

Group Policy

ENROLLEE CERTIFICATE

**State of Idaho
Vision**

**Group Number: 10040000
Policy Effective Date: July 1, 2023**

Benefit Period: July 1 through June 30

Notice to Buyer: This Policy provides vision benefits only.

Notice of Privacy Practices

Blue Cross of Idaho Health Services, Inc. (we, us, our) is committed to protecting the privacy of your personal financial and health information. We maintain physical, electronic, and procedural safeguards that comply with legal requirements. You can find an explanation of our privacy practices on our website at www.bcidaho.com/about_us/privacy_policy.asp or by calling 1-877-488-7788.



An Independent Licensee of the Blue Cross and Blue Shield Association

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho and Blue Cross of Idaho Care Plus, Inc., (collectively referred to as Blue Cross of Idaho) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - o Qualified sign language interpreters
 - o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - o Qualified interpreters
 - o Information written in other languages

If you need these services, contact Blue Cross of Idaho Customer Service Department. Call 1-800-627-1188 (TTY: 711), or call the customer service phone number on the back of your card. If you believe that Blue Cross of Idaho has failed to provide these services or

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 711).

Arabic: انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجاناً اتصل على 1-800-627-1188 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

Chinese: 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY: 711)。

Farsi: توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

Japanese: 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188 (TTY: 711) まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Blue Cross of Idaho's Grievances and Appeals Department at:

Manager, Grievances and Appeals
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: grievances&appeals@bcidaho.com
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Nepali: ध्यान दनुहोस्: तपाईंले नेपाली बोलनुहुन्छ भने तपाईंको नमिति भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिविड: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711).

BENEFITS OUTLINE:

This Benefits Outline describes the benefits of this Policy in general terms. It is important to read the Policy 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. If you receive this document and/or any other notices electronically, you have the right to receive paper copies of the electronic documents upon request at no additional charge.

Throughout this Policy, Blue Cross of Idaho may be referred to as BCI. For Covered Services under the terms of this Policy, Maximum Allowance is the amount established by the Vision Care Services Vendor (VCSV) 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.

ELIGIBILITY AND ENROLLMENT

Eligible Employees are officers or employees of state agencies, departments, or institutions, including state officials, elected officials, or employees of other governmental entities which have contracted with the State of Idaho for medical expense coverage, who are working twenty (20) hours or more per week and who are not classified as a seasonal employee or a part-time temporary employee.

1. **Seasonal Employee.** An employee in a position for which the customary annual employment is six (6) months or less.
2. **Part-Time Temporary Employee.** An employee who is expected, at the time of hire, to work twenty (20) hours or more per week but less than thirty (30) hours per week, and whose term of employment is not expected to exceed five (5) consecutive months.

Employees hired on or after the Effective Date of this Policy will have coverage for him or herself and their Dependent(s) effective the first day of the month following date of hire, provided enrollment is completed within thirty (30) days of the date of hire.

(see the Policy for additional Eligibility and Enrollment provisions)



PEDIATRIC VISION CARE BENEFITS (VCSV)

(For Insureds under the age of 19 only)

BENEFITS OUTLINE

Visit our Website at www.bcidaho.com to locate a Participating Provider

*The Participating Provider is responsible for verifying benefits with the VCSV prior to rendering services. An Insured must provide the Participating Provider sufficient information to verify eligibility. Failure of the Insured to provide sufficient information may delay services and may affect benefit payment under this Policy.

| | | |
|---|---|--|
| <p>Service Frequency Limitations</p> | <ul style="list-style-type: none"> • Insured may receive one (1) eye exam per Benefit Period • Insured may receive one (1) pair of Lenses and Frame per Benefit Period • Insured may receive one (1) Contact lens exam and Contact Lens materials (based on modality) in lieu of glasses (Lenses and Frame) per Benefit Period | |
| <p align="center">Vision Services</p> | <p align="center">**Participating Provider <i>The Insured is responsible to pay these amounts:</i></p> | <p align="center">Nonparticipating Provider <i>The Insured is responsible to pay these amounts:</i></p> |
| <ul style="list-style-type: none"> • Exam • Lenses/Frame • Contact Lenses | <p>No Charge (Deductible does not apply)</p> | <p>50% of Maximum Allowance (Deductible does not apply)</p> |

Form No. SOIVisBO (07/23)

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding contract/policy, which contains all the terms and conditions of coverage and exclusions and limitations. Certain services not specifically noted may be excluded. Please refer to the contract/policy issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding contract/policy, the contract/policy will control.



HEALTHY SIGHT VISION CARE BENEFITS (VCSV)

(For Insureds over the age of 19 only)

BENEFITS OUTLINE

Visit our Website at www.bcidaho.com to locate a Participating Provider

1-844-348-0848

*The Participating Provider is responsible for verifying benefits with the VCSV prior to rendering services. An Insured must provide the Participating Provider sufficient information to verify eligibility. Failure of the Insured to provide sufficient information may delay services and may affect benefit payment under this Policy.

For Covered Providers and Services

Copayment

Insured pays \$20 per eye exam and/or \$20 per Frame and Lenses or Medically Necessary Contact Lenses.

Insured pays \$60 per Elective Contact Lens fitting and evaluation (in lieu of eyeglasses).

Service Frequency Limitations

Insured may receive:

- one (1) eye exam every twelve (12) months.
- one (1) pair of Lenses or one (1) pair of Medically Necessary Contact Lenses (in lieu of eyeglasses) or one (1) pair of Elective Contact Lenses (in lieu of eyeglasses) every twelve (12) months.
- one (1) Frame every twenty-four (24) months.
- If Contact Lenses are chosen, Insured will be eligible for a Frame twelve (12) months from the date contact lenses were obtained.

In-Network Services (*Participating Providers)

Payment for Services Rendered and Allowances:

Exam—Insured pays Copayment, as applicable, then BCI pays 100% of Maximum Allowance

Prescription Glasses—Insured pays Copayment, as applicable, then BCI pays 100% of Maximum Allowance for Basic Lenses and Medically Necessary Contact Lenses (in lieu of glasses). Includes Frame allowance of \$130.

Elective Contact Lenses—Insured pays Copayment, as applicable. Includes a Contact Lens fitting and evaluation and \$130 allowance for materials in place of benefits for Prescribed Lenses and Frame.

Out-of-Network Services (Nonparticipating Providers)

Reimbursement Allowances:

Professional Fees

Eye Exam: BCI pays up to \$50

Materials—Lenses per pair

Frame: BCI pays up to \$50

Single Vision Lenses: BCI pays \$50

Lined Bifocals Lenses: BCI pays up to \$80

Lined Trifocals Lenses: BCI pays up to \$95

Progressives Lenses: BCI pays up to \$95

Lenticular Lenses: BCI pays up to \$125

Contact Lenses per pair: \$70

Medically Necessary, up to Maximum Allowance: \$125

Elective Contact Lenses—includes a Contact Lens fitting and evaluation and an allowance for materials in place of benefits for Prescribed Lenses and Frame.

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding contract/policy, which contains all the terms and conditions of coverage and exclusions and limitations. Certain services not specifically noted may be excluded. Please refer to the contract/policy issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding contract/policy, the contract/policy will control.

