# 2025 BOOKLET FOR:

# STATE OF IDAHO

## Regence Choice Vision – Adult and Pediatric

## Group Number: 10060598

## Regence BlueShield of Idaho, Inc. Vision Benefits

Regence

# SCHEDULE OF BENEFITS

## State of Idaho Choice Vision

This Schedule of Benefits provides information regarding Your cost-shares for Covered Services and how Provider choice affects Your out-of-pocket expenses. This Schedule of Benefits is part of Your Booklet. Read the entire Booklet to understand the benefits, limitations, exclusions, defined terms and provisions of Your coverage.

| | Member Responsibility | |
|---|---|---|
| | **VSP Doctor** | **Out-of-Network Provider** |
| **Deductible per Plan Year** | $0 per Member | |

| **Benefit – Pediatric Vision (under age 19)** | **Member Responsibility** | |
|---|---|---|
| | **VSP Doctor** | **Out-of-Network Provider** |
| **Vision Examination**<br>• 1 routine eye examination every 12 months<br>• $50 limit for Out-of-Network Provider | 0% | 100% of billed charges; Your payment may be reimbursed up to the Out-of-Network Provider limits. |
| **Vision Hardware – Frames and lenses**<br>• 1 frame every 24 months<br>• $130 frame limit for VSP Doctor<br>• $130 elective contact lens limit, in lieu of all other frame and lens benefits<br>• $70 frame limit for VSP approved wholesale/retail vendor<br>• $50 frame limit for Out-of-Network Provider<br>• 1 pair of lenses (2 lenses) every 12 months<br>• Additional limitations apply for lenses, including contact lenses and lenses received from an Out-of-Network Provider, refer to the Adult Vision Benefits Section for each lens limitation | 0% | 100% of billed charges; Your payment may be reimbursed up to the Out-of-Network Provider limits. |
| **Contact Lens Evaluation and Fitting Examination**<br>• Once every 12 months<br>• $70 limit (including elective contacts) for Out-of-Network Provider; or<br>• $125 limit (including Necessary Contact Lenses) for Out-of-Network Provider | 0% | 100% of billed charges; Your payment may be reimbursed up to the Out-of-Network Provider limits. |
| **Low Vision Benefit – Supplemental Examinations (Testing)** | 0% | 100% of billed charges; Your payment may be |

| Benefit – Pediatric Vision (under age 19) | Member Responsibility | |
|---|---|---|
| | VSP Doctor | Out-of-Network Provider |
| • $1,000 (combined with supplemental aids) every 24 months<br>• 2 examinations (testing) every 24 months<br>• $125 limit for Out-of-Network Provider | | reimbursed up to the Out-of-Network Provider limit. |
| **Low Vision Benefit – Supplemental Aids**<br>• $1,000 (combined with supplemental examinations) every 24 months | 25% | 100% of billed charges; Your payment may be reimbursed up to 75% of the VSP Doctor allowed amount, subject to the $1,000 combined limit. |

| Covered Services (per Member) | | |
|---|---|---|
| Benefit – Adult Vision (age 19 or older) | Member Responsibility | |
| | VSP Doctor | Out-of-Network Provider |
| **Vision Examination**<br>• 1 routine eye examination every 12 months<br>• $50 limit for Out-of-Network Provider | $20 Copayment | $20 Copayment; Your payment may be reimbursed up to the Out-of-Network Provider limit. |
| **Vision Hardware – Frames and lenses**<br>• 1 frame every 24 months<br>• $130 frame limit for VSP Doctor<br>• $130 elective contact lens limit, in lieu of all other frame and lens benefits<br>• $70 frame limit for VSP approved wholesale/retail vendor<br>• $50 frame limit for Out-of-Network Provider<br>• 1 pair of lenses (2 lenses) every 12 months<br>• Additional limitations apply for lenses, including contact lenses and lenses received from an Out-of-Network Provider, refer to the Adult Vision Benefits Section for each lens limitation | $20 Copayment | $20 Copayment; Your payment may be reimbursed up to the Out-of-Network Provider limit. |
| **Contact Lens Evaluation and Fitting Examination**<br>• Once every 12 months<br>• $70 limit (including elective contacts) for Out-of-Network Provider; or<br>• $125 limit (including Necessary Contact Lenses) for Out-of-Network Provider | 0% | 100% of billed charges; Your payment may be reimbursed up to the Out-of-Network Provider limits. |

| Covered Services (per Member) | | |
|---|---|---|
| **Benefit – Adult Vision (age 19 or older)** | **Member Responsibility** | |
| | **VSP Doctor** | **Out-of-Network Provider** |
| **Low Vision Benefit – Supplemental Examinations (Testing)**<br>• $1,000 (combined with supplemental aids) every 24 months<br>• 2 examinations (testing) every 24 months<br>• $125 limit for Out-of-Network Provider | 0% | 100% of billed charges; Your payment may be reimbursed up to the Out-of-Network Provider limit. |
| **Low Vision Benefit – Supplemental Aids**<br>• $1,000 (combined with supplemental examinations) every 24 months | 25% | 100% of billed charges; Your payment may be reimbursed up to 75% of the VSP Doctor allowed amount, subject to the $1,000 combined limit. |

# Introduction

Regence BlueShield of Idaho, Inc.

**Street Address:**
1602 21st Avenue
Lewiston, ID 83501

**NOTICE TO BUYER: THIS BOOKLET PROVIDES VISION BENEFITS ONLY.**

This Booklet provides the evidence and a description of the terms and benefits of coverage. All covered benefits are subject to the terms, conditions, exclusions, and limitations in this Booklet. The agreement between the Group and Regence BlueShield of Idaho, Inc. (called the "Contract") contains all the terms of coverage. Your plan administrator has a copy.

This Booklet describes benefits effective **July 1, 2025**, or the date Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Us and makes it void. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your Provider before receiving care.

In this Booklet, the terms "We," "Us" and "Our" refer to Regence BlueShield of Idaho, Inc. (hereafter referred to as "Regence BlueShield of Idaho") and the term "Group" means the organization whose employees may participate in this coverage. References to "You" and "Your" refer to the Enrolled Employee and/or Enrolled Dependents. Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized.

**Notice of Privacy Practices:** Regence BlueShield of Idaho has a Notice of Privacy Practices that is available by calling Customer Service or visiting the website listed below.

## CONTACT INFORMATION

If You have Provider or benefit questions specific to Your vision coverage, call VSP at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance), Monday – Saturday, 6 a.m. – 5 p.m., Pacific Time. You may also visit VSP's website at **vsp.com**.

Mail Your VSP Doctor claims to the following address:

Vision Service Plan
P.O. Box 495907
Cincinnati, OH 45249

Mail Your Out-of-Network Provider claims to the following address:

Vision Service Plan
P.O. Box 495918
Cincinnati, OH 45249

For questions about Your vision coverage, write to VSP at the following address:

Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100

If You have membership questions, talk with one of Our Customer Service representatives. Phone lines are open Monday – Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m., Pacific Time.

Customer Service: 1 (800) 854-5585
(TTY: 711)

Visit Our website at: **regence.com**

For assistance in a language other than English, call the Customer Service telephone number.

# Using Your Booklet

## YOUR PARTNER IN VISION CARE

This vision coverage is provided by Us, in collaboration with Vision Service Plan (VSP), which coordinates the provision of benefits and claims processing for this plan. VSP is a separate company that provides vision benefit services.

## ACCESSING PROVIDERS

You are not restricted in Your choice of Provider for vision care or treatment. You control Your out-of-pocket expenses by choosing between "VSP Doctor" and "Out-of-Network Provider."

- **VSP Doctor.** Choosing VSP Doctors saves You the most in Your out-of-pocket expenses. VSP Doctors will not bill You for balances beyond any Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network Provider.** Choosing Out-of-Network Providers means Your out-of-pocket expenses will be higher than choosing a VSP Doctor. Also, an Out-of-Network Provider may bill You for balances beyond any Copayment and/or Coinsurance. This is referred to as balance billing.

For each benefit, We indicate in the Schedule of Benefits, the Provider You may choose and Your payment amount for each Provider option. See the Definitions Section for a complete description of VSP Doctor and Out-of-Network Provider. You can go to **vsp.com** for further Provider network information.

