2026 BOOKLET FOR:

STATE OF IDAHO

ACTIVE HDHP

Regence HSA Healthplan 3.0

Group Number: 500000000

Regence BlueShield of Idaho, Inc. Medical Benefits

Regence

Regence BlueShield of Idaho is an Independent Licensee
of the Blue Cross and Blue Shield Association

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Idaho Department of Insurance by visiting the department's website at **doi.idaho.gov/nosurprises** or calling the Consumer Affairs section at 1-208-334-4319 or toll-free in Idaho at 1-800-721-3272.

Visit **doi.idaho.gov/nosurprises** for more information about your rights under this law.

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Regence:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)

SCHEDULE OF BENEFITS

State of Idaho HDHP

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	
	In-Network Provider	**Out-of-Network Provider**
Coinsurance	20%	40%
Deductible per Plan Year • Except as noted with "Deductible waived," all benefits are subject to the Deductible and the Deductible must be met before benefits begin for any Member. However, the entire Family Coverage Deductible must be met before benefits begin for any Member.	$2,000 Single Coverage $4,000 Family Coverage	Shared with In-Network
Out-of-Pocket Maximum per Plan Year • The maximum In-Network Out-of-Pocket for any Member on Family Coverage is not to exceed $5,000, including the any Deductible. If a Member reaches this maximum amount prior to satisfying the In-Network Family Coverage Out-of-Pocket Maximum, including any Deductible, In-Network benefits will be paid at 100 percent of the Allowed Amount for that Member.	$5,000 Single Coverage $10,000 Family Coverage	$6,500 Single Coverage $13,000 Family Coverage

Be aware that Your actual costs for Covered Services provided by an Out-of-Network Provider may exceed this Booklet's Out-of-Pocket Maximum amount. Also, Out-of-Network Providers can bill You for the difference between the amount charged and Our Allowed Amount and that amount does not apply toward any Out-of-Pocket Maximum. Refer to the notice "Your Rights and Protections Against Surprise Medical Bills" attached to this Booklet for information regarding reimbursement and balance billing applicable to Out-of-Network Providers for certain services.

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies		
Benefit	**Member Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Preventive Care	0%, Deductible waived	40%
Preventive Care – Adult Immunizations	0%, Deductible waived	0%, Deductible waived

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies		
Benefit	**Member Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Preventive Care – Childhood Immunizations	0%, Deductible waived	0%, Deductible waived
Preventive Care – Expanded Immunizations	20%	40%
Office or Urgent Care Visits – Illness or Injury	20%	40%
Other Professional Services	20%	40%
Professional Services Available by a Licensed Pharmacist • Benefits available for Albertsons and Safeway Pharmacists	0%	
Acupuncture • 18 visits per Plan Year, combined with Spinal Manipulation visits	20%	40%
Ambulance Services • Out-of-Network services apply to the In-Network Out-of-Pocket Maximum	20%	
Blood Bank • Out-of-Network services apply to the In-Network Out-of-Pocket Maximum	20%	
Dental Hospitalization	20%	40%
Diabetic Education	20%	40%
Dialysis	20%	40%
Durable Medical Equipment	20%	40%
Emergency Room • Out-of-Network services apply to the In-Network Out-of-Pocket Maximum	20%	

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies		
Benefit	**Member Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Hearing Aids and Evaluations • 2 hearing aid devices every 3 Plan years • 45 outpatient speech and language therapy visits within 12 months from the receipt of a hearing aid, bone conduction device or cochlear implant • Additional limitations apply, refer to the Medical Benefits Section	20%	40%
Home Health Care	20%	40%
Hospice Care	0%	40%
Hospital Care – Inpatient and Outpatient	20%	40%
Hospital Care – Ambulatory Surgical Center	10%	40%
Infusion Therapy	20%	40%
Maternity Care	20%	40%
Medical Foods	20%	40%
Mental Health or Substance Use Disorder Services • For information regarding EAP services, refer to the Value-Added Services Appendix	20%	40%
Neurodevelopmental Therapy • 20 visits combined for occupational and speech therapy per Plan Year • 40 visits for physical therapy per Plan Year • Additional limitations apply, refer to the Medical Benefits Section	20%	40%
Newborn Care	20%	40%
Nutritional Counseling	20%	40%

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies		
Benefit	**Member Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Orthotic Devices • Specific limits apply for Members with diabetes, refer to the Medical Benefits Section	20%	40%
Palliative Care	0%	40%
Prosthetic Devices	20%	40%
Radiology and Laboratory Services • 1 breast screening per Plan Year is not subject to any cost-sharing when received from an In-Network Provider. Refer to the Medical Benefits Section for criteria.	20%	40%
Rehabilitation Services • No limit for inpatient days • 20 visits combined for occupational and speech therapy per Plan Year • 40 visits for physical therapy per Plan Year • Additional limitations apply, refer to the Medical Benefits Section	20%	40%
Repair of Teeth	20%	40%
Skilled Nursing Facility • 30 inpatient days per Plan Year	20%	40%
Spinal Manipulations • 18 visits per Plan Year, combined with Acupuncture visits	20%	40%
Temporomandibular Joint (TMJ) Disorders • $2,000 per Member Lifetime	20%	40%
Transplants	20%	40%
Transplants – Travel Expenses • 30 days per transplant episode (limit is combined for Member and companion(s)) • Additional limitations apply, refer to the Medical Benefits Section	100% of all expenses. Your travel expenses may be reimbursed subject to Your Deductible and travel expense limit.	

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies		
Benefit	**Member Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Virtual Care – Store and Forward Services	20%	40%
Virtual Care – Telehealth	Vendor: 0%	40%
	All other Providers: 20%	

<table>
<tr><th colspan="3">Covered Services (per Member)
Unless Otherwise Noted the Deductible Applies</th></tr>
<tr><th rowspan="2">Benefit</th><th colspan="2">Member Responsibility</th></tr>
<tr><th>Participating Pharmacy</th><th>Nonparticipating Pharmacy</th></tr>
<tr><td rowspan="8">Prescription Medications – from a Pharmacy
You are not responsible for any Deductible when you fill a prescription for most diabetic drugs.
You are not responsible for any Deductible, Copayment and/or Coinsurance for lancets, test strips and alcohol swabs.
You are not responsible for any Deductible, Copayment and/or Coinsurance when you purchase insulin syringes and needles within 90-days of insulin purchase.
You are not responsible for any Deductible, Copayment and/or Coinsurance when You fill a prescription for medications specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medications list. To obtain this list visit Our website or contact Customer Service. Contact Information is available in the Introduction Section.
You are not responsible for any Copayment and/or Coinsurance when You fill prescriptions for medications intended to treat opioid overdose that are on the Opioid Rescue Medication Value List. To obtain this list visit Our website or contact Customer Service. Contact Information is available in the Introduction Section.
34-day supply for Prescription Medications from a retail Pharmacy; 90-day supply from an extended supply network (ESN) Pharmacy.
30-day supply for Specialty Medications
Cost-sharing for insulin will not exceed $100 per 30-day supply
Additional benefit and limitations apply, refer to the Prescription Medications Section</td><td colspan="2">20% for each Tier 1 medication on the Drug List</td></tr>
<tr><td colspan="2">20% for each Tier 2 medication on the Drug List</td></tr>
<tr><td colspan="2">20% for each Tier 3 medication on the Drug List</td></tr>
<tr><td colspan="2">20% for each Tier 4 medication on the Drug List</td></tr>
<tr><td>20% for each Tier 5 specialty drug on the Drug List from a Participating Specialty Pharmacy</td><td>90% for each Tier 5 specialty drug on the Drug List from a Nonparticipating Specialty Pharmacy</td></tr>
<tr><td>20% for each Tier 6 specialty drug on the Drug List from a Participating Specialty Pharmacy</td><td>90% for each Tier 6 specialty drug on the Drug List from a Nonparticipating Specialty Pharmacy</td></tr>
<tr><td colspan="2">50% for each Compound Medication</td></tr>
</table>

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies		
Benefit	**Member Responsibility**	
	Participating Pharmacy	**Nonparticipating Pharmacy**
Prescription Medications – from a Home Delivery Supplier • You are not responsible for any Deductible when you fill a prescription for diabetic drugs. • You are not responsible for any Deductible, Copayment and/or Coinsurance for lancets, test strips and alcohol swabs. • You are not responsible for any Deductible, Copayment and/or Coinsurance when you purchase insulin syringes and needles within 90-days of insulin purchase. • 90-day supply for Prescription Medications • Cost-sharing for insulin will not exceed $300 per 90-day supply • Additional benefit and limitations apply, refer to the Prescription Medications Section	20% for each Tier 1 medication on the Drug List	
	20% for each Tier 2 medication on the Drug List	
	20% for each Tier 3 medication on the Drug List	
	20% for each Tier 4 medication on the Drug List	
	50% for each Compound Medication	

Introduction

Regence BlueShield of Idaho, Inc.

Street Address:
1602 21st Avenue
Lewiston, ID 83501

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, 2026**, 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

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

Phone lines are open Monday through Friday 5 a.m. to 8 p.m. and Saturday 8 a.m. to 4:30 p.m., Pacific time.

Contact Customer Service:

- if You have questions;
- if You would like to learn more about Your coverage;
- if You would like to request written or electronic information regarding any other plan that We offer;
- to talk with one of Our Customer Service representatives;
- via Our website, **regence.com**, to submit a claim online or chat live with a Customer Service representative;
- to request a copy of Your identification card (or print a copy via Our website); or
- for assistance in a language other than English.

Mail Your claims to the following address:

P.O. Box 1106
Lewiston, ID 83501-1106

For questions about Your plan or to contact Us, Our Customer Service and correspondence address is:

P.O. Box 1106
Lewiston, ID 83501-1106

Case Management: Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. For additional information, refer to the Medical Benefits Section or call Case Management at 1-866-543-5765.

BlueCard® Program: This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence BlueShield of Idaho serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Call Customer Service to learn how to have access to care through the BlueCard Program.

Regence HSA Healthplan 3.0

ACCESSING PROVIDERS

You are not restricted in Your choice of Provider for care or treatment of an Illness or Injury. You control Your out-of-pocket expenses by choosing between "In-Network" and "Out-of-Network" Providers.

- **In-Network.** Choosing In-Network Providers saves You the most in Your out-of-pocket expenses. In-Network Providers will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. NOTE: Covered Services for Preventive Care and Immunizations provided by a Provider that has any form of participating contract to provide services and supplies to Our Members in accordance with the provisions of this coverage, will be covered at the In-Network benefit level.
- **Out-of-Network.** Choosing Out-of-Network Providers means Your out-of-pocket expenses will be higher than choosing an In-Network Provider. Also, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. This is referred to as balance billing. Refer to the notice "Your Rights and Protections Against Surprise Medical Bills" attached to this Booklet for information regarding reimbursement and balance billing applicable to Out-of-Network Providers for certain services.

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 In-Network and Out-of-Network. You can go to **regence.com** for further Provider network information.

ADDITIONAL ADVANTAGES OF MEMBERSHIP

Advantages of membership include access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to Our website and Our mobile application to help You navigate Your way through health care decisions. For access, You just set up Your free account once and it is always up to You whether to participate. **THESE SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS IN YOUR BOOKLET.** Additional information about some programs and services can be found in the Value-Added Services Appendix at the end of this Booklet.

- **Go to regence.com or Our mobile application.** You can use these secure applications to:
    - view recent claims, benefits and coverage;
    - find a contracting Provider or identify Participating Pharmacies;
    - use tools to estimate upcoming health care costs and otherwise help You manage health care expenses;
    - get suggestions to improve or maintain wellness and participate in self-guided motivational online wellness programs;
    - learn about prescriptions for various Illnesses;
    - compare medications based upon performance and cost and get assistance in switching to less costly, equally effective alternative medications, if You wish; and
    - 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 applications, 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 HEALTH PLAN, BUT ARE NOT INSURANCE.**

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Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits, Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximum. 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.

This is a high deductible health plan that may include "single" or "family" coverage.

Single Coverage means only one person has coverage. Examples include, but are not limited to:

- an employee who is the only one in their Family who has coverage;
- spouses who both work for the Group and have each filled out an application and are Enrolled Employees on separate coverages; or
- an Enrolled Dependent who is continuing insurance coverage on their own.

Family Coverage means two or more members of the same Family have the same coverage.

MAXIMUM BENEFITS

Some Covered Services may have a specific Maximum Benefit. Those Covered Services will be provided until the specified Maximum Benefit has been reached. Any days, visits, services, or supplies that are applied toward any Deductible will be applied against the Maximum Benefit limit. 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.

DEDUCTIBLES

The Deductible is the amount You must pay each Plan Year before We will provide payments for Covered Services. Only Allowed Amounts for Covered Services are applied to satisfy the Deductible. There is a Single Coverage Deductible amount and a Family Coverage Deductible amount. The Single Coverage Deductible is satisfied by a Member who is enrolled on Single Coverage.

The Family Coverage Deductible is satisfied when any combination of Family Members' payments total the Family Coverage Deductible amount.