State of Idaho

Vision

BLUE CROSS OF IDAHO HEALTH SERVICE, INC.

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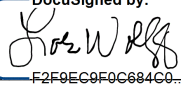
ACCEPTANCE

In consideration of the accepted Blue Cross of Idaho fully insured proposal, and the continuing payment of premiums when due, and subject to all terms of this Policy, Blue Cross of Idaho hereby agrees to provide each enrolled Insured of the Group the benefits of this Policy (Group Policy Number 10040000), beginning on each Insured's Effective Date.

This Policy renews on an annual basis. Premium payments are due on a month-to-month basis. The Group's Policy Date is July 1, 2023 to June 30, 2024.

State of Idaho
Department of Administration
650 West State Street
P.O. Box 83720
Boise, ID 83720-0003

Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID 83707

DocuSigned by:

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Lori Wolff
Interim Director, Department of Administration



Paul Zurlo
President, Health Markets
July 1, 2023

HOW TO SUBMIT CLAIMS

An Insured must submit a claim to BCI's designated Vision Care Services Vendor (VCSV), Vision Service Plan (VSP) in order to receive benefits for Covered Services. There are two (2) ways for an Insured to submit a claim:

1. The vision service Provider can file the claim for the Insured. Most Providers will submit a claim on an Insured's behalf if the Insured shows them a BCI identification card and tells them they have coverage through VSP.
2. The Insured can send the claim to VSP.

To File an Insured's Own Claims

Most In-Network (Participating) vision service Providers will submit a claim for the Insured. If the Insured receives services from an Out-of-Network (Nonparticipating) vision service Provider, the Insured can file the claim directly to VSP. To submit an Out-of-Network claim:

1. The Insured can visit VSP's Website at www.vsp.com and sign in as a Member. Click on the "Benefits" link and then the "Submit a Claim" under the heading "Oops! Did You Go Out of Network" Instructions for completing the form are described. Once completed, mail the form to VSP at the address listed below.
2. Include a copy of the itemized billing statement or receipts and be sure to include the following information:
 - a. Doctor's name or office name
 - b. Name of patient
 - c. Date of Service
 - d. Each service received and the amount paid

Mail to:

Vision Service Plan
Attention: Claims Services
P. O. Box 385018
Birmingham, AL 35238-5018

For assistance with claims the Insured can call VSP Customer Service at 1-844-348-0848 Monday through Friday 6 a.m. – 7 p.m. MT.

How the Insured is Notified

If the Insured receives services from an In-Network Provider (Participating), the Provider will provide a statement explaining the cost of the services. If the Insured receives services from an Out-of-Network Provider (Nonparticipating), VSP will provide a statement of costs to the Insured with a reimbursement check.

ELIGIBILITY AND ENROLLMENT SECTION

I. Eligibility and Enrollment

All Eligible Employees will have the opportunity to apply for coverage under this Policy. All applications submitted to Blue Cross of Idaho (BCI) by the Group now or in the future, shall be for Eligible Employees or Eligible Dependents only. Once enrolled under the Policy, Eligible Employees may not change to another Policy until an Open Enrollment Period.

A. Eligible Employee

Eligible Employees who are officers or employees of state agencies, departments, or institutions, including state officials, elected officials, or employees of other governmental entities which have contracted with the State of Idaho for medical expense coverage, who are working twenty (20) hours or more per week and who are not classified as a seasonal employee or a part-time temporary employee.

1. **Seasonal Employee.** An employee in a position for which the customary annual employment is six (6) months or less.
2. **Part-Time Temporary Employee.** An employee who is expected, at the time of hire, to work twenty (20) hours or more per week but less than thirty (30) hours per week, and whose term of employment is not expected to exceed five (5) consecutive months.

Employees hired on or after the Effective Date of this Policy will have coverage for themselves and their Dependent(s) effective the first day of the month following date of hire, provided enrollment is completed within thirty (30) days of the date of hire.

B. Eligible Dependent

Eligible Dependent means: (1) The spouse of the Enrollee and/or (2) the children of an Enrollee or Enrollee's spouse, up to their 26th birthday. The term "children" includes natural children, stepchildren, adopted children, or children in the process of adoption from time placed with the Enrollee. The term "children" also includes children legally dependent upon the Enrollee or Enrollee's spouse for support where a normal parent-child relationship exists with the expectation that the Enrollee 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 the Enrollee, a parent-child relationship shall not be deemed to exist even though the Enrollee or the Enrollee's spouse provides support.

1. A child as described in the first sentence of subparagraph B who has attained age twenty-six (26) provided:
 - a) The child is medically certified as incapable of self-sustaining employment due to an intellectual disability or physical handicap that began prior to age twenty-six (26);
 - b) The child is chiefly dependent upon the Enrollee or the Enrollee's spouse for support and maintenance; and
 - c) The Enrollee submits proof of such child's incapacity and dependency as described in this subparagraph two (2) within thirty-one (31) days of such child's attainment of age twenty-six (26) and as subsequently required by BCI and/or the Group at reasonable intervals.

C. Conditions

1. An Eligible Employee's spouse may not enroll in this plan if said spouse is an Eligible Employee of the Group and enrolled in any other Health Benefit Plan offered by the Group.
2. Under special circumstances approved by the Group, other children under the custodial care of the Enrollee may be considered as Eligible Dependent(s).
3. If both parents are Eligible Employees of the Group and enrolled in any Health Benefit Plan offered by the Group, eligible dependent children may be enrolled under one or the other parent's policy, but not both.

An Enrollee must notify BCI and/or within thirty (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. Group Employee Premium Contribution

If applicable, the Group agrees to pay the appropriate percentage of the premium for each enrolled Insured, as determined through legislative appropriations. The employee shall authorize the Group to withhold, deduct or collect the monthly payment and remit such payments to BCI in accordance with the application form submitted by each employee. In the event of COBRA, Leave of Absence Without Pay, or other circumstances, the Enrollee may be required to pay the entire premium.

III. Miscellaneous Eligibility and Enrollment Provisions

- A.** The Group agrees to collect required Enrollee payments through payroll withholding and be responsible for making the required payments to BCI. If, during the Benefit Period, the Group offers to its employees any other hospital, medical, or surgical coverage that is available to the Group from BCI, but not provided by or through BCI, including but not limited to, coverage under a fee for service/indemnity plan, managed care organization or other similar program or plan, BCI, at its sole option and upon thirty (30) days written notice to the Group, may recalculate the required premiums for the Group's Insureds. Thereafter, the Group must timely pay the recalculated premiums to maintain coverage under this Policy.
- B.** Before the Effective Date of the change, the Group shall submit all eligibility changes for Enrollees and Eligible Dependents on a BCI approved form (electronic application, e-mail, etc.).
- C.** For an Eligible Employee to enroll himself or herself and any Eligible Dependents for coverage under this Policy (or for an Enrollee to enroll Eligible Dependents for coverage) the Eligible Employee or Enrollee, as the case may be, must complete a BCI application and submit it through the Group to BCI.
- D.** Except as provided otherwise in this section and after completion of any applicable eligibility waiting period as determined by the Group, the Effective Date of coverage for an Eligible Employee or an Eligible Dependent will be the first day of the month following the month of enrollment.
- E.** The Effective Date of coverage for an Eligible Employee and any Eligible Dependents listed on the Eligible Employee's application is the Group's Policy Date if the application is submitted to BCI by the Group on or before the Policy Date. Employees hired on or after the Effective Date of this Policy will have coverage for themselves and their Dependents effective the first day of the month following date of hire, provided enrollment is completed within thirty (30) days of the date of hire.
- F.** An Enrolled Eligible Employee who becomes disabled prior to July 1, 2017 shall be able to maintain their coverage up to thirty (30) months following date of disability, as determined by the group's Life/Disability insurance carrier, upon payment of appropriate premium. An Enrolled Eligible Employee who becomes disabled on or after July 1, 2017 shall be able to maintain their coverage up to six (6) months following date of disability, as determined by the group's Life/Disability insurance carrier, upon payment of appropriate premium.
- G.**
 - 1. Except as provided otherwise in subparagraphs G2. and G3. below, the initial enrollment period is thirty (30) days for Eligible Employee and Eligible Dependents. The initial enrollment period begins on the date the Eligible Employee or Eligible Dependent first becomes eligible for coverage under this Policy.
 - 2. The initial enrollment period is sixty (60) days for an Eligible Dependent who is an Enrollee's newborn natural child, or child who is adopted by the Enrollee, or placed for adoption with the Enrollee before age eighteen (18). 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 Policy from and after the date of birth for sixty (60) days.

