INTRODUCING YOUR EMPLOYEE BENEFITS PROGRAM

The State of Idaho is pleased to provide a comprehensive benefit program to our eligible employees. For your protection, the program offers you and your family a variety of group insurance benefits including:

- **Blue Cross of Idaho Traditional and PPO Medical Plans:** Providing hospital, physician, prescription drug and vision benefits. EAP benefits are included in each medical plan, with claims management provided by Business Psychology Associates.
- **Delta Dental Plan**: Covers routine and preventive care, basic services, major services and orthodontia.
- **Life Insurance:** Basic Life provided by the State, at no cost to you. Also available is an optional Supplemental Life plan for all eligible employees and State Police Optional Life, for all eligible police officer members of the Idaho State Police.
- **Disability Program**: Short Term Disability and Long Term Disability coverages automatically provided to all eligible employees, at no cost to you.
- **Flexible Spending Accounts:** If you're eligible, the Medical Reimbursement and Dependent Care Reimbursement Accounts can help you save money on your out-of-pocket health and dependent care expenses.
- **Premium Only Plan:** Lets you save money by having your monthly medical and dental premiums deducted from your pay on a pre-tax basis.

This is a summary of the State of Idaho employee benefit programs. Since this is just a brief overview of how the plans work and the benefits they pay, it does ***not*** include all the details about plan provisions, exclusions or limitations. To get the details, be sure to refer to the individual plan contracts included in this handbook at: http://adm.idaho.gov/insurance/contracts.htm .

All plans are administered by the Director of the Department of Administration. The Director is empowered to amend or terminate these plans or any benefits provided by these plans at any time. Participants will be notified as to any such changes as required by governing regulations. Neither this handbook nor any of the State's policies for benefit plans should be considered a contract for purposes of employment or payment of compensation or benefits.

The Director exercises the ultimate discretionary authority and control over the plan and the management and disposition of plan assets. Benefit payments are subject to the provisions of each plan contract. Costs associated with this publication are available from the Department of Administration, Office of Group Insurance in accordance with Section 60-202, Idaho Code – 01/97/2, 500/530l-0461.

TABLE OF CONTENTS

IMPORTANT NUMBERS AND ADDRESSES **4**
OFFICE OF GROUP INSURANCE 4
BENEFITS ONLINE 4
BENEFIT PLANS 5

ABOUT THE PLANS **6**
ELIGIBLE EMPLOYEES 6
ELIGIBLE DEPENDENTS 6
DUAL COVERAGE 6
INITIAL ENROLLMENT AND WHEN COVERAGE BEGINS 7
WAITING PERIODS 8
Medical Plans 8
Dental Plan 8
COORDINATION OF BENEFITS (COB) 8
QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) 8
WHEN COVERAGE ENDS 8
BENEFITS WHILE ON A LEAVE OF ABSENCE 9
Leave Without Pay (LWOP) 9
Family Medical Leave Act (FMLA) 9
Leave With Pay 9
Disability Leave 10
COBRA RIGHTS — CONTINUING HEALTH CARE COVERAGE 10
COBRA Qualifying Events 10
COBRA Extensions 10
COBRA Election 11
Termination of COBRA 11
CONVERSION PRIVILEGES 11
RETIREE BENEFITS 11

MONTHLY PREMIUMS *FISCAL YEAR 2008* **12**
MEDICAL, DENTAL AND VISION 12
BASIC LIFE 13
DISABILITY COVERAGE 14
SUPPLEMENTAL LIFE INSURANCE 14
STATE POLICE OPTIONAL LIFE 14

PREMIUM ONLY PLAN (POP) **15**
MAKING CHANGES 15

MEDICAL PLANS **16**
HOW THE BLUE CROSS OF IDAHO TRADITIONAL PLAN WORKS 16
HOW THE BLUE CROSS OF IDAHO PPO PLAN WORKS 16
MEDICAL PLAN BENEFITS AT A GLANCE 17
Blue Cross Traditional Plan 17
Blue Cross PPO Plan 21
MORE ABOUT YOUR MEDICAL BENEFITS 27
Electing or Declining Coverage 27
Changing Elections 27
Filing Medical Claims 27
Filing Vision Benefit Claims 27

DENTAL PLAN **28**
DECLINING DEPENDENT DENTAL 28
HOW THE DELTA DENTAL PLAN WORKS 28
DENTAL PLAN BENEFITS AT A GLANCE 29
MORE ABOUT YOUR DENTAL PLAN BENEFITS 29
Filing Claims 29

LIFE INSURANCE PLANS **30**
HOW BASIC LIFE WORKS 30
HOW ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) WORKS 31
HOW SUPPLEMENTAL LIFE WORKS 31
HOW STATE POLICE OPTIONAL LIFE WORKS 32
MORE ABOUT YOUR LIFE INSURANCE BENEFITS 32
Your Beneficiary 32
Proof of Good Health 32
Delay of Coverage 32
Filing Claims 32

DISABILITY PROGRAM **33**
HOW THE PLANS WORK 33
Other Sources of Income 34
Filing Claims 34

FLEXIBLE SPENDING ACCOUNTS **35**
HOW THE PLANS WORK 35

IMPORTANT NUMBERS AND ADDRESSES

OFFICE OF GROUP INSURANCE

The Office of Group Insurance, Department of Administration as established in Idaho Code 67, Chapter 57, sponsors and is responsible for the administration of all group medical, dental, life, accidental death and dismemberment, disability, and Flexible Spending Account insurance contracts and policies for the employees of the State of Idaho and their dependents.

To ask questions or obtain information about your benefit coverage, contact the Office of Group Insurance at:

Street Address:	650 W. State Street, Room 100, Boise, ID
Mailing Address:	P.O. Box 83720 Boise, ID 83720-0035
Phone Number:	208-332-1860 (Local) 1-800-531-0597 (Toll-Free Long Distance)
TDD Voice Relay:	1-800-377-1363
TDD Service with Text:	1-800-377-3529
Email:	**ogi@adm.idaho.gov**

BENEFITS ONLINE

Learn about available benefits by going online to the Office of Group Insurance website at http://adm.idaho.gov/insurance/ or the State of Idaho Employee Portal at www.employee.idaho.gov/.

