

ALPS HEALTH SOLUTIONS IDAHO LAWYERS TRUST

GROUP BENEFITS PLAN

2008 SCHEDULE OF BENEFITS



CONTACT:

TODD POINTS

PHONE: (800) 367-2577

FAX: (406) 7287416

tpoints@alpsnet.com

www.IdahoLawyerBenefit.com

The Idaho Lawyer Benefit Plan is not considered insurance and does not participate in the state guaranty association

SCHEDULE OF BENEFITS

The Schedule of Benefits consists of the summary of Cost Sharing Provisions and the Maximums and Limitations set forth below:

COST SHARING PROVISIONS

The Cost Sharing Provisions set forth below are only a summary. All other Plan terms, maximums, limits and exclusions apply.

THE BENEFIT PERIOD IS A CALENDAR YEAR

Benefit Description	Basic Plan	Standard Plan	Premium Plan	HDHP Plan A	HDHP Plan B
Deductible per Covered Person.	\$2,000	\$1,000	\$500	\$2,500	\$2,500
Deductible per family.	\$4,000	\$2,000	\$1,000	\$5,000	\$5,000
Out-of-Pocket Maximum. <i>PPO Out-of-Pocket Maximum does not apply towards Non-PPO OOP. Non-PPO Out-of-Pocket Maximum does not apply towards PPO Out-of-Pocket Maximum</i>	\$4,000 PPO \$4,000 Non-PPO	\$3,000 PPO \$3,000 Non-PPO	\$1,000 PPO \$1,000 Non- PPO	\$2,500 PPO \$2,500 Non-PPO	\$5,000 PPO \$5,000 Non-PPO
Out-of-Pocket Maximum per covered family. <i>PPO Out-of-Pocket Maximum does not apply towards Non-PPO OOP. Non-PPO Out-of-Pocket Maximum does not apply towards PPO Out-of-Pocket Maximum</i>	\$8,000 PPO \$8,000 Non-PPO	\$6,000 PPO \$6,000 Non-PPO	\$2,000 PPO \$2,000 Non-PPO	\$5,000 PPO \$5,000 Non-PPO	\$10,000 PPO \$10,000 Non-PPO
Lifetime Maximum for all causes.	\$3,000,000	\$3,000,000	\$3,000,000	\$3,000,000	\$3,000,000

Benefit Description	Basic Plan	Standard Plan	Premium Plan	HDHP Plan A	HDHP Plan B
<p>Physician office visit.</p> <p>The Co-payment applies only to those charges for evaluation and management that are performed in an office by the provider.</p> <p>Copayment does not apply towards the Out-of-Pocket Maximum and will continue to apply after satisfaction of the Out-of-Pocket Maximum.</p>	Benefit % Applies, Deductible Applies	\$30 copay, Deductible Waived PPO; Benefit % Applies, Deductible Applies Non-PPO	\$20 copay, Deductible Waived PPO; Benefit % Applies, Deductible Applies Non-PPO	Benefit % Applies, Deductible Applies	Benefit % Applies, Deductible Applies
Benefit Percentage. (After the Deductible is satisfied, the Plan pays the stated Benefit Percentage of the Maximum Eligible Expense (“MEE”) until the Covered Person or family has paid the Out-of-Pocket Maximum. After the Covered Person or family has paid the Out-of-Pocket Maximum, the Plan then pays 100% of the MEE).	60% PPO 50% Non-PPO	80% PPO 65% Non-PPO	80% PPO 65% Non-PPO	100% PPO 100% Non-PPO	80% PPO 60% Non-PPO
Preventive Care. (See “Preventive Care” in the section titled “Limited Medical Benefits”). Deductible is waived. Plan pays:	100% of <i>MEE</i> up to a maximum benefit of \$500 per Covered Person per Calendar Year	100% of <i>MEE</i> up to a maximum benefit of \$500 per Covered Person per Calendar Year	100% of <i>MEE</i> up to a maximum benefit of \$500 per Covered Person per Calendar Year	100% of <i>MEE</i> up to a maximum benefit of \$500 per Covered Person per Calendar Year	100% of <i>MEE</i> up to a maximum benefit of \$500 per Covered Person per Calendar Year