In order to continue coverage beyond the sixty (60) days outlined above, the Enrollee must complete an enrollment application and submit the required premium within thirty-one (31) days of the date monthly billing is received by the Group and a notice of premium is provided to the Enrollee by the Group.

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, provided the child is enrolled during the applicable initial enrollment period.

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 Policy, '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 Policy, "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 sixty (60) 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 will be the first day of the month following the date of marriage.

H. Late Enrollee

If an Eligible Employee or an Eligible Dependent does not enroll during the applicable initial enrollment period described in Paragraph G. of this section, the Eligible Employee or Eligible Dependent is a Late Enrollee. 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 Policy Date.

I. Special Enrollment Periods

An Eligible Employee or Eligible Dependent will not be considered a Late Enrollee if:

1. The Eligible Employee or Eligible Dependent meets each of the following:
 - a) The individual was covered under Qualifying Previous Coverage at the time of the initial enrollment period.
 - b) The individual lost coverage under Qualifying Previous Coverage as a result of termination of employment or eligibility, the involuntary termination of the Qualifying Previous Coverage.
 - c) The individual requests enrollment within thirty (30) days after termination of the Qualifying Previous Coverage.
2. The individual is employed by an employer that offers multiple Health Benefit Plans and the individual elects a different plan during an open enrollment period.
3. A court has issued a court order requiring that coverage be provided for an Eligible Dependent by an Enrollee under this Policy, and application for enrollment is made within thirty (30) days after issuance of the court order.
4. The individual first becomes eligible.
5. The Eligible Employee and/or Eligible Dependent become eligible for a premium assistance subsidy under Medicaid or the Children's Health Insurance Program (CHIP) and coverage under this Policy is requested no later than sixty (60) days after the date the Eligible Employee and/or Eligible Dependent is determined to be eligible for such assistance.
6. Coverage under Medicaid or CHIP for an Eligible Employee and/or Eligible Dependent is terminated as a result of loss of eligibility for such coverage, and coverage is requested under this Policy no later than sixty (60) days after the date of termination of such coverage.

IV. Qualified Medical Child Support Order

- A. If this Policy provides for family coverage, BCI 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 judgment, 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 under this Policy 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 Policy, 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 Policy 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.** Within fifteen (15) days of receipt of a medical child support order, BCI will notify the party who sent the order, the group administrator and each affected child of the receipt and of the criteria by which BCI determines if the medical child support order is a QMCSO. 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.
- D.** BCI 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 Idaho Department of Health and Welfare.

PEDIATRIC VISION CARE BENEFITS SECTION (VCSV)

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

I. Eligibility

Pediatric Vision Care Benefits are available through the end of the month following the Insured's nineteenth (19th) birthday.

II. Coinsurance and Limitations on Frequency of Services

The Coinsurance amount and limitations on frequency of services are shown in the Benefit Outline.

III. Covered Providers

The following are Covered Providers under this section:

- Optometrist (OD)
- Ophthalmologist (MD or DO)

IV. Procedures for Obtaining Covered Services

A. An Insured must contact the Vision Care Services Vendor (VCSV) Participating Provider to make an appointment to receive Covered Services. The doctor is responsible for verifying eligibility and obtaining the necessary authorization from the VCSV prior to the delivery of service. Each authorization is valid for fifteen (15) days. An Insured must provide the Participating Provider sufficient information to verify eligibility. Failure of the Insured to provide sufficient information may delay services and may affect benefit payment under this Policy.

B. Should the Insured obtain services from a Nonparticipating Provider, the Insured is responsible for making payment in full to the Provider and will be reimbursed by the VCSV in accordance with the benefits available for Covered Services under this section.

V. Covered Services

When rendered by a Provider, benefits are provided for the following services:

- | | |
|---------------------------------|---|
| A. Eye Examination | E. Lined Bifocal Lenses* |
| B. Frame | F. Lined Trifocal Lenses* |
| C. Single Vision Lenses* | G. Contact Lens Exam and Contact Lenses in place of eyeglasses |
| D. Lenticular Lenses* | |

*Coverage includes Lenses in polycarbonate, plastic or glass. Scratch resistant and ultraviolet (UV) coatings also covered.

A. Eye Examination

An eye vision examination regardless of its Medical Necessity, including but not limited to, the following services:

(NOTE: Each test may not be indicated for every patient.)

1. **Intermediate Examination**—brief or limited routine check-up or vision survey.
2. **Vision Analysis**—various tests for prescription Lenses.
3. **Tonometry**—measurement of eye tension for glaucoma.
4. **Biomicroscopy**—examination of the living eye tissue.
5. **Central and/or Peripheral Field Study**—measurement of visual acuity in the central and/or peripheral field of vision.
6. **Dilation**—allows for a better view inside the eye, i.e., optic nerve blood vessels, etc.

B. Prescribed Lenses and Frames

When an eye examination indicates that new Lenses or a new Frame or both are necessary for the proper visual health and welfare of an Insured, they will be supplied, together with such professional services as necessary, which include but are not limited to:

1. Prescribing and ordering proper Lenses.
2. Assisting in the selection of a Frame.

3. Verifying the accuracy of the finished Lenses.
4. Proper fitting and adjustment of the eyeglasses.

The VCSV will limit the selection of Frames provided by Participating Providers. All Frames have a one-year manufacturer's warranty, and Lenses come with polycarbonate, scratch coating and ultraviolet (UV) protection included. If an Insured selects a Frame other than a Frame included in the allowed selection, the Nonparticipating Provider benefit level will be applied.

C. Contact Lenses

1. **Medically Necessary Contact Lenses**—Medically Necessary Contact Lenses are covered for Insureds when specific benefit criteria are satisfied and when prescribed by Insured's Participating Provider.

When the Participating Provider receives prior approval for such cases, they are fully covered by the VCSV and are in place of the benefits described for Prescribed Lenses and Frames.

