Regence BlueShield of Idaho Policy

Individual Group Number: 38001001

MANAGED CARE PLAN

2020 Medical Benefits

Regence

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 differently because of race, color, national origin, age, disability, or sex.

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

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

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

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 with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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 at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (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' hódíílnih 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

Silver 3200 POS

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 Policy. Read the entire Policy to understand the benefits, limitations, exclusions, defined terms and provisions of Your coverage.

	Insured Responsibility	
	In-Network Provider	**Out-of-Network Provider**
Coinsurance	30%	60%
Deductible per Calendar Year	$3,200 per Insured $6,400 per Family	$16,300 per Insured $32,600 per Family
Out-of-Pocket Maximum per Calendar Year	$8,150 per Insured $16,300 per Family	$81,500 per Insured $163,000 per Family

Be aware that Your actual costs for Covered Services provided by an Out-of-Network Provider may exceed this Policy's Out-of-Network Out-of-Pocket Maximum Amount. In addition, Out-of-Network Providers and Nonparticipating Pharmacies 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.

NOTE: You are required to obtain preauthorization from Us in advance of all inpatient services received from non-contracted Providers or a penalty will apply. Refer to the Preauthorization provision and Claims Administration Section for requirements and exceptions.

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Preventive Care and Immunizations	0%, Deductible waived	60%
Preventive Care – Expanded Immunizations	30%	60%
Office or Urgent Care Visits – Illness or Injury	Primary Physician or Practitioner – $30 Copayment, Deductible waived Specialist (including urgent care) – $60 Copayment, Deductible waived	60%
Other Professional Services	30%	60%
Ambulance Services • Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum	30%	

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Blood Bank • Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum	30%	
Dental Hospitalization • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Detoxification • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Diabetic Education	0%, Deductible waived	60%
Dialysis • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Durable Medical Equipment	30%	60%
Emergency Room • Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum	30%	
Gene Therapy and Adoptive Cellular Therapy • $7,500 combined for transportation, lodging and meal expenses per course of treatment • Out-of-Network services do not accrue to any Out-of-Pocket Maximum • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	Centers of Excellence facility – 30%	60%
Genetic Testing	30%	60%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Habilitation Services • No limit for inpatient days • 20 outpatient visits per Calendar Year • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Hearing Loss • 1 hearing aid device per ear every 36 months • 45 outpatient speech and language therapy visits within 12 months from the receipt of a hearing aid, bone conduction device or cochlear implant	30%	60%
Home Health Care	30%	60%
Hospice Care	30%	60%
Hospital Care – Inpatient, Outpatient and Ambulatory Surgical Center • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Maternity Care • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Medical Foods	30%	60%
Mental Health or Substance Use Disorder Services • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Newborn Care • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Nutritional Counseling • 3 visits per Calendar Year	30%	60%
Orthotic Devices	30%	60%
Palliative Care • 30 visits per Calendar Year	30%	60%
Prosthetic Devices	30%	60%
Rehabilitation Services • No limit for inpatient days • 20 outpatient visits per Calendar Year • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Repair of Teeth • Treatment must be provided within 12 months from the date of Injury	30%	60%
Retail Clinic Office Visits	$15 Copayment, Deductible waived	60%
Skilled Nursing Facility • 30 inpatient days per Calendar Year	30%	60%
Spinal Manipulations • 18 spinal manipulations per Calendar Year	30%	60%
Termination of Pregnancy • Allowed only for certain circumstances, refer to the Medical Benefits Section	30%	60%
Transplants • 14 days per Calendar Year for travel expenses (for the patient and care giver), after case management approval • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Virtual Care – Store and Forward Services	0%, Deductible waived	60%
Virtual Care – Telehealth	$10 Copayment, Deductible waived	60%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Virtual Care – Telemedicine	30%	60%

<table>
<tr><th colspan="3">Covered Services (per Insured)
Unless Otherwise Noted the Deductible Applies</th></tr>
<tr><th rowspan="2">Benefit</th><th colspan="2">Insured Responsibility</th></tr>
<tr><th>Participating Pharmacy</th><th>Nonparticipating Pharmacy</th></tr>
<tr><td rowspan="5">Prescription Medications – from a Pharmacy
• *$5 or 5% discount on Prescription Medications filled at a Preferred Pharmacy
• You are not responsible for any Deductible, Copayment and/or Coinsurance when You fill prescriptions for medications intended to treat opioid overdose that are on the Naloxone Value List. To obtain this list visit Our Web site or contact Customer Service. Contact Information is available in the Introduction Section.
• Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum
• 90-day supply for Prescription Medications (even if the packaging includes a larger supply)
• 30-day supply for Specialty Medications
• Multiple-month dispensing: the largest allowed quantity is the smallest multiple-month supply as packaged by the manufacturer
• Copayment is based on each 30-day supply</td><td colspan="2">*$15 Copayment, Deductible waived for each Preferred Generic Medication on the Drug List</td></tr>
<tr><td colspan="2">*25%, Deductible waived for each Generic Medication on the Drug List</td></tr>
<tr><td colspan="2">*30% for each Preferred Brand-Name Medication on the Drug List</td></tr>
<tr><td colspan="2">*50% for each Brand-Name Medication on the Drug List</td></tr>
<tr><td>40% for each Preferred Specialty Medication on the Drug List from a Participating Specialty Pharmacy</td><td>60% for each Preferred Specialty Medication on the Drug List from a Nonparticipating Pharmacy</td></tr>
<tr><td>50% for each Specialty Medication on the Drug List from a Participating Specialty Pharmacy</td><td>60% for each Specialty Medication on the Drug List from a Nonparticipating Pharmacy</td></tr>
<tr><td rowspan="4">Prescription Medications – from a Mail-Order Supplier
• Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum
• 90-day supply for Prescription Medications (even if the packaging includes a larger supply)
• Multiple-month dispensing: the largest allowed quantity is the smallest multiple-month supply as packaged by the manufacturer</td><td colspan="2">$30 Copayment, Deductible waived for each Preferred Generic Medication on the Drug List</td></tr>
<tr><td colspan="2">20%, Deductible waived for each Generic Medication on the Drug List</td></tr>
<tr><td colspan="2">25% for each Preferred Brand-Name Medication on the Drug List</td></tr>
<tr><td colspan="2">45% for each Brand-Name Medication on the Drug List</td></tr>
</table>

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	VSP Doctor	**Out-of-Network Provider**
Pediatric Vision (under age 19) • 1 routine eye examination per Calendar Year • 1 frame per Calendar Year • 1 pair of lenses (2 lenses) per Calendar Year • Contacts may be selected (once per Calendar Year) instead of frames and lenses • Low vision supplemental testing and supplemental aids every 2 Calendar Years • Additional limitations apply, refer to the Medical Benefits Section	Examination – 0%, Deductible waived	Examination – 50%, Deductible waived
	Hardware – 0%, Deductible waived	Hardware – 50%, Deductible waived
	Contact Lens Evaluation and Fitting Examination – 0%, Deductible waived	Contact Lens Evaluation and Fitting Examination – 50%, Deductible waived
	Low Vision Supplemental Testing – 0%, Deductible waived	Low Vision Supplemental Testing – 0%, Deductible waived
	Low Vision Supplemental Aids – 0%, Deductible waived	Low Vision Supplemental Aids – 0%, Deductible waived

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	In-Network Dentist	**Out-of-Network Dentist**
Pediatric Dental (under age 19) • Out-of-Network services apply to the In-Network Out-of-Pocket Maximum • Additional limitations apply, refer to the Medical Benefits Section	Preventive and Diagnostic Services – 0%, Deductible waived	
	Basic Services – 20%, Deductible waived	
	Major Services – 50%, Deductible waived	

Accidental Death Benefit – Refer to this Policy for details on this program	
With proof of death by Accidental Bodily Injury, We pay the following benefit:	
Policyholder (age 18 or older)	$10,000
Enrolled Spouse	$10,000
Enrolled Domestic Partner	$10,000
Enrolled Child	$2,500

Introduction

Regence BlueShield of Idaho, Inc.

Street Address:
1602 21st Avenue
Lewiston, ID 83501

Medical/Pediatric Dental Claims Address:
P.O. Box 31603
Salt Lake City, UT 84130-0603

Pediatric Vision Claims Address:
Vision Service Plan
P.O. Box 385020
Birmingham, AL 35238-5020

Medical/Pediatric Dental Customer Service/Correspondence Address:
P.O. Box 1827, MS CS B32B
Medford, OR 97501-9884

Pediatric Vision Customer Service/Correspondence Address:
Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100

Medical/Pediatric Dental Appeals Address:
P.O. Box 1408
Lewiston, ID 83501

Pediatric Vision Appeals Address:
Vision Service Plan
Attention: Complaint and Grievance Unit
P.O. Box 997100
Sacramento, CA 95899-7100

In this Policy, the terms "We," "Us" and "Our" refer to Regence BlueShield of Idaho, Inc. (hereafter referred to as "Regence BlueShield of Idaho") and the term "Policyholder" means a person who is enrolled for coverage with Regence BlueShield of Idaho and whose name appears on the records as the individual to whom this Policy was issued. References to "You" and "Your" refer to the Policyholder and/or Enrolled Dependents. Policyholder does not mean a dependent of this Policy. Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized.

POLICY

This Policy describes benefits effective **January 1, 2020**, for the Policyholder and Enrolled Dependents. This Policy provides the evidence and a description of the terms and benefits of coverage.

Regence BlueShield of Idaho, an independent licensee of the Blue Cross and Blue Shield Association, agrees to provide benefits for Medically Necessary services as described in this Policy, subject to all of the terms, conditions, exclusions and limitations in this Policy, including endorsements affixed hereto. This agreement is in consideration of the premium payments hereinafter stipulated and in further consideration of the application and statements currently on file with Us and signed by the Policyholder for and on behalf of the Policyholder and/or any Enrolled Dependents listed in this Policy, which are hereby referred to and made a part of this Policy.

RENEWABILITY

This Policy is guaranteed renewable at the option of the Policyholder subject to receipt of the monthly premium when due or within the grace period.

EXAMINATION OF POLICY

If, after examination of this Policy, the Policyholder is not satisfied for any reason with this Policy, the above-named Policyholder will be entitled to return this Policy within ten days after its delivery date. If the Policyholder returns this Policy to Us within the stipulated ten-day period, such Policy will be considered void as of the original Effective Date and the Policyholder generally will receive a refund of premiums paid, if any. If benefits already paid by this Policy exceed the premiums paid by the Policyholder, We will be entitled to retain the premiums paid and the Policyholder will be required to repay Us for the amount of benefits paid in excess of premiums.

ESSENTIAL HEALTH BENEFITS

This coverage complies with the essential health benefits in the following ten categories:

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

There is no annual or Lifetime maximum applicable to these services.

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.

OPEN ENROLLMENT PERIOD

The open enrollment period is the period of time, as designated by law, during which You and/or Your eligible dependents may enroll.

NOTICE OF PRIVACY PRACTICES

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

CONTACT INFORMATION

Customer Service: 1 (888) 232-5763
(TTY: 711)

Phone lines are open Monday – Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 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 Web site, **regence.com**, to chat live with a Customer Service representative; or
- for assistance in a language other than English.

Pediatric Vision Services – Vision Service Plan (VSP): 1 (844) 299-3041
(hearing impaired: 1 (800) 428-4833)

VSP phone lines are open Monday – Friday 5 a.m. – 8 p.m., Saturday 7 a.m. – 8 p.m. and Sunday 7 a.m. – 7 p.m.

Contact VSP if You have Provider or benefit questions specific to Your pediatric vision coverage. You may also visit VSP's Web site at **www.vsp.com**.

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.

Sean M. Robbins
President
Regence BlueShield of Idaho

Using Your Policy

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.
- **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.

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.

MEDICAL NEIGHBORHOODS

"Medical Neighborhood" means a medical Provider group which has committed to use Our cost and quality data to proactively engage Our Insureds while better managing their care and treatment. Medical Neighborhoods offer primary care and specialty Providers in a specific geographic area. Your Medical Neighborhood is Your partner, helping to coordinate all of Your care. When You enrolled in this Policy, You were required to select a Medical Neighborhood. If You did not select a Medical Neighborhood at the time You enrolled, You have been assigned a Medical Neighborhood based on Your geographical location. There is one Medical Neighborhood applicable to all covered Insureds. Your Medical Neighborhood is listed on Your member card. You may change Your Medical Neighborhood by calling Customer Service.