We do not pay for services applied toward the Deductible. Refer to the Schedule of Benefits to see what Covered Services are subject to the Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not apply toward the Deductible. In addition, the difference in cost between a Brand-Name Medication and its generic equivalent (or a Specialty Medication and its Specialty Biosimilar Medication) does not apply toward the Deductible. Further, any reduction in Your cost-sharing for Prescription Medications resulting from the use of any discount or a drug manufacturer coupon may not apply toward the Deductible.

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 the Deductible and/or 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.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the most You could pay in a Plan Year for Covered Services. Your payments of any Deductible, Copayments and/or Coinsurance apply to the Out-of-Pocket Maximum, unless specified otherwise. There is a Single Coverage Out-of-Pocket Maximum amount and a Family Coverage Out-of-Pocket Maximum amount for In-Network benefits and also for Out-of-Network benefits. The Single Coverage Out-of-Pocket Maximum is satisfied by a Member who is enrolled on Single Coverage.

The Family Coverage Out-of-Pocket Maximum is satisfied when any combination of Family Members' payments of their cost-shares for Covered Services total the Family Coverage Out-of-Pocket Maximum.

A Member's payment of any Deductible, Copayment and/or Coinsurance for ambulance, blood bank, emergency room services and Prescription Medications will apply toward the In-Network Out-of-Pocket Maximum amount. Additionally, services provided by a Provider that has an effective participating contract with Us or one of Our Affiliates (as further defined in the Definitions Section) will apply to the In-Network Out-of-Pocket Maximum amount. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. In addition, the difference in cost between a Brand-Name Medication and its generic equivalent (or a Specialty Medication and its Specialty Biosimilar Medication) does not apply toward the Out-of-Pocket Maximum. Further, any reduction in Your cost-sharing for Prescription Medications resulting from the use of any discount or a drug manufacturer coupon may not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum, benefits subject to the Out-of-Pocket Maximum will be paid at 100 percent of the Allowed Amount for the remainder of the Plan Year. The Coinsurance does not change to a higher payment level or apply to the Out-of-Pocket Maximum for some benefits. Refer to the Schedule of Benefits to determine if a Covered Service does not apply to the Out-of-Pocket Maximum.

HOW PLAN YEAR BENEFITS RENEW

The Deductible, Out-of-Pocket Maximum and Maximum Benefits are calculated on a Plan Year basis. Each July 1, those Plan Year maximums begin again. Some benefits have a separate Maximum Benefit based upon a Member's Lifetime and do not renew every Plan Year.

Medical Benefits

This section explains Your benefits for Covered Services. Referrals are not required before You can use any of the benefits of this coverage, including women's health care services. All benefits are listed alphabetically, with the exception of Preventive Care and Immunizations, Office or Urgent Care Visits, Other Professional Services, and Professional Services Available by a Licensed Pharmacist.

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care) and received from a Provider practicing within the scope of their license. All covered benefits are subject to the limitations, exclusions and provisions of this plan. In some cases, We may limit benefits or coverage to a less costly and Medically Necessary alternative item. A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service. See the Definitions Section for descriptions of Medically Necessary and the types of Providers who deliver Covered Services.

If benefits change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

Reimbursement may be available when You purchase new medical supplies, equipment and devices from a Provider or from an approved Commercial Seller. New medical supplies, equipment and devices purchased through an approved Commercial Seller are covered at the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item or the retail market value for that item. To learn more about how to access reimbursable new retail medical supplies, equipment and devices, visit Our website or contact Customer Service.

NOTE: If You choose to access new medical supplies, equipment and devices through Our website, We may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. **ANY SUCH DISCOUNTS OR COUPONS ARE A COMPLEMENT TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE.**

CASE MANAGEMENT

Case management is a program designed to provide early detection and intervention in cases of serious Illness or Injury that have the potential for continuing major or complex care. Case managers are experienced, licensed health care professionals. They will provide information, support and guidance and will work with Your Physicians or other health care professionals in supporting Your treatment plan and proposing alternative benefits.

PREAUTHORIZATION

Some Covered Services may require preauthorization. Those services require contracted Providers to obtain preauthorization from Us before providing such services to You. You will not be penalized if the contracted Provider does not obtain preauthorization from Us in advance and the service is determined to be not covered.

Non-contracted Providers are not required to obtain preauthorization from Us prior to providing services. You may be responsible for the cost of services provided by a non-contracted Provider if those services are not Medically Necessary or a Covered Service. You may request that a non-contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to receiving those services.

PREVENTIVE VERSUS DIAGNOSTIC SERVICES

Covered Services may be either preventive or diagnostic. "Preventive" care is intended to prevent an Illness, Injury or to detect problems before symptoms are noticed. "Diagnostic" care treats, investigates or diagnoses a condition by evaluating new symptoms, following up on abnormal test results or monitoring existing problems.

Your Provider's classification of the service as either preventive or diagnostic and any other terms in this Booklet will determine the benefit that applies. For example, colonoscopies and mammograms are covered in the Preventive Care and Immunizations benefit if Your Provider bills them as preventive and they fall within the recommendations identified in that benefit. Otherwise, colonoscopies and

mammograms are covered the same as any other Illness or Injury. You may want to ask Your Provider why a Covered Service is ordered or requested.

PREVENTIVE CARE AND IMMUNIZATIONS

Preventive care and immunization services provided by a professional Provider, facility or Retail Clinic that are within age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA) or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), or as required by state or federal guidance for a specific time period as a result of a government declared disease outbreak, epidemic, or other public health emergency, are covered for the following:

- routine physical examinations, well-women's care, well-baby care and routine health screenings;
- Provider counseling and Prescription Medications prescribed for tobacco use cessation;
- immunizations for adults and children;
- breast pump (including its accompanying supplies) per pregnancy as follows:
    - one new non-Hospital grade breast pump at the In-Network benefit level when obtained from a Provider (including a Durable Medical Equipment supplier); or
    - a comparable new breast pump may be obtained from an approved Commercial Seller in lieu of a Provider. Benefits for a comparable new breast pump obtained from an approved Commercial Seller will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value.
- United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods according to, and as recommended by HRSA, including, but not limited to:
    - condoms;
    - diaphragm with spermicide;
    - sponge with spermicide;
    - cervical cap with spermicide;
    - spermicide;
    - oral contraceptives (combined pill, mini pill and extended/continuous use pill);
    - contraceptive patch;
    - vaginal ring;
    - contraceptive shot/injection;
    - emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products);
    - intrauterine devices (both copper and those with progestin);
    - implantable contraceptive rod;
    - surgical implants; and
    - surgical sterilization procedures for women.

Prostate cancer screening is also covered when recommended by a Physician or Practitioner. Covered Services for prostate cancer screening include digital rectal examinations and prostate-specific antigen (PSA) tests.

NOTE: Covered Services that do not meet these criteria (for example, diagnostic colonoscopies or diagnostic mammograms) will be covered the same as any other Illness or Injury. In the event HRSA, USPSTF or the CDC adopt a new or revised recommendation, We have up to one year before coverage of the related services must be available and effective in this Booklet. For a list of Covered Services, including information about obtaining a new breast pump from an approved Commercial Seller, visit Our website or contact Customer Service.

Expanded Immunizations

Immunizations that do not meet age limits and frequency guidelines according to, and as recommended by, the USPSTF, HRSA or by the CDC are covered. Covered Services include immunizations for travel, occupation or residency in a foreign country. Contact Customer Service to verify what expanded immunizations are covered.

OFFICE OR URGENT CARE VISITS – ILLNESS OR INJURY

Office (including home, Retail Clinic or Hospital outpatient department) and urgent care visits are covered for treatment of Illness or Injury. Coverage does not include other professional services performed in the office or urgent care that are specifically covered elsewhere in the Medical Benefits Section, including, but not limited to, separate facility fees or outpatient radiology and laboratory services billed in conjunction with the visit.

OTHER PROFESSIONAL SERVICES

Services and supplies provided by a professional Provider are covered, subject to any specified limits as explained in the following paragraphs:

Medical Services and Supplies

Professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider.

Services and supplies also include:

- treatment of a Congenital Anomaly;
- administration of Provider-Administered Specialty Drugs;
- Virtual Care service facility fees;
- foot care associated with diabetes; and
- Medically Necessary foot care obtained from a professional Provider due to hazards of a systemic condition causing severe circulatory dysfunction or diminished sensation in the legs or feet.

Additionally, coverage includes certain Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) that are new and obtained from an approved Commercial Seller. Benefits for eligible new supplies will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible new medical supplies, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit Our website or contact Customer Service.

Diagnostic Procedures

Services for diagnostic procedures including cardiovascular testing, pulmonary function studies, stress tests, sleep studies and neurology/neuromuscular procedures.

Professional Inpatient

Professional inpatient visits for treatment of Illness or Injury. If pre-arranged procedures are performed by an In-Network Provider and You are admitted to an In-Network Hospital, We will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by an Out-of-Network Provider at the In-Network benefit level. Contact Customer Service for further information and guidance.

Surgical Services

Surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist. Covered Services include vasectomies.

Treatment of varicose veins is only covered when there is:

- active associated venous ulceration;
- objective documentation of persistent or recurrent bleeding from ruptured veins; or
- objective documentation of recurrent superficial phlebitis.

Therapeutic Injections

Therapeutic injections and related supplies, including clotting factor products, when given in a professional Provider's office.

A selected list of Self-Administrable Injectable Medications is covered in the Prescription Medications Section.

PROFESSIONAL SERVICES AVAILABLE BY A LICENSED PHARMACIST

A licensed Pharmacist practicing under the Idaho State Board of Pharmacy may provide services including, but not limited to, the following:

- administration and evaluation of:
  - cold sore treatment;
  - diabetes supplies (test strips, etc.);
  - flu prophylaxis;
  - hormonal contraceptives;
  - motion sickness;
  - prenatal vitamins;
  - rapid flu test;
  - rapid strep test;
  - urinary tract infection (UTI) diagnosis; or
  - yeast infections.

ACUPUNCTURE

Acupuncture is covered.

AMBULANCE SERVICES

Ambulance services to the nearest Hospital equipped to provide treatment are covered when any other form of transportation would endanger Your health and the transportation is not for personal or convenience purposes. Covered Services include licensed ground and air ambulance Providers.

Claims for ambulance services must include the locations You were transported to and from. The claim should also show the date of service, the patient's name, the group's and Your identification numbers.

APPROVED CLINICAL TRIALS

If You are accepted as a trial participant in an Approved Clinical Trial, Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating are covered as specified in the Schedule of Benefits. If an Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care. Additional specified limits are as further defined.

Definitions

The following definitions apply to this Approved Clinical Trials benefit:

Approved Clinical Trial means a phase I, phase II, phase III or phase IV clinical trial conducted in relation to prevention, detection or treatment of cancer or other Life-threatening Condition and that is a study or investigation:

- approved or funded by one or more of:
  - the National Institutes of Health (NIH), the CDC, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid or a cooperative group or center of any of those entities; or a cooperative group or center of the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
  - a qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or
  - the VA, DOD or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review.
- conducted under an investigational new drug application reviewed by the FDA or that is a drug trial exempt from having an investigational new drug application.

Life-threatening Condition means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Routine Patient Costs means items and services that typically are Covered Services for a Member not enrolled in a clinical trial, but do not include:

- an Investigational item, device or service that is the subject of the Approved Clinical Trial;
- items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Member; or
- a service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

BLOOD BANK
Services and supplies of a blood bank are covered, excluding storage costs.

DENTAL HOSPITALIZATION
When necessary to safeguard Your health, hospitalization for Dental Services is covered. Covered Services include inpatient and outpatient services and supplies (including anesthesia) at an Ambulatory Surgical Center or Hospital.

DIABETIC EDUCATION
Services and supplies for diabetic self-management training and education are covered. Diabetic nutritional counseling and nutritional therapy are covered in the Nutritional Counseling benefit.

DIALYSIS
Services and supplies for outpatient and home dialysis are covered, including hemodialysis, peritoneal dialysis, and hemofiltration. Dialysis received while inpatient is covered elsewhere in the Medical Benefits Section, such as the Hospital Care – Inpatient, Outpatient and Ambulatory Surgical Center benefit.

DURABLE MEDICAL EQUIPMENT
Durable Medical Equipment is covered, including, but not limited to, oxygen equipment, wheelchairs and supplies or equipment associated with diabetes (such as insulin pumps or continuous glucose monitors, and their supplies).

Additionally, new Durable Medical Equipment is covered when obtained from an approved Commercial Seller. Benefits for eligible new Durable Medical Equipment will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible new Durable Medical Equipment, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit Our website or contact Customer Service.

Generally, claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the location in which the equipment was received.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)
Emergency room services and supplies are covered, including outpatient charges for patient observation, medical screening examinations, and Medically Necessary detoxification services that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be preauthorized.

"Stabilization" means to provide Medically Necessary treatment:

- to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during or to result from, the transfer of the Member from a facility; and
- in the case of a covered Member, who is pregnant, to perform the delivery (including the placenta).

If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. Contact Customer Service for further information and guidance.

HEARING AIDS AND EVALUATIONS

Hearing aids and any associated evaluations are covered when necessary for treatment of hearing loss. Covered Services include the following:

- hearing aids (including evaluations);
- bone conduction sound processors (including examinations and fittings). Implantation and associated surgical services are covered in the Other Professional Services benefit;
- ear molds and replacement ear molds; and
- hearing aid checks and testing.