BENEFIT PLANS

Plan	Address and Website	Phone
Blue Cross of Idaho Medical Plans	***Blue Cross of Idaho*** P.O. Box 7408 Boise ID 83707 www.bcidaho.com	208-331-8897 or 1-866-804-2253 (toll-free long distance)
Delta Dental Plan	***Delta Dental*** 555 E. Parkcenter Blvd. Boise, ID 83706 www.deltadentalid.com	208-344-4546 or 1-888-333-3582 (toll-free long distance)
Life Insurance Plans	***Principal Life Insurance Co.*** Des Moines, IA 50392-0002	208-332-1860 or 1-800-531-0597
Disability Program	***Principal Life Insurance Co.*** Des Moines, IA 50392-0002	208-332-1860 or 1-800-531-0597
Flexible Spending Accounts	***Stanley, Hunt, DuPree, Rhine and Associates, Inc.*** P.O. Box 6400 Greenville, SC 29606 www.shdr.com	1-800-930-2417

ABOUT THE PLANS

Here's a brief summary of general provisions of your State of Idaho employee benefit Plans. Remember, for more details be sure to refer to the individual plan contracts, available online at http://adm.idaho.gov/insurance/contracts.htm.

ELIGIBLE EMPLOYEES

You are eligible for benefits if you are an officer or employee of a State department, agency or institution, working twenty (20) hours or more per week, or eighty-four (84) hours per month, and expected to work at least five (5) months during any consecutive twelve (12) month period. There are certain limitations as to employment classifications, which can be found in the individual plan documents or contracts in this handbook.

ELIGIBLE DEPENDENTS

Eligible Dependents include the following:

- Your legal spouse;
- Your unmarried children up to their 19th birthdays. The term "children" includes natural children, stepchildren, adopted children, or children in the process of adoption from the time placed with you. The term "children" also includes children legally dependent upon you or your spouse for support where a normal parent-child relationship exists with the expectation that you will continue to rear that child to adulthood. However, if one or both of that child's natural parents live in the same household with you, a parent-child relationship shall not be deemed to exist, even though you or your spouse provides support.
- Children may be covered beyond their 19th birthdays, but not beyond the end of the calendar month in which they attain the age of twenty-five (25), so long as they remain unmarried and are **eligible** to be claimed as dependents on your most recent U.S. Individual Income Tax return.

DUAL COVERAGE

You cannot be simultaneously insured under any of the State plans:

- As a member of more than one insurance class;
- As an insured individual and an insured dependent; or
- As more than one insured individual or insured dependent.

If you and your spouse both work for the State and are both eligible for the State's employee benefits program, each of you must be covered as an employee — neither of you may be covered as a dependent. Your dependent children may be covered only by one parent, not both.

INITIAL ENROLLMENT AND WHEN COVERAGE BEGINS

When you start work as an eligible employee, you'll need to complete and return all the applicable documents before benefits begin. Your payroll office will provide all the materials you'll need.

Here's a quick look at enrollment rules for the various plans and when coverage may begin under each:

Plans	When You May Enroll	When Coverage May Begin
Medical (including vision and EAP benefits)	Anytime after you start work as an eligible employee	If you enroll: • Within 30 days of your hire date, the first of the month following date of hire; or • After 30 days, the first of the month after you apply for coverage
Dental	Automatic when you enroll for medical	When your medical coverage begins
Basic Life Insurance	No enrollment required for employees or eligible dependents	The first day of the month following your date of hire
Supplemental Life Insurance	Anytime after you start work as an eligible employee	If you enroll: • Within 30 days of your hire date, the first of the month following date of hire • After 30 days, proof of good health will be required. Coverage begins the first of the month after your application is approved
State Police Optional Life Insurance	Same as Supplemental Life	Same as Supplemental Life
Disability Coverage	No enrollment required	The day your Basic Life coverage becomes effective
Flexible Spending Accounts	During annual open enrollment, provided you meet the eligibility requirements	July 1st
Premium Only Plan	Within 30 days after you start work. Enrollment required to elect or decline participation.	• If you enroll, your share of monthly costs will be deducted on a pre-tax basis starting the first paycheck your monthly premiums are withheld • If you decline participation, you'll pay your share of monthly premiums on a post-tax basis for the rest of the contract year

WAITING PERIODS

Medical Plans

The State employee medical plans have a twelve (12)-month waiting period before they will begin to pay benefits for pre-existing conditions. Please refer to the Blue Cross contracts at http://adm.idaho.gov/insurance/contracts.htm for specific details.

If you were covered by another medical plan within sixty-three (63) days of your date of hire with the State and you enroll for coverage within thirty (30) days of employment, the time enrolled under the prior plan may count toward fulfilling this twelve (12) month waiting period. For more information, contact the Office of Group Insurance.

Dental Plan

For all new dental plan enrollees, there is a twelve (12) month waiting period for major care (covered crowns, bridges, dentures) and orthodontia services. Please refer to the Delta Dental Plan contract http://adm.idaho.gov/insurance/contracts.htm for specific details.

Your time enrolled in a prior dental plan cannot be credited against the waiting period in the State's dental plan.

COORDINATION OF BENEFITS (COB)

In addition to your State plan coverage, if you or your enrolled dependents are covered under another group medical or dental plan, the plans' COB provisions will apply. Under COB, State plans will coordinate with your other plans to pay up to, but no more than, the total amount of covered expenses. Refer to the specific plan contract for COB details.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Individual insurance carriers administer all health insurance policies in compliance with applicable Idaho and Federal law. If a court enters a QMCSO or other order regarding enrollment of or payment of medical expenses for a dependent child or alternate recipient, you must provide a copy of the order to the Office of Group Insurance. Your insurance carrier will comply with the order to the extent possible.

WHEN COVERAGE ENDS

Your coverage under the various State sponsored benefit plans ends on the earliest of these dates:

- You cease to be a State employee. If your active status ends:
  - *Before the 15th of a month*, coverage will continue through the end of that month; or
  - *On or after the 15th of a month*, coverage will continue through the end of the following month;
- You cease to be eligible; or
- The plan is terminated.

For your enrolled dependents, coverage ends when your coverage ends or the end of the month in which they cease to be eligible for the plans — whichever comes first.

BENEFITS WHILE ON A LEAVE OF ABSENCE

The State allows employees to take paid and unpaid leaves of absence for a variety of reasons. For more about when and under what circumstances a leave may be approved, contact your Human Resources Office.

You may be able to continue your State benefit plan coverage for a period of time while you're on an approved leave. Keep in mind, after your State medical and dental coverages end, you may qualify for continued coverage via COBRA.

For more information, see the section *COBRA — Continuing Health Care* on page 10. After your group life insurance ends, as described in Conversion Privileges (see page 11), you may be able to convert your coverage to an individual policy.

Leave Without Pay (LWOP)

You may continue the following coverages for up to six (6) months (twelve [12] months if you're on employer-sponsored leave for professional or educational purposes), by self-paying the full monthly premiums, including any amount the State usually pays for active employees:

- Medical, Dental, Basic Life and Supplemental Life and/or State Police Optional Life coverage.

Disability insurance is *not* available for continuation during your leave — State-paid coverage ends after thirty (30) days, counted from the first day after your leave starts.