2. **Elective Contact Lenses**—if an Insured chooses Contact Lenses from a Participating Provider for reasons other than those mentioned above, VCSV provides benefits as follows: In lieu of eyeglasses as described for Prescribed Lenses and Frames, elective Contact Lens services and materials are covered with the following service limitations:
 - Contact Lens Exam services (Fitting and evaluation) covered once per frequency period
 - Standard (one pair annually) = 1 Contact Lens per eye (total 2 lenses)
 - Monthly (six-month supply) = 6 Lenses per eye (total 12 lenses)
 - Bi-weekly (three-month supply) = 6 Lenses per eye (total 12 lenses)
 - Dailies (three-month supply) = 90 Lenses per eye (total 180 lenses)

Contact Lenses are provided in place of spectacle lens and Frame benefits available herein.

3. **Reimbursement Allowance**—For Covered Services rendered by a Nonparticipating Provider, a determination of Medically Necessary versus Elective Contact Lenses will be consistent with Participating Provider services. Reimbursement for Medically Necessary and Elective Contact Lenses include a Contact Lens evaluation fee, fitting costs, and materials and is in place of all other benefits for materials, including eyeglass Lenses and Frame.

VI. Additional Amount of Payment Provisions

- A. The VCSV will pay the Participating Provider directly in accordance with the agreement between the VCSV and the Participating Provider.

A Participating Provider shall not make an additional charge to an Insured for amounts in excess of VCSV's payment except for noncovered services and amounts above the Contact Lens materials coverage and service limitations.

- B. If Covered Services are rendered by a Nonparticipating Provider:
 1. The Insured is responsible for paying the Provider in full. The Insured will be reimbursed in accordance with the benefits available, if any, as shown in the Benefit Outline.
 2. The Nonparticipating Provider is not obligated to accept VCSV's payment as payment in full. VCSV and Blue Cross of Idaho (BCI) are not responsible for the difference, if any, between VCSV's payment and the actual charge, any such difference is the Insured's responsibility.
 3. Benefits for Covered Services are subject to the same time and supply limits as those described for Covered Services received from a Participating Provider. Covered Services obtained from a Nonparticipating Provider are in place of obtaining services from a Participating Provider.

VII. Enrollee's Options

When an Insured selects any of the following options, VCSV pays the basic cost of the allowed Lenses, and the Insured is responsible for paying the additional costs for the following options:

1. Blended Lenses.
2. Contact Lenses, except as provided in this section.
3. Oversize Lenses.
4. Photochromic Lenses.
5. Tinted Lenses except Pink #1 and Pink #2.
6. Coating of the lens or Lenses.
7. Laminating of the lens or Lenses.
8. A Frame not included in the VCSV allowed selection.
9. Cosmetic Lenses.
10. Optional cosmetic processes.
11. Polycarbonate Lenses (except for Eligible Dependent Children).

**VISION CARE BENEFITS SECTION FOR INSUREDS 19 AND OLDER
(VCSV)**

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

I. Eligibility

For Insured's age nineteen (19) and older.

II. Copayment and Limitations on Frequency of Services

The Copayment amount and limitations on frequency of services are shown in the Benefits Outline.

III. Covered Providers

The following are Covered Providers under this section:

- Optometrist (OD)
- Ophthalmologist (MD)

IV. Procedures for Obtaining Covered Services

A. An Insured must contact the Vision Care Services Vendor (VCSV) Participating Provider to make an appointment to receive Covered Services. No preauthorization or special benefit form is required. The doctor is responsible for verifying eligibility and obtaining the necessary authorization from the VCSV prior to the delivery of service. Each authorization is valid for fifteen (15) days. An Insured must provide the VCSV Participating Provider sufficient information to verify eligibility. Failure of the Insured to provide sufficient information may delay services and may affect benefit payment under this Policy.

B. Should the Insured obtain services from a Provider who is not a VCSV Participating Provider, the Insured is responsible for making payment in full to the Provider and will be reimbursed by the VCSV in accordance with the benefits available for Covered Services under this section.

V. Covered Services

When rendered by a Covered Provider, benefits are provided for the following services:

- | | |
|--------------------------------|---|
| A. Eye Examination | D. Lined Bifocal Lenses |
| B. Frame | E. Lined Trifocal Lenses |
| C. Single Vision Lenses | F. Contact Lens fitting and evaluation and Contact Lenses in place of eyeglasses |

A. Eye Examination

A vision examination regardless of its Medical Necessity, including but not limited to, the following services:

(NOTE: Each test may not be indicated for every patient.)

1. **Intermediate Examination**—brief or limited routine check-up or vision survey.
2. **Vision Analysis**—various tests for prescription Lenses.
3. **Tonometry**—measurement of eye tension for glaucoma.
4. **Biomicroscopy**—examination of the living eye tissue.
6. **Central and/or Peripheral Field Study**—measurement of visual acuity in the central and/or peripheral field of vision.
6. **Dilation**—allows for a better view inside the eye, i.e., optic nerve blood vessels, etc.

B. Prescribed Lenses and Frames

When an eye examination indicates that new Lenses or a new Frame or both are necessary for the proper visual health and welfare of an Insured, they will be supplied, together with such professional services as necessary, which include but are not limited to:

1. Prescribing and ordering proper Lenses.
2. Assisting in the selection of a Frame.
3. Verifying the accuracy of the finished Lenses.
4. Proper fitting and adjustment of the eyeglasses.

The VCSV reserves the right to limit the cost of Frames provided by a Participating Provider. The allowance is published periodically by the VCSV to its Participating Providers and is set at a level to cover the majority of Frames in common use. If an Insured wishes to select a more expensive Frame than allowed in this section, the difference in cost is not the responsibility of the VCSV or Blue Cross of Idaho (BCI).

C. Contact Lenses

1. **Medically Necessary Contact Lenses**—Medically Necessary Contact Lenses are covered for Insureds when specific benefit criteria are satisfied and when prescribed by Insured's doctor.

When the Participating Provider receives prior approval for such cases, they are fully covered by the VCSV and are in place of the benefits described for Prescribed Lenses and Frames.

2. **Medically Necessary Contact Lenses** may be prescribed only for certain medical conditions.
2. **Elective Contact Lenses**—if an Insured chooses Contact Lenses from a Participating Provider for reasons other than those mentioned above, benefits are provided as follows: The initial basic examination will be covered in full (as described under Eye Examination) and an allowance will be paid toward a contact lens evaluation fee, fitting costs, and materials in place of the benefits described for Prescribed Lenses and Frames. The allowance amount is shown in the Benefits Outline.
3. **Reimbursement Allowance**—For Covered Services rendered by a Provider who is not a Participating Provider, a determination of Medically Necessary versus Elective Contact Lenses will be consistent with Participating Provider services. Reimbursement allowances for Medically Necessary and Elective Contact Lenses include a contact lens evaluation fee, fitting costs, and materials and is in place of all other benefits for materials, including eyeglass Lenses and Frame.

VI. Additional Amount of Payment Provisions

- A. The Insured will pay the Copayment, if any, to the Participating Provider for Covered Services and will pay for any additional services received not covered by this Policy. The VCSV will pay the Participating Provider directly in accordance with the agreement between the VCSV and the Participating Provider.

Subject to the applicable Copayment(s), the VCSV shall pay or otherwise secure the discharge of the cost of Covered Services rendered by a Participating Provider. A Participating Provider shall not make an additional charge to an Insured for amounts in excess of the VCSV's payment except for Copayments, noncovered services and amounts above the allowance for elective Contact Lenses.