"Hearing aid" means any nondisposable, wearable instrument designed to aid or compensate for impaired human hearing and any necessary part or ear mold for the instrument.

Cochlear implants are covered the same as any other Illness or Injury.

Covered Services do **not** include:

- over-the-counter hearing aids;
- routine hearing examinations;
- hearing assistive technology systems; or
- the cost of batteries or cords.

HOME HEALTH CARE

Home health care is covered when provided by a licensed agency or facility for home health care. Home health care includes all services for patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility.

Durable Medical Equipment associated with home health care services is covered in the Durable Medical Equipment benefit.

HOSPICE CARE

Hospice care is covered when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life-threatening disease with a limited prognosis. These services include acute and home care to meet the physical, psychosocial and special needs of a patient and their family during the final stages of Illness.

Durable Medical Equipment associated with hospice care is covered in the Durable Medical Equipment benefit.

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER

Services and supplies of a Hospital or an Ambulatory Surgical Center (including services of staff Providers) are covered for treatment of Illness or Injury. Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary.

INFUSION THERAPY

Inpatient, outpatient and home therapy services, supplies (including infusion pumps) and medications for infusion therapy are covered. Covered Services also include parenteral and enteral therapy.

MATERNITY CARE

Prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy and related conditions are covered. There is no limit for the patient's length of inpatient stay. The attending Provider will determine an appropriate discharge time in consultation with the patient. Coverage also includes termination of pregnancy only when done to preserve the life of the Member, to the extent such services are permitted under applicable law.

Certain services such as screening for gestational diabetes, breastfeeding support, supplies (for example, a breast pump) and counseling are covered in the Preventive Care and Immunizations benefit.

MEDICAL FOODS

Medical foods for inborn errors of metabolism are covered, including, but not limited to, formulas for Phenylketonuria (PKU). "Medical food" means a food which is formulated to be consumed or administered orally or enterally under the supervision of a Physician. Medical foods are intended for specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES

Mental Health and Substance Use Disorder Services are covered for treatment of Mental Health Conditions or Substance Use Disorders.

Additionally, applied behavioral analysis (ABA) therapy services are covered for treatment of autism spectrum disorders when prescribed by a duly licensed Provider and performed by a Provider or by another individual who has a Board Certified Behavioral Analysis (BCBA) certification issued by the Behavioral Analyst Certification Board.

Definitions

The following definitions apply to this Mental Health or Substance Use Disorder Services benefit:

Mental Health or Substance Use Disorder Services mean Medically Necessary outpatient services, detoxification, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of court ordered treatment (unless the treatment is Medically Necessary).

Mental Health Conditions mean mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association except as otherwise excluded. Mental disorders that accompany an excluded diagnosis are covered.

Residential Care means care in a facility setting that offers a defined course of therapeutic intervention and special programming in a controlled environment that also offers a degree of security, supervision and structure, and is licensed by the appropriate state and local authority to provide such services. Patients also must be medically monitored with 24-hour medical availability and 24-hour onsite clinician services. Residential Care does not include half-way houses, supervised living, group homes, wilderness courses or camps, Outward Bound, outdoor youth programs, outdoor behavioral programs, boarding houses, or settings that primarily either focus on building self-esteem or leadership skills or provide a supportive environment to address long-term social needs. However, services by Physicians or Practitioners in such settings may be covered if they are billed independently and would otherwise be a Covered Service.

Substance Use Disorders mean substance-related disorders included in the most recent edition of the DSM. Substance Use Disorder does not include addiction to or dependency on tobacco, tobacco products or foods.

NEURODEVELOPMENTAL THERAPY

Neurodevelopmental therapy services by a Physician or Practitioner are covered. Covered Services must be to restore or improve function for a Member with a neurodevelopmental delay. "Neurodevelopmental delay" means a delay in normal development that is not related to any documented Illness or Injury. Covered Services include only physical therapy, occupational therapy, speech therapy and maintenance services, if significant deterioration of the Member's condition would result without the service.

You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE
Services and supplies in connection with nursery care for the natural newborn or newly adoptive child are covered by the newborn's own coverage. The Newborn Child must be eligible and enrolled as explained in the Eligibility and Enrollment Section. There is no limit for the newborn's length of inpatient stay. "Newborn care" means the medical services provided to a Newborn Child following birth including Hospital nursery charges, the initial physical examination and a PKU test.

NUTRITIONAL COUNSELING
Services for nutritional counseling and nutritional therapy, such as diabetic counseling, discussions on eating habits, lifestyle choices and dietary interventions are covered for all conditions, including obesity.

ORTHOTIC DEVICES
Braces, splints, orthopedic appliances and orthotic supplies or apparatuses are covered when used to support, align or correct deformities or to improve the function of moving parts of the body.

For Members with diabetes, Covered Services include therapeutic shoes and inserts, limited to the following each Plan Year:

- one pair of custom-molded shoes;
- three pairs of custom inserts;
- one pair of extra-depth shoes;
- three pairs of extra-depth inserts.

Additionally, certain orthotic devices that are new are covered when obtained from an approved Commercial Seller. Benefits for eligible new orthotic devices will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible new orthotic devices, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit Our website or contact Customer Service.

We may elect to provide benefits for a less costly alternative item. Except as detailed above for Members with diabetes, off-the-shelf shoe inserts and orthopedic shoes are not covered.

PALLIATIVE CARE
Palliative care is covered when a Provider has assessed that a Member is in need of palliative services for a serious Illness (including remission support), life-limiting Injury or end-of-life care. "Palliative care" means specialized services received from a Provider in a home setting for counseling and home health aide services for activities of daily living.

All other Covered Services for a Member receiving palliative care remain covered the same as any other Illness or Injury.

PREVENTIVE CARE FOR SPECIFIED CHRONIC CONDITIONS
Services and supplies are covered when used to treat a Member diagnosed with the associated chronic condition and prescribed to prevent either exacerbation of the chronic condition or the development of a secondary condition. Covered Services as specified below are covered the same as for any other Illness or Injury, but are not subject to any applicable Deductible for In-Network services:

- blood pressure monitor with a diagnosis of hypertension;
- hemoglobin A1c testing and retinopathy screening with a diagnosis of diabetes;
- International Normalized Ratio (INR) testing with a diagnosis of liver disease and/or bleeding disorder;
- Low-Density Lipoprotein (LDL) testing with a diagnosis of heart disease; or
- peak flow meter with a diagnosis of asthma.

PROSTHETIC DEVICES
Prosthetic devices for functional reasons are covered to replace a missing body part, including artificial limbs, external or internal breast prostheses following a mastectomy and maxillofacial prostheses.

Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered in the appropriate facility benefit. Additionally, the repair or replacement of a prosthetic device due to normal use or growth of a child is covered.

RADIOLOGY AND LABORATORY SERVICES

Diagnostic services for treatment of Illness or Injury are covered, including services not covered in the Preventive Care and Immunizations benefit. Covered Services include the following:

- Medically Necessary genetic testing;
- complex imaging; and
- diagnostic mammography services.

"Complex imaging" means:

- bone density screening;
- computerized axial tomography (CT or CAT) scan;
- magnetic resonance angiogram (MRA);
- magnetic resonance imaging (MRI);
- positron emission tomography (PET); and
- single photon emission computerized tomography (SPECT).

Generally, claims for independent clinical laboratory services will be submitted to the Blue plan in the location in which the referring Provider is located.

Supplemental Breast Screening

You may receive one supplemental breast screening each Calendar Year, not subject to any cost-sharing when received from an In-Network Provider. "Supplemental breast screening" means a Medically Necessary and clinically appropriate examination of the breast using either standard or abbreviated magnetic resonance imaging, contrast mammogram imaging, or, if such imaging is not possible, ultrasound, if recommended by the treating Physician to screen for breast cancer when there is no abnormality seen or suspected in the breast.

You are eligible for the supplemental breast cancer screening, if You are at an increased risk of breast cancer due to any of the following criteria:

- personal history of atypical breast histologies;
- personal history or family history of breast cancer;
- genetic predisposition for breast cancer;
- prior therapeutic thoracic radiation therapy;
- lifetime risk of breast cancer of greater than twenty percent according to risk assessment tools based on family history;
- extremely dense breast tissue based on breast composition categories of the breast imaging and reporting data system established by the American College of Radiology; or
- heterogeneously dense breast tissue based on breast composition categories with any one of the following risk factors:
    - personal history of BRCA1 or BRCA2 gene mutations;
    - first-degree relative with a BRCA1 or BRCA2 gene mutation who has not undergone genetic testing;
    - prior therapeutic thoracic radiation therapy from ten to thirty years of age; or
    - personal history of Li-Fraumeni syndrome, Cowden syndrome or Bannayan-Riley-Ruvalcaba syndrome, or a first-degree relative with one of these syndromes.

REHABILITATION SERVICES

Inpatient and outpatient rehabilitation services and accommodations are covered as appropriate and necessary to restore or improve lost function caused by Illness or Injury. "Rehabilitation services" mean physical, occupational and speech therapy services only, including associated services such as massage when provided as a therapeutic intervention, and manipulations of extremities.

You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

REPAIR OF TEETH

Services and supplies for treatment required as a result of damage to or loss of sound natural teeth are covered when such damage or loss is due to an Injury.

SKILLED NURSING FACILITY

Inpatient services and supplies of a Skilled Nursing Facility are covered for treatment of Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary.

SPINAL MANIPULATIONS

Spinal manipulations are covered. Manipulations of extremities are covered in the Rehabilitation Services benefits.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Inpatient and outpatient services are covered for treatment of TMJ disorders which have one or more of the following characteristics:

- an abnormal range of motion or limitation of motion;
- arthritic problems;
- internal derangement; and/or
- pain in the musculature.

Covered Services include services that are:

- reasonable and appropriate for the treatment of a TMJ disorder;
- effective for the control or elimination of one or more of the following TMJ disorders:
    - pain;
    - infection;
    - disease;
    - difficulty in speaking; or
    - difficulty in chewing or swallowing food.

TRANSPLANTS

Transplants are covered, including transplant-related services and supplies. Covered Services for a transplant recipient include the following:

- heart;
- lung;
- kidney;
- pancreas;
- liver;
- cornea;
- multivisceral;
- small bowel;
- islet cell; and
- hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors:
    - either autologous (self-donor);
    - allogeneic (related or unrelated donor);
    - syngeneic (identical twin donor); or
    - umbilical cord blood (only covered for certain conditions).

For a list of covered transplants, contact Our Customer Service, as the list is subject to change. Any organ or tissue which is procured outside the United States and any transplant procedure performed outside the United States are not covered.

Donor Organ Benefits

Donor organ procurement costs are covered for a recipient. Procurement benefits are limited to:

- selection;
- removal of the organ;
- storage;
- transportation of the surgical harvesting team and the organ; and
- other such procurement costs.

Travel Expenses

Transportation and lodging expenses are covered, subject to the following specified limits:

- based on the generally accepted course of treatment in the United States as verified through Your case manager, the transplant would require an overnight stay that is greater than 50 miles away from home and within reasonable proximity to the treatment area;
- based on a transplant episode beginning up to five days prior to the transplant and ending three months post-transplant (or sooner if the Member is cleared by the treating Provider to return home);
- coverage is for the Member and one companion (or two companions if the Member is under the age of 19);
- commercial lodging expenses are limited to the IRS medical expense allowances (currently $50 per night for the Member, not to exceed $100 per night for the Member and companion(s) combined); and
- covered transportation expenses to and from the treatment area include only:
    - commercial coach class airfare;
    - commercial coach class train fare; or
    - documented auto mileage (calculated per IRS medical expense allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of the transplant treatment. We will reimburse You for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact Case Management for further information and guidance.

Coverage does not include travel expenses for the donor, meals or expenses outside of transportation and lodging.

VIRTUAL CARE

Virtual care services are covered for the use of telehealth or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment or management of a covered medical condition. Some Providers or virtual care vendors may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share.

"Virtual care vendors" mean a select group of Providers that have entered into an agreement with Us to provide virtual care services at a lower cost. To learn more about how to access virtual care services or Providers and virtual care vendors that may offer lower-cost services, visit Our website or contact Customer Service.

Store and Forward Services

"Store and forward services" mean secure one-way electronic asynchronous (not live or real-time) electronic transmission (sending) of Your medical information to a Provider which may include some forms of secure HIPAA compliant texting, chatting or data sharing. For example, store and forward services include using a secure patient portal to send a picture of Your swollen ankle to Your Provider for review at a later time. Store and forward services that are not secure and HIPAA compliant are not covered, including, but not limited to:

- telephone;
- facsimile (fax);
- short message service (SMS) texting; or
- e-mail communication.

Your Provider is responsible for meeting applicable requirements and community standards of care.

Telehealth

"Telehealth" means Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform, including when You are in a Provider's office or healthcare facility. For example, telehealth includes a live video call from Your home to discuss a possible eye infection with Your Provider or using the equipment at Your local Provider's office to have a live video call with a cardiologist in a different city. Separate charges for facility fees are covered in the Other Professional Services benefit.

Prescription Medications

This section explains Your benefits for Prescription Medications. Benefits will be paid in this Prescription Medications benefit, not any other provision, if a medication or supply is covered by both. For Provider-Administered Specialty Drug coverage, refer to the Provider-Administered Specialty Drugs benefit in the Medical Benefits Section.