Family Medical Leave Act (FMLA)

For questions about your eligibility for FMLA, how FMLA works and continuing benefits during FMLA, check with your Human Resources Office.

These continued benefits are available while you're on FMLA leave:

- **Medical and Dental:** The State will continue to pay its share of the premiums, the same as for active employees, while you continue to pay your share during approved FMLA leave. If you exhaust your twelve (12) week FMLA leave, you can continue coverage by self-paying the full cost for the balance of six (6) months following your initial date of leave.

- **Basic Life:** During the FMLA period, the State will pay the monthly premiums. After that, you can continue coverage by self-paying the full cost for a maximum of six (6) months from your initial date of leave.

- **Supplemental Life and Police Optional Life:** For up to six (6) months from the date you go on leave, by self-paying the full premiums.

Leave With Pay

While you're on authorized leave with pay, you'll maintain your active status. Consequently, your Medical, Dental, Basic Life, Supplemental Life and/or State Police Optional Life coverages will continue the same as for any other active employee. That means your payroll deductions will continue as usual.

Disability Leave

When you file a claim for disability benefits, the Office of Group Insurance will send you a detailed explanation of your options for continuing coverage, including your required premium contributions. In general, you may continue State coverage as follows:

- **Medical and Dental:** For up to thirty (30) months from your date of disability (as determined by our disability insurance carrier, Principal Life Insurance Company), or until your disability claim closes, whichever occurs first. During this period, you must pay your share of the monthly premium. While you're in active status (exhausting leave time), your share of the premium will continue to be deducted from your paycheck and your agency will continue to pay the employer's share. Once you are on inactive status, you may self-pay your portion of the monthly premium and the Office of Group Insurance will pay the employer's share of the premium for the balance of the coverage continuation period.

- **Basic Life and Supplemental Life:** For as long as your disability claim is open. Basic Life will continue at no cost to you, but you'll have to pay premiums for Supplemental Life during the first six (6) months following your date of disability. While you're in active status, premium deductions will continue to be deducted from your paycheck. Once you are inactive, you'll need to self-pay your portion of the monthly premium.

- **State Police Optional Life:** For as long as your disability claim is open. You must pay the premiums for the first six (6) months of your approved disability. While you're in active status, premium deductions will continue to be deducted from your paycheck. Once you are inactive, you'll need to self-pay your portion of the monthly premium.

COBRA RIGHTS — CONTINUING HEALTH CARE COVERAGE

After your eligibility for group health care coverage ends, you may be able to purchase continued medical and dental, on an individual basis, for a period of time under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). (See *COBRA Election* on page 11.)

COBRA Qualifying Events

You have the right to continue coverage under COBRA if you have one of the following *qualifying events*. The duration of COBRA coverage available to you depends on the specific event:

Qualifying Event	Individuals Eligible for COBRA	Duration of COBRA Coverage
Your termination of employment Your reduced working hours	Employee Spouse Dependent child	18 months from the date Active plan coverage ends
Your death Your divorce or legal separation	Spouse Dependent child	36 months from the date Active plan coverage ends
Loss of dependent child status	Child	36 months from the date Active plan coverage ends

COBRA Extensions

The eighteen (18) month COBRA period may be extended up to twenty-nine (29) months in the event you are disabled according to the Social Security Administration. Additional information about the twenty-nine (29) month COBRA period is available from the Office of Group Insurance.

If another qualifying event takes place during the eighteen (18) month continuation period that would entitle your dependents to a longer period of continued coverage, the COBRA period for your dependents may be extended. At the most, however, coverage cannot be extended more than thirty-six (36) months.

COBRA Election

To continue coverage, the insured person must complete a COBRA continuation enrollment form within sixty (60) days after group coverage terminates. The COBRA participant must pay the required monthly costs for the continuation of coverage. If you have any questions or need COBRA enrollment forms, contact the Office of Group Insurance at ogi@adm.idaho.gov.

NOTE: The insured person is responsible for notifying the Office of Group Insurance within thirty (30) days of a divorce or legal separation or when a dependent child ceases to be dependent as defined by the plan.

Termination of COBRA

COBRA coverage will end on the earliest of the following dates:

- At the end of the applicable eighteen (18), twenty-nine (29) or thirty-six (36) months of coverage continuation;
- The date the required contributions are no longer made;
- The date the COBRA participant becomes entitled to Medicare;
- The date the COBRA participant becomes covered by any other group health plan — if the new plan does not exclude or limit the person's coverage for preexisting conditions as a result of employment, reemployment or marriage; or
- The date the State terminates health care coverage for all employees.

CONVERSION PRIVILEGES

When COBRA medical coverage ends, you may be able to convert to an individual policy offered by your medical carrier. Also, after your State life insurance coverage ends, you may be able to convert to an individual policy offered by the insurance company — no evidence of insurability is required if you apply within thirty-one (31) days after your group coverage ends. Conversion policies are not available for disability coverage or dental coverage.

Costs, provisions and benefits of conversion policies may differ substantially from those of the group plans. To find out more about medical conversion policies, contact your insurance carrier. Contact the Office of Group Insurance for life insurance conversion information.

RETIREE BENEFITS

To be eligible for the State's retiree group medical plan, you must be receiving monthly retirement benefits from a State retirement system (PERSI, Judicial Branch, Department of Labor). Your unreduced regular retirement allowance must equal or exceed the Single retiree premium rate in effect on the date coverage becomes effective, **OR** you must have ten (10) or more years (20,800 or more hours) of credited state service. Retirees and their covered dependents have Blue Cross of Idaho medical coverage without vision benefits or dental coverage. For more about available retiree benefits, including who's eligible, see the Retired Employee Group Insurance Handbook. You can find this online at the Group Insurance home page: http://adm.idaho.gov/insurance/grp/Retirees/handbooks_manuals_retiree.htm.

MONTHLY PREMIUMS *FISCAL YEAR 2008*

The State group insurance plans each have a monthly premium — that's the amount it costs per month for coverage under the plan. For some benefits, the State pays a substantial portion of the premium and you pay the balance. For others, the State pays the full cost. For certain benefits, you pay the entire premium.

Premium costs can vary from one year to the next. Following is how the premiums are paid for fiscal year 2008.

MEDICAL, DENTAL AND VISION

You and the State share in the monthly cost of these coverages. How much you'll pay depends on which plan you choose and how many family members, including yourself, are enrolled. If you've elected to participate in the Premium Only Plan, your share of the monthly premium will be deducted from your paycheck on a pre-tax basis.