- B. If Covered Services are rendered by a Provider who is not a VCSV Participating Provider:
 1. The Insured is responsible for paying the Provider in full. The Insured will be reimbursed in accordance with the benefits available, if any, as shown in the Benefits Outline.
 2. The Nonparticipating Provider is not obligated to accept the VCSV's payment as payment in full. The VCSV and Blue Cross of Idaho (BCI) are not responsible for the difference, if any, between the VCSV's payment and the actual charge; any such difference is the Insured's responsibility.
 3. Benefits for Covered Services are subject to the same time limits and Copayments as those described for Covered Services received from a Participating Provider. Covered Services obtained from a Nonparticipating Provider are in place of obtaining services from a Participating Provider.
- C. The amounts shown in the Benefits Outline under Payment for Services Rendered by a Nonparticipating Provider are maximums. The actual amount paid in reimbursement to the Insured is either the amount indicated in the Benefits Outline, the amount actually charged, or the amount usually charged by the Provider of such services to their private patients, whichever is less.

VII. Exclusions and Limitations

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

A. Enrollee's Options

When an Insured selects any of the following options, the VCSV pays the basic cost of the allowed Lenses, and the Insured is responsible for paying the additional costs for the following options:

1. Blended Lenses.
2. Contact Lenses, except as provided in this section.
3. Oversize Lenses.
4. Progressive multi-focal Lenses.
5. Coating of the lens or Lenses.
6. Laminating of the lens or Lenses.
7. A Frame that costs more than the VCSV's allowance.
8. Cosmetic Lenses.
9. Optional cosmetic processes.
10. UV (ultraviolet) protected Lenses.
11. Polycarbonate Lenses (except for Eligible Dependent Children)
12. Low vision aids.

DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout this Policy. Other terms may be defined where they appear in this Policy. All Providers listed in this Policy 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 the VCSV to provide benefits. Definitions in this Policy 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.

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 Policy.

Benefit Period—the period of time from July 1 to June 30 of the following year, unless otherwise noted, during which an Insured accumulates annual benefit limits, Deductible amounts and out-of-pocket Limits and may receive Covered Services.

Blended Lenses—bifocals that do not have a visible dividing line.

Blue Cross of Idaho Health Service, Inc. (Blue Cross of Idaho or BCI)—a nonprofit mutual insurance company.

Coated Lenses—a substance added to a finished lens on one (1) or both surfaces.

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 Copayments.

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 Policy, 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.

Contact Lenses—ophthalmic corrective Lenses (either glass or plastic, ground or molded). They must be prescribed by an Optometrist or Ophthalmologist to be directly fitted to the Insured's eye.

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.

Cost Effective—a requested or provided medical service or supply that is Medically Necessary in order to identify or treat an Insured's health condition, illness or injury and that is:

1. Provided in the most cost-appropriate setting consistent with the Insured's clinical condition and the Covered Provider's expertise. For example, when applied to services that can be provided in either an Inpatient hospital setting or Outpatient hospital setting, the Cost Effective setting will generally be the outpatient setting. When applied to services that can be provided in a hospital setting or in a physician office setting, the Cost Effective setting will generally be the physician office setting.
2. Not more costly than an alternative service or supply, including no treatment and at least as likely to produce an equivalent result for the Insured's condition, Disease, Illness or injury.

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

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).

Effective Date—the date when coverage for an Insured begins under this Policy.

Eligible Dependent—(1) the spouse of the Enrollee and/or (2) the children of an Enrollee or Enrollee's spouse, up to their 26th birthday. The term "children" includes natural children, stepchildren, adopted children, or children in the process of adoption from time placed with the Enrollee. The term "children" also includes children legally dependent upon the Enrollee or Enrollee's spouse for support where a normal parent-child relationship exists with the expectation that the Enrollee 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 the Enrollee, a parent-child relationship shall not be deemed to exist even though the Enrollee or the Enrollee's spouse provides support.

Eligible Employee—employees who are officers or employees of state agencies, departments, or institutions, including state officials, elected officials, or employees of other governmental entities which have contracted with the State of Idaho for medical expense coverage, who are working twenty (20) hours or more per week, and who are not classified as a seasonal employee or a part-time temporary employee.

1. Seasonal Employee. An employee in a position for which the customary annual employment is six (6) months or less.
2. Part-Time Temporary Employee. An employee who is expected, at the time of hire, to work twenty (20) hours or more per week but less than thirty (30) hours per week, and whose term of employment is not expected to exceed five (5) consecutive months.

Employees hired on or after the Effective Date of this Policy will have coverage for themselves and their Dependents effective the first day of the month following date of hire, provided enrollment is completed within thirty (30) days of the date of hire.

Enrollee—an Eligible Employee 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 Employee or Eligible Dependent under this Policy, or if earlier, the first day of the probationary period for such enrollment.

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

Frame—a standard eyeglass Frame adequate to hold Lenses.

Group—the State of Idaho as represented by the Department of Administration.

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 Participating Provider.

Insured—an Enrollee or an enrolled Eligible Dependent covered under this Policy.

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 the VCSV, 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.

Large Employer—any person, firm, corporation, partnership or association that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar year, employed no less than fifty-one (51) Eligible Employees, the majority of whom were employed within this state. In determining the number of Eligible Employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.

Lenses—ophthalmic corrective Lenses (either glass or plastic, ground or molded). They must be prescribed by an Optometrist or Ophthalmologist to improve visual acuity or performance and to be fitted to a Frame. Amounts payable are based on a lens blank not more than sixty-one (61) millimeters in diameter, tinted no darker than the equivalent of Pink #1 or #2 and without photosensitive or anti-reflective properties.

Maximum Allowance—for Covered Services under the terms of this Policy, Maximum Allowance is the lesser of the billed charge or the amount established as the highest level of compensation for a Covered Service as established by the VCSV.

Medically Necessary (or Medical Necessity)—the Covered Service or supply recommended by the treating Covered Provider to identify or treat an Insured's condition, Disease, Illness or Accidental Injury and which is determined by BCI to be:

1. The most appropriate supply or level of service, considering potential benefit and harm to the Insured.
2. Proven to be effective in improving health outcomes:
 - a. For new treatment, effectiveness is determined by peer reviewed scientific evidence; or
 - b. For existing treatment, effectiveness is determined first by peer reviewed 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.

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 Policy.

The term Medically Necessary as defined and used in this Policy is strictly limited to the application and interpretation of this Policy, 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.

In determining whether a service is Medically Necessary, BCI considers the medical records and, the following source documents: Blue Cross Blue Shield Association Center for Clinical Effectiveness (CCE) 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, current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

Nonparticipating Provider—a Provider that has not entered into a written agreement with the VCSV regarding payment for Covered Services rendered to an Insured under this Policy.

Ophthalmologist—a doctor of medicine (M.D.) who is both a medical doctor and a surgeon. The ophthalmologist is licensed to exam, diagnose and treat disorders and diseases of the eye and visual system of the brain, as well as prescribe corrective lenses (glasses or contacts).

Optometrist—a person who is licensed and specializes in optometry to examine, measure and treat certain visual defects by means of corrective lenses or other methods that do not require a license as a physician.

