notify the party who sent the order and each affected child of the receipt and of the criteria BCI uses to determine if the medical child support order is a QMCSO. In addition, BCI will send an application to each affected child. The application must be completed by or on behalf of the affected child and promptly returned to BCI. With respect to a medical child support order, affected children may designate a representative for receipt of copies of notices sent to each of them.
  - 2. Within thirty (30) days after receipt of a medical child support order and a completed application, BCI will determine if the medical child support order is a QMCSO and will

notify the Enrollee, the party who sent the order, and each affected child of such determination.

- D.** BCI, on behalf of the Plan Administrator, will make benefit payments to the respective party for reimbursement of eligible expenses paid by an enrolled affected child or by an enrolled affected child's custodial parent, legal guardian, or the state Department of Health and Welfare as defined by the QMCSO.

## DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout this Plan. Other terms may be defined where they appear in this Plan. All Providers and Facilities listed in this Plan 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 Plan 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 from a sudden, unforeseen external force or object, occurring at a reasonably identifiable time and place, and without an Insured's foresight or expectation, which requires medical attention at the time of the accident. The force may be the result of the injured party's actions, but must not be intentionally self-inflicted unless caused by a medical condition or domestic violence. Contact with an external object must be unexpected and unintentional, or the results of force must be unexpected and sudden.

**Acute Care**—Medically Necessary Inpatient treatment in a Licensed General Hospital or other Facility Provider for sustained medical intervention by a Physician and Skilled Nursing Care to safeguard 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 an 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 Plan.

**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 Facility Provider that is primarily engaged in providing detoxification and rehabilitative care for Alcoholism, or Substance Abuse, or Addiction.

**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.

**Amendment (Amend)** – a formal document signed by the representatives of Coldwater Creek. The Amendment adds, deletes or changes the provisions of the Plan and applies to all covered persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.

**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.

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

**Benefit Period**—the specified period of time during which an Insured accumulates annual benefit limits, Deductible amounts and Out-of-pocket Limits.

**Blue Cross Of Idaho Health Service, Inc. (Blue Cross of Idaho or BCI)**—a nonprofit mutual insurance company, hired by Coldwater Creek to act as the third party Contract Administrator to perform claims processing and other specific administrative services as outlined in the Plan and/or Administrative Services Agreement.

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

**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.

**Clinical Nurse Specialist**—an individual licensed to practice as a Clinical Nurse Specialist.

**Clinical Psychologist**—an individual licensed to practice clinical psychology.

**Closed List of Dental Covered Services**—the Dental Covered Services listed in this section for which benefits are available.

**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 or Copayments, or both.

**Comprehensive Lifetime Benefit Limit**—the greatest aggregate amount payable by BCI, on behalf of the Plan Administrator and on behalf of an Insured for all Covered Services during all periods in which the Insured has been continuously enrolled or covered under any agreement, certificate, contract, or plan administered on behalf of Coldwater Creek. Payments applied toward specific Lifetime Benefit Limits also apply toward the all-inclusive Comprehensive Lifetime Benefit Limit.

**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 Plan, 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.

**Continuous Crisis Care**—Hospice Nursing Care provided during periods of crisis in order to maintain a terminally ill Insured at home. A period of crisis is one in which the Insured’s symptom management demands predominantly Skilled Nursing Care.

**Contract Administrator** – Blue Cross of Idaho has been hired as the third party Contract Administrator by the Plan Administrator to perform claims processing and other specified administrative services in relation to the Plan. The Contract Administrator is not an insurer of health benefits under this Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Contract Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

**Contracting Dentist**—a Dentist who has entered into a written agreement with BCI or its affiliates regarding payment for Dental Covered Services rendered to an Insured under a PPO Dental Option.

**Contracting Provider**—a Provider that has entered into a written agreement with BCI regarding payment for rendered Covered Services rendered to an Insured under a Preferred Blue 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.

**Covered Provider**—a Provider specified in this Plan 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 Plan for which benefits will be provided to an Insured.

**Creditable Coverage**—coverage of an individual under any of the following:

1. A group health plan.
2. Health insurance coverage.
3. Part A or part B of title XVIII of the Social Security Act (Medicare).
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928.
5. Chapter 55 of title 10, United States Code (Champus).
6. A medical care program of the Indian Health Service or of a tribal organization.
7. A State health benefits risk pool.
8. A health plan offered under chapter 89 of title 5, United States Code (FEHBP).
9. A public health plan (as defined in Federal regulations).
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Creditable Coverage does not include coverage consisting solely of coverage of Excepted Benefits.

**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 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, on behalf of the Plan Administrator, 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.

**Dental Hygienist**—a person licensed to practice dental hygiene who is acting under the supervision and direction of a Dentist. For BCI to provide benefits, the Dental Hygienist must be licensed in the state where service is rendered and the hygienist must be performing within the scope of license.

**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.

**Denturist**—a person licensed by the State of Idaho to engage in the practice of denturism. For BCI to provide benefits, the Denturist must be performing within the scope of license.

**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).

**Domestic Partner**—the partner of an Enrollee with a relationship that demonstrates the following:

1. Partners have executed an Affidavit of Domestic Partnership;
2. Cohabitation in an exclusive mutual commitment similar to that of marriage and have been involved in the domestic partnership for a period of not less than six consecutive months;
3. Neither partner is legally married to any other person nor has another Domestic Partner;

4. Partners are both of the age of consent and are not related by marriage or blood in a way that would otherwise prohibit marriage in the state of their residence;
5. Financial interdependence exists between the Enrollee and the Domestic Partner as evidenced by at least two of the following documents:
  - a) common ownership of real property or a common leasehold in real property;
  - b) common ownership of a motor vehicle;
  - c) joint bank account or joint credit account; or
  - d) designation as a beneficiary for life insurance or retirement benefits.

**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 Plan.

**Electroencephalogram (EEG) Provider**—a Facility Provider that participates with Medicare and has technologists certified by the American Board of Registration of Electroencephalographic and Evoked Potential Technologies to render Covered Services.

**Eligible Dependent**—a person eligible for enrollment under an Enrollee's coverage.

**Eligible Person (Full-time Employee)** – a regular, full-time employee, regularly working 32 compulsory hours per week, meaning *company-directed hours and days of work* and who has been granted that status by the Employer in writing. An employee who in any way restricts their available days and hours of work will not qualify as a regular, full-time employee and is not working *company-directed hours and days of work*.

An employee who regularly works 32 or more weekly *restricted* hours does not qualify as an Eligible Person. An employee who in any way restricts their available hours or days of work does not qualify as a regular, full-time employee.

**Eligible Person (Part-time Employee)** – the Plan is only available to Part-time Employees who were eligible and enrolled in the Plan prior to April 1, 2002. The Plan is closed to any Part-time Employee who did not enroll prior to April 1, 2002.

**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 or Maternity Admission Notification**—notification by the Insured to BCI of an Emergency Inpatient Admission resulting in an evaluation conducted by BCI to determine the Medical Necessity of an Insured's Emergency Inpatient Admission or unscheduled maternity admission, and the accompanying course of treatment.

**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.

**Employer** –Coldwater Creek, also the Plan Administrator.

**Enrollee**—an Eligible Person who has enrolled for coverage and has satisfied the requirements of the Eligibility and Enrollment Section.

**Enrollment Date**—the date of enrollment of an Eligible Person or Eligible Dependent under this Plan, or if earlier, the first day of the probationary period for such enrollment.