Your 2008 Monthly Premiums	Employee Only	Employee Plus Spouse	Employee Plus Child	Employee Plus Two Or More Children	Employee Plus Spouse And Child	Employee Plus Spouse And Children
Blue Cross of Idaho PPO Plan	$23.00	$59.00	$38.00	$53.00	$72.00	$80.00
Blue Cross of Idaho Traditional Plan	$29.50	$72.50	$48.00	$65.00	$88.00	$98.00
Vision Coverage	$0.00	$2.00	$3.00	$3.00	$4.00	$6.00
Delta Dental	$4.50	$26.75	$22.25	$34.75	$39.00	$45.25

BASIC LIFE

The State pays the premiums for this coverage — there's no cost to you.

DISABILITY COVERAGE

The State pays the full monthly cost for your Short Term Disability and Long Term Disability coverages. **NOTE: Since this coverage is employer-paid, if you ever become disabled under the plan you may have to pay income and FICA (Medicare/Social Security) taxes on some or all of the benefits you get.**

SUPPLEMENTAL LIFE INSURANCE

If you elect this coverage, you pay the entire monthly cost. How much you'll pay depends on your benefit amount and your age group. Following are rates for fiscal year 2008.

Your Age	Your Cost Per $1,000 Coverage
35 and under	.08
36-40	.12
41-45	.17
46-50	.27
51-55	.43
56-60	.77
61-65	1.04
66-70	1.59
71-75	2.27
76-80	3.43
81-85	5.11

STATE POLICE OPTIONAL LIFE

If you take this coverage, you'll pay fifty percent (50%) of the monthly premium and the State pays fifty percent (50%). Your current cost is $3.39 per month.

PREMIUM ONLY PLAN (POP)

The monthly premiums you pay for group insurance coverages are deducted from your paychecks throughout the year. If you pay for medical or dental coverage, you can choose to have those payments deducted before Federal or state income taxes or FICA taxes (Social Security/Medicare) taxes are withheld.

That's good news, because paying *pre-tax* can cut your tax bill — which means more take-home pay for you!

For details about the plan, see the plan contract online at: http://adm.idaho.gov/insurance/contracts.htm.

MAKING CHANGES

After initial enrollment, you may change your POP election *only* during the annual open enrollment period. Changes made at open enrollment become effective July 1st.

MEDICAL PLANS

Eligible employees can enroll themselves and their eligible dependents for medical coverage, and have the choice of a Blue Cross of Idaho Traditional or PPO plan. For details about the plans, see the plan contracts online at: http://adm.idaho.gov/insurance/contracts.htm.

HOW THE BLUE CROSS OF IDAHO TRADITIONAL PLAN WORKS

After you pay an annual deductible, the plan generally pays eighty percent (80%) of most Allowable Charges. You can use any provider you want — but you may save money when you use providers who belong to the Blue Cross of Idaho network of participating providers.

- **Participating Providers** have negotiated with Blue Cross of Idaho to provide plan participants with services at the plan's Allowable Charges. That means they'll accept plan benefits plus your share of the costs (any deductible, coinsurance or copayments) as payment in full.

- **Non-participating Providers** may charge more than the plan's Allowable Charges, which means you're responsible for any amounts that exceed the Allowable Charges plus any deductible and coinsurance amounts.

To locate participating providers, refer to the Blue Cross of Idaho Online Provider directory.

HOW THE BLUE CROSS OF IDAHO PPO PLAN WORKS

The PPO provides for In-Network and Out-of-Network benefits for most commonly provided services. After you pay an annual deductible, the plan generally pays eighty-five percent (85%) of most Allowable Charges provided by an In-Network provider. In-Network Physician Office Visits (office exam only) require a $20 copayment and are not subject to the annual deductible. Eligible Out-of-Network services are subject to a separate deductible, and are generally reimbursed at seventy percent (70%) of most Allowable Charges.

The PPO is not a managed care plan and you are not required to select a primary care physician. In addition, **referrals are not required under the plan,** you can use any provider you want. However, you save money when you use providers who belong to the Blue Cross of Idaho PPO network of participating providers.

- **In-Network Providers** have negotiated with Blue Cross of Idaho to provide plan participants with services at the plan's Allowable Charges. That means they'll accept plan benefits plus your share of the costs (any deductible, coinsurance or copayments) as payment in full.

- **Out-of-Network Providers** may charge more than the plan's Allowable Charges, which means you're responsible for any amounts that exceed the Allowable Charges plus any deductible and coinsurance amounts.

To locate participating providers, refer to the Blue Cross of Idaho Online Provider directory.

MEDICAL PLAN BENEFITS AT A GLANCE

BLUE CROSS TRADITIONAL PLAN

Here are examples of some *medically* necessary expenses covered by the State's Tradition plan. For plan details, including other covered expenses, exclusions and limitations, refer to the plan contracts at http://adm.idaho.gov/insurance/contracts.htm. **NOTE:** Annual amounts, including deductibles, out-of-pocket amounts and benefit limits, are based on a *policy year*. A policy year runs from July 1 through June 30.

Plan Features	Blue Cross of Idaho Traditional Plan
Deductibles • Individual • Family	 Insured pays first $350 of eligible expenses per Benefit Period Insureds pay a combination of $1,050 of eligible expenses for all Insureds under same Family Coverage per Benefit Period. *(No Insured may contribute more than the Individual Deductible amount toward the Family Deductible.)*
Out-Of-Pocket Limit ***Deductible plus Coinsurance*** • Individual • Family Out-of Pocket expenses associated with the following are not included in the Out-of-Pocket Limit: • Amounts that exceed the Maximum Allowance; • Amounts that exceed benefit limits; • Dental Covered Services, except Dental Services Related to Accidental Injury; • Vision Care Covered Services; • Prescription Drug Covered Services; and • Noncovered services or supplies.	 • Insured pays $4,300 of eligible expenses per Benefit Period • When an Insured has met the Out-Of-Pocket Limit, the benefits payable on behalf of the Insured for Covered Services will increase to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for vision care, dental covered services, and Prescription Drug Covered Services. • Insureds pay a combination of $8,600 of eligible expenses per Benefit Period • When Insureds have met the Out-of-Pocket Limit, the benefits payable on behalf of all the Insureds for Covered Services will increase to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for vision care, dental covered services, and Prescription Drug Covered Services. **(No Insured may contribute more than the Individual Out-of-Pocket Limit toward the Family Out-of-Pocket Limit.)**
Comprehensive Lifetime Benefit Limit	BCI 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.