Benefit Description	Basic Plan	Standard Plan	Premium Plan	HDHP Plan A	HDHP Plan B
Prescription Drug Coverage:	<input type="checkbox"/> Covered Person pays the first \$100 prescription drug deductible, then the greater of \$20 or 30% of cost on covered generic drugs; the greater of \$40 or 30% of cost on covered preferred brand drugs; and the greater of \$80 or 30% on covered non-preferred brand drugs. Mail order co-pay = 2x retail co-pay. <input type="checkbox"/> Covered Person pays 30% of cost on specialty prescriptions, prescription deductible is waived.	<input type="checkbox"/> Covered Person pays the first \$100 prescription drug deductible, then the greater of \$10 or 20% of cost on covered generic drugs; the greater of \$20 or 20% of cost on covered preferred brand drugs; and the greater of \$40 or 20% on covered non-preferred brand drugs. Mail order co-pay = 2x retail co-pay. <input type="checkbox"/> Covered Person pays 20% of cost on specialty prescriptions, prescription deductible is waived.	<input type="checkbox"/> Covered Person pays the first \$100 prescription drug deductible, then the greater of \$10 or 20% of cost on covered generic drugs; the greater of \$20 or 20% of cost on covered preferred brand drugs; and the greater of \$40 or 20% on covered non-preferred brand drugs. Mail order co-pay = 2x retail co-pay. <input type="checkbox"/> Covered Person pays 20% of cost on specialty prescriptions, prescription deductible is waived.	<input type="checkbox"/> Covered under medical plan, subject to medical deductible, with prescription discount card, including specialty prescriptions. Then plan pays 100%	<input type="checkbox"/> Covered under medical plan, subject to medical deductible, with prescription discount card, including specialty prescriptions. Then the greater of \$10 or 20% of cost on covered generic drugs; the greater of \$20 or 20% of cost on covered preferred brand drugs; and the greater of \$40 or 20% on covered non-preferred brand drugs. Mail order co-pay = 2x retail co-pay. Covered Person pays 20% of cost on specialty prescriptions.

Unless otherwise indicated in this Plan, the Deductibles and Benefit Percentages above apply to all benefits offered under the Plan.

The Covered Person is responsible for paying:

- **Deductibles**
- **Eligible Expenses up to the Out-of-Pocket Maximum amount and any amount over the Maximum Eligible Expense.**
- **Amounts that exceed benefit limitations, including the lifetime maximum benefit for all causes.**
- **Costs for all non-covered services**
- **Amounts that exceed the allowed charges for out-of-network providers (Non-PPO), except in certain circumstances (such as emergency care).**

In-Network Provider (PPO)

A PPO provider is either an individual (e.g., physician, nurse practitioner, physical therapist) or a facility (e.g., hospital) within a network of providers that has contracted with the Claims Administrator to provide services to Covered Persons under the Plan. A PPO provider has agreed to accept the Plan's Maximum Eligible Expense plus any deductible and co-payment as payment in full for covered services. There is no billing to the Covered Person in excess of the co-payment and deductible amount. The Claims Administrator sends payment directly to the PPO provider.

Covered Persons under the Plan can determine if a provider is a PPO In-Network Provider by calling the Claims Administrator's customer service number or by visiting the Claims Administrator's website at www.abpmtpa.com.

Out-of-Network Provider (Non-PPO)

A Non-PPO provider is not within a network of providers that has contracted directly with the Claims Administrator. A Non-PPO provider can bill the Covered Person the difference between the Maximum Eligible Expense and the total charge of the Non-PPO provider, plus any deductible and co-payment. Therefore, the Covered Person could incur higher out-of-pocket expenses by receiving services from a Non-PPO provider.