If Your Medical Neighborhood is No Longer Participating

If Your Medical Neighborhood decides to no longer participate or is otherwise terminated by Us, We will send You a letter and ask You to choose a new Medical Neighborhood. If You don't choose, You will then be assigned to a Medical Neighborhood based upon Your geographical area.

ADDITIONAL ADVANTAGES OF MEMBERSHIP

Regence membership includes 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 **regence.com** to help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE INDIVIDUAL POLICY, BUT ARE NOT INSURANCE.**

- **Go to regence.com.** You can use Our secure Web site to:
  - view recent claims, benefits and coverage;
  - find a contracting Provider;
  - participate in online wellness programs and use tools to estimate upcoming healthcare costs;
  - discover discounts on select items and services*;
  - identify Participating Pharmacies;
  - find alternatives to expensive medicines;
  - learn about prescriptions for various Illnesses; and
  - compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

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

Table of Contents

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 Policy 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 days, 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 Policy, regardless of the Provider rendering such services or supplies.

DEDUCTIBLES

The Deductible is the amount You must pay each Calendar Year before We will provide payments for Covered Services. The Deductible is satisfied by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible. There are two Deductible amounts: one for In-Network benefits and another for Out-of-Network benefits.

There are also two Family Deductible amounts: one for In-Network benefits and another for Out-of-Network benefits. The Family Deductible is satisfied when the Family members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount. However, no one Insured will be required to meet more than the individual Deductible amount toward the Family Deductible in a Calendar Year.

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. An Insured's Deductible amount paid toward Covered Services for ambulance, blood bank, emergency room services and Prescription Medications will apply toward the In-Network Deductible amount. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do 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 maximum amount You could pay in a Calendar Year for Covered Services. The Out-of-Pocket Maximum is satisfied by Your payments of any Deductible, Copayments and Coinsurance, unless specified otherwise. There are two Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits.

The In-Network Family Out-of-Pocket Maximum is satisfied when the Family members' Deductibles, Copayments and Coinsurance for Covered Services for that Calendar Year total and meet the In-Network Family Out-of-Pocket Maximum amount. However, no one Insured will be required to meet more than the individual In-Network Out-of-Pocket Maximum amount toward the Family Out-of-Pocket Maximum in a Calendar Year.

An Insured's payment of any Deductible, Copayments and/or Coinsurance for ambulance, blood bank, emergency room services, Prescription Medications and pediatric dental will apply toward the In-Network Out-of-Pocket Maximum amount. Any amounts You pay for non-Covered Services, Out-of-Network services for Gene Therapy and Adoptive Cellular Therapy or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. Further, any reduction in Your Copayment and/or Coinsurance for Prescription Medications resulting from the use of 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 any applicable 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 Calendar 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. There is no Family limit to the out-of-pocket expenses You pay for services received from an Out-of-Network Provider.

INPATIENT NON-EMERGENCY ADMISSIONS AT NONPARTICIPATING FACILITIES

The maximum Allowed Amount for facility charges of an inpatient non-emergency admission to a Nonparticipating Facility is $1,500 per day. In addition to Deductible and/or Coinsurance, You may be billed for the balance of billed charges, including any billed amount in excess of this maximum Allowed Amount, and the balance of billed charges will not apply to any Out-of-Pocket Maximum.

An admission will be "non-emergency" unless it is precipitated by emergency services for an Emergency Medical Condition. Emergency services include a medical screening examination within the capability of a Hospital emergency department, ancillary services routinely available to it to evaluate an Emergency Medical Condition and further medical examination and treatment within the capabilities of the Hospital staff and facilities.

An inpatient admission to a Nonparticipating Facility that begins as an emergency shall be regarded as an emergency admission through discharge and therefore will not be subject to the $1,500 per day maximum Allowed Amount.

HOW CALENDAR YEAR BENEFITS RENEW

The Deductible, Out-of-Pocket Maximum and Maximum Benefits are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again. Some benefits have a separate Maximum Benefit based upon an Insured's Lifetime and do not renew every Calendar 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 Visits and Other Professional Services.

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 Policy. 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 Web site or contact Customer Service.

NOTE: If You choose to access new medical supplies, equipment and devices through Our Web site, 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 YOUR INDIVIDUAL POLICY, BUT ARE NOT INSURANCE.**

PREAUTHORIZATION

Contracted Providers

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

Outpatient Services

Non-contracted Providers are not required to obtain preauthorization from Us prior to providing outpatient 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 outpatient services on Your behalf to determine Medical Necessity prior to receiving those services.

Inpatient Services

While We do not require non-contracted Providers to obtain preauthorization from Us prior to providing inpatient services, We do require preauthorization prior to receiving these services. You are responsible for obtaining preauthorization from Us before receiving inpatient services from non-contracted Providers. You may request that the non-contracted Provider assist You with this, but the Provider is not required to do so.

All costs for inpatient services received from a non-contracted Provider that are not Medically Necessary are Your responsibility. Inpatient services received from a non-contracted Provider that are Medically Necessary will be covered according to the terms of this Policy when preauthorization is obtained. However, a penalty of $1,000 or the Allowed Amount, whichever is less, will be applied to the Allowed Amount if You fail to obtain preauthorization of Medically Necessary inpatient services from non-contracted Providers. Payment of the penalty will not be applied toward any applicable Deductible, Copayment, Coinsurance or Out-of-Pocket Maximum.

We will not require preauthorization for emergency medical services, childbirth admissions or admissions

for Newborns who need medical care at birth.

NOTE: If We approve a preauthorization request from a Provider, We may not rescind the authorized service or supply after it has been provided, except in the case of fraud or misrepresentation, nonpayment of premium, exhaustion of any applicable benefit maximum or if the Insured for whom the preauthorization was granted is not enrolled at the time the service or supply is received.

PREVENTIVE CARE AND IMMUNIZATIONS

Preventive care 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) 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 for women, including, but not limited to:
    - female 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.

NOTE: Covered Services that do not meet these criteria (for example, diagnostic colonoscopies) will be covered the same as any other Illness or Injury. For a list of Covered Services, including information about obtaining a new breast pump from an approved Commercial Seller, visit Our Web site 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 VISITS – ILLNESS OR INJURY

Office, home or Hospital outpatient department visits are covered for Illness or Injury. All other professional services performed in the office, not billed as an office visit, or that are not related to the actual visit (such as, separate facility fees billed in conjunction with the office visit) are not considered an office 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 those to treat a Congenital Anomaly and foot care associated with diabetes.

Additionally, 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 Web site or contact Customer Service.

Professional Inpatient

Professional inpatient visits for Illness or Injury, including services for cardiac and pulmonary rehabilitation. 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. However, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Contact Customer Service for further information and guidance.

Radiology and Laboratory

Diagnostic services for treatment of Illness or Injury. This includes, but is not limited to, mammography services not covered in the Preventive Care and Immunizations benefit.

Claims for independent clinical laboratory services will be submitted to the Blue plan in the locale in which the referring Provider is located, regardless of where the examination of the specimen occurred. Refer to Your Blue plan network where the referring Provider is located for coverage of independent clinical laboratory services.

Diagnostic Procedures

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

Surgical Services

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

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.

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 and the group and member identification numbers.

APPROVED CLINICAL TRIALS

If an In-Network Provider is participating in an Approved Clinical Trial and will accept You as a trial participant, benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. 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. 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. 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 an Insured 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 Insured; 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.

DETOXIFICATION

Medically Necessary detoxification is covered.

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 inpatient and outpatient dialysis are covered (including outpatient hemodialysis, peritoneal dialysis and hemofiltration).

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment is covered, including, but not limited to, oxygen equipment, wheelchairs and supplies or equipment associated with diabetes.

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 Web site or contact Customer Service.

Claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the locale in which the equipment was received. Durable Medical Equipment is received where it is purchased at retail or, if shipped, where the Durable Medical Equipment is shipped to. Refer to Your Blue plan network where supplies were received for coverage of shipped Durable Medical Equipment.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Emergency room services and supplies are covered, including outpatient charges for patient observation and medical screening examinations that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be pre-authorized.

"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 Insured from a facility; and
- in the case of a covered female Insured, 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. However, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Contact Customer Service for further information and guidance.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

Gene therapies, adoptive cellular therapies as well as associated services and supplies are covered for Insureds who fulfill the Medical Necessity criteria.

NOTE: To be covered at the In-Network benefit level, gene therapy and/or adoptive cellular therapy must be received from one of Our Centers of Excellence facilities that is expressly identified as a Centers of Excellence for that therapy. Receiving Your therapy from one of Our Centers of Excellence facilities will save You the most in Your out-of-pocket expenses. For a list of covered therapies or to identify a Centers of Excellence facility, contact Our Customer Service, as the lists are subject to change.

Travel Expenses

Transportation, lodging and meal expenses incurred only as required for travel to one of Our Centers of Excellence facilities for treatment are covered up to the limit specified in the Schedule of Benefits. Coverage is for You and one companion (or two companions if You are under the age of 19). Covered travel expenses include only commercial airfare, commercial train fare or documented auto mileage (calculated per IRS allowances) to the Centers of Excellence facility. Additionally, local ground transportation within the treatment area to and from the Centers of Excellence facility is covered during the course of the treatment. We will reimburse You for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact Our Customer Service for further information and guidance.

GENETIC TESTING

Medically Necessary services for genetic testing are covered.

HABILITATION SERVICES

Inpatient and outpatient habilitation services are covered. "Habilitation services" mean health care services including physical, occupational, speech therapy and other services for an Insured with disabilities that help keep, learn or improve skills and functioning for daily living (for example, therapy for a child who isn't walking or talking at the expected age).

Outpatient habilitation visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Outpatient speech and language therapy associated with hearing loss is

covered in the Hearing Loss benefit.

HEARING LOSS

Hearing loss services and supplies are covered for an enrolled child with congenital or acquired hearing loss, that without intervention may result in cognitive or speech development deficits. Covered Services include the following:

- hearing evaluations;
- hearing aids;
- bone conduction sound processors (including examinations and fittings);
- ear molds and replacement ear molds;
- Medically Necessary diagnostic and treatment services; and
- outpatient speech and language therapy, when billed for hearing loss.

"Enrolled child" means an Enrolled Dependent who is a child of the Policyholder, enrolled spouse or enrolled domestic partner. "Hearing aid" means any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary part or ear mold for the instrument or device.

Outpatient speech and language therapy visits or hearing aids that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Cochlear implants are covered the same as any other Illness or Injury.

Covered Services do **not** include:

- 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, respite and home care to meet the physical, psychosocial and special needs of a patient and his or her family during the final stages of Illness.

Respite care is also covered to provide continuous care of the Insured and allow temporary relief to family members from the duties of caring for the Insured. Respite days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. 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 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.

MATERNITY CARE

Prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or elective cesarean), complications of pregnancy and related conditions are covered for all female Insureds. There is no limit for the mother's length of inpatient stay. The attending Provider will determine an appropriate discharge time in consultation with the mother.

Certain services such as screening for gestational diabetes, breastfeeding support, supplies (for example, a breast pump) and counseling are covered in the Preventive Care 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 the treatment of Mental Health Conditions or Substance Use Disorders.

Additionally, applied behavioral analysis (ABA) therapy services are covered for inpatient and outpatient 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, residential care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), home health services and 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.

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.

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

Nutritional counseling and diabetic counseling are covered. Nutritional counseling visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

ORTHOTIC DEVICES

Medically Necessary orthotics are covered, including, but not limited to:

- braces;
- back or special surgical corsets; and
- splints for extremities and trusses.

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 Web site or contact Customer Service.

We may elect to provide benefits for a less costly alternative item. Covered Services do **not** include:

- custom or off-the-shelf shoes or boots (unless permanently attached to a brace) including any adjustments or additions;
- orthopedic shoes;

- lifts;
- arch supports;
- splints for aligning the toes; and
- any other foot support devices or orthotics related to the feet.