Services BCI Covers	Amount of Payment
Physician Office Visits	BCI pays 80% of Maximum Allowance after Deductible
Hospital Services • Includes coverage for newborn nursery charges • Insureds should check with BCI at (208) 331-8897 or 1-866-804-2253 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 Notification, as appropriate.	BCI pays 80% of Maximum Allowance after Deductible
Employee Assistance Program (EAP) • Administered and preauthorized by Business Psychology Associates (BPA) 1-877-427-2327 or (208) 343-4180	1 – 5 visits per person per Benefit Period
Mental Health and Substance Abuse Inpatient Services • Facility and Professional Services • Services must be preauthorized by BPA 1-877-427-2327 or (208) 343-4180	BCI pays 80% of Maximum Allowance after Deductible (up to 8 days per Insured, per Benefit Period) *(Benefits will be extended with no annual maximum if an insured's diagnosis falls within the Mental Health Parity guidelines)*
Mental Health and Substance Abuse Outpatient Services • Facility and Professional Services • Services must be preauthorized by BPA 1-877-427-2327 or (208) 343-4180	BCI pays 80% of Maximum Allowance after Deductible (up to 30 visits per Insured, per Benefit Period) *(Benefits will be extended with no annual maximum if an insured's diagnosis falls within the Mental Health Parity guidelines)*
Wellness/Preventive Care Services • For specifically listed Covered Services	BCI pays 100% of Maximum Allowance (up to $250 per Insured, per Benefit Period) *(For services in excess of the above limit, BCI pays 80% of the Maximum Allowance after Deductible)*
• For services not specifically listed *Specific benefits are for:* • *Well Baby care and Well Child care – routine or scheduled examinations, including Rubella and PKU tests* • *Adult examinations – annual physical examinations, including pap tests, preventive screening mammogram services, fecal occult blood test, PSA tests, cholesterol panel, and CBC and SMAC blood tests* • *Immunizations – Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rubella, Tetanus, Varicella (Chicken Pox) and routine immunizations included in the State of Idaho Vaccine for Children Program, as amended or revised. (Other immunizations may be covered at the discretion of BCI when Medically Necessary. No benefits are provided for travel vaccines.)*	BCI pays 80% of Maximum Allowance after Deductible

Prescription Drug Benefits		
	Contracting	Noncontracting
Tier 1: Generic Drugs **Tier 2: Brand Name Drugs – no Generic available** **Tier 3: Brand Name Drugs – Generic available** One (1) Copayment for ***each*** 30-day supply Two (2) Copayments for ***each*** 90-day supply of Maintenance drugs only (1-30 day supply, 1 copayment; 31-90 day supply, 2 copayments) **Note:** Certain prescription drugs have Generic equivalents. If the Insured or Provider requests a Brand Name Drug and a Generic Drug is available, the Insured is responsible for the difference between the price of the Generic Drug and the Brand Name Drug plus any applicable Copayment.	Insured pays $10 per prescription Insured pays $18 per prescription Insured pays $40 + difference between Brand Name and Generic Drug, per prescription	Insured pays $25 ***and*** 20% of balance, per prescription
Diabetes Management **Insulin Syringes / Needles** Insulin syringes/needles covered if purchased within 30 days of Insulin purchase (only 1 copayment required) **Other Diabetic Supplies** Benefits shall be provided for blood sugar diagnostics: • Lancets • Swabs • Test strips	Insulin subject to above listed pharmacy copays Insured pays $10 per item	Insured pays $25 ***and*** 20% of balance, per purchase
Contraceptives **Oral Contraceptives Only** • *Only* oral contraceptives are covered for the enrolled employee or employee's enrolled spouse • Prescription birth control drugs *are not* covered for dependent children	Subject to above listed pharmacy copayments	Insured pays $25 ***and*** 20% of balance, per purchase

Vision Care Benefits (VSP)	
Plan Features	VSP Pays Up to the Amounts Listed
Professional Fees	• Eye Exam $32
Materials – Lenses Per Pair	• Single Vision, up to $32 • Bifocal, up to $60 • Trifocal, up to $72 • Lenticular, up to $100 • Frame, up to $30
Contact Lenses – Per Pair (evaluation, materials and fittings only)	• Effective, up to $47 • Medically Necessary, up to $100
Service Frequency Limitations	• Insured may receive one (1) eye exam every twelve (12) months. • Insured may receive one (1) pair spectacle lenses or contact lenses every twelve (12) months. • Insured may receive one (1) frame every twenty-four (24) months.

BLUE CROSS PPO PLAN

Here are examples of some *medically* necessary expenses covered by the State's PPO plan. For plan details, including other covered expenses, exclusions and limitations, refer to the plan contracts at http://adm.idaho.gov/insurance/contracts.htm. **NOTE:** Annual amounts, including deductibles, out-of-pocket amounts and benefit limits, are based on a *policy year*. A policy year runs from July 1 through June 30.

Plan Features	Blue Cross of Idaho PPO Plan In-Network	Blue Cross of Idaho PPO Plan Out-Of-Network
Deductibles • Individual	Insured pays first $250 of eligible expenses per Benefit Period, except for specifically listed In-Network Wellness/Preventive Care Services, Physician office visits, and preventive screening mammogram services	Insured pays first $500 of eligible expenses per Benefit Period
• Family	Insureds pay a combination of $750 of eligible expenses for all Insureds under same Family Coverage per Benefit Period, except for specifically listed In-Network Wellness / Preventive Care Services, Physician office visits, and preventive screening mammogram services *(No insured may contribute more than the Individual Deductible amount toward the Family Deductible.)*	Insureds pay a combination of $1,500 of eligible expenses for all Insureds under same Family Coverage per Benefit Period *(No Insured may contribute more than the Individual Deductible amount toward the Family Deductible.)*
Out-Of-Pocket Limit ***Coinsurance plus Deductible*** • Individual	• Insured pays $3,250 of eligible expenses per Benefit Period	• Insured pays $6,500 of eligible expenses per Benefit Period
• Family	• Insureds pay a combination of $6,750 of eligible expenses per Benefit Period	• Insureds pay a combination of $13,500 of eligible expenses per Benefit Period
Out-of-pocket expenses associated with the following are not included in the Out-of-Pocket Limit: • Amounts that exceed the Maximum Allowance; • In-Network Copayments; • Amounts that exceed benefit limits; • Dental Covered Services, except Dental Services Related to Accidental Injury; • Vision Care Covered Services; • Prescription Drug Covered Services; • Noncovered services or supplies.	*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 Wellness Covered Services, Physician office visits, preventive screening mammogram services, dental covered services, vision care, Prescription Drug Covered Services, and amounts exceeding benefit limits.* **(No Insured may contribute more than the Individual Out-of-Pocket Limit toward the Family Out-of-Pocket Limit.)**	*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 dental covered services, vision care, Prescription Drug Covered Services, and amounts exceeding benefit limits.* **(No Insured may contribute more than the Individual Out-of-Pocket Limit toward the Family Out-of-Pocket Limit.)**

Plan Features	Blue Cross of Idaho PPO Plan In-Network	Blue Cross of Idaho PPO Plan Out-Of-Network
• **Comprehensive Lifetime Benefit Limit**	BCI 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.	