Non-PPO Benefit Exception

A Non-PPO Provider is a Physician or Licensed Health Care Provider which is not under contract with a PPO recognized by this Plan. When a covered service is rendered by a Non-PPO provider, charges will be paid as if the service were rendered by a PPO Provider only under one of the following circumstances:

1. Charges for an Emergency as defined by this Plan, limited to only those emergency medical procedures necessary to treat and stabilize an eligible injury or illness and then only to the extent that the same are necessary in order for the Covered Person to be transported, at the earliest medically appropriate time to a PPO Hospital, clinic or other facility, or discharged; or
2. Charges which are incurred as a result of and related to confinement in or use of a PPO Hospital, clinic or other facility only for Non-PPO services and providers over whom or which the Covered Person does not have any choice in or ability to select.
3. Charges for services not available within the PPO Network.
4. The Covered Person's principle residence is located in a Non-PPO Area. The Covered Person has received services, treatments or supplies from a Non-PPO Provider who is physically located within a Non-PPO Area, but for which there is no PPO Provider who renders the same service, treatment or supply. Non-PPO Area is defined by any zip code assigned to that city or town by the U.S. Postal Service.

MAXIMUMS AND LIMITATIONS

MAMMOGRAMS

Deductible	Waived
Benefit Percentage	100%
Maximum Benefit per Mammogram.....	\$125

ORTHOTIC SUPPLY

Deductible	Applies
Benefit Percentage	Applies
Maximum Benefit per Benefit Period	\$350
Maximum Benefit per Lifetime.....	\$700

DURABLE MEDICAL EQUIPMENT

Deductible	Applies
Benefit Percentage	Applies
Maximum Benefit per Benefit Period	\$15,000
Maximum Benefit per Lifetime.....	\$30,000

PROSTHETIC APPLIANCE

Deductible	Applies
Benefit Percentage	Applies
Maximum Benefit per Benefit Period	\$15,000
Maximum Benefit per Lifetime.....	\$30,000

HOSPICE CARE

Deductible	Applies
Benefit Percentage	Applies
Maximum Benefit per Benefit Period	\$10,000
Maximum Benefit per Lifetime.....	\$20,000

REHABILITATION THERAPY

Deductible	Applies
Benefit Percentage	Applies
Maximum Benefit per Lifetime (Inpatient).....	\$100,000

PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY

Deductible	Applies
Benefit Percentage	Applies
Maximum Benefit per Benefit Period	\$5,000

DIABETIC EDUCATION COUNSELING (Limited to counseling by a registered Dietician or Physician)

Deductible	Waived
Benefit Percentage	100%
Maximum Benefit per Benefit Period	\$250

HOME HEALTH CARE

Deductible	Applies
Benefit Percentage	Applies
Maximum number of Visits per Benefit Period	180

ACCIDENTAL INJURY BENEFIT

Deductible	Waived
Benefit Percentage	100%
Maximum Benefit per Accident	\$500

HOSPITAL LIMITATIONS

Deductible	Applies
Benefit Percentage	Applies
Hospital Room and Board Limitation	Average Semi-Private
Intensive Care Unit Limitation	MEE

CHIROPRACTIC CARE

Deductible	Waived
Benefit Percentage	Applies
Maximum Benefit per Treatment	\$25
Maximum Number of Treatments per Benefit Period	35
Maximum Benefit for Diagnostic X-rays per Benefit Period	\$100

“Treatment” includes all services provided during a calendar day

PREVENTIVE CARE

Routine Outpatient Well-child Care (Through 2 years of age)

Deductible	Waived
Benefit Percentage	100%
Maximum Number of Visits Through 2 Years of Age	12

Routine Adult Care

Deductible	Waived
Benefit Percentage	100%
Maximum Benefit per Benefit Period	\$500