## ADDITIONAL ADVANTAGES OF MEMBERSHIP

Advantages of membership include access to discounts on select items and services, personalized health/vision care planning information, health/vision-related events and innovative health/vision-decision tools, as well as a team dedicated to Your personal vision care needs. You also have access to Our website to help You navigate Your way through treatment decisions. **THESE SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS IN YOUR BOOKLET.**

- **Go to regence.com.** Use the secure website to access information about Regence Advantages. Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services. We have contracted with several program partners, listed on the secure website, to offer discounts on their products and services, such as hearing care, health and wellness products and vision care.*

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by this plan, that also may create savings or administrative fees for Us. **ANY SUCH DISCOUNTS OR COUPONS ARE COMPLEMENTS TO THE GROUP VISION PLAN, BUT ARE NOT INSURANCE.**

# Table of Contents

# Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits, Copayments and Coinsurance. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the Schedule of Benefits and benefit sections in this Booklet to see what Your benefits are.

## MAXIMUM BENEFITS

Some Covered Services may have a specific Maximum Benefit. Those Covered Services will be provided until the specified Maximum Benefit (which may be a number of visits, services, supplies, dollar amount or specified time period) has been reached. Refer to the Schedule of Benefits to determine if a Covered Service has a specific Maximum Benefit.

You will be responsible for the total billed charges for Covered Services that are in excess of any Maximum Benefits. You will also be responsible for charges for any other services or supplies not covered by this plan, regardless of the Provider rendering such services or supplies.

## COPAYMENTS

Copayments are a specific dollar amount that You pay directly to the Provider at the time You receive a specified service. A Provider may or may not request any applicable Copayment at the time of service. Refer to the Schedule of Benefits to see what Covered Services are subject to a Copayment.

## COINSURANCE (PERCENTAGE YOU PAY)

Your Coinsurance is the percentage You pay when Our payment is less than 100 percent. The Coinsurance varies, depending on the service or supply You received and who rendered it. Your Coinsurance applies once You have satisfied any applicable Copayment for Covered Services up to any Maximum Benefit. Your Coinsurance will be based upon the lesser of either the billed charges or the Allowed Amount. We do not reimburse Providers for charges above the Allowed Amount.

## HOW PLAN YEAR BENEFITS RENEW

Certain Maximum Benefits are calculated on a Plan Year basis. Each July 1, those Plan Year maximums begin again.

# Pediatric Vision Benefits

This section explains Your benefits for Covered Services for Members under the age of 19.

### VISION EXAMINATION
Professional comprehensive routine eye examination or visual analysis is covered, including:

- prescribing and ordering proper lenses;
- verifying the accuracy of the finished lenses; and
- progress or follow-up work as necessary.

### VISION HARDWARE
Hardware including frames, contacts and lenses is covered, subject to any specified limits. Lenses are limited to standard, or blue-light filter, glass, or plastic lenses for one of the following:

- single vision;
- lined bifocal;
- standard progressive;
- lined trifocal;
- lenticular;
- non-prescription ready-made sunglasses;
- non-prescription ready-made blue-light filter glasses;
- elective contacts;* or
- Necessary Contact Lenses.**

Coverage for lenses received from an Out-of-Network Provider is specified in the Schedule of Benefits up to the following Maximum Benefit limits:

- $50 single vision;
- $80 lined bifocal;
- $95 standard progressive;
- $95 lined trifocal;
- $125 lenticular;
- $70 elective contacts* (including any contact lens evaluation and fitting examination); or
- $125 Necessary Contact Lenses** (including any contact lens evaluation and fitting examination).

*Elective contact lenses are in lieu of all other frame and lens benefits. When You receive elective contact lenses, You will not be eligible for any frames or other types of lenses again until the next Plan Year. A VSP Doctor can only submit one claim on Your behalf per Plan Year. If that claim does not exhaust Your elective contact allowance, then You can pay up front and submit additional claims to VSP until that allowance is exhausted.

**Necessary Contact Lenses are available with a Plan Year supply if You have a specific condition for which contact lenses provide better visual correction. Necessary Contact Lenses are in lieu of all other frame and lens benefits. When You receive Necessary Contact Lenses, You will not be eligible for any frames or other types of lenses again until the next Plan Year.

### CONTACT LENS EVALUATION AND FITTING EXAMINATION
Services and supplies for contact lens evaluation and fitting examinations are covered. For an Out-of-Network Provider, the Contact Lens Evaluation and Fitting Examination benefit and elective or Necessary Contact Lenses combined, will not exceed the limit indicated above in the Vision Hardware benefit.

### LOW VISION BENEFIT
Low vision benefits for Members are covered if vision loss is sufficient enough to prevent reading and performing daily activities. Consult Your Provider for more details and to see if You fall within this category. Covered Services include professional services and ophthalmic materials, subject to any specified limits as explained in the following paragraphs:

### Supplemental Examinations (Testing)
Supplemental examinations (complete low vision testing, analysis and diagnosis) which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or low vision aids where indicated.

### Supplemental Aids
Low vision aids, including, but not limited to:

- optical;
- non-optical; and
- associated training.

## DISCOUNTS FROM VSP DOCTORS
Discounts are available for the following services or supplies when received from a VSP Doctor:

- when You receive a complete pair of glasses, You are entitled to receive a 20 percent discount on non-covered materials;
- You are entitled to receive a 15 percent discount on contact lens examination services, beyond the covered vision examination; and
- VSP Doctors may request an additional vision examination within 12 months if necessary, at a discount.

Discounts are applied to the VSP Doctor's usual and customary fees and are unlimited for 12 months on or following the date of the patient's last eye examination.

Discounts do **not** apply to:

- vision care benefits obtained from Out-of-Network Providers; or
- sundry items, including, but not limited to:
    - contact lens solutions;
    - cases;
    - cleaning products; or
    - repairs of spectacle lenses or frames.

**THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THIS PEDIATRIC VISION BENEFIT, BUT ARE NOT INSURANCE.**

# Adult Vision Benefits

This section explains Your benefits for Covered Services for Members age 19 and over.

### VISION EXAMINATION

Professional comprehensive routine eye examination or visual analysis, is covered, including:

- prescribing and ordering proper lenses;
- verifying the accuracy of the finished lenses; and
- progress or follow-up work as necessary.

### VISION HARDWARE

Hardware including frames, contacts and lenses is covered, subject to any specified limits. Lenses are limited to standard, or blue-light filter, glass or plastic lenses for one of the following:

- single vision;
- lined bifocal;
- standard progressive;
- lined trifocal;
- lenticular;
- non-prescription ready-made sunglasses;
- non-prescription ready-made blue-light filter glasses;
- elective contacts;* or
- Necessary Contact Lenses.**

Coverage for lenses received from an Out-of-Network Provider is specified in the Schedule of Benefits up to the following Maximum Benefit limits:

- $50 single vision;
- $80 lined bifocal;
- $95 standard progressive;
- $95 lined trifocal;
- $125 lenticular;
- $70 elective contacts* (including any contact lens evaluation and fitting examination); or
- $125 Necessary Contact Lenses** (including any contact lens evaluation and fitting examination).

*Elective contact lenses are in lieu of all other frame and lens benefits. When You receive elective contact lenses, You will not be eligible for any frames for 24 months or for other types of lenses for 12 months. A VSP Doctor can only submit one claim on Your behalf per Plan Year. If that claim does not exhaust Your elective contact allowance, then You can pay up front and submit additional claims to VSP until that allowance is exhausted.

**Necessary Contact Lenses are available with a 12 month supply if You have a specific condition for which contact lenses provide better visual correction. Necessary Contact Lenses are in lieu of all other frame and lens benefits. When You receive Necessary Contact Lenses, You will not be eligible for any frames for 24 months or for other types of lenses for 12 months.

### CONTACT LENS EVALUATION AND FITTING EXAMINATION

Services and supplies for contact lens evaluation and fitting examinations are covered. For an Out-of-Network Provider, the Contact Lens Evaluation and Fitting Examination benefit and elective or Necessary Contact Lenses combined, will not exceed the limit indicated above in the Vision Hardware benefit.

### LOW VISION BENEFIT

Low vision benefits for Members are covered if vision loss is sufficient enough to prevent reading and performing daily activities. Consult Your Provider for more details and to see if You fall within this category. Covered Services include professional services and ophthalmic materials, subject to any specified limits as explained in the following paragraphs:

### Supplemental Examinations (Testing)
Supplemental examinations (complete low vision testing, analysis and diagnosis) which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or low vision aids where indicated.

### Supplemental Aids
Low vision aids, including, but not limited to:

- optical;
- non-optical; and
- associated training.