Services BCI Covers	Amount of Payment	
	In-Network	Out-of-Network
Physician Office Visits	Insured pays $20 Copayment per visit *(Any additional services, such as lab, x-ray, and other Diagnostic Services are subject to Deductible and Coinsurance)*	BCI pays 70% of Maximum Allowance after Deductible
Hospital Services • Includes coverage for newborn nursery charges • Insureds should check with BCI (208) 331-8897 or 1-866-804-2253 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 Notification, as appropriate.	BCI pays 85% of Maximum Allowance after Deductible	BCI pays 70% of Maximum Allowance after Deductible
Employee Assistance Program (EAP) • Administered and preauthorized by Business Psychology Associates (BPA) 1-877-427-2327 or (208) 343-4180	1 – 5 visits per person per Benefit Period	
Mental Health and Substance Abuse Inpatient Services • Facility and Professional Services • Services must be preauthorized by BPA 1-877-427-2327 or (208) 343-4180	BCI pays 85% of Maximum Allowance after Deductible	BCI pays 70% of Maximum Allowance after Deductible
	(up to 8 days per Insured, per Benefit Period) *(Benefits will be extended with no annual maximum if an insured's diagnosis falls within the Mental Health Parity guidelines)*	
Mental Health and Substance Abuse Outpatient Services • Facility and Professional Services • Services must be preauthorized by BPA 1-877-427-2327 or (208) 343-4180	BCI pays 85% of Maximum Allowance after Deductible	BCI pays 70% of Maximum Allowance after Deductible
	(up to 30 visits per Insured, per Benefit Period) *(Benefits will be extended with no annual maximum if an insured's diagnosis falls within the Mental Health Parity guidelines)*	

Services BCI Covers	Amount of Payment	
	In-Network	Out-of-Network
Wellness/Preventive Care Services For specifically listed services • *Well Baby and Well Child care – routine or scheduled Well Baby and Well-Child examinations, including Rubella and PKU tests* • *Adult examinations – annual physical examinations, including pap tests, fecal occult blood tests, PSA tests, cholesterol panel, and CBC and SMAC blood tests* • *Immunizations – Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rubella, Tetanus, Varicella (Chicken Pox) and routine immunizations included in the State of Idaho Vaccine for Children Program, as amended or revised. (Other immunizations may be covered at the discretion of BCI when Medically Necessary. No benefits are provided for travel vaccines.)*	Insured pays $20 Copayment per visit Immunizations require no Copayment	No benefits
For services not specifically listed	BCI pays 85% of Maximum Allowance after Deductible	

Prescription Drug Benefits		
	In-Network	Out-of-Network
Tier 1: Generic Drugs **Tier 2: Brand Name Drugs – no Generic available** **Tier 3: Brand Name Drugs – Generic available** One (1) Copayment for ***each*** 30-day supply Two (2) Copayments for ***each*** 90-day supply of Maintenance drugs only (1-30 day supply, 1 copayment; 31-90 day supply, 2 copayments) **Note:** Certain prescription drugs have Generic equivalents. If the Insured or Provider requests a Brand Name Drug and a Generic Drug is available, the Insured is responsible for the difference between the price of the Generic Drug and the Brand Name Drug plus any applicable Copayment.	Insured pays $10 per prescription Insured pays $18 per prescription Insured pays $40 + difference between Brand Name and Generic Drug, per prescription	Insured pays $25 ***and*** 20% of balance, per prescription
Diabetes Management **Insulin Syringes / Needles** Insulin syringes/needles covered if purchased within 30 days of Insulin purchase (only 1 copayment required) **Other Diabetic Supplies** Benefits shall be provided for blood sugar diagnostics: • Lancets • Swabs • Test strips	Insulin subject to above listed pharmacy copays Insured pays $10 per item	Insured pays $25 ***and*** 20% of balance, per purchase
Contraceptives **Oral Contraceptives Only** • *Only* oral contraceptives are covered for the enrolled employee or employee's enrolled spouse • Prescription birth control drugs *are not* covered for dependent children	Subject to above listed pharmacy copays	Insured pays $25 ***and*** 20% of balance, per purchase

Vision Care Benefits (VSP)	
Plan Features	VSP Pays Up to the Amounts Listed
Professional Fees	• Eye Exam $32
Materials – Lenses Per Pair	• Single Vision, up to $32 • Bifocal, up to $60 • Trifocal, up to $72 • Lenticular, up to $100 • Frame, up to $30
Contact Lenses – Per Pair (evaluation, materials and fittings only)	• Effective, up to $47 • Medically Necessary, up to $100
Service Frequency Limitations	• Insured may receive one (1) eye exam every twelve (12) months. • Insured may receive one (1) pair spectacle lenses or contact lenses every twelve (12) months. • Insured may receive one (1) frame every twenty-four (24) months.

MORE ABOUT YOUR MEDICAL BENEFITS

Electing or Declining Coverage

Enrollment information is available from your Human Resources or payroll representative. To enroll yourself and eligible dependents, you must complete an online enrollment form if your agency is on the State Controller's Payroll system, or a hardcopy form if your agency maintains its own payroll system. To *decline* medical coverage, complete the *declination of coverage* section of the enrollment form.

Once you have enrolled in a medical plan, you may not change to another plan until the next Open Enrollment period.

Changing Elections

After your initial enrollment period, you may:

- *Add family members* at any time. You have sixty (60) days to enroll new family members acquired through marriage, birth or adoption. Coverage for a new spouse or stepchildren will begin the first of the month following your date of marriage. Newborns and newborn adoptive children have coverage on their date of birth; adoptive children older than sixty (60) days will have coverage effective on their date of placement with you. If you wait longer than sixty (60) days to enroll them, coverage will be effective the first day of the month following the date you complete the enrollment form.

- *Drop coverage for yourself or dependents at any time.*

Filing Medical Claims

After you enroll, you'll get an identification card from Blue Cross of Idaho. Whenever you receive services from a participating or In-Network provider, just show your ID card — the provider will bill the plan on your behalf.

When you use a non-participating or Out-of-Network provider, you may have to make a claim for reimbursement.

- Submit a detailed invoice from your provider. Be sure to include your name, Blue Cross of Idaho subscriber identification number, and the name of your employer. The address is:

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

Filing Vision Benefit Claims

Blue Cross of Idaho contracts with Vision Service Plan (VSP) for administration of vision benefits. When you use a VSP contracting provider, you won't need to submit the claim - your provider will bill VSP for you. If you use a non-participating VSP provider, you may need to submit the claim yourself.