Orthoptics—the teaching and training process for improvement of visual perception and coordination of the two (2) eyes for efficient and comfortable binocular vision.

Out-of-Network Services—any Covered Services rendered by a Nonparticipating 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 Coinsurance for eligible Covered Services.

Outpatient—an Insured who receives services or supplies while not an inpatient.

Participating Provider—a Provider that has entered into a written agreement with the VCSV regarding payment for Covered Services rendered to an Insured under this Policy.

Photochromic Lenses—Lenses that change color with intensity of sunlight.

Physician—a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) licensed to practice medicine.

Plano Lenses—lenses that have no refractive power.

Policy—this Policy, which includes only the Benefits Outline, Group application, individual enrollment applications, Insured identification cards, any written endorsements, riders, amendments, attachments or any other written agreements between BCI and the Group executed by an authorized officer of BCI.

Policy Date—the date specified in this Policy on which coverage commences for the Group (July 1).

Post-Service Claim—any claim for a benefit under this Policy that does not require prior authorization before services are rendered.

Pre-Service Claim—any claim for a benefit under this Policy that requires prior authorization before services are rendered.

Provider—a person or entity that is licensed, where required, to render Covered Services. For the purposes of this Policy, Providers include only Ophthalmologists and Optometrists.

Single Coverage—the enrollment of only the Enrollee under this Policy.

Surgery—within the scope of a Provider's license, the performance of:

1. Generally accepted operative and cutting procedures.
2. Invasive procedures using specialized instruments.
3. Customary preoperative and postoperative care.

Tinted Lenses—Lenses that have an additional substance added to produce constant tint.

Vision Care Services Vendor (VCSV)—an entity contracting with BCI to provide Vision Care Services to its Insureds.

EXCLUSIONS AND LIMITATIONS SECTION

The following exclusions and limitations apply to the entire Policy, unless otherwise specifically listed as a Covered Service in this Policy.

I. General Exclusions and Limitations

There are no benefits for services, supplies, drugs or other charges that are:

- A.** Not Medically Necessary.
- B.** In excess of the Maximum Allowance.
- C.** 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 Physicians, and other Providers.
- D.** Investigational in nature.
- E.** 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.
- F.** Provided or paid for by any federal governmental entity or unit except when payment under this Policy is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefore would vary, or are or would be affected by the existence of coverage under this Policy.
- G.** Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.
- H.** Furnished by a Provider who is related to the Insured by blood or marriage and who ordinarily dwells in the Insured's household.
- I.** Received from a vision, or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- J.** Rendered prior to the Insured's Effective Date.
- K.** For telephone consultations, and all computer or Internet communications; for failure to keep a scheduled visit or appointment; for completion of a claim form; for interpretation services; 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.
- L.** For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.
- M.** 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 Policy, 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 policy 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 their estate for such services, supplies, drugs or other charges so provided by BCI in connection with such Illness, Disease, Accidental Injury or other condition.

- N.** For which an Insured would have no legal obligation to pay in the absence of coverage under this Policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage or charges in connection with work for compensation or charges; or for which reimbursement or payment is contemplated under an agreement with a third party.
- O.** 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.
- P.** Provided outside the United States, which if had been provided in the United States, would not be a Covered Service under this Policy.
- Q.** Furnished by a Provider or caregiver that is not listed as a Covered Provider.
- R.** For the purchase of Therapy or Service Dogs/Animals and the cost of training/maintaining said animals.
- S.** Orthoptics or other vision training and any associated supplemental testing.
- T.** Plano Lenses.
- U.** Two (2) pair of eyeglasses in place of bifocals.
- V.** Replacement of Lenses, Frames or Contact Lenses furnished hereunder that are lost or broken (Lenses, Frames or Contact Lenses are only replaced at the normal intervals when Covered Services are otherwise available).
- W.** Medical or surgical treatment of the eye(s).
- X.** Any eye examination or any corrective eyewear required by an employer as a condition of employment.
- Y.** Low vision aids, unless specified as a Covered Service in this Policy.
- Z.** Solutions and/or cleaning products for eyeglasses or Contact Lenses.
- AA.** For Congenital Anomalies, or for developmental malformations, unless the patient is an Eligible Dependent child.
- AB.** For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.

II. Preexisting Condition Waiting Period

There are no waiting periods for treatment of preexisting conditions under this Policy.

GENERAL PROVISIONS SECTION

I. Entire Policy—Changes

This Policy, which includes only the Benefits Outline, Group application, individual enrollment application, data and information, Insured identification cards, and any written endorsements, riders, amendments or other written agreements, and any policies, terms, conditions, or requirements incorporated by reference at bcidaho.com approved in writing by an authorized Blue Cross of Idaho officer, is the entire Policy between the Group and BCI. No agent or representative of Blue Cross of Idaho, other than a Blue Cross of Idaho officer, may change this Policy or waive any of its provisions. This Policy supplants and replaces any and all previous oral or written agreements, certificates, contracts, policies or representations, which shall have no further force and effect.

II. Records of Insured Eligibility and Changes in Insured Eligibility

- A. The Group shall furnish completed applications or other BCI approved forms required by BCI for it to provide coverage of the Group's Insureds under this Policy. In addition, the Group will provide written notification to BCI within thirty (30) days of the Effective Date of any changes in an Insured's enrollment and benefit coverage status under this Policy.
- B. A notification by the Group to BCI must be furnished on BCI approved forms, and according to rules and regulations of BCI. The notification must include all information reasonably required by BCI to effect changes, and must be accompanied by payment of applicable premiums.

III. Termination or Modification of this Policy

- A. The Group or BCI may unilaterally terminate or modify the terms of this Policy as required by statutory and/or regulatory changes. Such termination or modification shall be effective immediately or as required by the statutory or regulatory change. BCI shall give the Group written notice of such modification or termination.
- B. This Policy may be unilaterally terminated by BCI for any of the following:
 - 1. For the Group's fraud or intentional misrepresentation of a material fact.
 - 2. If BCI elects not to renew all of its Health Benefit Plans delivered or issued for delivery to Large Employers in the state of Idaho. In which case, BCI will provide notice to the Group and its Insureds of such nonrenewal at least one hundred eighty (180) days in advance of the date of nonrenewal.
- C. If the Group fails to pay premiums as agreed in the Eligibility and Enrollment Section, this Policy will terminate without notice at the end of the period for which the last premiums were paid. However, if the Group makes premium payments within sixty (60) days after the due date, BCI will reinstate this Policy as of the due date. No benefits are available during this sixty (60) day period unless all premiums are properly paid before expiration of the sixty (60) day period.
- D. No more than 120 days prior to the date of annual renewal, BCI must provide to the Group a written proposal of renewal rates for the then current benefit plan.

IV. Termination or Modification of an Insured's Coverage Under this Policy

- A. If an Enrollee ceases to be an Eligible Employee 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.
- B. Except as provided in this paragraph, coverage for an Insured who is no longer eligible under this Policy 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 a dependent child incapable of self-sustaining employment by reason of intellectual disability 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 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 may require such subsequent proof once each year. Coverage for the dependent child will continue so long as this Policy remains in effect, the child's disability and financial dependency exists, and the child has not exhausted benefits.