PALLIATIVE CARE

Palliative care is covered when a Provider has assessed that an Insured 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.

Palliative care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. All other Covered Services for an Insured receiving palliative care remain covered the same as any other Illness or Injury.

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. Covered Services include voice boxes to replace all, part of or a surgically removed larynx. 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.

Synthesized, artificial speech or communications output device, appliance, system or computer system designed to provide speech output or to aid an inoperative or unintelligible voice are not covered.

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 or for neurodevelopmental purposes. "Rehabilitation services" mean physical, occupational and speech therapy services only, including associated services such as massage when provided as a therapeutic intervention.

Outpatient rehabilitation visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Outpatient speech and language therapy associated with hearing loss is covered in the Hearing Loss benefit. Inpatient cardiac and pulmonary rehabilitation are covered the same as any other Illness or Injury. Outpatient cardiac and pulmonary rehabilitation are not covered.

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.

RETAIL CLINIC OFFICE VISITS

Office visits in a Retail Clinic are covered for treatment of Illness or Injury. All other professional services performed in the Retail Clinic, not billed as an office visit, or that are not related to the actual visit are not considered an office visit.

SKILLED NURSING FACILITY

Inpatient services and supplies of a Skilled Nursing Facility are covered for 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 necessary.

Skilled Nursing Facility days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Ancillary services and supplies, such as physical therapy, Prescription Medications and radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward the Maximum Benefit limit on Skilled Nursing Facility care.

SPINAL MANIPULATIONS

Spinal manipulations are covered. Manipulations of extremities are covered in the Rehabilitation Services benefit. Spinal manipulations that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

TERMINATION OF PREGNANCY
Termination of pregnancy (abortion) is covered for all female Insureds only when necessary to preserve the life of the female Insured on whom the abortion is performed.

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).

- travel expenses approved through case management, limited to:

    - transportation;
    - lodging; and
    - food costs.

Travel expenses that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. For a list of covered transplants, contact Our Customer Service, as the list is subject to change. Gene and/or adoptive cellular therapies are covered in the Gene Therapy and Adoptive Cellular Therapy benefit. 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.

VIRTUAL CARE
Virtual care services are covered. Virtual care refers to the utilization of telehealth, telemedicine 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. To learn more about how to access virtual care services, visit Our Website or contact Customer Service.

Store and Forward Services
Store and forward services are covered. "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. Store and forward services do not include, for example, non-secure HIPAA compliant telephone, 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 services are covered. "Telehealth" means Your live (real-time audio-only or audio and video

communication with a remote Provider) services through a secure HIPAA compliant platform when You are not in a healthcare facility.

Telemedicine
Telemedicine services are covered. "Telemedicine" means Your live (real-time audio-only or audio and video communication with a remote Provider) services through a secure HIPAA compliant platform when You are at a healthcare facility.

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.

Only Prescription Medications listed on the Drug List are covered, which can be viewed on Our Web site. Prescription Medications not on the Drug List may be covered in certain circumstances, see the Drug List Exception Process for additional information.

COVERED PRESCRIPTION MEDICATIONS

Prescription Medication benefits are available for the following:

- Prescription Medications;
- growth hormones, when preauthorized;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Injectable Medications) and teaching doses by which an Insured is educated to self-inject;
- diabetic supplies, when obtained with a Prescription Order, except insulin pumps or continuous glucose monitors and their supplies are covered in the Durable Medical Equipment benefit:
    - test strips;
    - glucagon emergency kits; and
    - insulin syringes.
- 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 women's prescription and over-the-counter contraception methods according to, and as recommended by the HRSA and when obtained with a Prescription Order:
    - female 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).

If Your Provider believes that Our covered preventive medications, including women's 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 Web site 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 Web site or contact Customer Service.

Drug List Changes

Any removal of a Prescription Medication from Our Drug List will be posted on Our Web site 30 days prior to the effective date of that change unless the removal is done on an emergency basis or if an equivalent 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 in 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 is 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 Web site. You or Your Provider may request preauthorization by calling Customer Service or by completing and submitting the form on Our Web site.

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.

Pharmacy Network Information

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

You must present Your member card to identify Yourself as Our Insured when obtaining Prescription Medications from a Pharmacy or Mail-Order Supplier. If You do not present Your member 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 Web site 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.

Mail-Order

You can use mail-order services to purchase covered Prescription Medications. Mail-order coverage applies when Prescription Medications are purchased from a Mail-Order Supplier and the claim is submitted electronically. Not all Prescription Medications are available from Mail-Order Suppliers.

You may also obtain covered Prescription Medications from a non-contracted mail-order Pharmacy, if the non-contracted mail-order Pharmacy is registered and agrees to dispense covered Prescription Medications according to the same terms and conditions as those provided by a Mail-Order Supplier. In this case, covered Prescription Medications dispensed by the non-contracted mail-order Pharmacy will be covered in the same manner as covered Prescription Medications dispensed by a Mail-Order Supplier.

To buy Prescription Medications through the mail, send all of the following items to the Mail-Order Supplier at the address shown on the prescription mail-order form (which also includes refill instructions) available on Our Web site or from Your Group:

- a completed prescription mail-order 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

Refills obtained from:

- a Pharmacy are covered when You have taken 75 percent of the previous prescription;
    - except, Schedule II or III controlled substance medications may be refilled only after You have taken 85 percent of the previous prescription.
- a Mail-Order Supplier are covered after You have taken all but 20 days of the previous Prescription Order.

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.
- feel You need a refill sooner than allowed, a refill exception will be considered on a case-by-case basis. You may request an exception by calling Customer Service.

Manufacturer Coupons
Any reduction in Your cost-sharing resulting from the use of a drug manufacturer coupon may not apply toward the 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
- **Day Supply Limit**
  Prescription Medications benefits are limited to the days' supply shown in the Schedule of Benefits.

- **Maximum Quantity Limit**

  - For certain Prescription Medications, We establish maximum quantities other than those listed in the Schedule of Benefits. 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 member 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.
  - Any amount over the established maximum quantity is not covered, except if 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;
- anti-aging;
- repair of sun-damaged skin; or
- reduction of redness associated with rosacea.

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.

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.

Insulin Pumps and Pump Administration Supplies
Except as provided in the Durable Medical Equipment benefit, insulin pumps and supplies 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 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, 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 Lower Cost 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 an Insured who is at risk of experiencing an opiate-related overdose; or
- an epinephrine auto-injector to an Insured 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:

Covered Prescription Medication Expense means the total payment a Participating Pharmacy or Participating Mail-Order Supplier has contractually agreed to accept as full payment for a Prescription Medication. A Participating Pharmacy or Participating Mail-Order 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 Web site 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.

Mail-Order Supplier means a mail-order Pharmacy with which We have contracted for mail-order 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 or Preferred 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. To find a Preferred Pharmacy, visit Our Web site or contact Customer Service.

Participating Specialty Pharmacy means a Specialty Pharmacy for 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 his or her 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, provide 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.

Preferred Brand-Name Medication and 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.

Preferred Generic Medication and 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.

Preferred Specialty Medications and Specialty Medications means 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 Web site or contact Customer Service.

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 Medications, Self-Administrable Medications, 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 Pharmacy means a Pharmacy that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. To find a Specialty Pharmacy, visit Our Web site 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 Brand-Name Medication benefit level. Substituted Medication also means a Specialty Medication not on the Drug List that is approved for coverage at the Specialty Medication benefit level.

Pediatric Vision Services

Vision Services are covered for Insureds under the age of 19. Coverage will be provided for an Insured until the last day of the monthly period in which the Insured turns 19 years of age. The BlueCard Program does not apply to Vision Services covered in this Pediatric Vision Services benefit. Benefits will be paid in this Pediatric Vision Services benefit, not any other provision, if a service or supply is covered by both.

This pediatric vision coverage is provided by Us, in collaboration with Vision Service Plan Insurance Company (VSP), which coordinates the provision of benefits and claims processing for this Policy.

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 Deductible, 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 Deductible, Copayment and/or Coinsurance. This is referred to as balance billing.

VISION EXAMINATION

Professional complete medical eye examination or visual analysis is covered, including:

- prescribing and ordering proper lenses;
- assisting in the selection of frames;
- verifying the accuracy of the finished lenses;
- proper fitting and adjustment of frames;
- subsequent adjustments to frames to maintain comfort and efficiency; and
- progress or follow-up work as necessary.

VISION HARDWARE

Hardware including frames, contacts and lenses is covered, subject to any specified limits as explained in the following paragraphs:

Frames

Frames from VSP Doctors or Out-of-Network Providers. However, for the VSP Doctor benefit level, frames are limited to the Otis & Piper Eyewear Collection.

Lenses

Standard glass, plastic or polycarbonate lenses for one of the following:

- single vision;
- lined bifocal;
- lined trifocal;
- lenticular;
- photochromic lenses;
- elective contacts*; or
- Necessary Contact Lenses**.

Any of the following lens enhancements:

- scratch coating;
- UV (ultraviolet) protection; and
- tinting.

*Contact lenses are in lieu of all other frame and lens benefits. When You receive contact lenses, You will not be eligible for any frames and/or lenses again until the next Calendar Year. One of the following elective contact lens types may be chosen:

- standard (one pair annually);
- monthly (six-month supply);
- bi-weekly (three-month supply); or
- dailies (three-month supply).

**An annual supply of Necessary Contact Lenses if You have a specific condition for which contact lenses provide better visual correction.

CONTACT LENS EVALUATION AND FITTING EXAMINATION
Services and supplies for contact lens evaluation and fitting examinations are covered.

LOW VISION BENEFIT
Low vision benefits for Insureds are covered if vision loss is sufficient enough to prevent reading and performing daily activities. Consult Your VSP Doctor 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 Testing
Supplemental testing (complete low vision 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 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. Professional judgment will be applied when evaluating prescriptions written by an Out-of-Network Provider.

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 VISION BENEFIT, BUT ARE NOT INSURANCE.

PEDIATRIC VISION 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 his or her 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 Deductible, 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 Web site, **www.vsp.com**. Be sure the claim is complete and includes the following information:

- Your name;
- Your date of birth;
- Your address;
- member identification number;
- 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 385020
Birmingham, AL 35238-5020

Concerns about Claim Denial or Other Action

If You have a concern regarding a claim denial or other action in these Pediatric Vision Services benefits and wish to have it reviewed, You may Appeal. See the Appeal Process for a description of the process for Appeals. Additionally, if you have questions regarding reimbursement and subrogation recovery, see the Right of Reimbursement and Subrogation Recovery Section.

EXCLUSIONS

The following exclusions apply to this Pediatric Vision Services Section and are not covered:

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.

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

Costs for Services and/or Supplies Exceeding Benefit Allowances

Lens Enhancements

Except as provided in the Vision Hardware benefit, lens enhancements are not covered, including, but not limited to:

- anti-reflective coating;
- color coating;
- mirror coating;
- blended lenses;
- cosmetic lenses;
- laminated lenses;
- oversize lenses; or
- standard, premium and custom progressive multifocal 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.

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

Plano Lenses (Less Than a ± .50 Diopter Power)

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

Two Pair of Glasses in Lieu of Bifocals

DEFINITIONS
The following definitions apply to this Pediatric Vision Services Section:

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 amount determined to be reasonable charges for Covered Services. The Allowed Amount may be based upon billed charges for some services.

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.

Benefit Authorization means VSP has approved benefits for You.

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

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

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 Deductible, Copayment and/or Coinsurance amount for Covered Services.

Vision Service means those vision-related services, supplies, treatment or accommodation provided for the diagnosis or correction of visual acuity. These services must be received from a Physician or optometrist practicing within the scope of his or her license.

VSP Doctor means an optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials to Insureds in accordance with the provisions of this coverage.

Pediatric Dental Services

Dental Services are covered for Insureds under the age of 19. Coverage will be provided for an Insured until the last day of the monthly period in which the Insured turns 19 years of age. The BlueCard Program does not apply to Dental Services covered in this Pediatric Dental Services benefit. Benefits will be paid in this Pediatric Dental Services benefit, not any other provision, if a service or supply is covered by both.