Prescription Medications listed on the Drug List are covered. Prescription Medications not on the Drug List may be covered as described in the Drug List Exception Process provision. To view the Drug List and find medications by tier, visit Our website or contact Customer Service.

COVERED PRESCRIPTION MEDICATIONS

Prescription Medication benefits are available for the following:

- Prescription Medications;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Injectable Medications) and teaching doses by which a Member is educated to self-inject;
- diabetic supplies, when obtained with a Prescription Order, including:
    - lancets;
    - test strips;
    - glucagon emergency kits; and
    - insulin syringes.
- certain continuous glucose monitors and insulin pumps (including their supplies), that are on the Drug List, may be purchased from a Pharmacy when obtained with a Prescription Order; continuous glucose monitors and insulin pumps (including their supplies) are also covered in the Medical Benefits Section;
- Compound Medications;
- Specialty Medications (including, but not limited to, medications for multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders and hepatitis C);
- Self-Administrable Cancer Chemotherapy Medication;
- immunizations for travel, occupation or residency in a foreign country; and
- certain Prescription Medications that are administered by Your Provider as determined by the Pharmacy and Therapeutics (P&T) Committee.

Additionally, the following preventive medications obtained from a Participating Pharmacy are covered at no charge to You, including, but not limited to:

- immunizations for adults and children according to, and as recommended by the CDC and/or USPSTF;
- certain preventive medications according to, and as recommended by the USPSTF, that are on the Drug List and when obtained with a Prescription Order:
    - aspirin;
    - fluoride;
    - iron; and
    - medications for tobacco use cessation.
- FDA-approved prescription and over-the-counter contraception methods according to, and as recommended by the HRSA and when obtained with a Prescription Order:
    - condoms;
    - diaphragm with spermicide;
    - sponge with spermicide;
    - cervical cap with spermicide;
    - spermicide;
    - oral contraceptives (combined pill, mini pill and extended/continuous use pill);

- contraceptive patch;
- vaginal ring;
- contraceptive shot/injection; and
- emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products).

When preventive medications or immunizations are obtained from a Nonparticipating Pharmacy, You will be responsible for any Deductible, Copayment and/or Coinsurance listed above for Prescription Medications. If Your Provider believes that Our covered preventive medications, including contraceptives, are medically inappropriate for You, You may request an equivalent preventive medication by contacting Customer Service. For additional information on covered Prescription Medications, visit Our website or contact Customer Service.

PRESCRIPTION MEDICATIONS CLAIMS AND ADMINISTRATION

Preauthorization

Some Prescription Medications may require preauthorization before they are dispensed. We notify participating Providers, including Pharmacies, which Prescription Medications require preauthorization. Prescription Medications that require preauthorization must have medical information provided by the prescribing Provider to determine Medical Necessity. Prescribed Medications that require preauthorization will not be covered until they are preauthorized. For a list of medications that require preauthorization or if You have any questions, visit Our website or contact Customer Service.

Drug List Changes

Any removal of a Prescription Medication from Our Drug List will be posted on Our website 30 days prior to the effective date of that change unless the removal is done on an emergency basis or if an equivalent biosimilar or Generic Medication becomes available without prior notice. In the case of an emergency removal, the change will be posted as soon as possible.

If You are taking a Prescription Medication while it is removed from the Drug List and its removal was not due to the Prescription Medication being removed from the market, becoming available over-the-counter or issuance of a black box warning by the Federal Drug Administration, We will continue to cover Your Prescription Medication for the time period required to use Our Drug List exception process to request continuation of coverage for the removed Prescription Medication and receive a decision through that process, unless patient safety requires an expedited replacement.

Drug List Exception Process

Non-Drug List medications are not covered by Your Prescription Medications benefit. However, a Prescription Medication not on the Drug List may be covered in certain circumstances.

"Non-Drug List" means those self-administered Prescription Medications not listed on the Drug List.

To request coverage for a Prescription Medication not on the Drug List, You or Your Provider will need to request preauthorization so that We can determine that a Prescription Medication not on the Drug List is Medically Necessary. Your Prescription Medication not on the Drug List may be considered Medically Necessary if:

- medication policy criteria are met, if applicable;
- You are not able to tolerate a covered Prescription Medication(s) on the Drug List;
- Your Provider determines that the Prescription Medication(s) on the Drug List is not therapeutically effective for treating Your covered condition; or
- Your Provider determines that a dosage required for effective treatment of Your covered condition differs from the Prescription Medication on the Drug List dosage limitation.

The specific medication policy criteria to determine if a Prescription Medication not on the Drug List is Medically Necessary are available on Our website. You or Your Provider may request preauthorization by calling Customer Service or by completing and submitting the form on Our website.

Once preauthorization has been approved, the Prescription Medication not on the Drug List will be available for coverage at the Substituted Medication Copayment and/or Coinsurance level determined by Your benefit and will apply toward any Deductible or Out-of-Pocket Maximum.

Your Responsibility for Cost Differences of Chosen Medications

You will be responsible for the applicable Copayment and/or Coinsurance for the Brand-Name Medication or Specialty Medication at the time of purchase. You will also be responsible for paying excess costs above Your applicable cost-share if either of the following occur:

- if You choose to fill a Prescription Order with a Brand-Name Medication and an equivalent Generic Medication is available, You will be responsible for paying the difference in cost; or
- if You choose to fill a Prescription Order with a Specialty Medication and a Specialty Biosimilar Medication is available, You will be responsible for paying the difference in cost.

The excess in cost does not apply toward any Deductible or any Out-of-Pocket Maximum. If the prescribing Provider specifies that the Brand-Name Medication or Specialty Medication must be dispensed, You will still be responsible for the excess in cost.

Pharmacy Network Information

A nationwide network of Participating Pharmacies is available to You. You can find Participating Pharmacies on Our website or by contacting Customer Service.

You must present Your identification card to identify Yourself as Our Member when obtaining Prescription Medications from a Pharmacy or Home Delivery Supplier. If You do not present Your identification card You may be charged more than the Covered Prescription Medication Expense.

Claims Submitted Electronically

Participating Pharmacies will submit claims electronically. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, We will pay the Nonparticipating Pharmacy directly. Nonparticipating Pharmacies, however, may charge amounts in excess of Covered Prescription Medication Expenses. If that happens, You will be responsible for the excess amounts, as well as any Deductible, Copayment and/or Coinsurance shown electronically to the Nonparticipating Pharmacy at the time of purchase.

Claims Not Submitted Electronically

It is best to use a Participating Pharmacy so Your claims can be submitted electronically, and so You won't have to pay the difference between the Pharmacy's charges and the Covered Prescription Medication Expense in addition to Your Deductible, Copayment and/or Coinsurance.

However, when a claim is not submitted electronically, You must pay for the Prescription Medication in full at the time of purchase. For reimbursement, complete a Prescription Medication claim form and mail a copy of the form and the Prescription Medication receipt to Us. To find the Prescription Medication claim form, visit Our website or contact Customer Service.

We will reimburse You directly based on the Covered Prescription Medication Expense, minus the applicable Deductible, Copayment and/or Coinsurance that would have been required had the medication been purchased from a Participating Pharmacy.

Home Delivery

You can use home delivery services to purchase covered Prescription Medications. Home delivery coverage applies when Prescription Medications are purchased from a Home Delivery Supplier and the claim is submitted electronically. Not all Prescription Medications are available from Home Delivery Suppliers.

You may also obtain covered Prescription Medications from a non-contracted home delivery Pharmacy, if the non-contracted home delivery Pharmacy is registered and agrees to dispense covered Prescription Medications according to the same terms and conditions as those provided by a Home Delivery Supplier. In this case, covered Prescription Medications dispensed by the non-contracted home delivery Pharmacy

will be covered in the same manner as covered Prescription Medications dispensed by a Home Delivery Supplier.

To buy Prescription Medications through the mail, send all of the following items to the Home Delivery Supplier at the address shown on the prescription home delivery form (which also includes refill instructions) available on Our website or from Your Group:

- a completed prescription home delivery form;
- any Deductible, Copayment and/or Coinsurance; and
- the original Prescription Order.

Prescription Medications Dispensed by Excluded Pharmacies

We do not permit excluded Pharmacies to submit claims after the excluded Pharmacies have been added to the Office of the Inspector General (OIG) list. A Pharmacy may be excluded if it has been investigated by the OIG and appears on the OIG's exclusion list.

You will be notified if You are receiving medications from a Pharmacy that is later determined to be an excluded Pharmacy so that You may obtain future Prescription Medications from a non-excluded Pharmacy. Up to the time of notification, Your previously submitted claims will still be processed.

Refills

You may obtain Prescription Medication refills once You have taken a minimum threshold amount of the previous medication. The minimum threshold amount is based on several factors, such as:

- a six-month look back period;
- the type of medication (for example, FDA-approved prescription contraceptives, controlled substances, Specialty Medications, or drugs in an adherence program);
- state or federal laws; and
- generally, except for controlled substances, You must have taken at least 75 percent of the previous prescription.

However, if You:

- choose to refill Your Prescription Medications sooner, You will be responsible for the full cost of the Prescription Medication and those costs will not apply toward any Deductible and/or Out-of-Pocket Maximum.
- receive maintenance medications for chronic conditions, You may qualify for prescription "refill synchronization" which allows refilling Prescription Medications on the same day of the month.
- feel You need a refill sooner than allowed, a refill exception will be considered on a case-by-case basis.

Contact Customer Service for further information on prescription refills, refill synchronization, or to request an exception for an early refill.

Discounts or Manufacturer Coupons

Any reduction in Your cost-sharing resulting from the use of any discount or a drug manufacturer coupon may not apply toward the Deductible or Out-of-Pocket Maximum.

LIMITATIONS

The following limitations apply to this Prescription Medications Section, except for certain preventive medications as specified in the Covered Prescription Medications Section:

Prescription Medication Supply Limits

- **30-Day Supply Limit:**
    - **Specialty Medications** – the largest allowable quantity for a Specialty Medication purchased from a Specialty Pharmacy, is a 30-day supply, unless the medication has an FDA-approved dosing regimen that exceeds 30 days and is packaged in a multi-month supply package. The Copayment and/or Coinsurance, if applicable, is based on each 30-day supply. Specialty

Medications are not allowed through Home Delivery Suppliers. The first fill of Specialty Medications for hemophilia is allowed at a Pharmacy. Additional fills must be provided by a Specialty Pharmacy or Specialty Pharmacy designated as a Hemophilia Treatment Center (HTC).

- **34-Day Supply Limit:**
  - **Pharmacy** – the largest allowable quantity of a Prescription Medication purchased from a Pharmacy is a 34-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities. The Copayment and/or Coinsurance is based on each 34-day supply.
- **90-Day Supply Limit:**
  - **Pharmacy** – the largest allowable quantity of a Prescription Medication purchased from a retail Pharmacy is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities. The Copayment and/or Coinsurance is based on each 30-day supply.
  - **Extended Supply Network (ESN) Pharmacy** – the largest allowable quantity of a Prescription Medication purchased from an ESN Pharmacy is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities. The Copayment and/or Coinsurance is based on each 30-day supply.
  - **Home Delivery Supplier** – the largest allowable quantity of a Prescription Medication purchased from a Home Delivery Supplier is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
  - **Multiple-Month Supply** – the largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Pharmacy is a 90-day supply (even if the packaging includes a larger supply). The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The Copayment and/or Coinsurance is based on the Prescription Order up to a 34-day supply within that multiple-month supply.
- **6-Month Supply Limit:**
  - **Prescription Contraceptives** – the largest allowable quantity of an FDA-approved prescription contraceptive purchased from a Pharmacy, Home Delivery Supplier or Provider's office (if available) is a 6-month supply.

    A Provider may prescribe or You may purchase prescription contraceptives in smaller quantities. The Copayment and/or Coinsurance (if applicable) for an FDA-approved prescription contraceptive provided by a Pharmacy or Provider's office (if available) is based on each 30-day supply. The Copayment and/or Coinsurance (if applicable) for an FDA-approved prescription contraceptive provided by a Home Delivery Supplier is based on each 90-day supply.
- **Maximum Quantity Limit:**
  - For certain Prescription Medications, We establish maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. We use information from the FDA and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service.
  - For certain Self-Administrable Cancer Chemotherapy Medications, due to safety factors and the Member's ability to tolerate these medications, the Prescription Medication may be reduced to an initial 14-day or 15-day supply before larger quantities are dispensed.
  - Any amount over the established maximum quantity is not covered, except if We determine the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

EXCLUSIONS
The following exclusions apply to this Prescription Medications Section and are not covered:

Biological Sera, Blood or Blood Plasma

Bulk Powders
Except as included on Our Drug List and presented with a Prescription Order, bulk powders are not covered.

Cosmetic Purposes
Prescription Medications used for Cosmetic purposes, including, but not limited to:

- removal, inhibition or stimulation of hair growth, except as related to a covered medical condition;
- anti-aging; or
- repair of sun-damaged skin.

Devices or Appliances
Except as provided in the Medical Benefits Section, devices or appliances of any type, even if they require a Prescription Order are not covered.