## DISCOUNTS FROM VSP DOCTORS
Discounts are available for the following services or supplies when received from a VSP Doctor:

- when You receive a complete pair of glasses, You are entitled to receive a 20 percent discount on non-covered materials;
- You are entitled to receive a 15 percent discount on contact lens examination services, beyond the covered vision examination; and
- VSP Doctors may request an additional vision examination within 12 months if necessary, at a discount.

Discounts are applied to the VSP Doctor's usual and customary fees and are unlimited for 12 months on or following the date of the patient's last eye examination.

Discounts do **not** apply to:

- vision care benefits obtained from Out-of-Network Providers; or
- sundry items, including, but not limited to:
    - contact lens solutions;
    - cases;
    - cleaning products; or
    - repairs of spectacle lenses or frames.

**THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THIS ADULT VISION BENEFIT, BUT ARE NOT INSURANCE.**

# General Exclusions

The following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**, are not covered. However, these exclusions will not apply with regard to a Covered Service for an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by law.

### Certain Contact Lens Expenses

- artistically-painted or non-prescription contact lenses;
- contact lens modification, polishing or cleaning;
- refitting of contact lenses after the initial (90-day) fitting period;
- additional office visits associated with contact lens pathology; and
- contact lens insurance policies or service agreements.

### Conditions Caused by Active Participation in a War or Insurrection

The treatment of any condition caused by or arising out of a Member's active participation in a war or insurrection.

### Conditions Incurred in or Aggravated During Performances in the Uniformed Services

The treatment of any Member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

### Corneal Refractive Therapy (CRT)

Reversals or revisions of surgical procedures which alter the refractive character of the eye, including orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).

### Corrective Vision Treatment of an Experimental Nature

### Cosmetic Services and Supplies

Except for Medically Necessary services and supplies to treat a Congenital Anomaly, services and supplies for beautification, Cosmetic, or aesthetic purposes are not covered.

### Expenses Before Coverage Begins or After Coverage Ends

Services and supplies incurred before Your Effective Date under the Contract or after Your termination under the Contract.

### Facility Charges

Services and supplies provided in connection with facility services.

### Fees, Taxes, Interest

Except as required by law, the following fees, taxes and interest are not covered:

- charges for shipping and handling, postage, interest or finance charges that a Provider might bill;
- excise, sales or other taxes;
- surcharges;
- tariffs;
- duties;
- assessments; or
- other similar charges whether made by federal, state or local government or by another entity.

### Government Programs

Except as required by law (such as cases of medical emergency or coverage provided by Medicaid) or for facilities that contract with Us, benefits that are covered (or would be covered in the absence of this plan) by any federal, state or government program are not covered.

Additionally, except as required by law for emergency services, government facilities outside the service area are not covered.

### Illegal Activity
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by a Member's **voluntary participation in** an activity where the Member is found guilty of an illegal activity in a criminal proceeding or is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty or a no contest plea. If benefits already have been paid before the finding of guilt or liability is reached, We may recover the payment from the person We paid or anyone else who has benefited from it.

### Investigational Services
Investigational services are not covered, including, but not limited to:

- services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions); and
- any services or supplies provided by an Investigational protocol.

### Lens Enhancements
Except as provided in the Pediatric Vision benefit, lens enhancements are not covered, including, but not limited to:

- anti-reflective coating;
- color coating;
- mirror coating;
- scratch coating;
- blended lenses;
- Cosmetic lenses;
- laminated lenses;
- oversize lenses;
- premium and custom progressive multifocal lenses;
- photochromic lenses;
- tinted lenses, except Pink #1 and Pink #2; or
- UV (ultraviolet) protected lenses.

### Medical or Surgical Treatment of the Eyes
Medical or surgical treatment of the eyes, including reversals or revisions of surgical procedures of the eye.

### Motor Vehicle Coverage and Other Available Insurance
When motor vehicle coverage, other available insurance or contract is either issued to, or makes benefits available to a Member (whether or not the Member makes a claim with such coverage), expenses are not covered for services and supplies that are payable by any:

- automobile medical;
- personal injury protection (PIP);
- automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, Our Coordination of Benefits provision shall apply);
- underinsured or uninsured motorist coverage;
- homeowner's coverage;
- commercial premises coverage;
- excess coverage; or
- similar contract or insurance.

Further, the Member is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits in such contract or insurance are exhausted or

considered to no longer be Injury-related by the no-fault provisions of the contract, benefits will be provided accordingly.

### Non-Direct Patient Care
Non-direct patient care services are not covered, including, but not limited to:

- appointments scheduled and not kept (missed appointments);
- charges for preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at Our request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

### Orthoptics or Vision Training
Except as provided in the Low Vision benefit, orthoptics, vision training and any associated supplemental testing are not covered.

### Personal Items
Items that are primarily for comfort, convenience, Cosmetics, contentment, hygiene, aesthetics or other nontherapeutic purposes.

### Plano Lenses (Less Than a ± .50 Diopter Power)
Except for as provided in the Vision Hardware benefit, plano lenses are not covered.

### Replacements
Replacement of any lost, stolen or broken lenses and/or frames.

### Self-Help, Self-Care, Training or Instructional Programs
Except for services provided without a separate charge in connection with Covered Services that train or educate a Member, self-help, non-vision self-care and training or instructional programs are not covered.

### Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family are not covered.

"Immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings;
- Your child's or stepchild's spouse or domestic partner; and
- any other of Your relatives by blood or marriage who shares a residence with You.

### Services and Supplies That Are Not Medically Necessary
Services and supplies that are not Medically Necessary for the treatment of the diagnosis, preservation, or correction of visual acuity.

### Services and/or Supplies Not Described As Covered

### Subscription, Membership and Access-Related Fees
Fees for accessing care, treatment, or advice are not covered, whether the access is for virtual or in-person care. Excluded fees include, but are not limited to:

- concierge fees;
- subscription fees;
- membership fees;
- retainer fees;
- VIP or priority access fees; and
- any other access-related fees.

### Third-Party Liability
Services and supplies for treatment of Illness, Injury or health condition for which a third-party is or may be responsible.

### Travel and Transportation Expenses

### Two Pair of Glasses Instead of Bifocals

### Work-Related Conditions
Except when a Member is exempt from state or federal workers' compensation law, expenses for services or supplies incurred as a result of any work-related Illness or Injury (even if the service or supply is not covered by workers' compensation benefits) are not covered. This includes any claims resolved as a result of a disputed claim settlement.

If an Illness or Injury could be considered work-related, a Member will be required to file a claim for workers' compensation benefits before We will consider providing any coverage.

# Contract and Claims Administration

This section explains administration of benefits and claims, including situations that may arise when Your health care expenses are the responsibility of a source other than Us. Payment of benefits will be made in accordance with the terms and conditions of this Booklet.

### SUBMISSION OF CLAIMS AND REIMBURSEMENT

When You visit a VSP Doctor, the VSP Doctor will submit the claim directly to VSP for payment. However, if You visit an Out-of-Network Provider, You will need to pay the Provider's full fee at the time You receive the service or supply. Additionally, You will need to submit a claim to VSP for reimbursement of Covered Services, minus any Copayment and/or Coinsurance. THERE IS NO ASSURANCE THAT PAYMENT WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR HARDWARE. To get a claim form or to assist in submission of an Out-of-Network Provider claim, You may access Out-of-Network Reimbursement in My Benefits on VSP's website, **vsp.com**. Be sure the claim is complete and includes the following information:

- Your name;
- Your date of birth;
- Your address;
- Your identification number;
- the Group's name;
- a copy of the claim receipt from the Provider, including the:
    - Provider's name;
    - Provider's address;
    - date of service;
    - patient's name;
    - patient's date of birth;
    - patient's relation to You; and
    - services performed.

Submit the claim to:

Vision Service Plan
P.O. Box 495918
Cincinnati, OH 45249

### Timely Filing of Claims

Written proof of loss (submission of a claim) must be received within one year after the date of service. Claims that are not filed in a timely manner will be denied, unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. Benefits or coverage will not be invalidated nor reduced if it can be shown that it was not reasonably possible to file the claim and that the claim was submitted as soon as reasonably possible. You may appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner.

### Claim Determinations

Within 30 days of Our receipt of a claim, We will notify You of Our action. However, this 30-day period may be extended by an additional 15 days due to lack of information or extenuating circumstances. We will notify You of the extension within the initial 30-day period and provide an explanation of why the extension is necessary.

If We require additional information to process the claim, We must allow You at least 45 days to provide it to Us. If We do not receive the requested information within the time We have allowed, We will deny the claim.