ROUTINE PROSTATE SPECIFIC ANTIGEN (PSA) TEST

Deductible	Waived
Benefit Percentage	100%
Maximum Benefit per Period	\$70

ORGAN AND TISSUE TRANSPLANT SERVICES

Deductible	Applies
Benefit Percentage	Applies

Maximum Lifetime Benefit for each Procedure:

Liver Transplant	\$190,000
Heart Transplant	\$265,000
Kidney Transplant	\$75,000
Simultaneous Kidney / Pancreas Transplant	\$125,000
Pancreas Transplant	\$105,000
Lung Transplant	\$215,000
Heart / Lung	\$300,000
Allogenic Stem Cell (related)	\$215,000
Allogenic Stem Cell (unrelated)	\$285,000
Autologous Stem Cell	\$130,000
Other Eligible Transplant or Replacement Procedure	\$75,000
Maximum Aggregate Lifetime Benefit (All Transplant Procedures)	\$500,000

(Maximum Aggregate is subject to the Lifetime Maximum for all Causes)

Services subject to the lifetime maximums include, but are not limited to evaluation; pre-transplant, transplant, and post-transplant care (not including outpatient immunosuppressant drugs); organ donor search, procurement and retrieval; complications related to the procedure and follow-up care for services received during the 12-month period from the date of transplant.

Amounts exceeding the maximum case rate at contracted Centers of Excellence (also known as outliers) will be eligible for reimbursement under Medical benefits up to the Maximum Aggregate Benefit per Lifetime for All transplant procedures. Excess charges at non-contracted facilities will not be eligible for reimbursement.

Additional covered Services include:

1. Licensed ambulance travel for the recipient to the nearest hospital with appropriate facilities. **Charges are payable as specifically stated and limited in the Schedule of Medical Benefits for heart, heart/lung, liver, pancreas or bone marrow transplant procedures.**
2. Non ambulance travel expenses for:
 - a. transportation to and from the site of a Covered Organ Transplant for the recipient and one other person or if the recipient is a minor, transportation costs for two people to accompany the recipient, limited to the then establish IRS mileage rate if driving or the cost of coach class airfare if flying;
 - b. meals, limited to \$50 per person per day; and,
 - c. lodging expenses limited to \$150 per day.

MENTAL ILLNESS

Outpatient Expenses

Deductible	Waived
Benefit Percentage	Applies
Maximum Visits per Benefit Period.....	15

“Visit” for the purposes of this benefit means a session involving therapy counseling and testing which will not exceed one hour an thirty minutes in length, and including all psychological or psychiatric tests ordered during a visit, provided the testing occurs within seventy-two (72) hours after the visit.

Inpatient Expenses

Deductible	Waived
Benefit Percentage	Applies
Maximum Inpatient Days per Benefit Period.....	30
Maximum Lifetime Inpatient Days	90

ALCOHOLISM AND/OR CHEMICAL DEPENDENCY

Outpatient Expenses

Deductible	Applies
Benefit Percentage	Applies
Maximum Benefit per Benefit Period	\$5,000

Inpatient Expenses

Deductible	Applies
Benefit Percentage	Applies
Maximum Benefit per Lifetime.....	\$100,000

SCHEDULE OF DENTAL BENEFITS

Dental Benefit	ISB Dental Plan
Deductible	\$50
Diagnostic / Preventive Services	100%, deductible waived
Routine / Basic Care	80%
Major Restorative Care	50%
Annual Maximum Benefit	\$1,500
Orthodontia (Children only)	
Benefit Percentage	50%
Lifetime Maximum Benefit	\$1,500

VISION COST SHARING PROVISIONS:

<input type="checkbox"/>		Plan pays up to:
	Examination.	\$50 maximum. Limited to once each Benefit Period.
	Eyewear Materials: 1 Set of Frames & Lenses or 1 Set of Contacts or 1 year-supply of Disposable Contacts	\$150 maximum. Limited to once every two Benefit Periods.

EITHER CONTACT LENSES OR SPECTACLE LENSES, BUT NOT BOTH, ARE ELIGIBLE DURING ANY BENEFIT PERIOD.