- Submit a detailed invoice from your provider. Be sure to include your name, subscriber Blue Cross identification number, and the name of your employer. The address is:

  VSP
  PO Box 997105
  Sacramento CA 95899-7105

DENTAL PLAN

The State offers the Delta Dental Plan to you and your eligible family members. Participation in the plan is automatic for employees enrolled in one of the State's medical plans. **NOTE:** Dental is available ***only*** if you participate in a State employee medical plan — you can't elect dental coverage without electing medical.

DECLINING DEPENDENT DENTAL

As an employee, if you elect medical coverage, you're required to take dental. But you can decline dental coverage for your dependents anytime you want. To do that, select "Self only" in the Dental Enrollment section of the medical/dental enrollment form.

Once you've declined dependent dental coverage, you may only obtain it during an open enrollment period.

For details about the plan, including limitations, exclusions and waiting periods, see the plan contract available online at: http://adm.idaho.gov/insurance/contracts.htm.

HOW THE DELTA DENTAL PLAN WORKS

With this plan, you can use any licensed dentist for covered expenses, but it is to your advantage to use a participating Delta Dental Premium or PPO dentist whenever you can. Here's why:

- **Delta Premier and PPO participating dentists** have agreed to provide services to plan participants at a set schedule of negotiated fees. This means network participating dentists will accept plan benefits plus your share of costs (deductible and coinsurance) as payment in full.

- **Non-participating dentists** are not limited in how much they may charge. For these dentists, the plan pays covered costs based on Delta's average fee. If a non-participating dentist happens to charge more than the average fee, you have to pay the extra in addition to any amounts you may owe for the deductible and coinsurance.

To locate participating providers, refer to the Delta Dental Online Provider Directory.

DENTAL PLAN BENEFITS AT A GLANCE

Here's a brief look at how the Delta Dental Plan pays covered expenses. If you use the services of a Delta Dental contracting provider, benefits will be paid at Premier or PPO participating provider levels based on the contracting status of your dentist at the time services are rendered. See the plan contract for details.

Features and Covered Costs	Delta Dental Premier Participating Provider Benefits	Delta Dental PPO Participating Provider Benefits
Annual Deductible	$25 per person	$25* per person
Annual Maximum Benefit	$1,000 per person, not including orthodontic benefits	$1,000 per person, not including orthodontic benefits
Preventive and Diagnostic, Exams, Cleanings, X-Rays	Plan pays 70% of Allowable Benefits, after the deductible	Plan pays 85% of Allowable Benefits
Basic Restorative Services, Fillings	Plan pays 70% of Allowable Benefits, after the deductible	Plan pays 80% of Allowable Benefits, after the deductible
Oral Surgery, Root Canals, Extractions, Periodontics	Plan pays 50% of Allowable Benefits, after the deductible	Plan pays 80% of Allowable Benefits, after the deductible
Major Restorative Services, Crowns, Crown Build-Ups, Dentures, Bridges, after 12-month waiting period	Plan pays 50% of Allowable Benefits, after the deductible	Plan pays 50% of Allowable Benefits, after the deductible
Dependent Orthodontic Services, Only available for eligible dependent children up to age 17, after 12-month waiting period	Plan pays 50% of Allowable Benefits; $1,000 Lifetime Maximum Benefit	Plan pays 50% of Allowable Benefits; $1,000 Lifetime Maximum Benefit

* Deductible does not apply to PPO diagnostic and preventive services

MORE ABOUT YOUR DENTAL PLAN BENEFITS

Filing Claims

Soon after you complete initial enrollment, Delta Dental will send you a member identification card. When you use a participating dentist, your provider will use the information on your identification card to bill the plan directly and you won't have to make a claim.

If you use a non-participating dentist, you may have to make a claim for reimbursement. Just send a detailed invoice from your provider along with your name, employer's name, and subscriber identification number to:

Delta Dental
P.O. Box 2870
Boise, ID 83701

LIFE INSURANCE PLANS

For the financial protection of your family, the State offers a variety of life insurance plans:

- **Basic Life:** *Automatic* for all eligible employees, their spouses, and their unmarried dependent children, age 10 days to 25 years. The plan includes an Accidental Death & Dismemberment (AD&D) provision for employees only;
- **Supplemental Life:** *Optional plan* available to all eligible employees; and
- **State Police Optional Life:** *Optional plan* for all eligible police officer members of the Idaho State Police.

For details about the plans, see the Principal Life Insurance Company contract online at: http://adm.idaho.gov/insurance/contracts.htm.

HOW BASIC LIFE WORKS

If you die while enrolled, the plan will pay your full coverage amount to your beneficiary. (Benefits are reduced for employees age seventy [70] and older). As follows, coverage depends on your employee classification. Enrollment is automatic; however, you will need to designate a beneficiary. See your Human Resources or payroll office for details.

Employee Class	Employee Basic Life Benefit	Dependent Life Benefit
Class A – Certified Officials in active status who are elected Members of Legislature	$20,000	Spouse - $2,000 Dependent children - $1,000 each
Class B – Certified Officials not in Class A and all Employees in active status other than Class C employees; and **Class C** – Police officer members of the Idaho State Police as defined in Section 59-1303(3) of the Idaho Code	100% of annual salary (does not include overtime pay or bonuses). Minimum benefit: $20,000	Spouse - $2,000 Dependent children - $1,000 each

To determine the benefit, annual salary (does not include overtime pay or bonuses) is rounded up to the next $1,000 unless already a multiple of $1,000. For example, if your annual salary is:

- $34,000 per year, coverage would be $34,000; or
- $37,500 per year, coverage would be $38,000.

Terminally ill employees under age seventy (70) may apply for an *accelerated benefit*. Under this benefit, they may receive up to fifty percent (50%) of their Basic Life benefit amount while still living. The minimum benefit is $10,000, the maximum $100,000. The amount paid to beneficiaries will be reduced by the amount paid out as an accelerated benefit, plus any associated interest charges.

HOW ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) WORKS

The Accidental Death and Dismemberment (AD&D) benefit is available *only* to eligible Class B and C employees. AD&D pays a percentage of your annual salary for certain serious physical losses, including loss of life, due to a covered accident. Benefits are reduced for employees age seventy (70) or older.

AD&D benefits are in addition to any paid by Basic Life benefits or other State life insurance plans.

Covered Loss	AD&D Benefit
Loss of Life	100% of annual salary
Loss of Any of These: • Both hands or both feet; • Both eyes; • One hand and one foot; • One hand and one eye; or • One foot and one eye.	100% of annual salary
Loss of One Hand, One Foot, or One Eye	50% of annual salary

"Loss" of a hand or foot means complete, permanent severance at or above wrist or ankle joint. Loss of an eye means the entire and irrevocable loss of sight.