## CLAIMS RECOVERY

If We pay a benefit to which You or Your Enrolled Dependent was not entitled, or if We pay a person who is not eligible for benefits at all, We have the right to recover the payment from the person We paid or anyone else who benefited from it, including a provider of services. Our right to recovery includes the right to deduct the mistakenly paid amount from future benefits We would provide the Enrolled Employee or any Enrolled Dependents, even if the mistaken payment was not made on that person's behalf.

We regularly work to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, fraudulent claims, etc.). We will credit all amounts that We recover, less Our reasonable expenses for obtaining the recoveries, to Your Group's experience or the experience of the pool by which You or Your Group is rated. Crediting reduces claims expense and helps reduce future premium rate increases.

This Claims Recovery provision in no way reduces Our right to reimbursement or subrogation. Refer to the Right of Reimbursement and Subrogation Recovery provision for additional information.

## RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

As used herein, the term "third-party", means any party that is, or may be, or is claimed to be responsible for Illness or Injuries to You or for health conditions You experience. Such Illness, Injuries or health conditions are referred to as "third-party Injuries." Third-party includes any party responsible for payment of expenses associated with the care or treatment of third-party Injuries.

If We pay benefits under this Booklet to You for expenses incurred due to third-party Injuries, then We retain the right to repayment of the full cost of all benefits provided by Us on Your behalf that are associated with the third-party Injuries. Our rights of recovery apply to any recoveries made by or on Your behalf from the following sources, including, but not limited to:

- payments made by a third-party or any insurance company on behalf of the third-party;
- any payments or awards from an uninsured or underinsured motorist coverage policy;
- any worker's compensation or disability award or settlement; or
- any other payments from a source intended to compensate You for Injuries resulting from an accident or alleged negligence, including automobile medical, personal injury protection (PIP), automobile no-fault, premises medical payments coverage, homeowner's insurance coverage, commercial premises medical coverage or similar contract or insurance, when the contract or insurance is either issued to, or makes benefits available to You, whether or not You make a claim with such coverage.

By accepting benefits under this Booklet, You specifically acknowledge Our right of subrogation. When We pay health care benefits for expenses incurred due to third-party Injuries, We shall be subrogated to Your right of recovery against any party to the extent of the full cost of all benefits provided by Us. We may proceed against any party with or without Your consent.

By accepting benefits under this Booklet, You also specifically acknowledge Our right of reimbursement. This right of reimbursement attaches when We have paid benefits due to third-party Injuries and You or Your representative have recovered any amounts from a third-party. By providing any benefit under this Booklet, We are granted an assignment of the proceeds of any settlement, judgment or other payment received by You to the extent of the full cost of all benefits provided by Us. Our right of reimbursement is cumulative with and not exclusive of Our subrogation right and We may choose to exercise either or both rights of recovery.

In order to secure Our recovery rights, You agree to assign to Us any benefits or claims or rights of recovery You have in any automobile policy or other coverage, to the full extent of Our subrogation and reimbursement claims. This assignment allows Us to pursue any claim You may have, whether or not You choose to pursue the claim.

### Advancement of Benefits

If You have a potential right of recovery for Illnesses or Injuries from a third-party who may have legal responsibility or from any other source, We may advance benefits pending the resolution of a claim to the right of recovery and all of the following conditions apply:

- By accepting or claiming benefits, You agree that We are entitled to reimbursement of the full amount of benefits that We have paid out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Illness or Injury for which We have provided benefits.
- You or Your representative agree to give Us a first-priority lien on any recovery, settlement judgment or other source of compensation which may be received from any party to the extent of the full cost of all benefits associated with third-party Injuries provided by Us (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- Further, You agree to pay, as the first priority, from any recovery, settlement, judgment or other source of compensation, any and all amounts due to Us as reimbursement for the full cost of all benefits associated with third-party Injuries paid by Us (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- Our rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment or other characterization of the recovery by the Member and/or any third-party or the recovery source. We are entitled to reimbursement from the first dollars received from any recovery. This applies regardless of whether:

    - the third-party or third-party's insurer admits liability;
    - the health care expenses are itemized or expressly excluded in the recovery; or
    - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered in this Booklet.

- We will not reduce Our reimbursement or subrogation due to Your not being made whole. Our right to reimbursement or subrogation, however, will not exceed the amount of recovery.
- By accepting benefits under this Booklet, You or Your representative agrees to notify Us promptly (within 30-days) and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to third-party Injuries sustained by You.
- You and Your representative must cooperate with Us and do whatever is necessary to secure Our rights of subrogation and reimbursement under this Booklet. We may require You to sign and deliver all legal papers and take any other actions requested to secure Our rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third-party or other source). If We ask You to sign a trust agreement or other document to reimburse Us from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.
- You must agree that nothing will be done to prejudice Our rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by Us. You will also cooperate fully with Us, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify Us of any facts that may impact Our right to reimbursement or subrogation, including, but not necessarily limited to, the following:

    - the filing of a lawsuit;
    - the making of a claim against any third-party;
    - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
    - intent of a third-party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Illness or Injury that gives rise to Our right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).

- You and/or Your agent or attorney must agree to serve as constructive trustee and keep any recovery or payment of any kind related to Your Illness or Injury which gave rise to Our right of subrogation or reimbursement segregated in its own account, until Our right is satisfied or released.
- In the event You and/or Your agent or attorney fails to comply with any of these conditions, We may recover any such benefits advanced for any Illness or Injury through legal action.

- Any benefits We have provided or advanced are provided solely to assist You. By paying such benefits, We are not acting as a volunteer and are not waiving any right to reimbursement or subrogation.

We may recover the full cost of all benefits paid by Us under this Booklet without regard to any claim of fault on Your part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from Our recovery, and We are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by You to pursue Your claim or lawsuit against any third-party. In the event You or Your representative fail to cooperate with Us, You shall be responsible for all benefits paid by Us in addition to costs and attorney's fees incurred by Us in obtaining repayment.

### Motor Vehicle Coverage

If You are involved in a motor vehicle accident, You may have rights both with motor vehicle insurance coverage and against a third-party who may be responsible for the accident. In that case, this Right of Reimbursement and Subrogation Recovery provision still applies.

### Workers' Compensation

Here are some rules which apply in situations where a workers' compensation claim has been filed:

- You must notify Us in writing within five days of any of the following:
  - filing a claim;
  - having the claim accepted or rejected;
  - appealing any decision;
  - settling or otherwise resolving the claim; or
  - any other change in status of Your claim.
- If the entity providing workers' compensation coverage denies Your claim and You have filed an appeal, We may advance benefits for Covered Services if You agree to hold any recovery obtained in a segregated account for Us.

### Fees and Expenses

We are not liable for any expenses or fees incurred by You in connection with obtaining a recovery. However, You may request that We pay a proportional share of attorney's fees and costs at the time of any settlement or recovery to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid by Us. We have discretion whether to grant such requests.

### Future Related Expenses

Benefits for otherwise Covered Services may be excluded when You have received a recovery from another source relating to an Illness or Injury for which We would normally provide benefits. However, the amount of any Covered Services excluded in this provision will not exceed the amount of Your recovery.

## COORDINATION OF BENEFITS

If You are covered by any other Plan (as defined below), the benefits in this Booklet and those of the other Plan will be coordinated in accordance with the provisions of this section. NOTE: This section refers to a broad range of benefits, even though this plan is a vision only plan.

### Definitions

The following are definitions that apply to this Coordination of Benefits provision:

Allowable Expense means, with regard to services that are covered in full or part by this Booklet or any other Plan(s) covering You, the amount on which that Plan would base its benefit payment for a service, including Coinsurance or Copayments and without reduction for any applicable deductible. In no event shall benefits payable under the Contract and another Plan exceed the allowable charges for such benefits. The following are examples of expenses that are not an Allowable Expense:

- An expense or portion of an expense not covered by any of Your involved Plans.

- The difference between the cost of a private hospital room and the cost of a semiprivate hospital room, unless Your stay in a private hospital room is Medically Necessary or one of Your involved Plans provides coverage for private hospital rooms.
- Any expenses for other types of coverage or benefits when this coverage restricts coordination of benefits to certain types of coverage or benefits. This Coordination of Benefits provision applies to all benefits provided in this Booklet.
- Any amount by which a Primary Plan's benefits were reduced because You did not comply with that Plan's provisions regarding second surgical opinion or failed to use a preferred Provider.

When a Plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid.

Birthday means only the day and month in a Calendar Year and does not include the year in which the Member is born.