**Excepted Benefits**—benefits under one or more (or any combination thereof) of the following:

1. Coverage only for accident, or disability income insurance, or any combination thereof.
2. Coverage issued as a supplement to liability insurance.
3. Liability insurance, including general liability insurance and automobile liability insurance.
4. Workers' compensation or similar insurance.
5. Automobile medical payment insurance.
6. Credit-only insurance.
7. Coverage for on-site medical clinics.
8. Other similar insurance coverage, specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
9. Separately offered:
  - a) Limited scope dental or vision benefits.
  - b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
  - c) Such other similar, limited benefits as are specified in Federal regulations.
10. Independent, noncoordinated benefits offered as:
  - a) Coverage only for a specified disease or illness.
  - b) Hospital indemnity or other fixed indemnity insurance.
11. Benefits offered as a separate insurance policy: Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

**Family Coverage**—the enrollment of an Enrollee and two (2) or more Eligible Dependents under this Plan.

**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.

**Group**—Coldwater Creek, also referred to as the Employer.

**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. 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 Aide**—an individual employed by a Contracting Hospice, under the direct supervision of a licensed registered nurse (R.N.), who performs and trains others to perform, intermittent Custodial Care services which include but are not limited to, assistance in bathing, checking vital signs, and changing dressings.

**Home Health Nursing**—the delivery of Skilled Nursing services under the direction of a Physician to a Homebound patient in their home on an intermittent basis. Home Health Nursing is generally intended to transition a Homebound patient from a hospital setting to a home or prevent a hospital stay.

**Home Intravenous Therapy Company**— a Medicare Certified and licensed, where required, Pharmacy that is principally engaged in providing services, medical supplies, and equipment for certain home infusion Therapy Covered Services, to 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.

**Hospice Nursing Care**—Skilled Nursing Care and Home Health Aide services provided as a part of the Hospice Plan of Treatment.

**Hospice Plan Of Treatment**—a written plan of care that describes the services and supplies for the Medically Necessary palliative care and treatment to be provided to an Insured by a Hospice. The written plan of care must be established and periodically reviewed by the attending Physician.

**Hospice Therapy Services**—Hospice Therapy Services include only the following:

1. Hospice Physical Therapy—the treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain, to enable an Insured to maintain basic functional skills and to manage symptoms.
2. Respiratory Therapy
3. Speech Therapy

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

**Illness**—a deviation from the healthy and normal condition of any bodily function or tissue. An Illness can exist with or without 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.

**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 Plan.

**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, as determined by BCI, 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, 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.

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

**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 Clinical Professional Counselor (LCPC)**—a licensed individual providing diagnosis and treatment of Mental or Nervous Conditions.

**Licensed Clinical Social Worker (LCSW)**—a licensed individual providing diagnosis and treatment of Mental or Nervous Conditions.

**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. Health resort
  - e. Spa or sanatorium
  - f. Place for rest
  - g. Place for the aged
  - h. Place for the treatment or rehabilitative care of Mental or Nervous Conditions
  - i. Place for the treatment or rehabilitative care of Alcoholism or Substance Abuse or Addiction
  - j. Place for Hospice care
  - k. Residential Treatment Facility
  - l. Transitional Living Center

**Licensed Marriage And Family Therapist (LMFT)**—a licensed individual providing diagnosis and treatment of Mental or Nervous Conditions.

**Licensed Pharmacist**—an individual licensed to practice pharmacy.

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

**Lifetime Benefit Limit**—the greatest aggregate amount payable by BCI, on behalf of the Plan Administrator and on behalf of an Insured for specified Covered Services during all periods in which the Insured has been continuously enrolled or covered under any agreement, certificate, contract, or plan administered on behalf of Coldwater Creek. Payments applied toward specific Lifetime Benefit Limits also apply toward the all-inclusive Comprehensive Benefit Limit.

**Maximum Allowance**— for Covered Services under the terms of this Plan, Maximum Allowance is the lesser of the billed charge or the amount established as the highest level of compensation for a Covered Service. If the Covered Services are rendered outside the state of Idaho by 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.

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

**Medically Necessary (or Medical Necessity)**—the Covered Services or supplies required to identify or treat an Insured's condition, Disease, Illness or Accidental Injury and which, as recommended by the treating Physician or other Covered Provider and as determined by BCI, are:

1. The most appropriate supply or level of service, considering potential benefits and harms to the Insured.
2. Proven to be effective in improving health outcomes;
  - a. For new treatments, effectiveness is determined by scientific evidence;
  - b. For existing treatments, effectiveness is determined first by 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, compared to alternative treatments, including no treatment. Cost-effectiveness does not necessarily mean lowest price.

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

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

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

**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. As a condition of their contract with Blue Cross of Idaho, certain Contracting Providers must be certified by Medicare.

**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, nonbiological, 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 Dentist**—a Dentist who has not entered into a written agreement with BCI or its affiliates regarding payment for Dental Covered Services rendered to an Insured under a PPO Dental Option.

**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 this 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**—an individual licensed to practice optometry.

**Organ Procurement**—Diagnostic Services and medical services to evaluate or identify an acceptable donor for a recipient and a donor's surgical and hospital services directly related to the removal of an organ or tissue for such purpose. Transportation for a donor or for a donated organ or tissue is not an Organ Procurement service.

**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).

**Orthotic Devices**—any rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or Diseased body part.

**Out-Of-Network Services**—any Covered Services rendered by a Noncontracting provider.

**Out-Of-Pocket Limit**—the amount of Out-of-pocket expenses incurred during one (1) 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.

**Plan**—the Administrative Services Agreement between Blue Cross of Idaho and the Group and all endorsements, Amendments and attachments to such agreement.

**Plan Administrator**—the Plan Administrator, Coldwater Creek, who is the sole fiduciary of the Plan, has all discretionary authority to interpret the provisions and control the operation and administration of the Plan within the limits of the law. All decisions made by the Plan Administrator, including final determination of Medical Necessity, shall be final and binding on all parties. Coldwater Creek also reserves the right to modify eligibility and/or Preexisting Condition clauses for new Plan participants who join the Plan as a result of a merger, acquisition or for any employee who was covered under a labor agreement plan during a previous period of employment to which Coldwater Creek, contributes, provided that coverage under this Plan begins within 31 days of the date coverage under the previous Plan terminates. Coldwater Creek may choose to hire a consultant and/or Contract Administrator to perform specified duties in relation to the Plan. The Plan Administrator also has the right to amend, modify or terminate the Plan at any time or in any manner as outlined in the Administrative Services Agreement.

The administration of the Plan document is under the supervision of the Plan Administrator, Coldwater Creek. The Employee Benefits Department of Coldwater Creek acts on behalf of the Plan Administrator. Coldwater Creek has agreed to indemnify each employee in the Employee Benefits Department for any liability he/she incurs as a result of acting on behalf of the Plan Administrator, except if such liability is due to his/her gross negligence or misconduct.

**Plan Date**—the date specified in this Plan on which coverage commences for the Group.

**Plan Sponsor** —Coldwater Creek.

**Podiatrist**—an individual licensed to practice podiatry.

**Post-Service Claim**—any claim for a benefit under this Plan that does not require Prior Authorization 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**—a physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months preceding the Enrollment Date. A pregnancy existing on the Enrollment Date is not a Preexisting Condition under this Plan. Genetic information is not considered a Preexisting Condition in the absence of a diagnosis of the condition related to such information.

**Preferred Blue PPO**—a preferred provider organization product offered through BCI.

**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 Plan that requires Prior Authorization before services are rendered.

**Primary Care Giver**—a person designated to give direct care and emotional support to an Insured as part of a Hospice Plan of Treatment. A Primary Care Giver may be a spouse, relative, or other individual who has personal significance to the Insured. A Primary Care Giver must be a volunteer who does not expect or claim any compensation for services provided to the Insured.