Diagnostic Agents
Except as provided in the Medical Benefits Section, diagnostic agents used to aid in diagnosis rather than treatment are not covered.

Digital Therapeutics
Except as included on Our Drug List and presented with a Prescription Order, digital therapeutics are not covered.

Foreign Prescription Medications
Except for the following, foreign Prescription Medications are not covered:

- Prescription Medications associated with an Emergency Medical Condition while You are traveling outside the United States; or
- Prescription Medications You purchase while residing outside the United States.

These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered in this section if obtained in the United States.

General Anesthetics
Except as provided in the Medical Benefits Section, general anesthetics are not covered.

Medical Foods
Except as provided in the Medical Benefits Section, medical foods are not covered.

Medications that are Not Considered Self-Administrable
Except as provided in the Medical Benefits Section or as specifically indicated in this Prescription Medications Section, medications that are not considered self-administrable are not covered.

Nonprescription Medications
Except for the following, nonprescription medications that by law do not require a Prescription Order are not covered:

- medications included on Our Drug List;
- medications approved by the FDA; or
- a Prescription Order by a Physician or Practitioner.

Nonprescription medications include, but are not limited to:

- over-the-counter medications;

- vitamins;
- minerals;
- food supplements;
- homeopathic medicines;
- nutritional supplements; and
- any medications listed as over-the-counter in standard drug references, regardless of state law prescription requirements, such as pseudoephedrine and cough syrup products.

Prescription Medications Dispensed in a Facility
Prescription Medications dispensed to You while You are a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed by this benefit if obtained from a Pharmacy.

Prescription Medications for Obesity or Weight Reduction/Control
Except as included on Our Drug List, Prescription Medications that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered.

Prescription Medications Found to be Less than Effective under Drug Efficacy Safety Implementation (DESI)

Prescription Medications Not Approved by the FDA

Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order

Prescription Medications Not on the Drug List
Except as provided through the Drug List Exception Process provision, Prescription Medications that are not on the Drug List are not covered.

Prescription Medications Not within a Provider's License
Prescription Medications prescribed by Providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.

Prescription Medications with Therapeutic Alternatives
Prescription Medications for which there are covered therapeutically equivalent (similar safety and efficacy) alternatives or over-the-counter (nonprescription) alternatives.

Prescription Medications without Examination
Except as provided in the Virtual Care benefit, whether the Prescription Order is provided by mail, telephone, internet or some other means, Prescription Medications without a recent and relevant in-person examination by a Provider, are not covered. Additionally, this exclusion does not apply to a Provider or Pharmacist who may prescribe:

- an opioid antagonist to a Member who is at risk of experiencing an opiate-related overdose; or
- an epinephrine auto-injector to a Member who is at risk of experiencing anaphylaxis.

An examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

DEFINITIONS
The following definitions apply to this Prescription Medications Section:

Brand-Name Medication means a Prescription Medication that is marketed and sold by limited sources or is listed in widely accepted references as a Brand-Name Medication based on manufacturer and price.

Compound Medication means two or more medications that are mixed together by the Pharmacist. To be covered, Compound Medications must contain a Prescription Medication that has been approved by the FDA and may be subject to review for Medical Necessity.

Covered Prescription Medication Expense means the total payment a Participating Pharmacy or Home Delivery Supplier has contractually agreed to accept as full payment for a Prescription Medication. A Participating Pharmacy or Home Delivery Supplier may not charge You more than the Covered Prescription Medication Expense for a Prescription Medication.

Drug List means Our list of selected Prescription Medications. We established Our Drug List and We review and update it routinely. It is available on Our website or by calling Customer Service. Medications are reviewed and selected for inclusion on Our Drug List by an outside committee of Providers, including Physicians and Pharmacists.

Extended Supply Network (ESN) means a Participating Pharmacy that can fill up to a 90-day supply of Maintenance Medications.

Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references as a Generic Medication. "Equivalent" means the FDA ensures that the Generic Medication has the same active ingredients, meets the same manufacturing and testing standards, and is as safe and as effective as the Brand-Name Medication. Medications available only from one source (also referred to as "single source") are not considered Generic Medications. If listings in widely accepted references are conflicting or indefinite about whether a Prescription Medication is a generic or Brand-Name Medication, We will decide.

Home Delivery Supplier means a home delivery Pharmacy with which We have contracted for home delivery services.

Nonparticipating Pharmacy means a Pharmacy with which We neither have a contract nor have contracted access to any network it belongs to.

Nonparticipating Specialty Pharmacy means a Specialty Pharmacy with which We neither have contract nor have contracted access to any network it belongs to.

Participating Pharmacy means either a Pharmacy with which We have a contract or a Pharmacy that participates in a network for which We have contracted to have access.

Participating Specialty Pharmacy means a Specialty Pharmacy with which We have a contract or a Specialty Pharmacy that participates in a network for which We have contracted to have access.

Pharmacist means an individual licensed to dispense Prescription Medications, counsel a patient about how the medication works, any possible adverse effects and perform other duties as described in their state's Pharmacy practice act.

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed.

Pharmacy and Therapeutics (P&T) Committee means an officially chartered group of practicing Physicians and Pharmacists who review the medical and scientific literature regarding medication use. The P&T Committee also provides input and oversight of the development of Our Drug List and medication policies. Additionally, the P&T Committee is free from conflict of interest of drug manufacturers and the majority of whom are also free from conflict of interest of Your coverage.

Prescription Medications and Prescribed Medications mean medications and biologicals that:

- relate directly to the treatment of an Illness or Injury;
- legally cannot be dispensed without a Prescription Order;
- by law must bear the legend, "Prescription Only"; or

- are specifically included on Our Drug List.

Prescription Order means a written prescription, oral or electronic request for Prescription Medications issued by a Provider who is licensed to prescribe medications.

Self-Administrable Prescription Medication, Self-Administrable Medication, Self-Administrable Injectable Medication or Self-Administrable Cancer Chemotherapy Medication means a Prescription Medication labeled by the manufacturer as intended to be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician's office or clinic). Self-Administrable Cancer Chemotherapy Medications include oral Prescription Medications used to kill or slow the growth of cancerous cells. Information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that is considered a relevant and reliable indication of safety and acceptability is used to determine a Self-Administrable Medication. We do not consider Your status, such as Your ability to administer the medication, when determining whether a medication is self-administrable.

Specialty Biosimilar Medication means an FDA-approved Prescription Medication that has a biological similarity to a Specialty Medication. The Specialty Biosimilar Medication is identical in function to the comparable Specialty Medication and may be more cost efficient. Similar to the FDA's requirements for a generic equivalent, a Specialty Biosimilar Medication must meet the same manufacturing and testing standards, and must be as safe and effective as the comparable Specialty Medication.

Specialty Medications mean medications that may be used to treat complex conditions, including, but not limited to:

- multiple sclerosis;
- rheumatoid arthritis;
- cancer;
- clotting factor for hemophilia or similar clotting disorders; and
- hepatitis C.

Information from the manufacturer, scientific literature, practice standards, Medicare practices and other information that is considered relevant and reliable is used to determine a Specialty Medication. For a list of such medications, visit Our website or contact Customer Service.

Specialty Pharmacy means a Pharmacy or designated Hemophilia Treatment Center (HTC) that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. To find a Specialty Pharmacy, visit Our website or contact Customer Service.

Substituted Medication means a Generic Medication or a Brand-Name Medication not on the Drug List that is approved for coverage at the Tier 4 benefit level. Substituted Medication also means a Specialty Medication not on the Drug List that is approved for coverage at the Tier 6 benefit level.

Tier 1 means medications that provide the highest overall value. Mostly includes Generic Medications but may include some Brand-Name Medications.

Tier 2 means medications that provide moderate overall value. Mostly includes Generic Medications but may include some Brand-Name Medications.

Tier 3 means medications that provide moderate overall value. Usually includes Brand-Name Medications that are categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

Tier 4 means medications that provide lower overall value. Usually includes Brand-Name Medications that are categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

Tier 5 means Specialty Medications that provide moderate overall value, categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

Tier 6 means Specialty Medications that provide lower overall value, categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

General Exclusions

The following are the general exclusions from coverage, other exclusions may apply as described elsewhere in this Booklet.

SPECIFIC 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 federal law; or
- a preventive service as specified in the Preventive Care and Immunizations benefit and/or in the Prescription Medications Section.

Activity Therapy

The following activity therapy services are not covered:

- creative arts;
- play;
- dance;
- aroma;
- music;
- equine or other animal-assisted;
- recreational or similar therapy; and
- sensory movement groups.

Adventure, Outdoor, or Wilderness Interventions and Camps

Outward Bound, outdoor youth or outdoor behavioral programs, or courses or camps that primarily utilize an outdoor or similar non-traditional setting to provide services that are primarily supportive in nature and rendered by individuals who are not Providers, are not covered, including, but not limited to, interventions or camps focused on:

- building self-esteem or leadership skills;
- losing weight;
- managing diabetes;
- contending with cancer or a terminal diagnosis; or
- living with, controlling or overcoming:
    - blindness;
    - deafness/hardness of hearing;
    - a Mental Health Condition; or
    - a Substance Use Disorder.

Services by Physicians or Practitioners in adventure, outdoor or wilderness settings may be covered if they are billed independently and would otherwise be a Covered Service in this Booklet.

Assisted Reproductive Technologies

Assisted reproductive technologies, regardless of underlying condition or circumstance, are not covered, including, but not limited to:

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer;

- other artificial means of conception; or
- any associated surgery, medications, testing or supplies.

Certain Therapy, Counseling and Training
Except as provided in the Employee Assistance Program (EAP), the following therapies, counseling and training services are not covered:

- educational;
- vocational;
- social;
- image;
- self-esteem;
- milieu or marathon group therapy;
- premarital or marital counseling; and
- job skills or sensitivity training.

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.

Cosmetic/Reconstructive Services and Supplies
Except for treatment of the following, Cosmetic and/or reconstructive services and supplies are not covered:

- a Congenital Anomaly;
- to restore a physical bodily function lost as a result of Illness or Injury; or
- related to breast reconstruction following a Medically Necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice.

"Reconstructive" means services, procedures or surgery performed on abnormal structures of the body, caused by Congenital Anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Counseling in the Absence of Illness
Except as required by law, counseling in the absence of Illness is not covered.

Custodial Care
Except as provided in the Palliative Care benefit, non-skilled care and helping with activities of daily living is not covered.

Dental Services
Except as provided in the Repair of Teeth benefit, Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues are not covered, including treatment that restores the function of teeth.

Elective Abortion
Except when performed to preserve the life of the enrolled Member, to the extent such services are permitted under applicable law, termination of pregnancy (elective abortion) is 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.

Family Counseling
Except when provided as part of the treatment for a child or adolescent with a covered diagnosis, family counseling is not covered.

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 listed below, government facilities or government facilities outside the service area are not covered:

- facilities contracting with the local Blue Cross and/or Blue Shield plan; or
- as required by law for emergency services.

Hearing Aids and Other Devices
Except for cochlear implants or as provided in the Hearing Aids and Evaluations benefit, hearing aids (externally worn or surgically implanted) or other hearing devices are not covered.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses are not covered, including, but not limited to:

- treatment of painful physical conditions;
- Mental Health Conditions;
- Substance Use Disorders; or
- for anesthesia purposes.

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.

Illegal Services, Substances and Supplies
Services, substances and supplies that are illegal as defined by state or federal law.

Individualized Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids and supports as provided in an IEP developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility
Except to the extent Covered Services are required to diagnose such condition, treatment of infertility is not covered, including, but not limited to:

- surgery;
- uterine transplants;
- fertility medications; and
- other medications associated with fertility treatment.

Investigational Services
Except as provided in the Approved Clinical Trials benefit, 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.

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
Except as provided in the Virtual Care benefit, 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).

Obesity or Weight Reduction/Control
Except as provided in the Nutritional Counseling benefit or as required by law, services or supplies that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered, including, but not limited to:

- medical treatment;
- medications;
- surgical treatment (including treatment of complications, revisions and reversals); or
- programs.

Orthognathic Surgery
Except for treatment of the following, orthognathic surgery is not covered:

- orthognathic surgery due to an Injury;
- temporomandibular joint disorder;
- sleep apnea (specifically, telegnathic surgery);
- developmental anomalies; or
- Congenital Anomaly.

"Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development performed to restore the proper anatomic and functional relationship of the facial bones.

"Telegnathic surgery" means skeletal (maxillary, mandibular and hyoid) advancement to anatomically enlarge and physiologically stabilize the pharyngeal airway to treat obstructive sleep apnea.

Over-the-Counter Contraceptives
Except as provided in the Prescription Medications Section or as required by law, over-the-counter contraceptive supplies are not covered.

Personal Items
Items that are primarily for comfort, convenience, Cosmetics, contentment, hygiene, environmental control, education or general physical fitness are not covered, including, but not limited to:

- telephones;
- televisions;
- air conditioners, air filters or humidifiers;
- whirlpools;
- heat lamps;
- light boxes;
- weightlifting equipment; and
- therapy or service animals, including the cost of training and maintenance.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment are not covered (even if recommended or prescribed by Your Provider), including, but not limited to:

- hot tubs; or
- membership fees to spas, health clubs or other such facilities.