Closed Panel Plan means a Plan that provides health benefits to a Member primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel member. If the Primary Plan is a Closed Panel Plan and the Secondary Plan is not a Closed Panel Plan, the Secondary Plan shall provide benefits as if it were the Primary Plan when a Member uses a non-panel Provider, except for emergency services or authorized referrals that are provided by the Primary Plan.

Custodial Parent means the parent awarded custody of a child by a court decree. In the absence of a court decree, the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation is the Custodial Parent.

Group-Type Coverage is a coverage that is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including blanket coverage. Group-Type Coverage does not include an individually underwritten and issued guaranteed renewable coverage, even if the coverage is purchased through payroll deduction at a premium savings to the covered person.

Plan means any of the following with which this coverage coordinates benefits:

- group and non-group insurance contracts and subscriber contracts;
- uninsured group or Group-Type Coverage arrangements;
- group and non-group coverage through Closed Panel Plans;
- Group-Type Coverage;
- medical care components of long-term care coverage, such as skilled nursing care;
- Medicare or other governmental benefits, except as provided below; and
- medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts.

Plan does **not** include:

- hospital indemnity coverage or other fixed indemnity coverage;
- school accident-type coverage that covers students for accidents only, including athletic injuries, either on a 24-hour basis or a "to and from school basis";
- specified disease or specified accident coverage;
- accident only coverage;
- long-term care insurance for non-medical services (such as personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care and custodial care) or that pay a fixed daily benefit without regard to actual expenses incurred or services;
- limited benefit health coverage;
- Medicare supplement coverage;
- a Medicaid state plan; or

- a governmental plan that, by law, provides benefits that are excess to those of private insurance or other nongovernmental coverage.

Primary Plan means the Plan that must determine its benefits for Your health care before the benefits of another Plan and without taking the existence of that other Plan into consideration. (This is also referred to as that Plan being "primary" to that other Plan.) There may be more than one Primary Plan. A Plan is a Primary Plan with regard to another Plan in any of the following circumstances:

- the Plan either has no order of benefit determination provision, or its rules differ from those permitted in this provision; or
- both Plans use the order of benefit determination provision included herein and by that provision the Plan determines its benefits first.

Secondary Plan means a Plan that is not a Primary Plan. You may have more than one Secondary Plan. If You are covered by more than one Secondary Plan, the order of benefit determination provision decides the order in which Your Secondary Plans' benefits are determined in relation to each other.

Year means Calendar Year (January 1 through December 31).

### Order of Benefit Determination

The order of benefit determination is identified by using the first of the following rules that apply:

**Non-dependent Coverage:** A Plan that covers You other than as a dependent will be primary to a Plan for which You are covered as a dependent (except where this order of benefits would cause a violation of federal law concerning coordination of benefits with Medicare).

**Dependent Coverage:** Unless there is a court decree stating otherwise, Plans that cover You as a child shall determine the order of benefits as follows:

For a child whose parents are married or living together (whether or not they have ever been married):

- The Plan that covers You as the dependent of Your parent whose Birthday occurs earlier in the Year will be primary over a Plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year.
- If both parents covering You as a dependent have the same Birthday, the Plan of the parent who has been covered by their Plan longer shall be primary to the Plan of the parent who has been covered by their Plan for a shorter period.

For a child whose parents are divorced, separated or that are not living together (whether or not they have ever been married):

- If a court decree specifies that one of Your parents is responsible for Your health care expenses or health care coverage and that parent's Plan has actual knowledge of that term of the decree, the Plan of that parent is primary to the Plan of Your other parent. If the parent with responsibility has no health care coverage for Your health care expenses, but that parent's spouse does, that parent's spouse's Plan is the Primary Plan. If benefits have been paid or provided by a Plan before it has actual knowledge of the term in the court decree, these rules do not apply until that Plan's next Plan Year.
- If a court decree states that both parents are responsible for Your health care expenses or health care coverage, or a court decree states that the parents have joint custody without specifying that one parent has responsibility for Your health care expenses or health care coverage:
    - The Plan that covers You as the dependent of Your parent whose Birthday occurs earlier in the Year will be primary over a Plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year.
    - If both parents covering You as a dependent have the same Birthday, the Plan of the parent who has been covered by their Plan longer shall be primary to the Plan of the parent who has been covered by their Plan for a shorter period.

- If there is no court decree allocating responsibility for Your health care expenses or health care coverage:

    - The Plan covering the Custodial Parent shall be primary to the Plan covering Your Custodial Parent's spouse.
    - The Plan of Your Custodial Parent's spouse shall be primary to the Plan covering Your noncustodial parent.
    - Then the Plan covering Your noncustodial parent shall be primary to the Plan of Your noncustodial parent's spouse.

For a child covered by more than one Plan of individuals who are not the parents of the child, the order of benefit determination shall be determined as per the provisions set forth above as if those individuals were parents of the child.

**Active/retired or laid-off employees:** A Plan that covers You as an active employee (or as that employee's dependent) is primary to a Plan by which You are covered as a retired or laid off employee (or as the dependent of a retired or laid off employee). If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

**Continuation coverage:** A Plan which covers You as an employee or retired employee, or as an employee's or retired employee's dependent, will be primary to a Plan that is providing continuation coverage (pursuant to COBRA or a right of continuation by state or other federal law). If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply. This paragraph does not apply if an order of benefit determination can be made by the non-dependent coverage paragraph above.

**Longer/shorter length of coverage:** When none of the paragraphs above establishes an order of benefit determination, the benefits of the Plan that has covered You for the longer period of time will be determined before the benefits of the Plan that has covered You for the shorter period of time. To determine the length of time You have been covered by a Plan, two Plans will be treated as one if You were eligible by the second within 24 hours after the first ended. The start of a new Plan does not include:

- a change in the amount or scope of a Plan's benefits;
- a change in the entity that pays, provides or administers the Plan's benefits; or
- a change from one type of Plan to another (such as from a single-employer Plan to a multiple employer Plan).

Your length of time covered by a Plan is measured from Your first date of coverage with that Plan. If that date is not readily available for a group Plan, the date You first became a member of the group will be used as the date from which to determine the length of time coverage with the present Plan has been in force.

If an order of benefit determination is not identified by the preceding rules, the Plans shall share equally in the Allowable Expenses.

Each of the Plans by which You are covered, and each of the benefits within the Plan, will be considered separately in administering this Coordination of Benefits provision.

### Primary Health Plan Benefits

When, in accordance with the order of benefit determination, this coverage is the Primary Plan, We will pay the benefits in this Booklet as if no other Plan exists.

### Secondary Health Plan Benefits

If, in accordance with the order of benefit determination, one or more Plans are primary to this coverage, the benefits in this Booklet will be calculated as follows:

We will calculate the benefits that We would have paid for a service if this coverage were the Primary Plan. We will compare the Allowable Expense in this Booklet for that service to the Allowable Expense for it with the other Plan(s) by which You are covered. We will pay the lesser of:

- the unpaid charges for the service, up to the higher (highest) Allowable Expenses among the involved Plans, and
- the benefits that We would have paid for the service if this coverage were the Primary Plan.

Deductibles, Coinsurance and/or Copayments in this Booklet will be used in the calculation of the benefits that We would have paid if this were the Primary Plan, but they will not be applied to the unpaid charges You owe after the Primary Plan's payment. Our payment therefore will be reduced so that it, when combined with the Primary Plan's payment, does not exceed the higher (highest) Allowable Expense among the involved Plans and We will credit toward any deductible in this Booklet any amount that would have been credited to deductible if this coverage had been the only Plan.

If this coverage is the Secondary Health Plan according to the order of benefit determination and any other Plan(s) claim to be "always secondary" or use order of benefit determination rules inconsistent with those in this Booklet, We will pay benefits first, but the amount paid will be calculated as if this coverage is a Secondary Health Plan. If the other Plan(s) do not provide Us with the information necessary for Us to determine Our appropriate secondary benefits payment within a reasonable time after Our request, We shall assume their benefits are identical to Ours and pay benefits accordingly, subject to adjustment upon receipt of the information requested from the other Plan(s) within two years of Our payment.

Nothing contained in this Coordination of Benefits provision requires Us to pay for all or part of any service that is not covered by this coverage. Further, in no event will this Coordination of Benefits provision operate to increase Our payment over what We would have paid in the absence of this Coordination of Benefits provision.