**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 solely by BCI.

**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 Plan, Providers include only the following:

1. Facility Providers
  - a. Ambulatory Surgical Facility (Surgery Center)
  - b. Contracting Alcoholism or Substance Abuse Treatment Facility
  - c. Contracting Electroencephalogram (EEG) Provider
  - d. Contracting Hospice
  - e. Contracting Home Intravenous Therapy Company
  - f. Contracting Licensed Rehabilitation Hospital
  - g. Contracting Lithotripsy Provider
  - h. Contracting Psychiatric Hospital
  - i. Diagnostic Imaging Provider
  - j. Freestanding Diabetes Facility
  - k. Freestanding Dialysis Facility
  - l. Home Health Agency
  - m. Independent Laboratory
  - n. Licensed General Hospital
  - o. Prosthetic and Orthotic Supplier
  - p. Radiation Therapy Center
  - q. Skilled Nursing Facility
  
2. Professional Providers
  - a. Ambulance Transportation Service
  - b. Certified Nurse-Midwife
  - c. Certified Registered Nurse Anesthetist
  - d. Contracting Certified Speech Therapist
  - e. Chiropractic Physician
  - f. Clinical Nurse Specialist
  - g. Contracting Clinical Psychologist
  - h. Contracting Licensed Clinical Professional Counselor (LCPC)
  - i. Contracting Licensed Clinical Social Worker (LCSW)
  - j. Contracting Licensed Marriage and Family Therapist (LMFT)
  - j. Dentist/Denturist
  - k. Durable Medical Equipment Supplier
  - l. Contracting Licensed Occupational Therapist
  - m. Licensed Pharmacist
  - n. Contracting Licensed Physical Therapist
  - o. Nurse Practitioner
  - p. Optometrist/Optician
  - q. Physician
  - r. Physician Assistant
  - s. Podiatrist

**Psychiatric Hospital**—a Facility Provider principally engaged in providing diagnostic and therapeutic services and Rehabilitation Services for the Inpatient treatment of Mental or Nervous Conditions, Alcoholism or Substance Abuse or Addiction. These services are provided by or under the supervision of a staff of Physicians, and continuous nursing services are provided under the supervision of a licensed R.N. A Psychiatric Hospital provides these services for compensation from and on behalf of its patients.

**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.

**Respite Care**—care provided to a Homebound Insured as part of a Hospice Plan of Treatment. The purpose of Respite Care is to provide the Primary Care Giver a temporary period of rest from the stress and physical exhaustion involved in caring for the Insured at home.

**Single Coverage**—the enrollment of only the Enrollee under this Plan.

**Skilled Nursing Care**—nursing service that must be rendered by or under the direct supervision of a licensed 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 that 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.

**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.
4. Customary preoperative and postoperative care.

**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; for 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 a 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 Plan.

## EXCLUSIONS AND LIMITATIONS SECTION

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

### I. General Exclusions And Limitations

There are no benefits 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 this Plan is expressly required by federal law, or provided or paid for by any state or local governmental entity where its charges therefore would vary, or would be affected by the existence of coverage under this Plan, 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 Plan 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.

3. Benefits for reconstructive Surgery to correct an Accidental Injury are available even though the accident occurred while the Insured was covered under a prior insurer's coverage, if there is no lapse between the prior coverage and coverage under this Plan.
- L.** Rendered prior to the Insured's Effective Date, or during an Inpatient Admission commencing prior to the Insured's Effective Date except as specified in the General Provisions Section of this Plan.
- 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, 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 Inpatient admissions that are primarily for Diagnostic Services or Therapy Services; or for Inpatient admissions when the Insured is ambulatory and/or confined primarily for bed rest, special diet, behavioral problems, environmental change, or for treatment not requiring continuous bed care.
- P.** 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 this Plan.
- 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 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 this Plan.
- 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.** 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.
- V.** Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.
- W.** 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.
- X.** For Acute Care, rehabilitative care, or diagnostic testing or evaluation of Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, or for Pain Rehabilitation, except as specified as a Covered Service in this Plan.
- Y.** Incurred by an Eligible Dependent child for care or treatment of any condition arising from or related to pregnancy, childbirth, delivery, or an Involuntary Complication of Pregnancy, unless specifically provided as a Covered Service in this Plan.

- Z.** For any of the following, even if it is a result of a Congenital Anomaly or a developmental problem and even if it is Medically Necessary—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; or for alveolectomy or alveoloplasty when related to tooth extraction.
- AA.** For weight control or treatment of obesity or morbid obesity, even if Medically Necessary, including but not limited to Surgery for obesity. For reversals or revisions of Surgery for obesity, except when required to correct an immediately life-endangering condition.
- 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 Plan.
- AC.** For the reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties.
- AD.** 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.
- AE.** For Transplant services and Artificial Organs, except as specified as a Covered Service under this Plan.
- AF.** For acupuncture.
- AG.** 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 this 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.
- AH.** For Hospice Home Care, except as specified as a Covered Service in this Plan.
- AI.** For pastoral, spiritual, bereavement, family and/or marriage counseling.
- AJ.** For homemaker and housekeeping services or home-delivered meals.
- AK.** 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.
- AL.** For treatment or other health care of any Insured in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Insured to Covered Services under this Plan, if and to the extent those benefits are payable to or due the Insured 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 Insured, and the Insured’s heirs and personal representative against all insurers, underwriters, self-insurers, or other such obligors contractually liable or obliged to the Insured, 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.

- AM.** Any services or supplies for which an Insured would have no legal obligation to pay in the absence of coverage under this Plan or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage.
- AN.** 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, unless specified as a Covered Service under this Plan.
- AO.** For immunizations except as specifically provided as a Covered Service in the Plan.
- AP.** For breast reduction Surgery or Surgery for gynecomastia.
- AQ.** For nutritional supplements, nutritional replacements, nutritional formulas, prescription vitamins and minerals.
- AR.** For an elective abortion, surgical or medical, or complications from 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 this Plan.
- AS.** For alterations or modifications to a home or vehicle.
- AT.** For special clothing, including shoes (unless permanently attached to a brace).
- AU.** 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.
- AV.** Provided outside the United States, which if had been provided in the United States, would not be a Covered Service under this Plan.
- AW.** Furnished by a Provider or caregiver that is not listed as a Covered Provider, including but not limited to, Naturopaths.
- AX.** For self-help programs related to outpatient pulmonary and/or outpatient cardiac rehabilitation.
- AY.** For complications arising from the acceptance or utilization of noncovered services.
- AZ.** For the use of Hypnosis, as anesthesia or other treatment, except as specified as a Covered Service.
- AAA.** For dental implants, appliances, and/or prosthetics, and/or treatment related to Orthodontia, even when Medically Necessary, unless specified as a Covered Service in this Plan.
- AAB.** For arch supports, orthopedic shoes, and other foot devices.
- AAC.** Benefits for contraceptives, unless specified as a Covered Service in this Plan.
- AAD.** For wigs and cranial molding helmets.
- AAE.** 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.
- AAF.** For the purchase of Therapy or Service Dogs/Animals and the cost of training/maintaining said animals.

**II. Preexisting Condition Waiting Period**

If the eligible person or the eligible dependent has a Preexisting Condition, related expenses will not be considered if they are incurred before twelve (12) consecutive months from the Enrollment Date.