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

Preventive and diagnostic Dental Services are covered, subject to any specified limits as explained in the following:

- The following services are limited to two per Insured per Calendar Year:
  - bitewing x-ray sets;
  - preventive oral examinations;
  - cleanings;
  - diagnostic oral examinations;
  - topical fluoride application (excluding cleanings); and
  - topical fluoride varnish treatments.
- The following x-rays are limited to one per Insured in a three-year period:
  - complete intra-oral mouth x-rays; and
  - panoramic x-rays.
- Cephalometric x-rays.
- Preventive resin restoration in a moderate to high caries risk patient, permanent tooth, limited to one sealant per tooth in a three-year period.
- Sealants for permanent molars, limited to one per tooth in a three-year period.
- Space maintainers.

BASIC DENTAL SERVICES

Basic Dental Services are covered, subject to any specified limits as explained in the following:

- Complex oral surgery procedures including:
  - surgical extractions of teeth;
  - impaction;
  - alveoloplasty;
  - vestibuloplasty; and
  - residual root removal.
- Emergency treatment for pain relief. Restorative treatment on the same date of service as emergency treatment is not covered.
- Endodontic services including:
  - Apicoectomy;
  - Pulpotomy; and
  - root canal treatment.
- Fillings consisting of composite and amalgam restorations.
- General dental anesthesia or intravenous sedation administered in for:
  - extractions of partially or completely bony impacted teeth; or
  - to safeguard the Insured's health (for example, a child under seven years of age).
- Uncomplicated oral surgery procedures including:
  - removal of teeth;
  - biopsy;
  - incision; and

- drainage.

- Periodontal services including:

  - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery) limited to once per Insured per quadrant in a three-year period;
  - gingivectomy and gingivoplasty limited to once per Insured per quadrant in a three-year period;
  - periodontal maintenance limited to four per Calendar Year. (However, in no Calendar Year will any Insured be entitled to more than four examinations whether periodontal maintenance, preventive oral examinations or diagnostic oral examinations); and
  - scaling and root planing limited to once per Insured per quadrant in a two-year period.

- Adjustment and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within six months of insertion.

  - reline procedures, limited to once per Insured in a three-year period; and
  - rebase procedures, limited to once per Insured in a three-year period.

MAJOR DENTAL SERVICES

Major Dental Services are covered, subject to any specified limits as explain in the following:

- Bridges (fixed partial dentures), limited to one per Insured in a five-year period. Refer to the Basic Dental Services for coverage of adjustments and repairs.
- Crowns, inlays and onlays, limited to once per tooth per Insured in a seven-year period (no limit for stainless steel crowns). Coverage includes recement of crowns, inlays and onlays as well as repair of crowns, inlays, onlays and veneers.
- Dental implants limited to four per Insured Lifetime.
- Dental implant abutment repair limited to one per Insured in a five-year period.
- Dentures, full and partial, limited to one per Insured in a five-year period. Refer to the Basic Dental Services for coverage of adjustments and repairs.
- Occlusal guards limited to one in a twelve-month period.

PEDIATRIC DENTAL CLAIMS AND REIMBURSEMENT

In-Network Dentist Claims and Reimbursement

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

We will pay an In-Network Dentist directly for Covered Services. These In-Network Dentists may require You to pay any Deductible, Copayment and/or Coinsurance at the time You receive care or treatment. In-Network Dentists 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 Dentist Claims and Reimbursement

In order for Us to pay for Covered Services, You or the Out-of-Network Dentist must first send Us a claim. In most cases, We will pay the Dentist directly for Covered Services provided by an Out-of-Network Dentist. 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
- member identification number; and
- the group number.

Out-of-Network Dentists 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 Dentist and the Allowed Amount in addition to any amount You must pay due to any Deductible, Copayment and/or Coinsurance. For Out-of-Network Dentists, the Allowed Amount may be based upon the billed charges for some services or as otherwise required by law.

EXCLUSIONS
The following exclusions apply to this Pediatric Dental Services Section and are not covered:

Adjustments
Adjustment of a denture or bridgework which is done within six months after insertion by the same Dentist who installed the denture or bridgework.

Aesthetic Dental Procedures
Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth.

Bone Grafts
Bone grafts done in connection with extractions, apicoectomies or non-covered/ineligible implants.

Cone Beam Imaging/MRI Procedures

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

- Dentally Appropriate services and supplies to treat a Congenital Anomaly; or
- to restore a physical bodily function lost as a result of Illness or Injury.

"Cosmetic" means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

"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 generally performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Decay Prevention
Supplies and materials to prevent decay are not covered, including, but not limited to:

- toothpaste;
- fluoride gels;
- dental floss; and
- teeth whiteners.

Duplicate Services
Services submitted by a Dentist which are for the same services performed on the same date for the same Insured by another Dentist.

Experimental or Investigational Services

Fabrication of Athletic Mouth Guard

Facility Expenses
Services and supplies related to facility expenses are not covered, including, but not limited to:

- those performed by a Dentist who is compensated by a facility for similar Covered Services performed for an Insured; and
- costs or any additional fees that the Dentist or Hospital charges for treatment at the Hospital (inpatient or outpatient).

Failure to Comply
Services and supplies resulting from Your failure to comply with professionally prescribed treatment.

Gold-Foil Restorations

Nitrous Oxide

Oral Hygiene and Dietary Instructions

Oral Sedation

Orthodontic Dental Services
Except when Medically Necessary, orthodontic services and supplies are not covered, including, but not limited to:

- correction of malocclusion;
- craniomandibular orthopedic treatment;
- other orthodontic treatment;
- preventive orthodontic procedures;
- procedures for tooth movement, regardless of purpose; and
- repair of damaged orthodontic appliances.

Plaque Control Programs

Precision Attachments, Precious Metal Bases and Other Specialized Techniques

Provisional, Temporary and Duplicate Devices or Appliances

Replacements
Replacement of any lost, stolen or broken dental appliance, including but not limited, dentures or retainers.

Sealants
Except as provided for permanent molars, sealants are not covered.

Separate Charges
Services and supplies that may be billed as separate charges (services that should be included in the billed procedure) are not covered, including, but not limited to:

- any supplies;
- local anesthesia; and
- sterilization (office infection control charges).

Services and Supplies to Alter Vertical Dimension and/or Restore or Maintain the Occlusion
Services and supplies to alter vertical dimension and/or restore or maintain the occlusion are not covered, including, but not limited to:

- equilibration;
- periodontal splinting;
- full mouth rehabilitation; and
- restoration for misalignment of teeth.

Services and Supplies Which the Insured Would Have No Legal Obligation to Pay in the Absence of this Coverage

Services Provided by Certain Entities
Services and treatment are not covered when received from a dental or medical department maintained by or on behalf of:

- an employer;
- mutual benefit association;
- labor union;

- trust;
- Veterans Administration Hospital; or
- similar person or group.

Specialized Procedures and Techniques

Teledentistry
Virtual care Dental Services are not covered.

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided in connection with TMJ disorder treatment.

Topical Medicament Center

DEFINITIONS
The following definitions apply to this Pediatric Dental Services Section:

Allowed Amount means:

- For In-Network Dentists, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Dentists, the amount determined to be reasonable charges for Covered Services. The Allowed Amount may be based upon billed charges for some services or as otherwise required by law.

Charges in excess of 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.

Dentally Appropriate means a Dental Service recommended by the treating Dentist or other Provider, who has personally evaluated the patient, and is all of the following:

- appropriate, based upon the symptoms, for determining the diagnosis and management of the condition;
- appropriate for the diagnosed condition, disease or Injury in accordance with recognized national standards of care;
- not able to be omitted without adversely affecting the Insured's condition; and
- not primarily for the convenience of the Insured, Insured's Family or Provider.

A DENTAL SERVICE MAY BE DENTALLY APPROPRIATE YET NOT BE A COVERED SERVICE IN THIS POLICY.

Dentist means an individual who is duly licensed to practice dentistry in all of its branches (including a doctor of medical dentistry, doctor of dental surgery or a denturist) or to practice as a dental hygienist who is permitted by his or her respective state licensing board, to independently bill third parties.

In-Network Dentist means a Dentist who has an effective participating contract with Us that designates him or her as a Dentist of Your network, to provide services and supplies to Insureds in accordance with the provisions of this coverage.

Out-of-Network Dentist means a Dentist that is not an In-Network Dentist. For Out-of-Network Dentist 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.

Accidental Death Benefit

Subject to the terms and conditions of this Section, We will pay the benefit shown here when We receive proof of death by Accidental Bodily Injury of the Policyholder, enrolled spouse, enrolled domestic partner, or an enrolled child as described in the following paragraphs.

BENEFIT
The following conditions must be met in order for this benefit to be payable:

- the death must result from Accidental Bodily Injury;
- the Accidental Bodily Injury must occur while covered by this Policy; and
- the death must occur within 365 days after the date of the Accidental Bodily Injury.

EXCLUSIONS
Even though a death results from Accidental Bodily Injury, no payment will be made according to this benefit if such Injury is caused by, or occurs as a result of, any of the following:

- suicide, intentionally self-inflicted Injury or any attempt to injure oneself, while sane or insane;
- active participation in a violent disorder or riot. "Active participation" does not include being at the scene of a violent disorder or riot during the performance of official duties;
- insurrection, war or any act of war, whether declared or undeclared;
- Injury suffered while serving in the armed forces of any country;
- committing or attempting to commit an assault or felony;
- any sickness or pregnancy existing at the time of the accident;
- voluntary use or consumption of any poison, chemical compound or drug, except a Prescription Medication used or consumed in accordance with the directions of the prescribing Physician;
- heart attack (including but not limited to myocardial infarction) or stroke (including but not limited to cerebral infarction);
- diagnostic test, medical or surgical treatment; or
- bodily infirmity or disease from bacterial or viral infections, other than infection caused from an Injury sustained while covered by this benefit.

GENERAL PROVISIONS

Notice of Claim
Written notice of any loss resulting in a claim being filed with this benefit must be given to Us within 20 days after the loss occurs, or as soon as reasonably possible.

Claim Forms
When notice of claim is received, We will send You the forms for filing proof of loss. If the forms are not received within 15 days, You can send Us written proof of loss without waiting for the forms.

Proof of Loss
You must give Us written proof of loss within 90 days after the date of the loss for which a claim is made. We will not deny or reduce any claim if it was not reasonably possible for You to give Us proof in the time required. In any event, You must give Us proof within one year after it is due, unless You are incapable of doing so.

Timely Payment of Claims
Losses covered by this benefit will be paid as soon as We receive written proof of such loss.

Payment of Claims
Losses covered by this benefit will be paid to You. Payment due at the time of Your death will be paid to Your estate.

Autopsy
We have the right to require an autopsy at Our expense where it is not forbidden by law.

Legal Actions
No legal action may be brought to recover on this benefit until 60 days after proof of loss has been furnished. No action may be brought after three years from the time written proof of loss is required to be

furnished.

DEFINITIONS

The following definition applies only to this Accidental Death Benefit Section:

Accidental Bodily Injury means immediate traumatic physical damage to the body which results directly from an unexpected and unintentional event, and which is independent of disease, bodily infirmity or any other cause.

General Exclusions

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

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:

- 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;
- sensory movement groups; and
- wilderness or adventure programs.

Acupuncture

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

Aviation

Except for an injured Insured that is a passenger on a scheduled commercial airline flight or air ambulance, services in connection with Injuries sustained in aviation accidents (including accidents occurring in flight or in the course of take-off or landing) are not covered.

Breast Reduction

Except when following a Medically Necessary mastectomy, to the extent required by law, breast reductions are not covered. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice.

Certain Therapy, Counseling and Training

Except as provided in the Individual Assistance Program (IAP) Section, if applicable, the following therapies, counseling and training services are not covered:

- educational;
- vocational;
- social;
- image;
- milieu or marathon group therapy;
- premarital or marital counseling;
- IAP services; 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 an Insured's active participation in a war or insurrection.

Conditions Incurred in or Aggravated During Performances in the Uniformed Services
The treatment of any Insured'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.

"Cosmetic" means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

"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 Pediatric Dental Services or the Repair of Teeth benefits, 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 Abortions
Elective abortions are not covered.