Private-Duty Nursing
Private-duty nursing, including ongoing shift care in the home.

Provider-Administered Specialty Drugs
Provider-Administered Specialty Drugs that are not obtained through the designated Specialty Pharmacy for Provider-Administered Specialty Drugs are not covered.

Reversals of Sterilizations
Services and supplies related to reversals of sterilization.

Routine Foot Care

Routine Hearing Examinations

Self-Help, Self-Care, Training or Instructional Programs
Except as provided in the Medical Benefits Section or for services provided without a separate charge in connection with Covered Services that train or educate a Member, self-help, non-medical self-care, and training or instructional programs are not covered, including, but not limited to:

- childbirth-related classes including infant care; and
- instructional programs that:
    - teach a person how to use Durable Medical Equipment;
    - teach a person how to care for a family member; or
    - provide a supportive environment focusing on the Member's long-term social needs when rendered by individuals who are not Providers.

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 an Illness or Injury.

Services Required by an Employer or for Administrative or Qualification Purposes
Physical or mental examinations and associated services (laboratory or similar tests) required by an employer or primarily for administrative or qualification purposes are not covered.

Administrative or qualification purposes include, but are not limited to:

- admission to or remaining in:
    - school;
    - a camp;
    - a sports team;
    - the military; or
    - any other institution.
- athletic training evaluation;
- legal proceedings (establishing paternity or custody);
- qualification for:
    - employment or return to work;
    - marriage;
    - insurance;
    - occupational injury benefits;
    - licensure; or
    - certification.
- travel, immigration or emigration.

Sexual Dysfunction
Except as provided in the Mental Health Services benefit, treatment, services and supplies are not covered for or in connection with sexual dysfunction regardless of cause.

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
Except as provided in the Ambulance benefit or as otherwise provided in the Medical Benefits Section, travel and transportation expenses are not covered.

Varicose Vein Treatment
Except as provided in the Other Professional Services benefit, treatment of varicose veins is not covered.

Vision Care
Vision care services are not covered, including, but not limited to:

- routine eye examinations;
- vision hardware;
- visual therapy;
- training and eye exercises;
- vision orthoptics;
- surgical procedures to correct refractive errors/astigmatism; and
- reversals or revisions of surgical procedures which alter the refractive character of the eye.

Wigs
Wigs or other hair replacements regardless of the reason for hair loss or absence.

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.

ALTERNATIVE BENEFITS

Alternative benefits are benefits for services or supplies that are not otherwise covered under the Contract, but for which We may approve coverage after case management evaluation and analysis. We may cover alternative benefits through case management if We determine, in Our sole discretion, that alternative benefits are Medically Necessary and will result in overall reduced covered costs and improved quality of care. Before coverage of alternative benefits and the processing of associated claims, We, You (or Your legal representative) and, when required by Us, Your Physician or other Provider must agree in writing to the specific terms and conditions for payment. Alternative benefits are approved on a case-specific basis only. The fact that We may cover alternative benefits for You does not set any precedent for coverage of continued or additional alternative benefits for You, or anyone else covered.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims are submitted and payment is due, We decide whether to pay You, the Provider or You and the Provider jointly. We may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child.

In-Network Provider Claims and Reimbursement

You must present Your identification card to an In-Network Provider and furnish any additional information requested. The Provider will submit the necessary forms and information to Us for processing Your claim.

We will pay an In-Network Provider directly for Covered Services. These Providers may require You to pay any Deductible, Copayment and/or Coinsurance at the time You receive care or treatment. In-Network Providers have agreed not to bill You for balances beyond any Deductible, Copayment and/or Coinsurance and to accept the Allowed Amount as payment in full for Covered Services.

Out-of-Network Provider Claims and Reimbursement

In order for Us to pay for Covered Services, You or the Out-of-Network Provider must first send Us a claim. In most cases, We will pay You directly for Covered Services provided by an Out-of-Network Provider. Be sure the claim is complete and includes the following information:

- an itemized description of the services given and the charges for them;
- the date treatment was given;
- the diagnosis;
- the patient's name;
- Your identification number; and
- the group number.

If the treatment is for an Injury, include a statement explaining the date, time, place and circumstances of the Injury when You send Us the claim.

Out-of-Network Providers have not agreed to accept the Allowed Amount as payment in full for Covered Services. You are responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount in addition to any amount You must pay due to Deductible, Copayment and/or Coinsurance. For Out-of-Network Providers, the Allowed Amount may be based upon the billed charges for some services, as determined by Us or as otherwise required by law.

NOTE: Refer to the notice "Your Rights and Protections Against Surprise Medical Bills" attached to this Booklet for information regarding reimbursement and balance billing applicable to Out-of-Network Providers for certain services.

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.

CONTINUITY OF CARE
You may qualify to receive 90 days of continued coverage (or 90 days from the date You are no longer a continuing care patient, whichever is earlier) at the In-Network benefit level, if one of the following situations apply:

- Your Provider was a contracted In-Network Provider, but is no longer contracted (this provision does not apply if the contract with the Provider was terminated due to a failure to meet quality standards or for fraud); or
- Your Group's Contract with Us is terminated for reasons other than fraud, and your Group's new health plan does not include Your In-Network Provider in its network.

To qualify for continued coverage, You must be:

- undergoing a course of treatment for a certain serious and complex condition from the Provider;
- undergoing a course of institutional or inpatient care from the Provider;
- scheduled to undergo non-elective surgery from the Provider (including postoperative care following surgery);
- pregnant and undergoing a course of treatment for pregnancy from the Provider; or
- determined to be terminally ill and receiving treatment for such Illness from the Provider.

We will notify You of Your right to receive continued care from the Provider or You may contact Us with a need for continued care. Coverage under this Continuity of Care provision will be subject to the benefits of this Booklet and provided on the same terms and conditions as any other In-Network Provider. Your Provider must accept the Allowed Amount and cannot bill You for any amount beyond any Deductible, Copayment and/or Coinsurance. Contact Customer Service for further information and guidance.

OUT-OF-AREA SERVICES
We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever You access health care services outside of the geographic area We serve, the claim for those services may be processed through one of these Inter-Plan Arrangements.

When You receive care outside of the geographic area We serve, You may receive it from Providers as described below. Providers that contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue") as a preferred Provider are paid at the In-Network benefit level and will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. Providers that contract with the Host Blue as a participating Provider are paid at the Out-of-Network benefit level and may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Some Providers ("Out-of-Network Providers") don't contract with the Host Blue.

BlueCard Program

In the BlueCard Program, when You obtain Covered Services within the geographic area served by a Host Blue, We will remain responsible for doing what We agreed to in the Contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Providers that participate in the BlueCard Program.

When You receive Covered Services outside Our service area and the claim is processed through the BlueCard Program, the amount You pay for Covered Services is calculated based on the lower of:

- the billed charges for Your Covered Services; or
- the negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" is a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with a Provider or group of Providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of Providers. Host Blues may use several factors to set an estimated or average price, including types of settlements, incentive payments, and/or other credits or charges. Estimated and average pricing may also take into account adjustments to correct Host Blue estimates of past prices. However, such adjustments will not affect the price used for Your claim because those adjustments will not be applied after a claim has already been paid.

Value-Based Programs

You may receive Covered Services under a Value-Based Program ("VBP") inside a Host Blue's service area. Host Blue may pay Providers that participate in a VBP for reaching agreed-upon cost and quality goals, meeting outcome measures, and coordinating care between its Providers. You will not be responsible for paying fees associated with a VBP, except when a Host Blue passes these fees to Us through average pricing or fee schedule adjustments.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state law may require a surcharge, tax, or other fee. If applicable, We will include any such surcharge, tax, or other fee as part of the claim charge passed on to You.

Out-of-Network Providers Outside Our Service Area

When Covered Services are provided outside of Our service area by Out-of-Network Providers, the amount You pay will normally be based on either Host Blue's Out-of-Network Provider local payment or pricing arrangements required by applicable state law. We may use other payment methods in certain situations, such as billed charges for Covered Services, the payment We would make if the health care services had been obtained within Our service area, or a special negotiated payment to determine the amount We will pay for services provided by Out-of-Network Providers. In any of these situations, You may be responsible for the difference between the Out-of-Network Provider's billed amount and Our payment for Covered Services. Federal or state law, as applicable, will govern payments for Out-of-Network emergency services.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

If You are outside the United States, You may be able to take advantage of Blue Cross Blue Shield Global® Core ("BCBS Global® Core") when accessing Covered Services. BCBS Global® Core is unlike the BlueCard Program available in the United States in certain ways. For instance, although BCBS Global® Core helps You access a provider network, the network is not served by a Host Blue.

You may have to pay the Provider upfront and submit any claims to Us Yourself in order to obtain reimbursement for those services. When You pay for Covered Services outside the United States, You should complete and submit a BCBS Global® Core claim form with the Provider's itemized bill(s) to the service center (address is on the form) to initiate claims processing. If You contact the BCBS Global® Core service center for assistance, in most cases, Hospitals will not require You to pay for covered inpatient services (except for any applicable Deductible, Copayment and/or Coinsurance). In such cases, the Hospital will also submit Your claims to the service center.

If You need medical assistance services (or help locating a Provider) outside the United States, or if You need assistance with a claim submission, You should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary. The claim form is available from Us, the service center, or online at **www.bcbsglobalcore.com**.

Covered Services received from Providers outside the United States may not be subject to state or federal protections from surprise or balance billing, and therefore You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

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, at Our discretion, 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 Medical 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.

Coordination of Benefits with a High Deductible Health Plan

Laws strictly limit the types of other coverages that a health savings account (HSA) participant may carry in addition to their qualified high deductible health plan. The benefits of maintaining an HSA are jeopardized if impermissible types of other coverages are maintained. We will coordinate benefits according to this Coordination of Benefits provision, regardless of whether other coverage is permissible per HSA law or not. It is Your responsibility to ensure that You do not maintain other coverage that might jeopardize any HSA tax benefit that You plan to claim.

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 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. There is one appeal to Us, as well as an additional voluntary external review that You may pursue. Certain situations requiring a faster decision may qualify for an expedited appeal as described below.

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.

INTERNAL APPEAL

All internal appeals, including expedited appeals, must be pursued within 180 days of Your receipt of Our determination (or, in the case of the initial appeal, within 180 days of Your receipt of Our original adverse decision that You are appealing). If You don't appeal within this time period, You will not be able to continue to pursue the appeal process and may jeopardize Your ability to pursue the matter in any forum.

Internal appeals are reviewed by an employee or employees who were not involved in the initial decision that You are appealing. In appeals that involve issues requiring medical judgment, the decision is made by Our staff of health care professionals.

What You May Appeal – Internal Appeal

You may appeal disputes regarding:

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

Voluntary External Review – Independent Review Organization (IRO)

For information regarding a voluntary external review, refer to the Your Right to an Independent External Review – Notice provision below.

INTERNAL EXPEDITED APPEAL

If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision from the regular appeal process, You or Your treating Provider may specifically request an expedited appeal within 180 days of Your receipt of Our determination.

The internal expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. Internal expedited appeals are reviewed by employees who were not involved in, or subordinate to anyone involved in, the initial denial determination. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the expedited appeal time frame) to provide written materials, including written testimony on Your behalf.

What You May Appeal – Internal Expedited Appeal

An expedited appeal is available if one of the following applies:

- the application of regular appeal time frames on a Pre-Service or concurrent care claim either:
  - could jeopardize Your life, health or ability to regain maximum function; or
  - according to a Provider with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment; or
- the treatment would be significantly less effective if not promptly initiated.

Voluntary Expedited Review – IRO
For information regarding a voluntary expedited external review, refer to the Your Right to an Independent External Review – Notice provision below.

FILING AN INTERNAL APPEAL
Both internal and internal expedited appeals can be initiated through either written or verbal request using any of the following methods:

Method of Request	Contact Information
Secure Online Account	Sign-in to Your account at **regence.com**, navigate to appeals and complete an appeal request
E-mail	MemberAppeals@regence.com
Fax	1-888-496-1542
Phone	Call the Customer Service phone number on Your identification card
Mail	Attn: Member Appeals Regence BlueShield of Idaho P.O. Box 1106 Lewiston, ID 83501-1106

INTERNAL APPEAL DETERMINATION TIMING
We will send Our decision on Your internal appeal as follows:

Type of Appeal	How and When to Expect a Response
Post-Service appeal	In writing, within 35 days of Our receipt of the appeal.
Pre-Service appeal for preauthorization	In writing, within 35 days of Our receipt of the appeal.
Expedited appeal	By phone, fax or e-mail within 72 hours of Our receipt of the appeal, followed by written notice within 3 working days.

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW – NOTICE
Read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with Us. If You request an independent external review of Your claim, the decision made by the independent reviewer will be binding and final on Us. You will have the right to further review of Your claim by a court, arbitrator, mediator or other dispute resolution entity, only if Your plan is subject to ERISA, as more fully explained in the Binding Nature of the External Review Decision provision below.

You must first exhaust Our internal grievance and appeal process. Exhaustion of that process includes completing an internal appeal, or unless You requested or agreed to a delay, Our failure to respond to a standard appeal within 35 days in writing or to an urgent appeal within three working days of the date You filed Your appeal. We may also agree to waive the exhaustion requirement for an external review request. You may file for an expedited appeal with Us and an expedited external review with the Idaho Department of Insurance (hereafter "DOI") at the same time if Your request qualifies as an urgent care request, as defined in the Expedited External Review Request provision below.