The Preexisting Condition limitation will be reduced by any Creditable Coverage (not including any coverage preceding a break in coverage of 63 days or more) determined to exist under a previous health plan. The determination regarding the length of any Preexisting Condition limitation period that applies to the eligible person or eligible dependent will be made within a reasonable time following receipt of a certificate of coverage or other accurate and reliable information relating to prior Creditable Coverage. The eligible person or eligible dependent will be notified of this determination and the basis relied upon in support for such determination.

If the enrollee while eligible for coverage under this Plan, adopts a child or a child is placed with them for adoption and the child is otherwise eligible for coverage under this Plan, the waiting period will be waived, if the child is enrolled within sixty (60) days of the qualifying event.

**III. Comprehensive Lifetime Benefit Limit**

The Comprehensive Lifetime Benefit Limit for Covered Services is shown in the Benefits Outline and is subject to all of the other provisions of this Plan, including any and all Lifetime Benefit Limits for certain specified Covered Services. However, if an Insured has previously received benefits under one (1) or more agreements, certificates, contracts and/or policies administered by BCI for Employer, the amount of benefits furnished while continuously enrolled under all such previous agreements, certificates, contracts, and policies will be deducted from the Comprehensive Lifetime Benefit Limit available to the Insured under this Plan. When an Insured has reached his or her Comprehensive Lifetime Benefit Limit, no further benefits shall be owed or paid to the Insured under this Plan or any other agreement, certificate, contract or policy administered by BCI for the Employer.

**IV. Restoration**

\$5,000 is the amount that will be restored each Benefit Period to an Insured's Comprehensive Lifetime Benefit Limit as long as the Insured has not previously reached his or her Comprehensive Lifetime Benefit Limit. However, in no event will the amount restored exceed the amount paid by BCI for Covered Services in the preceding Benefit Period.

## GENERAL PROVISIONS SECTION

### I. Termination Or Modification Of An Insured's Coverage Under This Plan

- A.** If an Enrollee ceases to be an Eligible Person or the Group does not remit the required premium, the Enrollee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day of the last month for which payment was made. If the Group does not remit the required payments as required by the Administrative Services Agreement and Blue Cross of Idaho elects to terminate this Agreement, the enrollee's coverage and the coverage of any and all enrolled eligible dependents will terminate on the last day for which the Group reimbursed Blue Cross of Idaho for the payment of claims and administrative fees.
- B.** Except as provided in this paragraph, coverage under this Plan will terminate on the date an Insured no longer qualifies as an Insured, as defined in the Eligibility and Enrollment Section. Coverage will not terminate because of age for an Insured who is an unmarried dependent child incapable of self-sustaining employment by reason of mental handicap or retardation or physical handicap, who became so incapable prior to reaching the age limit, and who is chiefly dependent on the Enrollee for support and maintenance, provided the Enrollee, within thirty-one (31) days of when the dependent child reaches the age limit, has submitted to BCI (at the Enrollee's expense) a Physician's certification of such dependent child's incapacity. BCI, on behalf of the Plan Administrator, may require, at reasonable intervals during the two (2) years following when the child reaches the age limit, subsequent proof of the child's continuing disability and dependency. After two (2) years, BCI, on behalf of the Plan Administrator, may require such subsequent proof once each year. Coverage for the dependent child will continue so long as this Plan remains in effect, the child's disability and financial dependency exists, and the child has not exhausted benefits.
- C.** Termination or modification of this Plan automatically terminates or modifies all of the Insured's coverage and rights hereunder. It is the responsibility of the Group to notify all of its Insureds of the termination or any modification of this Plan, and BCI's notice to the Group, upon mailing or any other delivery, constitutes complete and conclusive notice to the Insureds.
- D.** Except as otherwise provided in this Plan, no benefits are available to an Insured for Covered Services rendered after the date of termination of an Insured's coverage.
- E.** The Plan Administrator, may terminate or retroactively rescind an Insured's coverage under this Plan for any misrepresentation, omission, or concealment of fact by, concerning, or on behalf of any Insured that was or would have been material to the Plan Administrator's acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.
- F.** Prior to legal finalization of an adoption, the coverage provided in this Plan for a child placed for adoption with an Enrollee continues 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 terminates on the last day of the month in which such event occurs.
- G.** Coverage under this Plan will terminate for an Eligible Dependent on the last day of the month he or she no longer qualifies as an Eligible Dependent due to a change in eligibility status.

### II. Plan Administrator—COBRA and ERISA

BCI is not the plan administrator for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments to it; nor is BCI the plan administrator for the Employee Retirement Income Security Act (ERISA) and any amendments to it. Except for services BCI has agreed to perform regarding COBRA, the Plan Sponsor is responsible for satisfaction of notice, disclosure, and other obligations

if these laws are applicable to the Group. For additional information please see the “How to Continue Coverage under COBRA” document at the back of this Plan.

### **III. Contract Between BCI And The Group—Description Of Coverage**

This Plan is a contract between BCI and the Group. BCI will provide the Group with copies of the Plan to give to each Enrollee as a description of coverage, but this Plan shall not be construed as a contract between BCI and any Enrollee. BCI’s mailing or other delivery of copies of this Plan to the Group constitutes complete and conclusive issuance and delivery thereof to each Enrollee.

### **IV. Applicable Law**

This Plan shall be governed by and interpreted according to the laws of the state of Idaho.

### **V. Benefits To Which Insureds Are Entitled**

- A.** Subject to all of the terms of this Plan, an Insured is entitled to benefits for Covered Services in the amounts specified in the benefit sections and/or in the Benefits Outline.
- B.** In the event of an Inpatient Admission that occurs prior to the Group’s transfer to BCI and the Effective Date of coverage under this Plan, benefits will be provided only when the Insured receives services that are Covered Services under this Plan. The outgoing carrier has primary responsibility for providing benefits for the Inpatient treatment from the date of admission until the first of the following events occur:
- The Insured is discharged,
  - The Benefit Period under the previous coverage ends, or
  - Until benefits under the outgoing carrier’s policy are exhausted.
- BCI will provide benefits for Covered Services incurred following the Effective Date of coverage reduced by the benefits paid by the outgoing carrier.
- 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 for Covered Services specified in this Plan are provided only for Covered Services that are rendered by the Covered Providers specified in the benefit sections of this Plan 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. The Plan Administrator and/or BCI shall not assume nor have any liability for conditions beyond its control which affect the Insured’s ability to obtain Covered Services.
- F.** Coldwater Creek intends the Plan to be permanent, but because future conditions affecting Coldwater Creek cannot be anticipated or foreseen, Coldwater Creek reserves the right to amend, modify, or terminate the Plan at any time, which may result in the termination or modification of the Insureds’ Coverage. Expenses incurred prior to the Plan modification or termination will be paid as provided under the terms of the Plan prior to its modification or termination. Any material change made to this Plan will be provided in writing within sixty (60) days of the effective date of change.

### **VI. Notice Of Claim**

BCI will process claims for benefits on behalf of the Group according to the Administrative Services Agreement between the parties. A claim for Covered Services must be submitted within one year from the date of service and must include all the information necessary for BCI, on behalf of the Plan Administrator, to determine benefits.

### **VII. Release And Disclosure Of Medical Records And Other Information**

- A.** In order to effectively apply the provisions of this Plan, 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 the Insured’s 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 the

Insured's privacy, BCI treats all information in a confidential manner. For further information regarding BCI's privacy policies and procedures, the Insured may request a copy of BCI's Notice of Privacy Practices by contacting customer service at the number provided in this Plan.

- B. As a condition of coverage under this Plan, 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.

#### **VIII. Exclusion Of General Damages**

Liability under this Plan for benefits conferred hereunder, including recovery under any claim or breach of this Plan, 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.