### Right to Receive and Release Needed Information

Certain facts are needed to apply coordination of benefits provisions. We have the right to decide which facts We need. We may get needed facts from, or give them to, any other organization or person as permitted by law, and need not tell or get the consent of any person to do this. You will promptly furnish to Us any information necessary or appropriate to administer this Coordination of Benefits provision. Receipt of such information by Us will be a condition precedent to Our obligation to provide benefits in this Booklet.

### Facility of Payment

Any payment made by any other Plan(s) may include an amount that should have been paid by this coverage. If so, We may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this coverage. We 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 reasonable cash value of the benefits provided in the form of services.

### Right of Recovery

If We provide benefits to or on behalf of You in excess of the amount that would have been payable in this Booklet by reason of Your coverage with any other Plan(s), We will be entitled to recover from You, Your assignee or beneficiary, or from the other Plan(s) upon request.

A Secondary Plan that provides benefits in the form of services may recover the reasonable cash value of the services from the Primary Plan to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by it.

# Appeal Process

If You or Your Representative wish to seek review of a claim denial or other dispute that is identified below, You may appeal.

NOTE: For all appeals, written materials provided in support of the appeal that include others' medical or health records and other personal health information should not be submitted.

### WHAT YOU MAY APPEAL

You may appeal disputes regarding:

- access to health care benefits, including an adverse benefit determination made pursuant to utilization management;
- claims payment, handling, or reimbursement for health care services;
- issues pertaining to the contractual relationship between a Member and Us;
- recission of Your benefit coverage by Us; and
- other matters as specifically required by law or regulation.

Your initial appeal (first-level or expedited) must be pursued within 180 days of Your receipt of the original adverse decision that You are appealing. If You don't appeal within this time period, You will not be able to pursue the appeal process and may jeopardize Your ability to pursue the matter in any forum. When Your initial appeal request is received, You will be sent written acknowledgement within five days for a first-level appeal or within 72 hours for an expedited appeal.

### FILING AN APPEAL

Appeals can be initiated through either a written or verbal request using any of the following methods:

| Method of Request | Contact Information |
|---|---|
| Secure Online Account | Create an account or complete the form available at **vsp.com** |
| Phone | Call 1 (844) 299-3041 for VSP's Customer Service department<br>Call 1 (800) 428-4833 for hearing impaired customer assistance<br>Customer Services hours: Monday – Saturday, 6 a.m. – 5 p.m., Pacific Time |
| Mail | Attn: Appeals Department<br>Vision Service Plan<br>P.O. Box 2350<br>Rancho Cordova, CA 95741 |

### APPEAL DETERMINATION TIMING

VSP will send its decision on Your appeal as follows:

| Type of Appeal | When to Expect a Response |
|---|---|
| First-level appeal | In writing, within 30 days of VSP's receipt of the appeal. |
| Second-level (panel-level) appeal | In writing, within 30 days of VSP's receipt of the appeal. |
| Expedited appeal | Verbal notice as soon as possible, but no later than 72 hours of receipt of the appeal, followed by written notice within 72 hours of the date of the decision. |

## FIRST-LEVEL APPEALS

First-level appeals are reviewed by an employee(s) of VSP who was not involved in the adverse decision. You or Your Representative will be given a reasonable opportunity to provide written materials, including written testimony.

## SECOND-LEVEL (PANEL-LEVEL) APPEALS

Second-level appeals must be pursued within 60 days of Your receipt of VSP's decision on the first-level appeal. If You don't appeal within this time period, You will not be able to pursue the appeal process and may jeopardize Your ability to pursue the matter in any forum. Second-level appeals are reviewed by an employee(s) of VSP who was not involved in, or subordinate to anyone involved in, the prior decision. You or Your Representative will be given a reasonable opportunity to provide written materials, including written testimony.

## EXPEDITED APPEALS

If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision under the regular appeal process, You or Your Provider may specifically request an expedited appeal. The expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. Expedited appeals are reviewed by an employee(s) of VSP who was not involved in, or subordinate to anyone involved in, the initial denial determination. Reviewers include an appropriate clinical peer in the same or similar specialty as would typically manage the case. You or Your Representative will be given the opportunity (within the constraints of the expedited appeals time frame) to provide written materials, including written testimony on Your behalf.

## DEFINITIONS

The following definitions apply to this Appeal Process Section:

Representative means an individual authorized to represent You for the appeal. A Representative may be:

- Your treating Provider (for expedited appeals, a health care professional with knowledge of Your medical condition is recognized as Your Representative);
- an individual You have identified as Your Representative in a written communication to VSP; or
- an individual identified as Your Representative to VSP Customer Service.

No authorization is required from the parent(s) or legal guardian of an enrolled dependent child who is less than 13 years old.

# Eligibility and Enrollment

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible or during an annual open enrollment period. It describes when coverage under the Contract begins for You and/or Your eligible dependents. Payment of any corresponding monthly premiums is required for coverage to begin on the indicated dates.

## INITIALLY ELIGIBLE AND WHEN COVERAGE BEGINS

You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of initially becoming eligible for coverage per the eligibility requirements in effect with the Group and as stated in the following paragraphs. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

If You and/or Your eligible dependents do not enroll for coverage under the Contract when first eligible or You do not enroll in a timely manner, You and/or Your eligible dependents must wait until the next annual open enrollment period to enroll.

### Employees

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 20 hours or more per week and who are not classified as a Seasonal Employee or Part-Time Temporary Employee.

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

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

An Enrolled Employee who becomes disabled shall be able to maintain their coverage up to six months following the date of disability, as determined by the Group's Life/Disability insurance carrier, upon payment of the appropriate premium.

### Dependents

Your Enrolled Dependents are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when We have enrolled them in coverage under the Contract. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your (or Your spouse's) child who is under age 26 and who meets any of the following criteria:
    - Your (or Your spouse's) natural child, stepchild, adopted child or child legally Placed with You (or Your spouse) for adoption;
    - a child for whom You (or Your spouse) have court-appointed legal guardianship; or
    - a child for whom You (or Your spouse) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your spouse's) child who is age 26 or over and incapable of self-support because of intellectual disability or physical handicap that began before the child's 26th birthday. You must complete and submit Our affidavit of dependent eligibility form, with written evidence of the child's incapacity, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
    - the child is an enrolled child immediately before their 26th birthday; or

- the child's 26th birthday preceded Your Effective Date and the child has been continuously covered as a dependent on either a parent's or legal guardian's group coverage since that birthday.

Our affidavit of dependent eligibility form is available by visiting Our website or by calling Customer Service.

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.

Under special circumstances approved by the Group, other children under the custodial care of the Enrolled Employee may be considered as eligible dependents.

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 plan, but not both.

## NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request and the appropriate premium (if any) is received by Us within 31 days of the date the monthly premium invoice is received by the Group and a notice of premium (if any) is provided to You by the Group.

Enrollment will be effective from:

- the moment of birth for a Newborn Child if a completed enrollment form is received within 60 days following the date of birth; or
- Placement of a Newly Adopted Child with the Enrolled Employee for 60 days, but will continue from then on only if a completed enrollment form is received within 60 days following Placement with the Enrolled Employee.

## ANNUAL OPEN ENROLLMENT PERIOD

The annual open enrollment period is the period of time before the Group's Renewal Date and is the only time, other than initial eligibility, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form on behalf of all individuals You want enrolled. Coverage will begin on the Effective Date.

## DOCUMENTATION OF ELIGIBILITY

You must promptly provide (or coordinate) any necessary and appropriate information to determine the eligibility of a dependent. We must receive such information before enrolling a person as a dependent under the Contract.

# When Coverage Ends

This section describes the situations when coverage will end for You and/or Your Enrolled Dependents. You must notify Us within 30 days of the date on which an Enrolled Dependent is no longer eligible for coverage.

No person will have a right to receive any benefits after the date coverage is terminated. Termination of Your or Your Enrolled Dependent's coverage under the Contract for any reason will completely end all Our obligations to provide You or Your Enrolled Dependent benefits for Covered Services received after the date of termination. This applies whether or not You or Your Enrolled Dependent is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while the Contract was in effect.

## CONTRACT TERMINATION

If the Contract is terminated or not renewed by the Group or Us, coverage ends for You and Your Enrolled Dependents on the date the Contract is terminated or not renewed.

## WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your Enrolled Dependents on the last day of the month in which Your eligibility ends. However, it may be possible for You and/or Your Enrolled Dependents to continue coverage under the Contract according to the COBRA Continuation of Coverage Section.

### Termination of Your Employment or You are No Longer Eligible

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Contract, coverage will end for You and all Enrolled Dependents on the last day of the month for which payment is made.