Filing an External Review Request

No later than four months from the date We issue a final notice of denial, You may submit a request for an external review as follows:

Method of Request	Contact Information
Mail	Attn: External Review Idaho Department of Insurance 700 W. State Street, 3rd Floor Boise, ID 83720-0043
Phone	1-208-334-4250; or 1-800-721-3272 (toll-free in Idaho)
Website	**www.doi.idaho.gov**

You may represent Yourself in Your request or You may name another person, including Your treating health care Provider, to act as Your authorized Representative for Your request. If You want someone else to represent You, You must include a signed Appointment of an Authorized Representative form with Your request.

Your written external review request to the DOI must include a completed form authorizing the release of any of Your medical records the IRO may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The DOI will not act on an external review request without Your completed authorization form.

If Your request qualifies for external review, Our final adverse benefit determination will be reviewed by an IRO selected by the DOI. We will pay the costs of the review.

What You May Appeal – Voluntary Standard External Review Request

If We issue a final adverse benefit determination of Your request to provide or pay for a health care service or supply that is a Covered Service, You may have the right to have Our decision reviewed by health care professionals who have no association with Us. You have this right only if Our denial decision involved:

- the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of Your health care service or supply; or
- Our determination that Your health care service or supply was Investigational.

Voluntary Standard External Review Request Timing

You must file Your written external review request with the DOI within four months after the date We issue a final notice of denial.

Appeal Step	How and When to Expect a Response
The DOI sends a copy of Your request for external review to Us.	Within 7 days of the DOI's receipt of request.
We review Your request for eligibility for external review.	Within 14 days of Our receipt of Your request from the DOI.
We notify You and the DOI in writing whether Your request is eligible or what additional information is needed. You may appeal to the DOI if We find Your request ineligible.	Within 5 working days of completing Our review.
If Your request is eligible for external review, the DOI assigns an IRO and notifies You in writing.	Within 7 days of the DOI's receipt of Our notice of eligibility.
You may submit any additional information in writing to the IRO that You want the IRO to consider in its review.	Within 7 days of Your receipt of the DOI's notice of IRO assignment.
The IRO must provide written notice of its decision to You, Us, and the DOI.	Within 42 days after receipt of request for external review.
Upon receipt of a notice reversing the final adverse benefit determination, We approve the coverage that was the subject of the external review.	As soon as reasonably practicable, but no later than 1 working day of Our receipt of the IRO's decision reversing Our previous final adverse benefit determination.

What You May Appeal – Voluntary Expedited External Review Request

You may file a written urgent care request with the DOI for an expedited external review of a Pre-Service or concurrent service denial.

"Urgent care request" means a claim relating to an admission, availability of care, continued stay or health care service for which You received emergency services but have not been discharged from a facility, or any Pre-Service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

- could seriously jeopardize Your life or health or ability to regain maximum function;
- in the opinion of the treating health care professional with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment; or
- the treatment would be significantly less effective if not promptly initiated.

Voluntary Expedited External Review Request Timing

You may file for an internal expedited appeal with Us and for an expedited external review request with the DOI at the same time.

Appeal Step	How and When to Expect a Response
After the DOI sends a copy of Your request for expedited external review to Us, We will determine eligibility for review.	Within 2 full working days.
We notify You and the DOI whether Your request is eligible. You may appeal to the DOI if We find Your request ineligible.	Within 1 working day of completing Our review.
If Your request is eligible for review, the DOI assigns an IRO and notifies You.	Upon the DOI's receipt of Our notice of eligibility.
The IRO must provide notice of its decision to You, Us, and the DOI.	Within 72 hours after the date of receipt of the external review request.
The IRO must provide written confirmation of its decision.	Within 48 hours of the IRO's decision.
If the decision reverses Our denial, We approve the coverage that was the subject of the expedited external review.	As soon as reasonably practical, but no later than 1 working day, after Our receipt of the IRO's decision reversing Our previous decision.

Binding Nature of the External Review Decision

The external review decision by the IRO will be final and binding on both You and Us. **This means that if You elect to request external review of Your claim, You will be bound by the decision of the IRO. You will not have any further opportunity for review of Your claim after the IRO issues its final decision.** If You choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the IRO is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

DEFINITIONS

The following definitions apply to this Appeal Process Section:

Independent Review Organization (IRO) is an independent Physician review organization that acts as the decision-maker for voluntary external appeals and voluntary external expedited appeals and that is not controlled by Us.

Post-Service means any claim for benefits that is not considered Pre-Service.

Pre-Service means any claim for benefits which We must approve in advance, in whole or in part, in order for a benefit to be paid.

Representative means someone who represents You for the appeal. The Representative may be Your personal Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the appeal. No authorization is required from the parent(s) or legal guardian of an enrolled dependent child who is less than 13 years old. For expedited appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for each appeal). If no authorization exists and is not received in the course of the appeal, the determination and any personal information will be disclosed to You, Your personal Representative or treating Provider only.

Eligibility and Enrollment

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible, during a period of special enrollment 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, except as described in the Special Enrollment provision below.

Employees

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.

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.

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.

NOTE: Due to the nature of this high deductible health plan, adding dependents after January 1 of any year may change Your coverage from Single Coverage to Family Coverage, and may change the amount of Deductible and Out-of-Pocket Maximum that applies to Your coverage.

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your eligible dependents, even though You didn't do so when first eligible, and You do not have to wait for an annual open enrollment period. You must submit an enrollment form on behalf of all individuals who become eligible based on the provisions below.

If You declined coverage when first eligible, You (unless already enrolled) and/or Your eligible dependents are eligible to enroll for coverage under the Contract within 30 days from the date of one of the following qualifying events:

- You and/or Your eligible dependents lose coverage under another group or individual health benefit plan due to one of the following:
  - an employer's premium contributions to that other plan are terminated;
  - exhaustion of federal COBRA or any state continuation; or
  - loss of eligibility due to legal separation, divorce, death, termination of employment or reduction in hours.
- You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than Children's Health Insurance Program (CHIP)).
  - NOTE: If the qualifying event is involuntary loss of coverage with Medicaid or CHIP, You have 60 days from the date of the qualifying event to enroll.
- You lose coverage under Medicaid or CHIP.

For the above qualifying events coverage will be effective on the first day of the month following loss of coverage. Loss of eligibility does not include a loss because You failed to timely pay Your portion of the premium or when termination of coverage was due to fraud. It also doesn't include Your decision to terminate coverage. However, it may include Your decision to take another action (for example, terminating employment) that results in a loss of eligibility.

If You declined coverage when first eligible, You (unless already enrolled) and/or Your eligible dependents are eligible to enroll for coverage under the Contract within 60 days from the date of one of the following qualifying events:

- You marry;
- You acquire a new child by birth, adoption or Placement for adoption; or
- You and/or Your eligible dependents become eligible for premium assistance with Medicaid or CHIP.

For the above qualifying events coverage will be effective on the first of the month following the date of the qualifying event. However, if the qualifying event is a child's birth, adoption or Placement for adoption, coverage is effective from the date of the birth, adoption or Placement.

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 or a special enrollment period, 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 or the Other Continuation Options Sections.

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 or the Other Continuation Options Sections.

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 or the Other Continuation Options Sections.

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.

MILITARY LEAVE OF ABSENCE

If You are covered under this plan and are called to active duty or join any branch of the United States armed forces, and Your military duty would result in a loss of coverage under this plan, You are eligible for continued coverage under this plan for up to 24 months or the duration of Your military leave, whichever is shorter, under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Continuation of Coverage
This continuation of coverage is in lieu of and not in addition to any other continuation of coverage provisions. Your dependents do not have an independent right to elect USERRA coverage.

Premium Contributions
To maintain coverage during Your leave, You must pay premiums to the employer Group. If Your leave is less than 30 days, Your premium contribution rate will be the same as for active employees. If Your leave is 30 days or longer, Your premium contribution will not exceed 102% of the cost of coverage for active employees.

Provisions and Limitations
When Your coverage under this plan is reinstated, all provisions and limitations of this plan will apply as if You had not taken Your military leave and Your coverage had been continuous. You will not have to serve any group eligibility waiting period. However, this waiver of limitations does not provide coverage for any illness or injury caused or aggravated by Your military service, as determined by the Veterans Administration.

For complete information regarding Your rights under USERRA, contact the employer Group.

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.

CERTIFICATES OF CREDITABLE COVERAGE
Requests for and inquiries about required certificates relating to period(s) of creditable coverage under the Contract should be directed to the Group, or to Us at P.O. Box 1106, Lewiston, ID 83501-1106.

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.

Other Continuation Options

This section describes situations when coverage may also be extended for You and/or Your Enrolled Dependents beyond the date of termination.

Availability of Other Coverage

When eligibility under the Contract terminates at the end of or in lieu of any available COBRA continuation coverage period, or otherwise upon termination of this coverage, an individual insurance policy or Medicare supplement plan is available through Us. The policy or plan will have equal or lesser benefits than this coverage.

Pregnancy

If this Booklet provided for maternity benefits and any Member is pregnant at the time of termination of the Contract and the Member is not eligible for any replacement group coverage within 60 days of the termination of the Contract, We will provide benefits for pregnancy, childbirth or miscarriage as detailed in this Booklet for a period not to exceed 12 months beyond the date of termination.

Total Disability

If You are totally disabled at the time of termination of the Contract, We will continue to provide benefits for You for Covered Services received as a result of the disabling condition(s) beyond the date of termination of the Contract until the first of the following situations occurs:

- it has been 12 months from the date of termination;
- You are no longer totally disabled; or
- You have met the Maximum Benefits.

"Totally disabled" means a condition resulting from Illness or Injury in which, as certified by a Physician:

- An Enrolled Employee or spouse is completely unable to perform the substantial duties of any occupation or business for which they are qualified. "Qualified" means by reason of education, training or experience. In addition, the Enrolled Employee or spouse is not engaged in any occupation for wage or profit at the time of being totally disabled.
- A retiree or Enrolled Dependent is completely unable to engage in normal duties or activities of a person in good health who is the same gender and age.

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 health care Provider. We are not responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since We do not provide any health care services, We cannot be held liable for any claim or damages connected with Injuries You suffer while receiving health 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 modification or amendment of the Contract will affect the benefits of any Member who is, on the Effective Date of such modification or amendment, confined in a Hospital or other facility on an inpatient basis, until the first discharge from such facility occurring after such Effective Date.

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 or rewards through a value-added program.

WE ARE NOT RESPONSIBLE FOR HSA FINANCIAL OR TAX ARRANGEMENTS

You are solely responsible to ensure that this plan qualifies, and continues to qualify, for use with any HSA that You choose to establish and maintain. We do not assume any liability associated with Your contribution to an HSA during any period that this high deductible health plan does not qualify for use with an HSA. An HSA is a tax-exempt account established per Section 223(d) of the Internal Revenue Code exclusively for paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible but in order to qualify for and make contributions to an HSA, You must be enrolled in a qualified high deductible health plan (and not be enrolled in other coverage). Note that the tax references contained in this Booklet relate to federal income tax only. The tax treatment of HSA

contributions and distributions per Your state's income tax laws may differ from the federal tax treatment and differs from state to state.

We do not provide tax advice and assume no responsibility for reimbursement from the custodial financial institution for any HSA with which this high deductible health plan is used. Consult with Your financial or tax advisor for tax advice or for more information about Your eligibility for an HSA.

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.

WOMEN'S HEALTH AND CANCER RIGHTS

If You are receiving benefits in connection with a mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, We will provide coverage (subject to the same provisions as any other benefit) for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Definitions

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

Affiliate means a company with which We have a relationship that allows access to Providers in the state in which the Affiliate serves and includes only the following companies: Regence BlueCross BlueShield of Oregon in the state of Oregon, Regence BlueCross BlueShield of Utah in the state of Utah and Regence BlueShield in parts of the state of Washington.

Allowed Amount means:

- For In-Network Providers, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Providers who are not accessed through the BlueCard Program, the amount We have determined to be reasonable charges or have negotiated for Covered Services. The Allowed Amount may be based upon billed charges for some services, as determined by Us or as otherwise required by law.
- For Out-of-Network Providers accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to Us as the amount on which it would base a payment to that Provider. In exceptional circumstances, such as if the Host Blue does not identify an amount on which it would base payment, We may substitute another payment basis.

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 Customer Service.

Ambulatory Surgical Center means a distinct facility or that portion of a facility that operates exclusively to provide surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.

Booklet is the description of the benefits for this coverage. The Booklet is part of the Contract between the employer Group and Us. We will create and furnish Booklets to the Group identifying the general provisions and schedule of benefits, for distribution to each Enrolled Employee.

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

Commercial Seller includes, but is not limited to, retailers, wholesalers or commercial vendors that are not Providers, who are approved to provide new medical supplies, equipment and devices in accordance with the provisions of this coverage.

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 a service, supply, treatment or accommodation that is listed in the benefit sections in this Booklet.

Custodial Care means care for watching and protecting a patient, rather than being a Health Intervention. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided

by a person without medical or paramedical skills and/or is primarily to separate the patient from others or preventing self-harm.