- C. Termination or modification of this Policy 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 Policy, 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 Policy, no benefits are available to an Insured for Covered Services rendered after the date of termination of an Insured's coverage.
- E. Prior to legal finalization of an adoption, the coverage provided in this Policy 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.

- F. Coverage under this Policy will terminate for an Eligible Dependent on the last day of the month the Insured no longer qualifies as an Eligible Dependent due to a change in eligibility status.

V. Benefits After Termination of Coverage

- A. When this Policy remains in effect but an Insured's coverage terminates for reasons other than those specified in General Provisions IV.E., benefits will be continued:
 - 1. If the Insured is eligible for and properly elects continuation coverage in accordance with the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments thereto.

Most employers who employ twenty (20) or more people on a typical business day are subject to COBRA. If the Group is subject to COBRA, an Insured may be entitled to continuation coverage. Insureds should check with the Group for details.

- 2. For Covered Services of an Insured who is being treated as an Inpatient on the day the Insured's coverage terminates, but only until the Insured is discharged, or the end of the Benefit Period in which coverage terminated, or until benefits are exhausted, whichever occurs first. Benefits for Covered Services are limited to the Inpatient treatment of the condition, Accidental Injury, Disease or Illness causing the Inpatient confinement.
- B. When the Group or BCI terminates this Policy, benefits will be continued:
 - 1. For Covered Services of an Insured who is being treated as an Inpatient on the day the Insured's coverage terminates, but only until the Insured is discharged, or the end of the Benefit Period in which coverage terminated, or until benefits are exhausted, whichever occurs first. Benefits for Covered Services are limited to the Inpatient treatment of the condition, Accidental Injury, Disease or Illness causing the Inpatient confinement.
 - 2. For Covered Services directly related to a pregnancy that existed on the date of termination, in accordance with state law and regulations. Such Covered Services are subject to all the terms, limitations, and provisions of this Policy and will be provided for no more than twelve (12) consecutive months following the date coverage terminates or until the conclusion of the pregnancy, or until replacement coverage is in effect according to General Provisions section XXIX. of this Policy, whichever occurs first.
 - 3. For Covered Services directly related to a Total Disability that existed on the date of termination, in accordance with state law and regulations. Such Covered Services are subject to all the terms, limitations, and provisions of this Policy and will be provided for no more than twelve (12) consecutive months following the date coverage terminates or until the Total Disability ceases, whichever occurs first.

VI. Contract Between BCI and the Group—Description Of Coverage

This Policy is a contract between BCI and the Group. BCI will provide the Group with a copy of the Policy. This Policy shall not be construed as a contract between BCI and any Enrollee. BCI's mailing or other delivery of this Policy to the Group constitutes complete and conclusive issuance and delivery thereof to each Enrollee.

VII. Applicable Law

This Policy shall be governed by and interpreted according to the laws of the state of Idaho. BCI and the Group consent to the jurisdiction of the state courts of Ada County in the state of Idaho in the event of any dispute between them. The rights of

the Insureds and coverage under this Policy may be affected by applicable state and federal laws, including without limitation the Health Insurance Portability and Accountability Act.

VIII. Notice

Any notice required under this Policy must be in writing. BCI's notices to the Group will be sent to the Group's mailing address or electronic address as they appear on BCI's records, and mailing or any delivery to the Group constitutes complete and conclusive notice to the Insureds. Notice given to BCI must be sent to BCI's address contained in the Group Application. The Group shall give BCI immediate written notice of any change of address for the Group or any of its Insureds. BCI shall give the Group immediate written notice of any change in BCI's address. When BCI is required to give advice or notice, the depositing of such advice or notice with the U.S. Postal Service, regular mail, or the other delivery, including electronic distribution, conclusively constitutes the giving of such advice or notice on the date of such mailing or delivery.

IX. Benefits to Which Insureds are Entitled

- A.** Subject to all of the terms of this Policy, an Insured is entitled to benefits for Covered Services in the amounts specified in the benefit sections and/or in the Benefits Outline.
- B.** Benefits will be provided only if Covered Services are prescribed by, or performed by, or under the direction of a Covered Provider.
- C.** Benefits for Covered Services specified in this Policy are provided only for Covered Services that are rendered by the Covered Providers specified in the benefits sections of this Policy and that are regularly and customarily included in such Covered Providers' charges.
- D.** Covered Services are subject to the availability of Providers and the ability of the employees of such Providers to provide such services. BCI shall not assume nor have any liability for conditions beyond its control that affects the Insured's ability to obtain Covered Services.

XI. Notice of Claim

BCI is not liable under this Policy to provide benefits unless a proper claim is furnished to BCI that shows Covered Services have been rendered to an Insured. A claim must be provided within one (1) year from the date a Covered Service is rendered. The claim must include all the data necessary for BCI to determine benefits.

XI. Release and Disclosure of Medical Records and Other Information

In order to effectively apply the provisions of this Policy, 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 Policy.

Each Insured also authorizes disclosures to the employer, association, trust fund, union, or similar entity to which this Policy is issued for purposes of utilization review or audit and such other disclosures as may be permitted or required by law.

XII. Exclusion of General Damages

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

XIII. Payment of Benefits

- A.** The Insured authorizes BCI to make payments directly to Providers rendering Covered Services to the Insured for benefits provided under this Policy. Notwithstanding this authorization, BCI reserves and has the right to make such payments directly to the Insured. Except as provided by law, BCI's right to pay an Insured directly is not assignable by an Insured nor can it be waived without BCI's concurrence nor may the right to receive benefits for Covered Services under this Policy be transferred or assigned, either before or after Covered Services are rendered.

- B.** Once Covered Services are rendered by a Provider, BCI is not obligated to honor Insured requests not to pay claims submitted by such Provider, and BCI shall have no liability to any person because of its rejection of such request. However, for good cause and in its sole discretion, BCI may nonetheless deny all or any part of any Provider claim.

XIV. 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 is not liable for any act or omission or for the level of competence of any Provider, and BCI has 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.

XV. 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.

XVI. Benefits for Medicare Eligibles Who are Covered Under This Policy

- A.** If the Group has twenty (20) or more employees, any Eligible Employee or spouse of an Eligible Employee who becomes or remains an Insured of the Group covered by this Policy after becoming eligible for Medicare (due to reaching age sixty-five (65)) is entitled to receive the benefits of this Policy as primary.
- 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 Employee, spouse of an Eligible Employee or dependent child of an Eligible Employee who becomes or remains an Insured of the Group covered by this Policy after becoming eligible for Medicare due to disability is entitled to receive the benefits of this Policy as primary.
- C.** An Insured eligible for Medicare based solely on end stage renal disease is entitled to receive the benefits of this Policy 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 benefits of this Policy as primary for thirty (30) months only, beginning with the month of Medicare entitlement.
- D.** The Group's retirees, if covered under this Policy, and Eligible Employees or spouses of Eligible Employees who are not subject to paragraphs A., B. or C. of this provision and who are Medicare eligible, will receive the benefits of this Policy 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.

XVII. Indemnity by the Group and Blue Cross of Idaho

Anything contained in this Policy notwithstanding, including any limitation on damages, the Group and BCI agree to defend, indemnify and hold harmless the other from and against any claim, demand, expense, loss, damage, cost, judgment, fee or liability the other receives, incurs or sustains that is caused by or arises out of any negligent act or omission of the indemnifying party related to this Policy. The indemnification obligation of the Group is subject to the limitations of the Idaho Tort Claims Act, including dollar amounts.