#### **IX. Payment Of Benefits**

Blue Cross of Idaho provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

- A. BCI, on behalf of the Plan Administrator, is authorized by the Insured to make payments directly to Providers rendering Covered Services to the Insured for benefits provided under this Plan. Notwithstanding this authorization, BCI, on behalf of the Plan Administrator, reserves and shall have the right to make such payments directly to the Insured. Except as provided by law, BCI's right, on behalf of the Plan Administrator, to pay an Insured directly is not assignable by an Insured nor can it be waived without BCI's concurrence, on behalf of the Plan Administrator, nor may the right to receive benefits for Covered Services under this Plan be transferred or assigned, either before or after Covered Services are rendered. Payments will also be made in accordance with any assignment of rights required by state Medicaid plan.
- B. Once Covered Services are rendered by a Provider, BCI, on behalf of the Plan Administrator, shall not be obliged to honor Insured requests not to pay claims submitted by such Provider, and BCI, on behalf of the Plan Administrator, shall have no liability to any person because of its rejection of such request; however, in its sole discretion, for good cause, BCI, on behalf of the Plan Administrator, may nonetheless deny all or any part of any Provider claim.
- C. Under normal conditions, all benefits are payable to the Provider of services or supplies. All other benefits are payable to the Provider of services or supplies and can only be paid directly to another party upon signed authorization from the Insured. If conditions exist under which a valid release or assignment cannot be obtained, this Plan may make payment to any individual or organization that has assumed the care or principal support for the Insured and is equitably entitled to payment. This Plan must make payments to the Insured's separated/divorced spouse, state child support agency or Medicaid agency if required by a qualified medical child support order (QMCSO), or state Medicaid law.

If required by law this Plan may also honor benefit assignments made prior to the Insured's death in relation to remaining benefits payable by this Plan.

Any payment made by BCI, on behalf of the Plan Administrator, in accordance with this provision will fully release the Plan Administrator of its liability to the Insured.

#### **X. Insured/Provider Relationship**

- A. The choice of a Provider is solely the Insured's.
- B. BCI does not render Covered Services but only makes payment for Covered Services received by Insureds. BCI and the Plan Administrator are not liable for any act or omission or for the level of competence of any Provider, and BCI and the Plan Administrator have 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.

**XI. Participating Plan**

BCI may, in its sole discretion, 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.

**XII. Coordination Of This Plan'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 the Contract, 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

4. The Contract covering the spouse of the non-Custodial Parent.

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**

- A. 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.
- B. 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.

**XIII. Benefits For Medicare Eligibles Who Are Covered Under This Plan**

- A.** If the Group has twenty (20) or more employees, any Eligible Person or spouse of an Eligible Person who becomes or remains an Insured of the Group covered by this Plan after becoming eligible for Medicare (due to reaching age sixty-five (65)) is entitled to receive the benefits of this Plan as primary, unless such Insured elects Medicare as his or her primary coverage. The Group must notify BCI in writing of any Insured’s election. Any Insured who elects Medicare as primary is not eligible for coverage under this Plan as of the date of such election.
- B.** If the Group has one hundred (100) or more employees or the Group is an organization which includes an employer with one hundred (100) or more employees, any Eligible Person, spouse of an Eligible Person or dependent child of an Eligible Person who becomes or remains an Insured of the Group covered by this Plan after becoming eligible for Medicare due to disability is entitled to receive the benefits of this Plan as primary, unless such Insured elects Medicare as his or her primary coverage. The Group must notify BCI in writing of any Insured's election. Any Insured who elects Medicare as primary is not eligible for coverage under this Plan as of the date of such election.
- C.** An Insured eligible for Medicare based solely on end stage renal Disease is entitled to receive the benefits of this Plan as primary for eighteen (18) months only, beginning with the month of Medicare entitlement, if Medicare entitlement is effective before March 1, 1996. If Medicare entitlement is effective on or after March 1, 1996, the Insured is entitled to receive the benefits of this Plan as primary for thirty (30) months only, beginning with the month of Medicare entitlement.
- D.** The Group’s retirees, if covered under this Plan, and Eligible Persons or spouses of Eligible Persons who are not subject to paragraphs A., B. or C. of this provision and who are Medicare eligible, will receive the benefits of this Plan reduced by any benefits available under Medicare. This applies even if the Insured fails to enroll in Medicare or does not claim the benefits available under Medicare.

**XIV. Incorporated By Reference**

All of the terms, limitations and exclusions of coverage contained in this Plan are incorporated by reference into all sections, endorsements, riders, and Amendments and are as effective as if fully expressed in each one unless specifically noted to the contrary.

**XV. 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 Plan.

**B. Formal Appeal**

An Insured who wishes to formally appeal a Pre-Service Claim decision by BCI, on behalf of the Plan Administrator, may do so through the following process:

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and the documents in support of such appeals may be submitted by phone or facsimile. The appeal should set forth the reasons why the Insured contends BCI’s decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

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

**C.** An Insured who wishes to formally appeal a Post-Service Claims decision by BCI, on behalf of the Plan Administrator, may do so through the following process:

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

**D. External Review**

At BCI's discretion, and on behalf of the Plan Administrator, an additional review is available for Adverse Benefit Determinations based upon medical issues including medical necessity and investigational treatment. An Insured must first exhaust both levels of the formal appeals process before submitting a request for External Review to the Appeals and Grievance Coordinator. A request for External Review must be sent within sixty (60) days of the date of Blue Cross of Idaho's second formal written appeal decision. External Review will be made by an impartial provider, associated with an independent review organization, who practices in the same or a similar specialty as the one involved in the review. The Independent Review Organization will issue a determination within sixty (60) days of receipt of the request for External Review.

Submission of an appeal for External Review is voluntary and does not affect an Insured's right to file a civil action under section 502(a) of the Employee Retirement Income Security Act (ERISA) following the exhaustion of the formal appeals process, except that the time to file such action shall be tolled while the External Review is pending.

**XVI. 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 Plan, the Enrollee must reimburse the erroneous benefits to BCI, on behalf of the Plan Administrator.

The reimbursement is due and payable as soon as BCI notifies the Enrollee and requests reimbursement. BCI, on behalf of the Plan Administrator, 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, on behalf of the Plan Administrator, may reduce benefits or reduce an allowance for benefits as a set-off toward reimbursement.

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

**XVII. Subrogation and Reimbursement Rights Of Blue Cross Of Idaho**

The benefits of this Plan 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, on behalf of the Plan Administrator under this Plan or any other Blue Cross of Idaho plan, agreement, certificate, contract or plan, Blue Cross of Idaho, on behalf of the Plan Administrator shall be subrogated and succeed to the rights of the 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, on behalf of the Plan Administrator may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

Subrogation is taking over the Insured's right to receive payments from other parties. The Insured or his or her legal representative will transfer to Blue Cross of Idaho, on behalf of the Plan Administrator any rights he or she may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Insured. Thus, Blue Cross of Idaho, on behalf of the Plan Administrator 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, on behalf of the Plan Administrator will be reimbursed in full for all benefits paid even if the Insured is not made whole or fully compensated by the recovery. Moreover, Blue Cross of Idaho and the Plan Administrator are not responsible for any attorney's fees, other expenses or costs incurred by the Insured without the prior written consent of Blue Cross of Idaho and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Insured hires regardless of whether amounts recovered are used to repay benefits paid by Blue Cross of Idaho, on behalf of the Plan Administrator.

Additionally, Blue Cross of Idaho, on behalf of the Plan Administrator may at its option elect to enforce its right of reimbursement from the 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, on behalf of the Plan Administrator in its investigation, evaluation, litigation and/or collection efforts in

connection with the injury, harm or loss and shall do nothing whatsoever to prejudice the Plans reimbursement rights and efforts.