### Nonpayment of Premium

If You fail to make required timely premium contributions, coverage will end for You and all Enrolled Dependents.

## WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs, coverage ends for Your Enrolled Dependents on the last day of the month in which their eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Contract according to the COBRA Continuation of Coverage Section.

### Divorce or Annulment

Eligibility ends for Your enrolled spouse and the spouse's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the month following the date a divorce or annulment is final.

### Death of the Enrolled Employee

If You die, coverage for Your Enrolled Dependents ends on the last day of the month in which Your death occurs.

### Loss of Dependent Status

- Eligibility ends on the last day of the month in which an enrolled child exceeds the dependent age limit.
- Eligibility ends on the date in which an enrolled child is removed from Placement due to disruption of Placement before legal adoption.
- Eligibility ends on the last day of the month in which an enrolled child is no longer an eligible dependent for any other cause not described above.

## OTHER CAUSES OF TERMINATION

Members terminated for the following reason may be able to continue coverage under the Contract according to the COBRA Continuation of Coverage Section.

## Fraud or Misrepresentation

We have issued this Booklet in reliance upon all information furnished to Us by You or on behalf of You and Your Enrolled Dependents. No statement made for effecting insurance will void such insurance or reduce benefits unless such statement is contained in a written instrument signed by You.

In the event of any intentional misrepresentation of material fact or fraud by the Group, coverage under the Contract will terminate for the Group.

## FAMILY AND MEDICAL LEAVE

If Your Group grants You a leave of absence per the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA") the following rules will apply. The Act is generally applicable to private employers of 50 or more employees and public employers of any size. You will be entitled to continued coverage with this provision only to the extent You are eligible for leave under the terms of the FMLA:

- You and Your Enrolled Dependents will remain eligible to be enrolled under the Contract during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
    - to care for Your Newborn Child;
    - to care for Your spouse, child or parent with a serious health condition;
    - the Placement of a child with You for adoption or foster care; or
    - You suffer a serious physical or mental health condition.

During the FMLA leave, You must continue to pay the monthly premium through the Group on time. The provisions described here will not be available if the Contract terminates.

If You and/or Your Enrolled Dependents elect not to remain enrolled during the FMLA leave, You (and/or Your Enrolled Dependents) will be eligible to be reenrolled under the Contract on the date You return from the FMLA leave. In order to reenroll after You return from a FMLA leave, You must sign a new enrollment form as if You were a newly eligible employee. In this situation, if You reenroll within the required time, all of the terms and conditions of the Contract will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Enrolled Dependents) will receive credit for any waiting period served before the FMLA leave and You will not have to re-serve any probationary period under the Contract, although You and/or Your Enrolled Dependents will receive no waiting period credits for the period of noncoverage.

You and/or Your Enrolled Dependents will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage according to this provision. Entitlement to FMLA leave does not constitute a qualifying event for COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to groups that are required by law to comply. The Group must keep Us advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

## LEAVE OF ABSENCE

If You are granted a non-FMLA temporary leave of absence by Your Group, You can continue coverage for up to six months. Premiums must be paid through the Group in order to maintain coverage during a leave of absence.

A leave of absence is an employer-granted period off work made at Your request during which You are still considered to be employed and are carried on the Group's employment records. A leave can be granted for any reason acceptable to the Group. If You are on leave for an FMLA-qualifying reason, You remain eligible under the Contract only for a period equivalent to FMLA leave and may not also continue coverage with a non-FMLA leave.

If You and/or Your Enrolled Dependents elect not to remain enrolled during the leave of absence, You (and/or Your Enrolled Dependents) may reenroll under the Contract only during the next annual open enrollment period.

# COBRA Continuation of Coverage

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups.

If Your Group is subject to COBRA, COBRA continuation is available to Your Enrolled Dependents if they lose eligibility because:

- Your employment is terminated (unless the termination is for gross misconduct);
- Your hours of work are reduced;
- You die;
- You and Your spouse divorce or the marriage is annulled;
- You become entitled to Medicare benefits; or
- Your enrolled child loses eligibility as a child under this coverage.

COBRA also is available to You if You lose eligibility because Your employment terminates (other than for gross misconduct) or Your hours of work are reduced. (A special COBRA continuation also applies to You and Your Enrolled Dependents per certain conditions if You are retired and Your Group files for bankruptcy.)

There are some circumstances involving disability or the occurrence of a second one of these events that can result in extension of the limited period of continuation following a termination of employment or reduction in working hours. COBRA also can terminate earlier than the maximum periods.

### General Rules

You or Your Enrolled Dependents are responsible for payment of the full premium for COBRA continuation, plus an administration fee, even if the Group contributes toward the premiums of those not on COBRA continuation. The administration fee is two percent or, during any period of extension for disability, 50 percent.

In order to preserve Your and Your Enrolled Dependent's rights with COBRA, You or Your Enrolled Dependents must inform the Group in writing within 60 days of:

- Your divorce or annulment or a loss of eligibility of a child;
- Your initial loss of eligibility due to Your termination of employment or reduction in working hours and You experience another one of the events listed above; or
- a Social Security disability determination that You or Your Enrolled Dependent were disabled per Social Security at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that You or Your Enrolled Dependent is no longer disabled per Social Security, You or Your Enrolled Dependent must provide the Group notice of that determination within 30 days of the date it is made.)

The Group also must meet certain notification, election and payment deadline requirements. It is very important that You keep the Group informed of the current address of all Members who are or may become qualified beneficiaries.

If You or Your Enrolled Dependents do not elect COBRA continuation coverage, coverage under the Contract will end according to the terms of the Contract and We will not pay claims for services provided on and after the date coverage ends.

### Notice

The Contract includes additional details on the COBRA Continuation provisions outlined here and complete details are available from Your Group.

# General Provisions and Legal Notices

This section explains various general provisions and legal notices regarding Your benefits under this coverage.

### CHOICE OF FORUM
Any legal action arising out of the Contract must be filed in a court in the state of Idaho.

## GOVERNING LAW AND DISCRETIONARY LANGUAGE
**The Contract will be governed by and construed in accordance with the laws of the United States of America and by the laws of the state of Idaho without regard to its conflict of law rules. The plan administrator, the Group, delegates Us discretion for the purpose of paying benefits under this coverage only if We determine that You are entitled to them and of interpreting the terms and conditions of the benefit plan. Final determinations pursuant to this reservation of discretion do not prohibit or prevent a claimant from seeking judicial review of those determinations in federal court. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when You seek judicial review of Our determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the benefit plan. We are not the plan administrator, but are an insurance company that provides insurance to this benefit plan, and the court will determine the level of discretion that it will accord determinations.**

### GROUP IS AGENT
The Group is Your agent for all purposes under the Contract and not Our agent. You are entitled to health care benefits pursuant to an agreement between Us and the Group. In the Contract, the Group agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in this Booklet. You, through the enrollment form signed by the Enrolled Employee, and as beneficiaries of the Contract, acknowledge and agree to the terms, provisions, limitations and exclusions in this Booklet.

### LIMITATIONS ON LIABILITY
You have the exclusive right to choose a vision care Provider. We are not responsible for the quality of vision care You receive, since all those who provide care do so as independent contractors. Since We do not provide any vision care services, We cannot be held liable for any claim or damages connected with Injuries You suffer while receiving vision services or supplies provided by professionals who are neither Our employees nor agents.

In addition, We will not be liable to any person or entity for the inability or failure to procure or provide the benefits in this Booklet by reason of epidemic, disaster or other cause or condition beyond Our control.

### MODIFICATION OF CONTRACT
We shall have the right to modify or amend the Contract from time to time. However, no modification or amendment will be effective until a minimum of 30 days (or as required by law) after written notice has been given to Members or to the Group. The modification must be uniform within the product line and at the time of renewal. Exceptions to this modification provision for circumstances beyond Our control are further addressed in the Contract.

### NO WAIVER
The failure or refusal of either party to demand strict performance of the Contract or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the Contract will be considered waived by Us unless such waiver is reduced to writing and signed by one of Our authorized officers.

## NONASSIGNMENT AND NONASSIGNMENT OF VOTING RIGHTS

Only You are entitled to benefits under the Contract. These benefits are not assignable or transferable to anyone else and You (or a custodial parent or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits or payments to any person, corporation or entity. Any attempted assignment, transfer or delegation of benefits will be considered null and void and will not be binding on Us. You may not assign, transfer or delegate any right of representation or collection other than to legal counsel directly authorized by You on a case-by-case basis.