Dental Service means services or supplies (including medications) that are provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Member's home.

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.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency room to result in any one of the following:

- placing the Member's health, or with respect to a pregnant Member, the Member's health or the health of the unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

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.

Essential Benefits are determined by the U.S. Department of Health and Human Services (HHS) and are subject to change, but currently include at least the following general categories and the items and services covered within the categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services (including behavioral health treatment);
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services;
- chronic disease management; and
- pediatric services including oral and vision care.

Family means an Enrolled Employee and any Enrolled Dependents.

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.

Hospital means a facility that is licensed as a general acute or specialty Hospital by the state in which the Hospital is located. A Hospital provides continuous 24-hour nursing services by registered nurses. A Hospital has an attending medical staff consisting of one or more Physicians. A Hospital per this definition is not, other than incidentally, a place for rest, a nursing home or a facility for convalescence.

Illness means a:

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

Illness does not include any state of mental health or mental disorder (which is otherwise defined).

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.

In-Network means a Provider:

- that has an effective participating contract with Us, that designates the Provider as in Your network, to provide services and supplies to Members in accordance with the provisions of this coverage. Your network is preferred; or
- that has an effective participating contract with one of Our Affiliates (designated as a preferred Provider in the "In-Network"), to provide services and supplies to Members in accordance with the provisions of this coverage.

If We or one of Our Affiliates have more than one Provider network from which the employer Group may choose for benefits under the Contract, then the Providers contracted with the network selected by the employer Group will be considered the only In-Network Providers for purpose of payment of benefits. For In-Network Provider reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

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:

- If a medication or device, the Health Intervention must have final approval from the FDA as being safe and effective for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the medication may be provided when so used.
- 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.
- Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.
- 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.

Lifetime means the entire length of time a Member is continuously covered under the Contract (which may include more than one coverage) through the Group with Us.

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.

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 means a Provider that is not In-Network. For Out-of-Network Provider services, You may be billed for balances over Our payment level in addition to any Deductible, Copayment and/or Coinsurance amount for Covered Services provided inside or outside the area that We or one of Our Affiliates serves.

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.

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. Practitioners include, but are not limited to:

- podiatrists;

- psychologists;
- certified nurse midwives;
- certified registered nurse anesthetists;
- dentists (doctor of medical dentistry, doctor of dental surgery, denturist, or a dental hygienist who is permitted by their respective state licensing board to independently bill third parties); and
- other professionals practicing within the scope of their respective licenses.

Provider means:

- a Hospital;
- a Skilled Nursing Facility;
- an Ambulatory Surgical Center;
- a Physician;
- a Practitioner; or
- other individual or organization which is duly licensed to provide medical or surgical services.

Retail Clinic means a walk-in health clinic located within a retail operation and providing, on an ambulatory basis, preventive and primary care services. A Retail Clinic does not include:

- an office or independent clinic outside a retail operation;
- an Ambulatory Surgical Center;
- an urgent care center;
- a Hospital;
- a Pharmacy;
- a rehabilitation facility; or
- a Skilled Nursing Facility.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Skilled Nursing Facility means a facility or distinct part of a facility which is licensed by the state in which it is located as a nursing care facility and which provides skilled nursing services by or under the direction and supervision of a registered nurse.

Appendix: Value-Added Services

Your Regence coverage includes access to the value-added services detailed in this Appendix. Services may be provided through third-party program partners who are solely responsible for their services. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS OF THIS BOOKLET.** These value-added services may work alongside Your coverage. Such services are otherwise covered in the benefits provisions of this Booklet.

For additional information regarding any of these value-added services, visit Our website or contact Customer Service. Contact information for value-added services for specific program partners is also included below, if applicable.

CARE MANAGEMENT

Receive one-on-one help and support in the event You have a chronic, serious or sudden Illness or Injury. An experienced care management nurse will serve as Your single point of contact and personal advocate to help You understand Your Providers' instructions, help prepare You for an elective surgical procedure, assist in coordinating overall care, connecting to special medical expertise and accessing other Plan Sponsor services and programs. Your nurse is supported by a multidisciplinary team made up of doctors, social workers, Pharmacists and behavioral health experts that can be accessed for additional consultation. The goal is to offer assistance in navigating through Your health care needs, including working with Your community resources to provide a personalized touch and to enhance the quality of Your wellbeing. Care management nurses proactively outreach by telephone and educational mailings or You may request support by directly contacting a nurse. To learn more, call 1 (866) 543-5765.

DECISION SUPPORT SERVICES

If You are diagnosed with a complex condition, require surgery, or have a chronic condition, You have access to consult a specialist to learn more about Your condition. This service is designed to help You make an educated and informed decision about Your treatment options. Specialists in a wide range of medical subspecialties are available to assist You by video chat or phone.

This service does not provide medical diagnosis, treatment, or prescriptions of any kind. All information provided is intended for informational and health education purposes only, and is not intended to create a physician-patient relationship as defined by state and federal law. This service is not a substitute for professional medical diagnosis or treatment. This program may not be available for all conditions.

DIABETES MANAGEMENT

If You are identified to participate, the Diabetes Management program is an online program that has extensive support tools such as glucose tracking, live coaching, and emotional support to help You improve health and manage diabetes. To better track blood sugar levels and provide more focused support, You will be provided a glucose monitor.

DIABETES PREVENTION

The Diabetes Prevention program is an online program that has extensive support tools such as weight tracking, live coaching, online lessons of diabetes prevention-specific curriculum, and emotional support to help You track five key healthy behaviors (weight, food, mood, steps and exercise) and prevent diabetes. To provide more focused support, You will be provided a weight scale.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

An EAP is short-term, confidential counseling with no out-of-pocket expense. This EAP is available to the following "clients":

- the Enrolled Employee;
- the Enrolled Employee's legal dependents (whether or not they are enrolled in this coverage or living in the Enrolled Employee's home); and
- anyone living in the Enrolled Employee's home (whether or not they are enrolled in this coverage or related to the Enrolled Employee).

You will receive a welcome packet that includes contact information and details of the following services which are provided as part of this EAP:

- **24-Hour Crisis Counseling**
- The EAP hotline number is answered by professional counselors 24 hours a day, 7 days a week. Call 1-800-922-2687 or visit **guidanceresources.com** (Web ID: SOIEAP).

- **Short-Term Counseling**
  An "incident" means a separate event or events occurring in the client's life. Six counseling sessions will be covered per incident. Each client affected by an incident will be eligible for a total of six counseling sessions. If two or more clients are seen together in a joint session, the session is counted as one visit for each attending client.

- **Referral**
  If the counselor and client determine the problem cannot be handled in short-term counseling, the counselor may refer the client to extended care, community resources or another Provider as best suited to address the issue and referred services will not be part of this EAP. Services not included in this EAP will be subject to the benefits in this Booklet.

- **Follow-up**
  When necessary and appropriate, the counselor may follow up with the client after short-term counseling and/or referral to assess the appropriateness of the referral and to see if this EAP service can be of further assistance.

HYPERTENSION MANAGEMENT

If You are identified to participate, the Hypertension Management program is an online program that has extensive support tools such as food and activity tracking, live coaching and medication optimization support to help You improve health and manage hypertension. To better track blood pressure levels and provide more focused support, You will be provided a blood pressure monitor.

IDENTITY THEFT PROTECTION

You have access to the Identity Theft Protection program, which includes the following:

- credit monitoring: monitors activity that may affect credit;
- fraud detection: identifies potentially fraudulent use of identity or credit; and
- fraud resolution support: assists in addressing issues that arise in relation to credit monitoring and fraud detection.

INDIVIDUALIZED MEDICATION SUPPORT

If You are identified to participate, the Individualized Medication Support program provides potential cost-savings opportunities through individualized care management of complex conditions. Individualized care is provided through outreach and collaboration with You and Your Provider.

JOINT, SPINE AND MUSCLE PROGRAM

The Joint, Spine and Muscle program is a digitally delivered program that is provided at no cost to You, to help manage mobility and pain with Your joints, spine, and muscles. In addition, based upon Your specific health condition, You may have access to a customized care plan including guided exercise therapy, one-on-one video coaching with a care team, curated health education, and behavior change support. For those who do not have a way to participate in the digital program please visit Our website or contact Customer Service. You may be eligible for the following at no cost to You:

- exercise bands;
- wearable motion sensors and chargers;
- wearable pain relief device; and/or
- yoga mat.

KIDNEY HEALTH MANAGEMENT

If You are identified to participate, the Kidney Health Management program addresses the medical management needs of chronic kidney disease (CKD) stages 3, 4, 5 and unknown as well as end stage renal disease (ESRD). The program defers progression of CKD, reduces the cost of care by avoiding adverse events such as emergency room visits, hospitalizations and post-acute care.

NURSE ADVICE

You have access to registered nurses to answer Your health-related questions or concerns and to help You make informed decisions on seeking the appropriate level of care (whether to seek care in an emergency room, urgent care, office visit or self-care at home). This service is available to You on an unlimited basis at no additional cost. However, if You are experiencing a medical emergency, immediately call 911 instead.

PREGNANCY PROGRAM

Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions. The Pregnancy Program can provide answers and assistance so that You can relax and enjoy those nine life-changing months.

If You are expecting a child, this program offers access to a nurse 24 hours a day, 7 days a week and educational materials tailored to Your needs. Since the Pregnancy Program is most beneficial when You enroll early in a pregnancy, call 1-888-JOY-BABY (569-2229) or visit Our website right away to get started.

REGENCE EMPOWER

Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. It may include the following:

- earning up to a total of $25 in gift cards for completion of well-being activities such as an online health risk assessment;
- incentives to reward participation in healthy activities; and
- online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals.

2026 BOOKLET FOR:

STATE OF IDAHO

Regence Choice Vision – Adult and Pediatric

Group Number: 500000000

Regence BlueShield of Idaho, Inc. Vision Benefits

Regence

Regence BlueShield of Idaho is an Independent Licensee
of the Blue Cross and Blue Shield Association

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	

Covered Services (per Member)		
Benefit – Pediatric Vision (under age 19)	**Member Responsibility**	
	VSP Doctor	**Out-of-Network Provider**
Vision Examination • 1 routine eye examination every 12 months • $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 • 1 frame every 24 months • $130 frame limit for VSP Doctor • $130 elective contact lens limit, in lieu of all other frame and lens benefits • $70 frame limit for VSP approved wholesale/retail vendor • $50 frame limit for Out-of-Network Provider • 1 pair of lenses (2 lenses) every 12 months • 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 • Once every 12 months • $70 limit (including elective contacts) for Out-of-Network Provider; or • $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.

Benefit – Pediatric Vision (under age 19)	Member Responsibility	
	VSP Doctor	Out-of-Network Provider
Low Vision Benefit – Supplemental Examinations (Testing) • $1,000 (combined with supplemental aids) every 24 months • 2 examinations (testing) every 24 months • $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 • $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 • 1 routine eye examination every 12 months • $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 • 1 frame every 24 months • $130 frame limit for VSP Doctor • $130 elective contact lens limit, in lieu of all other frame and lens benefits • $70 frame limit for VSP approved wholesale/retail vendor • $50 frame limit for Out-of-Network Provider • 1 pair of lenses (2 lenses) every 12 months • 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.

Covered Services (per Member)		
Benefit – Adult Vision (age 19 or older)	**Member Responsibility**	
	VSP Doctor	**Out-of-Network Provider**
Contact Lens Evaluation and Fitting Examination • Once every 12 months • $70 limit (including elective contacts) for Out-of-Network Provider; or • $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) • $1,000 (combined with supplemental aids) every 24 months • 2 examinations (testing) every 24 months • $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 • $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, 2026**, 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 through Saturday, 6 a.m. to 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 through Friday 5 a.m. to 8 p.m. and Saturday 8 a.m. to 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.**

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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 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 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; and
- 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 workers' 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 Call 1-800-428-4833 for hearing impaired customer assistance Customer Service hours: Monday through Saturday, 6 a.m. to 5 p.m., Pacific time
Mail	Attn: Appeals Department Vision Service Plan P.O. Box 2350 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.

MILITARY LEAVE OF ABSENCE

If You are covered under this plan and are called to active duty or join any branch of the United States armed forces, and Your military duty would result in a loss of coverage under this plan, You are eligible for continued coverage under this plan for up to 24 months or the duration of Your military leave, whichever is shorter, under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Continuation of Coverage
This continuation of coverage is in lieu of and not in addition to any other continuation of coverage provisions. Your dependents do not have an independent right to elect USERRA coverage.

Premium Contributions
To maintain coverage during Your leave, You must pay premiums to the employer Group. If Your leave is less than 30 days, Your premium contribution rate will be the same as for active employees. If Your leave is 30 days or longer, Your premium contribution will not exceed 102% of the cost of coverage for active employees.

Provisions and Limitations
When Your coverage under this plan is reinstated, all provisions and limitations of this plan will apply as if You had not taken Your military leave and Your coverage had been continuous. You will not have to serve any group eligibility waiting period. However, this waiver of limitations does not provide coverage for any illness or injury caused or aggravated by Your military service, as determined by the Veterans Administration.

For complete information regarding Your rights under USERRA, contact the employer Group.

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

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