"Elective abortion" means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed. Coverage for non-elective abortions is provided in the Termination of Pregnancy benefit.

Facilities Without a Provider Legally Required to be on Duty
Admission and treatment in a setting where neither a Physician nor licensed nurse is legally required to be on duty at all times that a patient is admitted.

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 state 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 Policy) 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 Loss 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 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;
- fertility drugs; 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 an Insured (whether or not the Insured 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 Insured 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, as required by law or for treatment of obesity-related comorbid medical conditions (for example, diabetes, high blood pressure and heart disease), 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;
- sleep apnea; 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.

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;
- weight lifting 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.

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

Riot, Rebellion and Illegal Acts
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by an Insured's **voluntary participation in** any of the following:

- a riot;
- an armed invasion or aggression;
- an insurrection;
- a rebellion; or
- an act deemed illegal by an officer or a court of law.

Routine Foot Care

Routine Hearing Examinations

Self-Help, Self-Care, Training or Instructional Programs
Except as provided in the Diabetic Education and Nutritional Counseling benefits or for services provided without a separate charge in connection with Covered Services that train or educate an Insured, self-help, non-medical self-care and training programs are not covered, including, but not limited to:

- childbirth-related classes including infant care; and
- instructional programs including those that teach a person how to use Durable Medical Equipment or how to care for a family member.

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 for Administrative or Qualification Purposes
Physical or mental examinations and associated services (laboratory or similar tests) 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;
    - marriage;
    - insurance;
    - occupational injury benefits;
    - licensure; or
    - certification.
- immigration or emigration.

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

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided for TMJ disorder treatment.

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 for the following, treatment of varicose veins is not covered:

- when there is associated venous ulceration; or
- persistent or recurrent bleeding from ruptured veins.

Vision Care
Except as provided in the Pediatric Vision Services Section, 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 an Insured 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, an Insured will be required to file a claim for workers' compensation benefits before We will consider providing any coverage.

Policy 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.

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 member 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; and
- the Policyholder's identification 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 any Deductible, Copayment and/or Coinsurance. For Out-of-Network Providers, the Allowed Amount may be based upon the billed charges for some services, if required by law.

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.

Time of Payment of Claims

Although there are no indemnity benefits in this Policy, state law requires that You be informed that:

- We will pay indemnities payable by this Policy for any loss (other than loss for which this Policy provides a periodic payment) immediately upon receipt of due written proof of such loss.

- Subject to due written proof of loss, We will pay all accrued indemnities for loss for which this Policy provides periodic payment not less frequently than monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

We will pay for any loss upon receipt of due written proof of loss.

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 ("Association"). Whenever You obtain health care services outside Our service area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

We cover health care services received outside of Our service area. As used in this Out-of-Area Services provision, "Out-of-Area Covered Services" means Covered Services obtained outside Our service area. Out-of-Area Covered Services will be provided at the Out-of-Network benefit level specified in the Schedule of Benefits, except emergency care (including ambulance) and urgent care services will be provided at the In-Network benefit level.

When You receive care outside Our service area, You will receive it from one of two kinds of Providers. Most Providers ("In-Network Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Out-of-Network Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

BlueCard Program

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

The BlueCard Program enables You to obtain Out-of-Area Covered Services, as defined above, from a health care Provider participating with a Host Blue, where available. The participating provider will automatically file a claim for the Out-of-Area Covered Services provided to You, so there are no claim forms for You to fill out. You will be responsible for any Out-of-Network Deductible, Coinsurance and Copayments as specified in the Schedule of Benefits. Contact Us within 24 hours of admission to a Hospital so that We may coordinate Your care.

Emergency Care Services: If You experience an Emergency Medical Condition while traveling outside of Our service area, go to the nearest emergency room.

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

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your health care Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price We have used for Your claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, We will include any surcharge, tax or other fee as part of the claim charge

passed on to You.

Nonparticipating Providers Outside Our Service Area

- **Your Liability Calculation.** When Out-of-Area Covered Services are provided by Out-of-Network Providers, the amount You pay for such services will normally be based on either the Host Blue's Out-of-Network Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the Out-of-Network Provider bills and the payment We will make for the Out-of-Area Covered Services as set forth in this Policy. Federal or state law, as applicable, will govern payments for Out-of-Network emergency services.
- **Exceptions.** In certain situations, We may use other payment methods, such as billed covered charges, 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 these situations, You may be liable for the difference between the amount that the Out-of-Network Provider bills and the payment We will make for the Out-of-Area Covered Services as set forth in this Policy.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

If You are outside the United States (hereinafter "BlueCard service area"), You may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Out-of-Area Covered Services. Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when You receive care from Providers outside the BlueCard service area, You will typically have to pay the Providers and submit the claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, You should call the service center at 1 (800) 810-BLUE 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.

- **Inpatient Services**
  In most cases, if You contact the service center for assistance, Hospitals will not require You to pay for covered inpatient services, except for Your applicable Deductible, Coinsurance, etc. In such cases, the Hospital will submit Your claims to the service center to begin claims processing. However, if You paid in full at the time of services, You must submit a claim to receive reimbursement for Out-of-Area Covered Services.

- **Outpatient Services**
  Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require You to pay in full at the time of services. You must submit a claim to obtain reimbursement for Out-of-Area Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**
  When You pay for Out-of-Area Covered Services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from the service center or online at **www.bcbsglobalcore.com**. If You need assistance with Your claim submission, You should call the service center at 1 (800) 810-BLUE or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week.

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 Policyholder or any of his or her 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 the experience

of the pool by which You are 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 Policy 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 Policy, 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 Policy, 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 Policy, 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 Insured 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 Policy.

- 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 Policy, 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 Policy. 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 Policy 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.

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 Policy and those of the other Plan will be coordinated in accordance with the provisions of this section.

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 Policy 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 by this Policy 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 Policy.
- 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 Insured is born.

Closed Panel Plan means a Plan that provides health benefits to an Insured 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 an Insured 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 his or her Plan longer shall be primary to the Plan of the parent who has been covered by his or her 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 contract 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 his or her Plan longer shall be primary to the Plan of the parent who has been covered by his or her 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; and 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 Policy 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 Policy 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 Policy 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 Policy were the Primary Plan.

Deductibles, Coinsurance and Copayments in this Policy 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 Policy any amount that would have been credited to Deductible if this Policy had been the only Plan.

If this Policy 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 Policy, We will pay benefits first, but the amount paid will be calculated as if this Policy 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 Policy.

Facility of Payment

Any payment made by any other Plan(s) may include an amount that should have been paid by this Policy. 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 Policy 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 (any Representative authorized by You) has a concern regarding a claim denial or other action by Us in this Policy and wishes to have it reviewed, You may Appeal. There is one level of internal Appeal You may pursue within Regence BlueShield of Idaho. In some circumstances there is an additional voluntary Appeal level You may pursue. Certain matters requiring quicker consideration may qualify for a level of expedited Appeal and are described separately later in this section.

FILING APPEALS

For pediatric vision benefits, We have delegated certain activities, including Appeals, to VSP, though We retain ultimate responsibility over these activities. If You believe a policy, action or decision of VSP is incorrect, contact VSP. If VSP cannot resolve Your concern to Your satisfaction, You or Your Representative (any Representative authorized by You) may Appeal – that is, ask for VSP to review Your case again. A written request can be made by completing the form available on **www.vsp.com** or by sending the written request by mail to VSP at: Vision Service Plan, Attention: Complaint and Grievance Unit, P.O. Box 997100, Sacramento, CA 95899-7100. Verbal requests can be made by calling VSP.

For all other benefits in this coverage, if You believe a policy, action or decision of Ours is incorrect, contact Customer Service. If We cannot resolve Your concern to Your satisfaction, You or Your Representative (any Representative authorized by You) may Appeal – that is, ask for Us to review Your case again. A written request can be made by sending it to Us at: Appeals Coordinator, Regence BlueShield of Idaho, P.O. Box 1408, Lewiston, ID 83501 or facsimile 1 (888) 496-1542. Verbal requests can be made by calling Customer Service.

Appeals, including expedited Appeals, must be pursued within 180 days of Your receipt of Our original adverse decision that You are Appealing. External Appeals must be pursued within four months of Your receipt of Our determination. If You don't Appeal within these time periods, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum. When We receive an Appeal request, We will send a written acknowledgement.

We will send You free of charge, any new or additional evidence considered, relied upon, or generated by Us in connection with Your Appeal and any new rationale on which a final adverse benefit determination would be made. We will provide You this information as soon as possible and in advance of the date on which We will make Our final decision.

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. See Expedited Appeals later in this section for more information.

Appeals, including expedited Appeals, are reviewed by an employee or employees who were not involved in, or subordinate to anyone 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. You or Your Representative may submit written materials supporting Your Appeal, including written testimony on Your behalf. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Post-Service Investigational issue, a written notice of the decision will be sent within 20 working days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, We will send a written notice of the decision within 14 days of receipt of the Appeal.

An adverse decision may be overturned by Us at any time during the Appeal process if We receive newly submitted documentation and/or information which establishes coverage, or upon the discovery of an error, the correction of which would result in overturning the adverse decision.

VOLUNTARY EXTERNAL APPEAL – IRO

For information regarding a Voluntary External Appeal, refer to the Your Right to an Independent External Review – Notice provision below.

EXPEDITED APPEALS

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.

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. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the expedited Appeals time frame) to provide written materials, including written testimony on Your behalf. A verbal notice of the decision will be given to You within 72 hours after receipt of the Appeal. A written notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than three working days after the verbal notice.

Voluntary Expedited Appeal – IRO

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

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.

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.

You must first exhaust Our internal grievance and Appeal process. Exhaustion of that process includes completing all levels of 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 for an expedited external review with the Idaho Department of Insurance at the same time if Your request qualifies as an urgent care request, as defined in the Expedited External Review Request provision below.

You may submit a written request for an external review, no later than four months from the date We issue a final notice of denial. Submit the written request for an external review to: Idaho Department of Insurance, ATTN: External Review, 700 W State Street, 3rd Floor, Boise, ID 83720-0043. For more information and for an external review request form see the department's Web site at **www.doi.idaho.gov** or call the department's telephone number at 1 (208) 334-4250 or toll-free in Idaho at 1 (800) 721-3272.

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 Department of Insurance must include a completed form authorizing the release of any of Your medical records the Independent Review Organization (IRO) may require to reach a decision on the external review. The department 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 department. We will pay the costs of the review.

Standard External Review Request

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

- Within seven days after the department receives Your request, the department will send a copy to Us.
- Within 14 days after We receive Your request from the department, We will review Your request for eligibility.
    - Within five working days after We complete that review, We will notify You and the department in writing whether Your request is eligible or what additional information is needed.
    - If We deny Your eligibility for review, You may Appeal that determination to the department.
- If Your request is eligible for review, the department will assign an IRO to Your review within seven days of the receipt of Our notice. The department will also notify You in writing.
- Within seven days of the date You receive the department's notice of assignment to an IRO, You may submit any additional information in writing to the IRO that You want the IRO to consider in its review.
- The IRO must provide written notice of its decision to You, to Us and to the department within 42 days after receipt of an external review request.
- Upon receipt of a notice reversing the final adverse benefit determination, We shall approve as soon as reasonably practicable, but no later than one working day after receipt of the decision, the coverage that was the subject of the final adverse benefit determination.

Expedited External Review Request

You may file a written urgent care request with the Department of Insurance for an expedited external review of a Pre-Service or concurrent service denial. You may file for an expedited Appeal with Us and for an expedited external review request with the department at the same time.

"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.

The department will send Your expedited external review request to Us. We will determine, no later than the second full working day, whether Your request is eligible for review. We will notify You and the department no later than one working day after Our decision if Your request is eligible. If We deny Your eligibility for review, You may Appeal that determination to the department.

If Your request is eligible for review, the department will assign an IRO to Your review upon receipt of Our notice. The department will also notify You. The IRO must provide notice of its decision to You, to Us and to the department 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 notice of its decision. If the decision reverses Our denial, We will notify You and the department of Our intent to pay the Covered Service as soon as reasonably practicable, but not later than one working day after receiving notice of the 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.

Per 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.