XVIII. Incorporated by Reference

All of the terms, limitations and exclusions of coverage contained in this Policy 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.

XIX. Inquiry and Appeals Procedures

A. Informal Inquiry

BCI has delegated certain activities, including Appeals, to the VCSV, though BCI retains ultimate responsibility over these activities. For any initial questions concerning a claim, an Insured should call the VCSV phone number 844-348-0848. If the VCSV cannot resolve the Insured's concern to their satisfaction, the Insured or the Insured's authorized representative may submit a written request to the VCSV for review. A written request can be made by completing the form available on www.vsp.com Website or by sending the written request by mail to the VCSV at: Vision Service Plan, Attention: Complaint and Grievance Unit, P.O. Box 997100, Sacramento, CA 95899-7100. Verbal requests can be made by calling the VCSV phone number.

If the Insured's claim for benefits is denied and BCI issues an Adverse Benefit Determination, the Insured must first exhaust any applicable internal appeals process described below prior to pursuing legal action.

B. Formal Appeal

An Insured who wishes to formally appeal a Pre-Service Claim decision by BCI 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 by a BCI Medical Director, physician designee, or a VCSV designee. For non-urgent claim appeals, BCI or a VCSV designee 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 or its VCSV designee's mailing of the initial reconsideration decision. A BCI Medical Director or its VCSV designee who is not subordinate to the Medical Director or physician designee who decided the initial appeal, 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 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 or a VCSV designee'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 by a Medical Director or physician designee if the appeal requires medical judgment. BCI or a VCSV designee 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 (or a VCSV designee's) mailing of the initial reconsideration decision. A BCI Medical Director who is not the subordinate to the Medical Director, physician designee, or a VCSV designee who decided the initial appeal, will issue a final decision after consideration of all relevant information, if the appeal requires medical judgment. A final decision on the appeal will be made within thirty (30) days of its receipt. If the appeal does not require medical judgment, a BCI Vice President who did not decide the initial appeal will issue the decision.

D. External Review

At BCI's discretion, 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.

XX. Plan Administrator—COBRA

BCI is not the plan administrator for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments to it. Except for services BCI has agreed to perform regarding COBRA, the Group is responsible for satisfaction of notice, disclosure, and other obligations if these laws are applicable to the Group.

XXI. Reimbursement of Benefits Paid by Mistake

If BCI mistakenly makes payment for benefits on behalf of an Enrollee or their Eligible Dependent(s) that the Enrollee or their Eligible Dependent(s) is not entitled to under this Policy, the Enrollee must reimburse the erroneous payment to BCI.

The reimbursement is due and payable as soon as BCI notifies the Enrollee and requests reimbursement. BCI may also recover such erroneous payment from any other person or Provider to whom the payments were made. If reimbursement is not made in a timely manner, BCI may reduce benefits or reduce an allowance for benefits as a set-off toward reimbursement.

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

XXXII. Subrogation and Reimbursement Rights and Obligations of Blue Cross of Idaho

The benefits of this Policy will be available to an Insured when the Insured 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 under this Policy or any other Blue Cross of Idaho plan, agreement, certificate, contract or policy, Blue Cross of Idaho shall be subrogated and succeed to the rights of the Insured or, in the event of the Insured's death, to the rights of their heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Services in such an event, the Insured or their personal representative shall furnish Blue Cross of Idaho in writing with the names, addresses, and contact information 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 their personal representative concerning the injury, harm or loss. In addition, the insured shall furnish the name and contact information of the liability insurer or its adjuster of the third party including the policy number of any liability insurance that covers, or may cover, such injury, harm, or loss.

Blue Cross of Idaho 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 their legal representative will transfer to Blue Cross of Idaho any rights the Insured 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 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 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 is not responsible for any attorney's fees or other expenses or costs incurred by the Insured without 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, or otherwise.

Additionally, Blue Cross of Idaho may at its option elect to enforce its right of reimbursement from the Insured, or their 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 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 reimbursement rights and efforts.

The Insured shall pay Blue Cross of Idaho 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 under this Policy, 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 their 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 is not responsible for any attorney's fees or other expenses or costs incurred by the Insured without 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, or otherwise.

To the extent that Blue Cross of Idaho 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 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 benefits provided and payments made by Blue Cross of Idaho, and for benefits to be provided or payments to be made by Blue Cross of Idaho in the future on account of the injury, harm or loss giving rise to Blue Cross of Idaho's subrogation and reimbursement rights. Further, Blue Cross of Idaho's subrogation and reimbursement rights for such benefits and payments provided or to be provided 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 Blue Cross of Idaho.

Collections or recoveries made by an Insured for such injury, harm or loss in excess of such benefits provided and payments made shall first be allocated to such future benefits and payments that would otherwise be owed by the Plan on account of the injury, harm or loss giving rise to Blue Cross of Idaho's subrogation and reimbursement rights, and shall constitute a Special Credit applicable to such future benefits and payments that would otherwise be owed by Blue Cross of Idaho under this or any subsequent Blue Cross of Idaho Plan or coverage. Thereafter, Blue Cross of Idaho shall have no obligation to provide any further benefits or make any further payments until the Insured has incurred medical expenses in treatment of such injury, harm, or loss equal to such Special Credit.

XXIII. Independent Blue Cross and Blue Shield Plans

The Group (on behalf of itself and its participants), hereby expressly acknowledges its understanding this Policy constitutes a contract solely between the Group and BCI, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, as association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCI to use the Blue Cross Service Marks in the state of Idaho, and that BCI is not contracting as the agent of the Association. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Policy based upon representations by any person, entity, or organization other than BCI and that no person, entity, or organization other than BCI shall be held accountable or liable to the Group for any of BCI's obligations to the Group created

under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of BCI other than those obligations created under other provisions of this Policy.

XXIV. 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.

XXV. Membership, Voting, Annual Meeting and Participation

The Group, as the policyholder, is a member of BCI and is entitled to vote in person or by proxy at the meetings of policyholders. The Group shall designate to BCI in writing the person who has the right to vote in person or by proxy on behalf of the Group. The annual meeting of policyholders of BCI is held on the last Friday of April of each year at 2:00 p.m., at the corporation's registered office, 3000 East Pine Avenue, Meridian, Idaho. This notice shall be sufficient as to notification of such annual meetings. If any dividends are distributed, the policyholders shall share in them according to the articles of incorporation and bylaws of BCI and under the conditions set by the board of directors of BCI.

XXVI. Replacement Coverage

If this Policy replaces prior Group coverage within sixty (60) days of the date of termination of prior coverage, BCI shall immediately cover all employees and dependents validly covered under the prior coverage at the date of termination who meet the Group's eligibility requirements and who would otherwise be eligible for coverage under this Policy, regardless of any exclusions or limitations relating to active employment or nonconfinement.

XXVII. Coverage and Benefits Determination

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

XXVII. Coordination of this Policy'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 Group, 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.

In witness whereof, BLUE CROSS OF IDAHO HEALTH SERVICE, INC., by its duly authorized officer, has executed this Policy.

Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID 83707



Paul Zurlo
President, Health Markets