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

To the extent that Blue Cross of Idaho, on behalf of the Plan Administrator provides or pays benefits for Covered Services, Blue Cross of Idaho's rights of subrogation and reimbursement extend to any right the 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, on behalf of the Plan Administrator shall have the right, at its option, to seek reimbursement from, or enforce its right of subrogation against, the 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, on behalf of the Plan Administrator for Covered Services, and for benefits to be provided or payments to be made by Blue Cross of Idaho, on behalf of the Plan Administrator in the future on account of the injury, harm or loss giving rise to Blue Cross of Idaho's subrogation and reimbursement rights. Further, the Plans 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 the Plan Administrator.

Collections or recoveries made in excess of such incurred Plan expenses shall first be allocated to such future Plan expenses, and shall constitute a special Deductible applicable to such future benefits and services under this or any subsequent Plan. Thereafter, Blue Cross of Idaho, on behalf of the Plan Administrator 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.

#### **XVIII. 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.

#### **XIX. Bluecard Payment Calculations - Employee Information**

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

- The billed charges for your Covered Services, or
  - The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us.
- Often, this "negotiated price" will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care Provider or with a specified group of Providers. The price that reflects

average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount you pay is considered a final price.

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

**XX. 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 any time.

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.

**XXI. Coverage And Benefits Determination**

BCI is vested with authority and discretion to determine eligibility for coverage and whether a claim for benefits is covered under the terms of this Plan, based on all the terms and provisions set forth in this Plan, and also to determine the amount of benefits owed on claims which are covered.

**XXII. Transfer Privilege**

An Insured may be eligible to transfer his or her health care coverage to a BCI individual policy if the Insured ceases to be eligible for coverage under this Plan. If an Insured's enrollment status changes as indicated below, the following Insureds may apply for transfer if the Insured has not reached his or her Comprehensive Lifetime Benefit Limit:

- A. The Enrollee, if the Enrollee ceases to be an Eligible Person as specified in the Eligibility and Enrollment Section. The Enrollee may include enrolled Eligible Dependents in the Enrollee's application for transfer.
- B. An enrolled dependent child who ceases to be an Eligible Dependent as specified in the Eligibility and Enrollment Section.
- C. The Enrollee's spouse (if an Insured) upon entry of a final decree of divorce or annulment.
- D. Enrolled Eligible Dependents of the Enrollee upon the Enrollee's death.

To apply for a transfer, the Insured must submit a completed application and the appropriate premium to BCI within thirty (30) days after the loss of eligibility of coverage. If approved, benefits under the new policy are subject to the rates, regulations, terms, and provisions of the new policy.

If the Group or BCI terminates this Plan, and the Group provides another health care plan to its employees effective immediately after the termination of this Plan, no Insured will be entitled to this transfer privilege.

**XXIII. Health Care Providers Outside the United States**

The benefits available under this Plan 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 Plan.

## **RIGHTS OF PLAN PARTICIPANTS**

As a participant in the Employee Benefit Plan, you are entitled to certain rights under federal law.

According to the law, you have the right to examine, without charge at the Plan Administrator's office or other specific locations, all documents and contracts of the Plan that are filed with the U.S. Department of Labor, such as detailed annual reports and Plan Contracts. You may obtain copies of all documents upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. You are also entitled to receive a summary of the Plan's annual financial report.

If your claim for benefits under this Plan is denied in whole or in part, you will receive a written explanation of the reason for the denial. If you do not agree with the denial, you have the right to ask the Plan Administrator to review the claim. If you are not satisfied with the result of such a review, you may file suit in a state or federal court.

Federal law imposes duties on the individuals responsible for the operation of the Plan to do so carefully and in the interest of all participants. No one, including your Employer, a union, or any other person, may fire you or discriminate against you to prevent you from obtaining any benefit under the Plan or exercising your rights under federal law.

Under federal law, there are steps you can take to enforce your rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. The court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials unless the delay is beyond the control of the Plan Administrator. If the people who operate the Plan misuse the Plan's money, or if you are discriminated against for enforcing your rights you may seek assistance from the U.S. Department of Labor or file suit in a federal court. If you do file suit, the court will decide who should pay court costs and legal fees. If your case is upheld by the court, the court may order the person or organization you have sued to pay related expenses. If you lose or the court finds your case frivolous, you may be ordered to pay the court costs and legal fees.

If you have a question about this statement or about your rights under ERISA, HIPAA, or other applicable law, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, Seattle District Office, 1111 Third Avenue, Suite 815, MIDCOM Tower, Seattle, Washington 98101-3212, Phone: 206-553-7700 or as listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor 200 Constitution Avenue, NW, Washington, D.C. 20210.

## GENERAL INFORMATION

### Name and Address of the Plan Sponsor and Plan Administrator

Coldwater Creek  
One Coldwater Creek Drive  
Sandpoint, Idaho 83864  
208-265-7674

### Name and Address of the Third Party Contract Administrator

Blue Cross of Idaho  
3000 E. Pine Avenue  
Meridian, ID 83642-5995  
PO Box 7408  
Boise, Id 83707  
(208) 345-4550

### Name and Address of the Reinsurance Carrier

Blue Cross of Idaho  
3000 E. Pine Avenue  
Meridian, ID 83642-5995  
PO Box 7408  
Boise, Id 83707  
(208) 345-4550

### Name and Address of the Designated Agent for Service of Legal Process

Nathlie White  
One Coldwater Creek Drive  
Sandpoint, Idaho 83864

### Internal Revenue Service and Plan Identification Number

The corporate tax identification number assigned by the Internal Revenue Service is (#820419266) the Plan number is (#10030052).

### Plan Year

The Plan Year is the 12-month fiscal period for Employee Benefit Plan beginning July which is used for the purpose of IRS tax filing.

### Method of Funding Benefits

Health and dental benefits are self-funded from Employer and employee contributions.

Payments out of the Plan to health care providers on behalf of the covered person will be based on the provisions of the Plan.

# **How to Continue Coverage under COBRA**

*The following information is not administered by Blue Cross of Idaho and is not related or part of the Medical Benefit Plan administered by Blue Cross of Idaho. All requests and inquiries for services need to be directed to your Human Resources Department and/or your COBRA administrator.*

## How to continue coverage under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you and/or your eligible dependents may be eligible to continue medical coverage (called “COBRA coverage”) at group rates. This COBRA coverage is available in certain instances, called “qualifying events,” where coverage under the Coldwater Creek, Inc. Benefit Plan would otherwise end. You may elect to continue coverage at your own expense on an after-tax basis when the coverage that you have through the Coldwater Creek, Inc. Benefit Plan ends. The coverage described below may change as permitted or required by changes in any applicable law.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. In some states, state law provisions may also apply to the insurers offering benefits under the Coldwater Creek, Inc. Benefit Plan. (For more information, contact Conexis at the address shown under the Contacting the COBRA Administrator Section of the policy.)

You don’t have to show that you’re insurable to choose COBRA coverage. However, COBRA coverage is provided subject to your eligibility for coverage as described below. Coldwater Creek, Inc. reserves the right to terminate your coverage retroactively if it’s determined that you’re ineligible under the terms of the Coldwater Creek, Inc. Benefit Plan.

You’ll have to pay the entire cost of coverage – your share and Coldwater Creek, Inc.’s – plus a 2% administrative fee. There’s a grace period of at least 30 days for the payment of the regularly scheduled premium. A 45-day grace period applies for your first premium payment.

### COBRA at a glance

The following table provides an overview of available COBRA coverage. See the sections following the table for more details.