INFORMATION

For pediatric vision benefits, if You have any questions about the Appeal Process, contact VSP or write to the following address: Vision Service Plan, P.O. Box 997100, Sacramento, CA 95899-7100.

For all other benefits in this coverage, if You have any questions about the Appeal Process, contact Customer Service or write to the following address: Regence BlueShield of Idaho, P.O. Box 1827, MS CS B32B, Medford, OR 97501-9884.

DEFINITIONS

The following definitions apply to this Appeal Process Section:

Appeal means a written or verbal request from an Insured or, if authorized by the Insured, the Insured's Representative, to change a previous decision made by Us concerning:

- 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 an Insured and Us;
- rescission of Your health care Policy with Us; and
- other matters as specifically required by state law or regulation.

External Appeal means an Appeal for which You may have the right to have Our final adverse benefit determination reviewed by health care professionals who have no association with Us. You have this right only if Our denial of Your request to provide or pay for a health care service or supply 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.

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary Independent Review and voluntary expedited Independent Review, through an independent contractor relationship with Us and/or through assignment to Us via state regulatory requirements. The IRO is unbiased and 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 Insured who is an unmarried and dependent child and 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 level). 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 the terms of eligibility under this Policy for a Policyholder and his or her eligible dependents. It describes when coverage under this Policy begins for You and/or Your eligible dependents. Payment of any corresponding monthly premium is required for coverage to begin on the indicated dates.

WHEN COVERAGE BEGINS

You will be entitled to apply for coverage for Yourself and Your eligible dependents per the eligibility requirements as stated in the following paragraphs. Coverage for You and Your applying eligible dependents will begin on the first day of the month following acceptance and approval of the application by Us.

Residency Requirement

A Policyholder must reside in Our Service Area (and not elsewhere) and continue to live in Our Service Area. If You intend to reside in Our Service Area, You may apply, but You would not be eligible for coverage until You physically reside in Our Service Area. We routinely verify the residence of Our applicants. In order to verify Your current residency status, We may require You to provide Us with copy of:

- the front page of Your most recent income tax return;
- if You are a student, a letter from the college/university registrar noting Your local residence address; or
- alternate documentation as authorized by Us.

For purposes of maintaining this Policy, the Policyholder must remain a Resident within the Service Area (though a fixed address is not required). If it is necessary for the Policyholder to leave the Service Area for an extended period of time, the Policyholder may be required to submit appropriate documentation as proof of maintaining his or her primary residence within the Service Area during his or her absence. Medical treatment within the Service Area does not establish residency.

You must promptly notify Us if You move and are no longer a Resident in Our Service Area. We will terminate this Policy and refund any premium payments made for periods after the end of the billing cycle in which We acquire actual knowledge that You are no longer a Resident. The only exception to the termination policy is if You are a military service member who is stationed outside of Our Service Area, You will not be terminated if Your legal residence continues to be within Our Service Area.

Policyholder

An applicant must agree to the terms of this Policy by submitting a written application for approval and acceptance by Us. The application will be a part of this Policy. Applicants are eligible to apply for this Policy if they are not enrolled in Medicare and meet the Residency Requirement as stated above at the time of application for enrollment. Applications and statements made on the application will be binding on both the applicant and dependents.

Dependents

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

- The person to whom You are legally married (spouse).
- Your domestic partner, provided that all of the following conditions are met:
    - You have completed, executed and submitted an affidavit of qualifying domestic partnership form with regard to Your domestic partner;
    - both You and Your domestic partner are age 18 or older;
    - You and Your domestic partner share a close, personal relationship and are responsible for each other's common welfare;
    - neither You nor Your domestic partner is legally married to anyone else or has had another domestic partner within the 30 days immediately before submitting an application for Your domestic partner;
    - You and Your domestic partner share the same regular and permanent residence and intend to

continue doing so indefinitely;
- You and Your domestic partner share joint financial responsibility for Your basic living expenses, including food, shelter and medical expenses; and
- You and Your domestic partner are not more closely related by blood than would bar marriage in Your state of residence.

- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:

  - Your (or Your spouse's or Your domestic partner's) natural child, step child, adopted child or child legally Placed with You (or Your spouse or Your domestic partner) for adoption;
  - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; or
  - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).

- Your (or Your spouse's or Your domestic partner's) child who is age 26 or over and incapable of self-support because of intellectual disability or physical handicap that began before his or her 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, the child meets the requirements of a Disabled Dependent as defined in the Definitions Section below, and either:

  - he or she is an enrolled child immediately before his or her 26th birthday; or
  - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on group coverage or an individual plan issued by Us since that birthday.

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

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an application (and, for a domestic partner, an affidavit of qualifying domestic partnership form) and the appropriate premium (if any) is received by Us within 31 days of the date a notice of change in premium (if any) is received by You.

Enrollment will be effective from:

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

SPECIAL ENROLLMENT

Submit a completed application if You and/or Your eligible dependents have one of the following qualifying events. You (unless already enrolled) and Your eligible dependent(s) are eligible to enroll (except as specified otherwise below) for coverage under the Policy within 60 days from the date of the qualifying event:

- if You, Your spouse or domestic partner gain a new dependent child or, for a child, become a dependent child by birth, adoption or Placement for adoption;
- if You, Your spouse or domestic partner gain a new dependent child or, for a spouse or domestic partner or child, become a dependent through marriage or beginning a domestic partnership;
- unintentional, inadvertent or erroneous enrollment or non-enrollment resulting from an error, misrepresentation or inaction by an officer, employee or agent of Your Health Idaho or U.S. Department of Health and Human Services;
- can adequately demonstrate that a qualified health plan has substantially violated a material provision of Your contract with regard to You and/or Your eligible dependents;
- become newly eligible or newly ineligible for advance payment of premium tax credits or have a change in eligibility for cost-sharing reductions;
- lose eligibility for group coverage due to: death of a covered employee, an employee's termination of

employment (other than for gross misconduct), child status or certain employer bankruptcies;
- permanently move to a new Service Area; or
- loss of minimum essential coverage.

A qualifying event due to loss of minimum essential coverage does not include a loss because You failed to timely pay Your portion of the premium on a timely basis (including COBRA) or when termination of such coverage was because of rescission. It also doesn't include Your decision to terminate coverage.

For the above qualifying events coverage will be effective on the first of the calendar 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.

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 in this Policy.

DEFINITIONS

The following definitions apply to this Eligibility and Enrollment Section:

Resident means a person who is able to provide satisfactory proof of having residence within Our Service Area as his or her primary place of domicile.

Disabled Dependent means a child who is and continues to be both:

- incapable of self-sustaining employment by reason of intellectual disability or physical handicap; and
- chiefly dependent upon the Policyholder for support and maintenance.

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 this Policy 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 this Policy was in effect.

GUARANTEED RENEWABILITY AND POLICY TERMINATION

This Policy is guaranteed renewable, at the option of the Policyholder, subject to receipt of the monthly premium when due or within the grace period.

In the event We eliminate the coverage described in this Policy for the Policyholder and all Enrolled Dependents on their renewal dates, We will provide 90-days written notice to all Insureds covered by this Policy. We will make available to the Policyholder, on a guaranteed issue basis and without regard to the health status of any Insured covered through it, the option to purchase all other individual coverage(s) being offered by Us for which the Policyholder qualifies.

In addition, if We choose to discontinue offering coverage in the individual market, We will provide 180-days prior written notice to the Policyholder and all Enrolled Dependents. Written notice to the Director of the State of Idaho Department of Insurance, will be provided three days in advance of the written notice provided to the Policyholder and all Enrolled Dependents. In this case (when We discontinue coverage in a certain market), We will not write business in that market for a period of at least five years.

If this Policy is terminated or not renewed by the Policyholder or Us, coverage ends for You and Your Enrolled Dependents on the last day of the calendar month in which this Policy is terminated or not renewed so long as premium has been received for the calendar month.

MILITARY SERVICE

An Insured whose coverage under this Policy terminates due to entrance into military service may request, in writing, a refund of any prepaid premium on a pro rata basis for any time in which this coverage overlaps such military service.

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 calendar month in which Your eligibility ends so long as premium has been received for the calendar month.

Nonpayment of Premium

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

Termination by You

You have the right to terminate this Policy with respect to Yourself and Your Enrolled Dependents by giving notice to Us within 30 days. Upon receiving a request for termination, We will cancel this Policy on the last day of the calendar month following the date We receive such notice so long as premium has been received for the calendar month. We will refund You any premium received on an Insured's behalf for any period of ineligibility, providing that no benefits were paid during the interim. However, it may be possible for an ineligible dependent to continue coverage with this Policy according to the provisions below.

GRACE PERIOD

After payment of the first premium, a grace period of 30 days will be granted for the payment of the regular monthly premium. During this grace period this Policy shall not be terminated. However, if the premium has not been received during the grace period, this Policy shall be terminated at the end of the

month for which premium has been paid, not at the end of the grace period.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs, his or her coverage will end on the last day of the calendar month in which his or her eligibility ends so long as premium has been received for the calendar month. However, it may be possible for an ineligible dependent to continue coverage under this Policy according to the provisions below.

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 calendar month following the date a divorce or annulment is final so long as premium has been received for the calendar month.

Death of the Policyholder

If You die, coverage for Your Enrolled Dependents ends on the last day of the calendar month in which Your death occurs so long as premium has been received for the calendar month.

Policy Continuation

In the event that an Insured shall no longer meet eligibility as set forth above due to divorce, annulment, or death of the Policyholder, such Insured shall have the right to continue the coverage of this Policy without a physical examination, statement of health, or other proof of insurability.

Termination of Domestic Partnership

If Your domestic partnership terminates, eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the calendar month following the date of termination of the domestic partnership so long as premium has been received for the calendar month. Termination of Your domestic partnership includes any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. You may not file another affidavit of qualifying domestic partnership within 90 days after a request for termination of a domestic partnership has been received.

Loss of Dependent Status

- Eligibility ends on the last day of the calendar month in which an enrolled child exceeds the dependent age limit so long as premium has been received for the calendar month.
- 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 calendar month in which an enrolled child is no longer an eligible dependent for any other cause not described above so long as premium has been received for the calendar month.

OTHER CAUSES OF TERMINATION

Insureds may be terminated for any of the following reasons as explained below.

Fraudulent Use of Benefits

If You or Your Enrolled Dependent engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of material fact in connection with coverage, coverage under this Policy will terminate for that Insured.

Fraud or Misrepresentation in Application

We have issued this Policy in reliance upon all information furnished to Us by You or on behalf of You and Your Enrolled Dependents. In the event of any intentional misrepresentation of material fact or fraud regarding an Insured, We will take any action allowed by law or Policy, including denial of benefits, termination of coverage and/or pursuit of criminal charges and penalties. An Insured may re-apply for coverage 12 months after the date of a discontinuance of coverage, and shall not be deemed to have "Qualifying Coverage".

EXTENSION OF BENEFITS FOR CONTINUOUS LOSS

Termination of this Policy will not discontinue benefits for a continuous loss covered under this Policy if Your continuous loss commenced while this Policy was in force. The extension of benefits for Your

continuous loss applies to a single inpatient stay where You are admitted prior to the Policy termination date and Your stay extends after the Policy termination date, including any inpatient readmission that occurs within 30 days of Your initial discharge. The extension of benefits for Your continuous loss is also subject to any quantitative benefit limitations in the Policy that You have not exhausted as of the termination date, such as day or visit limitations or maximum dollar amounts allotted for benefits.

PREGNANCY BENEFIT EXTENSION

In the event We cancel or otherwise fail to renew this Policy, We shall provide for an extension of benefits for a pregnancy which commenced while this Policy was in force and for which benefits would have been payable had this Policy remained in force.

CERTIFICATES OF CREDITABLE COVERAGE

Requests for and inquiries about required certificates relating to period(s) of creditable coverage under this Policy should be directed to Us at P.O. Box 31603, Salt Lake City, UT 84130-0603.

General Provisions and Legal Notices

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

CHANGE OF BENEFICIARY

Although We do not require that You designate a beneficiary, state law requires that You be informed of Your right to designate or change a beneficiary. The consent of the beneficiary or beneficiaries will not be requisite to surrender or assignment of this Policy or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

CHOICE OF FORUM

Any legal action arising out of this Policy must be filed in a court in the state of Idaho.