A Contract holder entitled to vote on any matter of corporation business may not assign or in any way delegate such voting right to any other person or entity, other than by a validly executed written proxy filed with Us in compliance with Our bylaws.

## NOTICES

Any notice to Members or to the Group required in the Contract will be considered properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Enrolled Employee or to the Group will be addressed to the last known address appearing in Our records. If We receive a United States Postal Service change of address (COA) form for an Enrolled Employee, We will update Our records accordingly. Additionally, We may forward notice for an Enrolled Employee to the Group administrator if We become aware that We don't have a valid mailing address for the Enrolled Employee. Any notice to Us required in the Contract may be mailed to Our Customer Service address. However, notice to Us will not be considered to have been given to and received by Us until physically received by Us.

### Notice of Annual Meeting

The annual meeting of Regence BlueShield of Idaho Contract holders will be held at 10 a.m., Pacific Time on the third Wednesday of April at its corporate headquarters located at 1602 21st Avenue, Lewiston, ID.

## PREMIUMS

Premiums are to be paid in advance to Us by the Group on or before the premium due date. Failure by the Group to make timely payment of premiums may result in Our terminating the Group's or Member's coverage on the last day of the month through which premiums are paid or such later date as provided by applicable law.

## RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Group on behalf of itself and its Members expressly acknowledges its understanding that the Contract constitutes an agreement solely between the Group and Regence BlueShield of Idaho, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association), permitting Us to use the Blue Shield Service Mark in the state of Idaho and in Asotin and Garfield counties in the state of Washington and that We are not contracting as the agent of the Association. The Group on behalf of itself and its Members further acknowledges and agrees that it has not entered into the Contract based upon representations by any person or entity other than Regence BlueShield of Idaho and that no person or entity other than Regence BlueShield of Idaho will be held accountable or liable to the Group or the Members for any of Our obligations to the Group or the Members created under the Contract. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueShield of Idaho other than those obligations created under other provisions of the Contract.

## REPLACEMENT

In the event the Contract replaces another group contract or policy within 60 days of its termination, We will immediately cover all employees and dependents covered by the previous plan at the date of discontinuance, provided they meet the definition of an Enrolled Employee and Enrolled Dependent under the Contract and otherwise would be eligible for coverage by the previous plan.

## REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements You make in an enrollment form will be considered representations and not warranties. No statement made for obtaining coverage will void such coverage

or reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

## RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by Us. This information will be used for the purpose of facilitating health care treatment, payment of claims or business operations necessary to administer health care benefits; or as required by law.

The information requested or disclosed may be related to treatment or services received from:

- an insurance carrier or group health plan;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies;
- a clinic, hospital, long-term care or other medical facility; or
- a Physician, dentist, pharmacist or other physical or behavioral health care Practitioner.

Health information requested or disclosed by Us may include, but is not limited to:

- billing statements;
- claim records;
- correspondence;
- dental records;
- diagnostic imaging reports;
- hospital records (including nursing records and progress notes);
- laboratory reports; and
- medical records.

We are required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by visiting Our website or contacting Customer Service.

You have the right to request, inspect and amend any records that We have that contain Your personal health information. Contact Customer Service to make this request.

**NOTE: This provision does not apply to information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services and genetic testing. A specific authorization will be obtained from You in order for Us to receive information related to these health conditions.**

## TAX TREATMENT

We do not provide tax advice. Consult Your financial or tax advisor for information about the appropriate tax treatment of benefit payments and reimbursements.

## WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered, they must be incurred while coverage is in effect. Coverage is in effect when all of the following conditions are met:

- the person is eligible to be covered according to the eligibility provisions in the Contract;
- the person has enrolled in coverage and has been enrolled by Us; and
- premium for the person for the current month has been paid by the Group on a timely basis.

The expense of a service is incurred on the day the service is provided and the expense of a supply is incurred on the day the supply is delivered to You.

# Definitions

The following are definitions of important terms, other terms are defined where they are first used.

Allowed Amount means:

- For VSP Doctors, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Providers, the billed amount for Covered Services up to any described limit.

Charges in excess of the Allowed Amount are not considered reasonable charges and are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, contact VSP.

Booklet is the description of the benefits for this coverage. The Booklet is part of the Contract between the employer Group and Us.

Calendar Year means the period from January 1 through December 31 of the same year.

Congenital Anomaly means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. "Significant deviation" means a deviation which impairs the function of the body and includes, but is not limited to:

- the conditions of cleft lip and/or cleft palate;
- webbed fingers or toes;
- sixth fingers or toes;
- defects of metabolism; or
- any other conditions that are medically diagnosed to be Congenital Anomalies.

Cosmetic means services or supplies (including medications) that are provided primarily to improve or change appearance to normal structures of the body.

Covered Service means those vision-related services, supplies, treatments or accommodations required for the diagnosis, preservation, or correction of visual acuity. These services must be received from a Physician or optometrist practicing within the scope of their license.

Effective Date means the date specified by Us, following Our receipt of the enrollment form, as the date coverage begins for You and/or Your dependents.

Enrolled Dependent means an Enrolled Employee's eligible dependent who is listed on the Enrolled Employee's completed enrollment form and who is enrolled under the Contract.

Enrolled Employee means an employee of the Group who is eligible under the terms of the Contract, has completed an enrollment form and is enrolled under this coverage.

Experimental Nature means a procedure or lens that is not used universally or accepted by the vision care profession.

Frequency Period is the number of Plan Years, usually one or two, that must pass before benefits renew.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following:

- disease;
- Illness or Injury;
- genetic or Congenital Anomaly;
- pregnancy;
- biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or
- to maintain or restore functional ability.

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

Health Outcome means an outcome that affects health status as measured by the length or quality of a person's life. The Health Intervention's overall beneficial effects on health must outweigh the overall harmful effects on health.

Illness means a:

- congenital malformation that causes functional impairment;
- condition, disease, ailment or bodily disorder, other than an Injury; or
- pregnancy.

Injury means physical damage to the body caused by:

- a foreign object;
- force;
- temperature;
- a corrosive chemical; or
- the direct result of an accident, independent of Illness or any other cause.

An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

Investigational means a Health Intervention that We have classified as Investigational. We will review Scientific Evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is Investigational. A Health Intervention not meeting all of the following criteria is, in Our judgment, Investigational:

- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Illness or Injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, exercising prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose or treat an Illness, Injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice. "Generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors.
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease;
- not primarily for the convenience of the patient, Physician or other health care Provider; and
- not more costly than an alternative service or sequence of services or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

Member means an Enrolled Employee or an Enrolled Dependent.

Necessary Contact Lenses means contact lenses that are prescribed by Your VSP Doctor or Out-of-Network Provider for other than Cosmetic purposes.

Newborn Children means a child or children born during the term of the Contract to a parent who is an Enrolled Employee or spouse of an Enrolled Employee. Newborn Children also includes adopted newborn infants who are Placed with the Enrolled Employee within 60 days of the adopted child's date of birth. A child will no longer be a Newborn Child if they have a break in coverage of 63 or more days.

Newly Adopted Children means a child or children under the age of 18 who is Placed for adoption with an Enrolled Employee more than 60 days after the child's date of birth. A child will no longer be a Newly Adopted Child if they have a break in coverage of 63 or more days after Placement for adoption with the Enrolled Employee.

Out-of-Network Provider means any optometrist, optician, ophthalmologist or other licensed and qualified vision care Provider who has not contracted with VSP to provide vision care services and/or vision care materials. For Out-of-Network Provider services, You may be billed for balances over Our payment level in addition to any Copayment and/or Coinsurance amount for Covered Services.

Physician means an individual who is duly licensed to practice medicine and/or surgery in all of its branches or to practice as an osteopathic Physician and/or surgeon or optometrist.

Placed or Placement means physical Placement in the care of the adoptive Enrolled Employee. 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 Enrolled Employee signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child.

Plan Year means the 12-month period from July 1 through June 30 of the following Year; however, the first Plan Year begins with the Member's Effective Date.

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians.

Provider means a Physician, Practitioner or other individual or organization which is duly licensed to provide the services covered in this Booklet.

Scientific Evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of a Health Intervention on Health Outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the Health Intervention and Health Outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

VSP Doctor means a Physician or Practitioner (for example, an ophthalmologist or optometrist) who is duly licensed and who has contracted with VSP to provide vision care services and/or vision care materials to Members in accordance with the provisions of this coverage.

**For more information call Us at 1 (800) 854-5585**

**regence.com**

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