<b>Who Is Affected</b>	<b>Qualifying or Other Event</b>	<b>Who Is Eligible for COBRA Coverage</b>	<b>Duration of COBRA Coverage</b>
<b>You</b>	You leave employment for reasons other than gross misconduct	You and your eligible dependents (who lose coverage)	Up to 18 months

*This information is not administered by Blue Cross of Idaho and is not related or part of the Medical Benefit Plan administered by Blue Cross of Idaho. All requests and inquiries for services need to be directed to your Human Resources Department and/or your COBRA administrator.*

<b>Who Is Affected</b>	<b>Qualifying or Other Event</b>	<b>Who Is Eligible for COBRA Coverage</b>	<b>Duration of COBRA Coverage</b>
	You experience a reduction in hours below the level required for benefit eligibility	You and your eligible dependents (who lose coverage)	Up to 18 months
	You are Social Security disabled when you become eligible for COBRA or within the first 60 days after an 18-month COBRA continuation coverage period begins	You and your eligible dependents	Up to 29 months*
<b>Your Spouse, Domestic Partner or Dependent Child</b>	You die	Your eligible dependents (who lose coverage)	Up to 36 months
	You and your spouse become divorced or you and your domestic partner terminate your partnership	Your eligible dependents (who lose coverage)	Up to 36 months
	Your spouse or domestic partner and/or dependent child is disabled when he/she becomes eligible for COBRA or within the first 60 days after an 18-month COBRA continuation coverage period begins	You and your eligible dependents	29 months*
<b>Your Dependent Child</b>	Your dependent child is no longer an eligible dependent (for example, due to age limit)	Your dependent child (who loses coverage)	36 months

\* You're required to provide proof of eligibility for Social Security disability benefits to be eligible for the additional 11 months of COBRA coverage.

## **Who is eligible for COBRA**

If you're covered by the Coldwater Creek, Inc. Benefit Plan on the day before a qualifying event, you have the right to choose COBRA coverage if you lose that coverage because of a reduction in your hours of employment or the termination of your employment (unless you're terminated because of your gross misconduct).

If you're enrolled in the Coldwater Creek, Inc. Benefit Plan and don't return to work following a leave of absence qualifying under the Family and Medical Leave Act (FMLA), the event that will trigger COBRA coverage is the date that you indicate you won't be returning to work following the leave or the last day of the FMLA leave period, whichever is earlier.

If you're the spouse or domestic partner of an employee and you're covered by the Coldwater Creek, Inc. Benefit Plan on the day before the qualifying event, you're considered a qualified beneficiary. That means you have the right to choose COBRA coverage for yourself if you lose group health coverage under the Coldwater Creek, Inc. Benefit Plan for any of the following reasons:

- your spouse or domestic partner dies;
- your spouse's or domestic partner's employment is terminated (for reasons other than your gross misconduct) or your spouse's hours of employment are reduced; or
- you divorce or terminate your domestic partnership.

If you're an eligible dependent of an employee and you're covered under the Coldwater Creek, Inc. Benefit Plan on the day before the qualifying event, you're also considered a qualified beneficiary. This means you have the right to COBRA coverage if your coverage under the Coldwater Creek, Inc. Benefit Plan is lost for any of the following reasons:

- the employee dies;
- the employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced;
- the employee divorces or terminates a domestic partnership;
- you cease to be a "dependent child" under the Coldwater Creek, Inc. Benefit Plan.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption or placement for adoption) during that period of continuation coverage, the new child is a qualified beneficiary. In accordance with the terms of the Coldwater Creek, Inc. Benefit Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing Conexis with a written notice of the new child's birth, adoption or placement for adoption at the address listed under the Contacting the COBRA Administrator Section of the policy. This written notice should include information about the employee or qualified beneficiary receiving COBRA coverage and the new child who will be receiving COBRA coverage. Conexis may ask you to provide documentation supporting the birth, adoption or placement for adoption of the new child.

If the covered employee fails to notify Conexis in a timely fashion (in accordance with the terms of the Coldwater Creek, Inc. Benefit Plan), the covered employee won't be offered the option to elect COBRA coverage for the new child until the next annual enrollment period. Newly acquired eligible dependents (other than children born to, adopted by, or placed for adoption with the employee) won't be considered qualified beneficiaries but may be added to the employee's COBRA coverage as dependents by notifying Conexis, according to the Coldwater Creek, Inc. Benefit Plan's rules that apply to active employees.

### **Your duties**

Under the law, an active employee, a family member, or their representative must inform the Coldwater Creek Employee Benefits Manager or Administrator of a divorce, termination of domestic partnership or child's loss of dependent status under the Coldwater Creek, Inc. Benefit Plan. This notice must be provided within 60 days from the latest of (1) the date of the divorce, termination of domestic partnership or loss of dependent status, (2) the date coverage is lost because of the event, or (3) the date on which you were informed of the responsibility to provide the notice, and the Coldwater Creek, Inc. Benefit Plan's procedures for providing such notice to the Coldwater Creek Employee Benefits Manager or Administrator.

Notice must be provided to the Coldwater Creek Employee Benefits Manager or Administrator on the appropriate enrollment form, which may be obtained from the Coldwater Creek Employee Benefits Manager or Administrator. The form should be returned to Coldwater Creek Employee Benefits Manager or Administrator at the address shown under the Contacting the COBRA Administrator Section of the policy.

The notice must include information about the employee or qualified beneficiary requesting COBRA coverage and the qualifying event that gave rise to the individual's right to COBRA coverage.

If an active employee, family member, or personal representative fails to return the form to the employee's Coldwater Creek Employee Benefits Manager or Administrator during this 60-day period, any family member who loses coverage will lose the right to elect COBRA coverage.

When the Coldwater Creek Employee Benefits Manager or Administrator is notified that one of these events has happened, Conexis in turn will notify you that you have the right to choose COBRA coverage.

### **Employer's duties**

Qualified beneficiaries will be notified of the right to elect COBRA coverage (without any action required by the employee or a family member) if they lose coverage because of any of the following events:

- the employee dies;
- the employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced.

### **Electing COBRA**

To elect or inquire about COBRA coverage, contact your Coldwater Creek Employee Benefits Manager or Administrator or Conexis.

Under the law, you have 60 days to elect COBRA coverage measured from the date you would lose your active coverage because of one of the events described earlier, or, if later, 60 days after you receive notice of your right to elect COBRA coverage. An employee or family member who doesn't choose COBRA coverage within the time period described above loses the right to elect COBRA coverage. The employee and family members will be required to reimburse the Coldwater Creek, Inc. Benefit Plan for any claims mistakenly paid after the date coverage would normally have ended.

If you choose COBRA coverage, your coverage will be the same coverage you had immediately before the event and the same coverage that is being provided to similarly situated beneficiaries. "Similarly situated" refers to a current employee or dependent who hasn't had a qualifying event. You'll have the same opportunity to change coverage as active employees have, e.g. at annual enrollment or if you gain a new dependent. This also means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified in the same

way. Your COBRA rights are provided as required by law. If the law changes, your rights will change accordingly.

### **Separate elections**

Each qualified beneficiary has the right to elect COBRA coverage. This means that an eligible dependent can elect COBRA coverage even if the covered employee chooses not to. However, an employee or eligible dependent may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

### **Length of COBRA coverage**

If elected, COBRA coverage begins on the date your coverage as an active employee ends. For eligible dependents who no longer satisfy the requirements for dependent coverage, COBRA coverage begins on the date their dependent coverage ends. However, coverage won't take effect unless COBRA coverage is elected as described above and the required premium is received. The maximum duration of COBRA coverage depends on the reason you or your covered dependents are eligible for COBRA coverage.