GOVERNING LAW AND BENEFIT ADMINISTRATION

This Policy 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. We are an insurance company that provides insurance to this benefit plan and makes determinations for eligibility and the meaning of terms subject to Insured rights per this benefit plan that include the right to Appeal, review by an Independent Review Organization and civil action.

LEGAL ACTION

No action at law or in equity will be brought to recover with this Policy prior to the expiration of 60 days after written proof of loss has been provided in accordance with the requirements of this Policy. No such action will be brought after the expiration of three years after the time written proof of loss is required to be provided.

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 Policy by reason of epidemic, disaster or other cause or condition beyond Our control.

Insureds shall not, under any circumstances be liable, assessable or in any way subject to payment for the debts, liabilities, insolvency, impairment or any other financial obligations of Ours.

MODIFICATION OF POLICY

We shall have the right to modify or amend this Policy 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 the Policyholder. The modification must be uniform within the product line and at the time of renewal.

However, when a change in this Policy is beyond Our control (for example, legislative or regulatory changes take place), We may modify or amend this Policy on a date other than the renewal date, including changing the premium rates, as of the date of the change in this Policy. We will give You prior notice of a change in premium rates when feasible. If prior notice is not feasible, We will notify You in writing of a change of premium rates within 30 days after the later of the Effective Date or the date of Our implementation of a statute or regulation.

Provided We give notice of a change in premium rates within the above period, the change in premium rates shall be effective from the date for which the change in this Policy is implemented, which may be retroactive.

Payment of new premium rates after receiving notice of a premium change constitutes the Policyholder's acceptance of a premium rate change.

Changes can be made only through a modified Policy, amendment, endorsement or rider authorized and

signed by one of Our officers. No other agent or employee of Ours is authorized to change this Policy.

NO WAIVER

The failure or refusal of either party to demand strict performance of this Policy 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 this Policy 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 with this Policy. 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 Policyholder 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 Insureds required in this Policy will be considered properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Insured will be addressed to the Insured and/or the Policyholder at the last known address appearing in Our records. If We receive a United States Postal Service change of address (COA) form for a Policyholder, We will update Our records accordingly. Additionally, We may forward notice for an Insured if We become aware that We don't have a valid mailing address for the Insured. Any notice to Us required in this Policy 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.

PHYSICAL EXAMINATIONS AND AUTOPSY

We, at Our own expense, have the opportunity to examine Your person when and as often as it may reasonably be required during the pendency of a claim with this Policy and to make an autopsy in case of death where it is not forbidden by law.

PREMIUMS

Premiums are to be paid to Us by the Policyholder on or before the premium due date. Failure by the Policyholder to make timely payment of premiums may result in Our terminating this Policy on the last day of the calendar month through which premiums are paid or such later date as provided by applicable law.

Premium Payments

Premium payments will not be accepted from any Provider or facility offering health care services; entities that receive a majority of their funding from such Providers or facilities, unless from a private, not-for-profit organization that provides such payments on a charitable basis and does not benefit financially from the Insured's enrollment in a particular health insurance plan or use of any particular health care services or facilities; or as otherwise required by law or Department of Insurance Bulletin 16-04. Employer payments of individual policy premiums are also prohibited by law. Premium payments that do not meet these criteria will not be accepted and the Insured's Policy may be terminated for non-payment.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

You, on behalf of Yourself and any Enrolled Dependents, expressly acknowledge Your understanding that this Policy constitutes an agreement solely with Regence BlueShield of Idaho, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of the 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. You, on behalf of Yourself and any Enrolled Dependents, further acknowledge and agree that You have not entered into this Policy 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 You for any of Our obligations to You created under this Policy. 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 this Policy.

REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements You make in an application 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 Web site 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 this Policy;
- the person has applied and has been accepted for coverage by Us; and
- premium for the person for the current month has been paid by the Policyholder 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 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 determined to be reasonable charges for Covered Services. The Allowed Amount may be based upon billed charges for some services or as otherwise required by law. The maximum Allowed Amount for facility charges for an inpatient non-emergency admission at a Nonparticipating Facility will be $1,500 per day.
- 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, except that, for an inpatient non-emergency admission at a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day. 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.

The Allowed Amount is based upon many factors, including:

- the charge(s) of the Provider;
- the charge(s) of Providers with similar training and experience within a particular geographic area;
- pre-negotiated payment amounts;
- diagnostic related groupings (DRG);
- relative value scales; and/or
- the cost of providing the service or supply.

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.

Calendar Year means the period from January 1 through December 31 of the same year; however, the first Calendar Year begins on the Insured's Effective Date.

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.

Covered Service means a service, supply, treatment or accommodation that is listed in the benefits sections in this Policy.

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) and are Dentally Appropriate.

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 Insured's home.

Effective Date means the first day of coverage for You and/or Your dependents, following Our receipt and acceptance of the application.

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

Enrolled Dependent means a Policyholder's eligible dependent who is listed on the Policyholder's completed application and who has been accepted for coverage.

Family means a Policyholder and his or her 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. A Health Intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

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 Hospital pursuant to the laws of the state in which the Hospital is located and is primarily and continuously engaged in providing or operating on its premises or in facilities available to the Hospital on a prearranged basis and with the supervision of a staff of licensed Physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made. A Hospital provides continuous 24-hour nursing services by or with the direction of registered nurses. 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 bodily disorder or disease other than an Injury. All such bodily disorders existing concurrently, which are due to the same cause or pathologically related causes, shall be considered one Illness. Successive Illnesses resulting from the same cause, or from treatment or complications thereof, shall be considered as the same Illness.

Injury means a physical Injury caused by:

- an unexpected occurrence, independent of disease or bodily infirmity; or
- ingestion of toxic substances.

All bodily disorders sustained in the same mishap or accident or from treatment or complications thereof or pathologically related thereto shall be considered as one Injury. Bodily disorders resulting from allergies shall not be considered Injuries.

In-Network means a Provider:

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

For In-Network Provider reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

Insured means any person who satisfies the eligibility qualifications and is enrolled for coverage with this Policy.

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. A Health Intervention not meeting all of the following criteria is 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 by 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 an Insured is continuously covered by this Policy 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.

Newborn Children means a child or children born during the term of this Policy to a parent who is a Policyholder or spouse of a Policyholder. Newborn Children also includes adopted newborn infants who

are Placed with the Policyholder within 60 days of the adopted child's date of birth. A child will no longer be a Newborn Child if he or she has 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 a Policyholder more than 60 days after the child's date of birth. A child will no longer be a Newly Adopted Child if he or she has a break in coverage of 63 or more days after Placement for adoption with the Policyholder.

Nonparticipating Facility means an Out-of-Network facility that does not have any effective participating contract with Us, with one of Our Affiliates, or, if located outside the area that We and Our Affiliates serve, with another Blue Cross and/or Blue Shield organization in the BlueCard Program.

Out-of-Network means a Provider that is not In-Network. Out-of-Network also means a Provider outside the area that We or one of Our Affiliates serves, but who have contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program. 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 Policyholder. 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 Policyholder signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child.

Policy is the description of the benefits for this coverage. This Policy is also the agreement between You and Us for a health benefit plan.

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 his or her respective state licensing board to independently bill third parties); and
- other professionals practicing within the scope of his or her 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.

Service Area means the state of Idaho.

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.

Upfront Benefit (if applicable) means those Covered Services designated as "Upfront" which are usually accessible to the Insured without first having to satisfy any Deductible amount. There may not be any Coinsurance amount required for an Upfront Benefit. However, a Copayment may apply for each visit or access to an Upfront Benefit. Once an Upfront Benefit dollar or visit maximum has been reached, additional coverage is available subject to any Deductible, Copayment and/or Coinsurance. Refer to the Upfront Benefit in the Schedule of Benefits to determine coverage.

Regence

2020 Outline of Coverage

Silver 3200 POS

MANAGED CARE PLAN

Regence BlueShield of Idaho, Inc. Medical Benefits

OUTLINE OF COVERAGE
Silver 3200 POS

Introduction

This Outline of Coverage is a brief description of the important features of Your Policy. This Outline of Coverage is not the insurance contract and only the actual provisions of the Policy will control. After You are accepted, a Policy and member card will be mailed to You. Read Your Policy carefully. The Policy itself sets forth in detail the rights and obligations of both You and Regence BlueShield of Idaho, Inc. (hereafter referred to as "Regence BSI"). It is, therefore, important that You READ YOUR POLICY CAREFULLY.

This plan is designed to provide coverage for major Hospital, medical and surgical expenses incurred as a result of a covered Illness or Injury. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, in Hospital medical services and out of Hospital care, subject to any Deductibles, Copayments, Coinsurance or other limitations which may be set forth in the Policy.

The pediatric vision benefits are provided by Regence BSI, in collaboration with Vision Service Plan Insurance Company (VSP), which coordinates the provision of benefits and claims processing.

This is **not** a Medicare Supplement contract.

If You or a Family member becomes eligible for Medicare, You should review the Medicare Supplement Buyer's Guide available from Regence BSI. If You choose to continue coverage under the Policy and Medicare, the benefits of the Policy shall be reduced by any amounts paid by Medicare.

Renewability
The Policy is guaranteed renewable, at the option of the Policyholder, upon payment of the monthly premium when due or within the grace period.

Ten-Day Review Period
You will have ten days after You receive the Regence BSI Policy to review the provisions of the Policy and to review the benefits, limitations and exclusions of the plan before acceptance. You may cancel within the ten-day review period and receive a full refund of Your premium. There is no provision for premium refund after the ten-day review period. If Your premium is refunded, the Regence BSI Policy shall be void from the Effective Date.

Essential Health Benefits
This coverage complies with the essential health benefits in the following ten categories:

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

There is no annual or Lifetime maximum applicable to these services.

Notice of Annual Meeting
The annual meeting of Regence BSI contract holders shall be held at 10:00 a.m., Pacific Time on the

third Wednesday of April at its corporate headquarters located at 1602 21st Avenue, Lewiston, ID.

ACCESSING PROVIDERS

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.
- **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.

For each benefit, it is indicated in the Schedule of Benefits the Provider You may choose and Your payment amount for each provider option. You can go to **regence.com** for further Provider network information.

MEDICAL NEIGHBORHOODS

"Medical Neighborhood" means a medical Provider group which has committed to use Regence BSI's cost and quality data to proactively engage Insureds while better managing their care and treatment. Medical Neighborhoods offer primary care and specialty Providers in a specific geographic area. Your Medical Neighborhood is Your partner, helping to coordinate all of Your care. When You enrolled in the Policy, You were required to select a Medical Neighborhood. If You did not select a Medical Neighborhood at the time You enrolled, You have been assigned a Medical Neighborhood based on Your geographical location. There is one Medical Neighborhood applicable to all covered Insureds. Your Medical Neighborhood is listed on Your member card. You may change Your Medical Neighborhood by calling Customer Service.

What is Covered

Benefits are available for these Covered Services. Benefits are subject to all of the applicable exclusions, limitations and requirements of the Policy.

PREAUTHORIZATION

Contracted Providers

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

Non-Contracted Providers

Outpatient Services

Non-contracted Providers are not required to obtain preauthorization from Regence BSI prior to providing outpatient 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 outpatient services on Your behalf to determine Medical Necessity prior to receiving those services.

Inpatient Services

While Regence BSI does not require non-contracted Providers to obtain preauthorization from Regence BSI prior to providing inpatient services, Regence BSI does require preauthorization prior to receiving these services. You are responsible for obtaining preauthorization from Regence BSI before receiving inpatient services from non-contracted Providers. You may request that the non-contracted Provider assist You with this, but the Provider is not required to do so.

All costs for inpatient services received from a non-contracted Provider that are not Medically Necessary are Your responsibility. Inpatient services received from a non-contracted Provider that are Medically Necessary will be covered according to the terms of the Policy when preauthorization is obtained. However, a penalty of $1,000 or the Allowed Amount, whichever is less, will be applied to the Allowed Amount if You fail to obtain preauthorization of Medically Necessary inpatient services from non-contracted Providers. Payment of the penalty will not be applied toward any applicable Deductible, Copayment, Coinsurance or Out-of-Pocket Maximum.