HOW SUPPLEMENTAL LIFE WORKS

If you elect Supplemental Life coverage, the plan will pay benefits in addition to any paid by the Basic Life plan, including AD&D. See your Human Resource or payroll office for enrollment information.

Employee Class	Supplemental Life Benefit
Class A	$10,000
Class B *and* **Class C**	100% of annual salary (does not include overtime pay or bonuses), rounded to the next $1,000

HOW STATE POLICE OPTIONAL LIFE WORKS

This plan is available *only* to eligible **Class C employees,** police officer members of the Idaho State Police as defined in Section 59-1303(3) of the Idaho Code. Plan benefits equal $50,000, payable in addition to any benefits paid by other State life insurance plans.

MORE ABOUT YOUR LIFE INSURANCE BENEFITS

Your Beneficiary

This is the person you name to receive plan benefits if you die:

- Your beneficiary can be anyone you want;
- You can have different beneficiaries for each plan in which you're enrolled;
- You can have more than one (1) beneficiary per plan;
- You can change your beneficiary at any time simply by completing new forms; and
- If you die without a beneficiary, the plan will pay the benefit to the first of these survivors: your spouse, your children, your parents, your brothers and sisters, your executor or administrators.

You're the beneficiary for family members covered by for Basic Life.

Proof of Good Health

If you apply for Supplemental Life or Police State Optional coverage more than thirty (30) days after you start work, you'll have to submit a Health Statement form to show proof of your good health. In some cases, the insurance company may require further evidence of insurability. Proof of good health will also be required if you ever drop Supplemental Life but later want to re-enroll.

Delay of Coverage

If you're not in active status the day life insurance coverage is supposed to begin, coverage will begin the day you return to work. For dependents who are hospitalized, Basic Life coverage begins when they're released from the hospital.

Filing Claims

Claims for life insurance benefits should be submitted as soon as possible after the loss, but no later than twelve (12) months from the date of loss. Claim forms are available from the Office of Group Insurance or your payroll representative.

DISABILITY PROGRAM

The State's Disability Program can help replace a portion of your income if you're ever unable to work due to disability.

Disability benefits are provided only to eligible Class B and C employees. (See chart on page 24 for Class definitions.) If you're eligible, your coverage begins when your Basic Life coverage becomes effective, no special enrollment is required. The cost of the coverage is provided by the State as a portion of your Basic Life policy. For details about these plans, see the plan contract online at: http://adm.idaho.gov/insurance/contracts.htm.

HOW THE PLANS WORK

To qualify for Short Term Disability (STD) and Long Term Disability (LTD) benefits, you must meet the plans' definition of *Total Disability or Residual Disability* as defined in the contract. This means:

- For the first thirty (30) months of disability, you're unable to perform the essential functions of your regular occupation and unable to earn more than seventy percent (70%) of your monthly salary; and
- After thirty (30) months of disability, you're unable to perform the essential functions of any occupation for which you are or may reasonably become qualified based on your education, training or experience, and you are unable to earn more than sixty (60%) of your monthly salary.

Plan	Waiting Period	Maximum Benefit Period
Short Term Disability, benefits equal 60% of monthly pre-disability salary.	The longer of: • 30 continuous days of Total Disability, or • 30 continuous days of Residual Disability, or • The expiration of all accrued sick leave earned at the date of Disability	26 continuous weeks following the date of Total Disability or Residual Disability, as defined by Principal Life Insurance Company, less the Waiting Period
Long Term Disability, benefits equal 60% of your pre-disability monthly salary. Maximum benefit: $3,750 per month.	The longer of: • 26 continuous weeks of Total Disability or Residual Disability, or • The exhaustion of all sick leave earned as of the date of Total disability or Residual Disability	For each employee who becomes Totally Disabled or Residually Disabled (as defined by Principal Life Insurance Company) prior to age 70, benefits payable until the attainment of age 70: • For each employee who becomes Totally Disabled or Residually Disabled between the ages of 70 and 75, benefits are payable until the earlier of: ▪ Recovery; or ▪ Twelve (12) months of benefit payments under this contract. • For each employee who becomes Totally Disabled at age 75 or older, benefits are payable until the earlier of: ▪ Recovery; or ▪ Six (6) months of benefit payments under this contract.

Other Sources of Income

Benefits from the State's disability plans are reduced by *income from other sources* you or your dependents receive or are eligible to receive. Plan benefits plus the other income will combine to replace up to — but no more than — 60% of your pre-disability monthly salary.

Examples of *other sources of income* include:

- Workers' Compensation;
- Social Security;
- Unemployment benefits;
- Employment rehabilitation earnings; and
- Certain retirement benefits.

Filing Claims

To apply for disability plan benefits, you must file a claim as soon as possible. To obtain a Disability Claim packet, contact the Office of Group Insurance at ogi@adm.idaho.gov or (208) 332-1860 or 1-800-531-0597.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) offer a convenient and easy way to save money for eligible medical and dependent care expenses. If you're interested, you can participate in either or both of these plans, whatever suits your needs:

- **Medical Reimbursement Account:** Reimburses out-of-pocket health care costs not covered by any other plan; and

- **Dependent Care Account:** Reimburses the cost of dependent care necessary for you and your spouse to work or attend school full-time.

The ***only*** **time you may enroll** in the FSA plan is during the annual open enrollment period, usually held in late April or early May. To be eligible, you must have ten (10) months of continuous State of Idaho service as of a July 1 Plan Year start date and be eligible to enroll in one of the State's medical plans. Elections you make during open enrollment will apply for the entire Plan year, starting July 1 and continuing through June 30. For details about the plans, see the FSA plan contract online at: http://adm.idaho.gov/insurance/contracts.htm.

HOW THE PLANS WORK

When you enroll, you elect how much you want to contribute to each FSA for the coming plan year. Your contributions are deducted from your paychecks on a pre-tax basis and go directly into the FSA of your choice under your name. When you incur an eligible expense, first you pay the bill out of your own pocket then you submit a claim for reimbursement. All medical Reimbursement Account claims must be accompanied by the Explanation of Benefits your insurance carriers send you when they process claims.

Here's how much you can contribute to each account:

- **Medical Reimbursement Account:** Maximum of $3,000 per plan year; and

- **Dependent Care Account: M**aximum of $5,000 per plan year.

You have until October 31 to file a claim for any expenses incurred during the preceding Plan year or its 75 day grace period.

It's important to keep in mind that the IRS says you must forfeit any money left in your FSA account after the filing deadline. If you're like most people, though, you should be able to avoid forfeiting money by realistically and conservatively choosing how much you're likely to need in the coming year.