If group health coverage ends because of your termination of employment or reduction in hours, COBRA coverage may continue for you and your covered eligible dependents for up to 18 months.

COBRA coverage for your covered eligible dependents may continue for up to 36 months if coverage would otherwise end because:

- you die;
- you divorce or terminate a domestic partnership; or
- your dependent child loses eligibility for coverage.

### **Additional qualifying events**

Your eligible dependents may have additional qualifying events while they are covered by COBRA. These events can extend their 18-month continuation period to 36 months, but in no event will they have more than 36 months of COBRA measured from the date of the first qualifying event [or loss of coverage] that originally allowed them to elect coverage. This

extension may be available to the eligible dependent receiving continuation coverage if the employee or former employee dies, gets divorced or terminates a domestic partnership, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the additional event would have caused the eligible dependent to lose coverage under the Coldwater Creek, Inc. Benefit Plan had the first qualifying event not occurred. However, if termination of employment or reduction of hours follows Medicare enrollment, the COBRA coverage period for your eligible dependents is 36 months from the Medicare enrollment date or 18 months from the subsequent termination or reduction of hours, whichever is longer.

The law requires a qualified beneficiary to notify Conexis if any of these additional qualifying events occur. This notice must be provided within 60 days from the latest of (1) the date of the second qualifying event, (2) the date coverage would have been lost because of the event, or (3) the date on which the qualified beneficiary is informed of the responsibility to provide the notice. The notice must include Coldwater Creek, Inc. Benefit Plan's procedures for providing such notice.

Notice of the additional qualifying event must be provided to Conexis on the appropriate form, which may be obtained from Conexis. The form should be returned to Conexis at the address shown under the Contacting the COBRA Administrator Section of the policy.

The notice must include information about the qualified beneficiary requesting additional COBRA coverage and the qualifying event that gave rise to the individual's right to additional COBRA coverage.

If a qualified beneficiary (or their representative) fails to provide the appropriate notice to Conexis during the 60-day notice period, the qualified beneficiary won't be entitled to extended COBRA coverage.

### **Special rules for disability**

The 18 months of COBRA coverage may be extended to 29 months if an employee or covered family member is determined by the Social Security Administration to be disabled at any time during the first 60 days of an 18-month COBRA coverage period. This 11-month extension is available to all family members who have elected COBRA coverage due to the termination of employment or reduction in hours. It applies even to family members who aren't disabled.

To benefit from the extension, the qualified beneficiary must provide Conexis with the disability determination within 60 days after the later of (1) the Social Security Administration's determination of disability, (2) the date on which a qualifying event occurs, (3) the date coverage

is lost because of the qualifying event, or (4) the date on which the qualified beneficiary is informed of the responsibility to provide the notice, and the Coldwater Creek, Inc. Benefit Plan's procedures for providing such notice to Conexis. The notice of Social Security disability must be furnished to Conexis before the end of the original 18-month COBRA coverage period.

If, during COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, Conexis must be informed within 30 days of either the re-determination or the date on which the qualified beneficiary is informed of the responsibility to provide the notice and the procedures for providing such notice. This notice must be provided to Conexis on the appropriate form, which may be obtained from Conexis. The 11-month COBRA extension will end at the end of the month in which the notice is received. The notice must include information about the employee or covered family member requesting a disability COBRA coverage extension or notifying Conexis that he/she is no longer disabled.

If a qualified beneficiary is receiving COBRA coverage under a disability extension and has another qualifying event during the 29-month continuation period, then the COBRA coverage period extends until 36 months after the date coverage was originally lost. The qualified beneficiary must provide the appropriate notice to Conexis as described under the Contacting the COBRA Administrator Section of the policy.

#### Early termination of COBRA coverage

The law provides that your COBRA coverage may be cut short before the expiration of the 18-, 29- or 36-month period for any of the following reasons:

- Coldwater Creek, Inc. Benefit Plan no longer provides group health coverage to any of its employees;
- the premium for COBRA coverage isn't paid on time (within the applicable grace period);
- the qualified beneficiary becomes covered – after the date COBRA coverage is elected – under another group health plan that doesn't contain any applicable exclusion or limitation for any pre-existing condition of the individual;
- the qualified beneficiary first becomes entitled to Medicare after the date COBRA coverage is elected; or
- coverage has been extended for up to 29 months due to disability, and the Social Security Administration has made a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated early because of your participation in that other plan.

## **COBRA and FMLA**

Taking an approved leave under the Family and Medical Leave Act (FMLA) isn't considered a qualifying event that would make you eligible for COBRA coverage. However, a COBRA qualifying event occurs if:

- you or your eligible dependent is covered by the Coldwater Creek, Inc. Benefit Plan on the day before the leave begins (or you or your eligible dependent becomes covered during the FMLA leave); and
- you don't return to employment at the end of the FMLA leave or you terminate employment during your leave.

Your COBRA coverage may begin on the earlier of the following:

- when you definitively inform Coldwater that you're not returning to work; or
- the end of the leave, if you don't return to work.

## **Cost of COBRA Coverage**

Under the law, you may be required to pay up to 102% of the cost of COBRA coverage. If your coverage is extended from 18 months to 29 months for disability, you may be required to pay up to 150% of the cost of COBRA coverage beginning with the 19th month of coverage.

The cost of group health coverage periodically changes. If you elect COBRA coverage, Conexis will notify you of any changes in the cost. Premiums are established in a 12-month determination period and will increase during that period if the Coldwater Creek, Inc. Benefit Plan has been charging less than the maximum permissible amount, if the qualified beneficiary changes coverage level, or in the case of a disability extension.

The initial payment for COBRA coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis. You have a grace period of at least 30 days.

### **Contacting the COBRA Administrator**

If you have any questions about COBRA coverage or the application of the law, contact your Coldwater Creek Employee Benefits Manager or Administrator or the COBRA Administrator, Conexis, at the addresses listed below. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

Also, you must notify Conexis in writing immediately at the address listed below if:

- your marital or domestic partnership status has changed;
- you or your eligible dependent has changed address; or
- a dependent loses eligibility for dependent coverage under the terms of the Coldwater Creek, Inc. Benefit Plan.
- All notices and other communications regarding COBRA coverage and the Coldwater Creek, Inc. Benefit Plan-sponsored group health plan should be directed to your local Coldwater Creek Employee Benefits Manager or Administrator or Conexis at:

### **Coldwater Creek Employee Benefits Manager or Administrator**

For Parkersburg, WV Call Center and Distribution Center Employees:  
601 Coldwater Creek Drive, Mineral Wells, WV 26120  
(304) 420-0400

For Coeur d'Alene, ID Call Center Employees:  
751 Hanley Avenue, Coeur d'Alene, ID 83815  
(208) 665-1000

For Sandpoint Corporate and all Retail Employees –  
One Coldwater Creek Drive, Sandpoint, ID 83864  
(208) 263-2266

## **CONEXIS**

Attn: Written Correspondence Team  
PO Box 226101  
Dallas, TX 75222

### **Coverage certificate**

When your COBRA coverage ends, you automatically receive a certificate of coverage that:

- confirms that you had whatever medical coverage you continued through COBRA; and
- states how long you were covered.

If you become eligible for other medical coverage that excludes or delays coverage for certain pre-existing conditions, you can use this certificate to receive credit – against the new plan’s pre-existing condition limit – for the time you were covered by the Coldwater Creek, Inc. Benefit Plan.

In addition to the certificate you receive automatically, you also may request an additional certificate within 24 months after coverage ends.