We will not require preauthorization for emergency medical services, childbirth admissions or admissions for newborns who need medical care at birth.

NOTE: If Regence BSI approves a preauthorization request from a Provider, Regence BSI may not rescind the authorized service or supply after it has been provided, except in the case of fraud or misrepresentation, nonpayment of premium, exhaustion of any applicable benefit maximum or if the Insured for whom the preauthorization was granted is not enrolled at the time the service or supply is received.

INPATIENT AND OUTPATIENT HOSPITAL/SKILLED NURSING FACILITY

- Semi-private room accommodations
- Ancillary services and supplies
- Emergency room services
- Ambulatory surgical center
- Dialysis treatment, chemotherapy and radiation therapy
- X-ray and laboratory services
- Inpatient rehabilitation
- Skilled Nursing Facility services

HOME HEALTH CARE/HOME INFUSION THERAPY SERVICES

- Home health care services provided in Your home
- Home infusion therapy services provided in Your home
- Other services and supplies

PHYSICIAN SERVICES

- Preventive Care and Immunizations (in accordance with age limits and frequency guidelines as set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Services and Resources Administration (HRSA))
- Office visits
- Surgical services
- Assistant surgeon services
- Anesthesia services
- Inpatient medical services
- Outpatient medical services
- Diagnostic services
- Chemotherapy and radiation therapy
- Preventive services
- Skilled nursing services
- Dialysis treatment
- Mental Health or Substance Use Disorder Services

PRESCRIPTION MEDICATIONS

OTHER SERVICES

- Approved Clinical Trials
- Diabetic Education
- Diabetic Supplies
- Durable Medical Equipment
- Medical/surgical supplies
- Ambulance services
- Inpatient/outpatient maternity care
- Hearing loss services
- Hospice (inpatient/outpatient and respite)
- Nutritional counseling
- Outpatient habilitation services
- Outpatient rehabilitation services
- Palliative care
- Repair of teeth
- Transplants (including case management approved travel expenses)
- Spinal manipulations
- Virtual care (includes store and forward services, telehealth and telemedicine)

PEDIATRIC VISION SERVICES

The following pediatric vision benefits are provided for covered Insureds under the age of 19.

- Vision examination
- Vision hardware:

    - Frames (frames are limited to the Otis & Piper Eyewear Collection if received from a VSP Doctor)
    - Standard glass, plastic or polycarbonate lenses
    - Elective contacts*
    - Necessary Contact Lenses**
    - Specific lens enhancements

    *Contact lenses are in lieu of all other frame and lens benefits. When You receive contact lenses, You will not be eligible for any frames and/or lenses again until the next Calendar Year. One of the following elective contact lens types may be chosen:

    - standard (one pair annually);
    - monthly (six-month supply);
    - bi-weekly (three-month supply); or
    - dailies (three-month supply).

**An annual supply of Necessary Contact Lenses You have a specific condition for which contact lenses provide better visual correction.

- Contact lens evaluation and fitting examination
- Low vision supplemental testing and supplemental aids

PEDIATRIC DENTAL SERVICES

The following pediatric dental benefits are provided for covered Insureds under the age of 19.

Preventive and Diagnostic Dental Services

- The following services are limited to two per Insured per Calendar Year:
  - bitewing x-ray sets;
  - preventive oral examinations;
  - cleanings;
  - diagnostic oral examinations;
  - topical fluoride application (excluding cleanings); and
  - topical fluoride varnish treatments.
- The following x-rays are limited to one per Insured in a three-year period:
  - complete intra-oral mouth x-rays; and
  - panoramic x-rays.
- Cephalometric x-rays.
- Preventive resin restoration in a moderate to high caries risk patient, permanent tooth, limited to one sealant per tooth in a three-year period.
- Sealants for permanent molars, limited to one per tooth in a three-year period.
- Space maintainers

Basic Dental Services

- Complex oral surgery procedures including:
  - surgical extractions of teeth;
  - impaction;
  - alveoloplasty;
  - vestibuloplasty; and
  - residual root removal.
- Emergency treatment for pain relief. Restorative treatment on the same date of service as emergency treatment is not covered.
- Endodontic services including:
  - Apicoectomy;
  - Pulpotomy; and
  - root canal treatment.
- Fillings consisting of composite and amalgam restorations.
- General dental anesthesia or intravenous sedation administered in for:
  - extractions of partially or completely bony impacted teeth; or
  - to safeguard the Insured's health (for example, a child under seven years of age).
- Uncomplicated oral surgery procedures including:
  - removal of teeth;
  - biopsy;
  - incision; and
  - drainage.
- Periodontal services including:

- complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery) limited to once per Insured per quadrant in a three-year period;
- gingivectomy and gingivoplasty limited to once per Insured per quadrant in a three-year period;
- periodontal maintenance limited to four per Calendar Year. (However, in no Calendar Year will any Insured be entitled to more than four examinations whether periodontal maintenance, preventive oral examinations or diagnostic oral examinations); and
- scaling and root planing limited to once per Insured per quadrant in a two-year period.

- Adjustment and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within six months of insertion.

  - reline procedures, limited to once per Insured in a three-year period; and
  - rebase procedures, limited to once per Insured in a three-year period.

Major Dental Services

- Bridges (fixed partial dentures), limited to one per Insured in a five-year period. Refer to the Basic Dental Services for coverage of adjustments and repairs.
- Crowns, inlays and onlays, limited to once per tooth per Insured in a seven-year period (no limit for stainless steel crowns). Coverage includes recement of crowns, inlays and onlays as well as repair of crowns, inlays, onlays and veneers.
- Dental implants limited to four per Insured Lifetime.
- Dental implant abutment repair limited to one per Insured in a five-year period.
- Dentures, full and partial, limited to one per Insured in a five-year period. Refer to the Basic Dental Services for coverage of adjustments and repairs.
- Occlusal guards limited to one in a twelve-month period.

ACCIDENTAL DEATH BENEFIT

All Regence BSI Individual coverage plans include a death benefit payable when Regence BSI receives proof of death caused by accidental means. Adult Policyholders, covered spouses, covered domestic partners and covered children are eligible for this benefit. Benefits are subject to the terms set forth in the Policy.

Exclusions

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:

- 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;
- sensory movement groups; and

Acupuncture

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

Aviation

Except for an injured Insured that is a passenger on a scheduled commercial airline flight or air ambulance, services in connection with Injuries sustained in aviation accidents (including accidents occurring in flight or in the course of take-off or landing).

Breast Reduction

Except when following a Medically Necessary mastectomy, to the extent required by law, breast reductions are not covered. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice.

Certain Therapy, Counseling and Training

Except as provided in the Individual Assistance Program (IAP) Section, if applicable, the following therapies, counseling and training services are not covered:

- educational;
- vocational;
- social;
- image;
- milieu or marathon group therapy;
- premarital or marital counseling;
- IAP services; 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 Your active participation in a war or insurrection.

Conditions Incurred in or Aggravated During Performances in the Uniformed Services
The treatment of any 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.

"Cosmetic" means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

"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 Pediatric Dental Services or the Repair of Teeth Benefits, 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 Abortions
Elective abortions are not covered.

"Elective abortion," means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed. Coverage for non-elective abortions is provided in the Termination of Pregnancy benefit.

Facilities Without a Provider Legally Required to be on Duty
Admission and treatment in a setting where neither a Physician nor licensed nurse is legally required to be on duty at all times that a patient is admitted.

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 state 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 the Policy) 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 Loss 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 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;
- fertility drugs; 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 an Insured (whether or not the Insured 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, Regence BSI's 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 Insured 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 Regence BSI's 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, as required by law or for treatment of obesity-related comorbid medical conditions (for example, diabetes, high blood pressure and heart disease), 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;
- sleep apnea; 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.

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;
- weight lifting 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.

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

Riot, Rebellion and Illegal Acts
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by an Insured's **voluntary participation in** any of the following:

- a riot;
- an armed invasion or aggression;
- an insurrection;
- a rebellion; or
- an act deemed illegal by an officer or a court of law.

Routine Foot Care

Routine Hearing Examinations

Self-Help, Self-Care, Training or Instructional Programs
Except as provided in the Diabetic Education and Nutritional Counseling benefits or for services provided without a separate charge in connection with Covered Services that train or educate an Insured, self-help, non-medical self-care and training programs are not covered, including, but not limited to:

- childbirth-related classes including infant care; and
- instructional programs including those that teach a person how to use Durable Medical Equipment or how to care for a family member.

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 for Administrative or Qualification Purposes
Physical or mental examinations and associated services (laboratory or similar tests) 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;
  - marriage;
  - insurance;
  - occupational injury benefits;
  - licensure; or
  - certification.
- immigration or emigration.

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

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided for TMJ disorder treatment.

Third-Party Liability
Services and supplies for treatment of Illness, Injury or health conditions 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 for the following, treatment of varicose veins is not covered:

- when there is associated venous ulceration; or
- persistent or recurrent bleeding from ruptured veins.

Vision Care
Except as provided in the Pediatric Vision Services Section, 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 an Insured 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, an Insured will be required to file a claim for workers' compensation benefits before Regence BSI will consider providing any coverage.

PRESCRIPTION MEDICATION EXCLUSIONS
Biological Sera, Blood or Blood Plasma

Bulk Powders
Except as included on Regence BSI's 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;
- anti-aging;
- repair of sun-damaged skin; or
- reduction of redness associated with rosacea.

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.

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.

Insulin Pumps and Pump Administration Supplies
Except as provided in the Durable Medical Equipment benefit, insulin pumps and supplies 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 Regence BSI's 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 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, 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 Lower Cost 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 an Insured who is at risk of experiencing an opiate-related overdose; or
- an epinephrine auto-injector to an Insured 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

PEDIATRIC VISION EXCLUSIONS
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.

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

Costs for Services and/or Supplies Exceeding Benefit Allowances

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

- anti-reflective coating;
- color coating;
- mirror coating;
- blended lenses;
- cosmetic lenses;
- laminated lenses;
- oversize lenses; or
- standard, premium and custom progressive multifocal 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.

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

Plano Lenses (Less Than a ± .50 Diopter Power)

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

Two Pair of Glasses in Lieu of Bifocals

PEDIATRIC DENTAL EXCLUSIONS
Adjustments
Adjustment of a denture or bridgework which is done within six months after insertion by the same Dentist who installed the denture or bridgework.

Aesthetic Dental Procedures
Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth.

Bone Grafts
Bone grafts done in connection with extractions, apicoectomies or non-covered/ineligible implants.

Cone Beam Imaging/MRI Procedures

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

- Dentally Appropriate services and supplies to treat a Congenital Anomaly; or
- to restore a physical bodily function lost as a result of Illness or Injury.

"Cosmetic" means services or supplies that are applied to normal structures of the body primarily to

improve or change appearance.

"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 generally performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Decay Prevention
Supplies and materials to prevent decay are not covered, including, but not limited to:

- toothpaste;
- fluoride gels;
- dental floss; and
- teeth whiteners.

Duplicate Services
Services submitted by a Dentist which are for the same services performed on the same date for the same Insured by another Dentist.

Experimental or Investigational Services

Fabrication of Athletic Mouth Guard

Facility Expenses
Services and supplies related to facility expenses are not covered, including, but not limited to:

- those performed by a Dentist who is compensated by a facility for similar Covered Services performed for an Insured; and
- costs or any additional fees that the Dentist or Hospital charges for treatment at the Hospital (inpatient or outpatient).

Failure to Comply
Services and supplies resulting from Your failure to comply with professionally prescribed treatment.

Gold-Foil Restorations

Nitrous Oxide

Oral Hygiene and Dietary Instructions

Oral Sedation

Orthodontic Dental Services
Except when Medically Necessary, orthodontic services and supplies are not covered, including, but not limited to:

- correction of malocclusion;
- craniomandibular orthopedic treatment;
- other orthodontic treatment;
- preventive orthodontic procedures;
- procedures for tooth movement, regardless of purpose; and
- repair of damaged orthodontic appliances.

Plaque Control Programs

Precision Attachments, Precious Metal Bases and Other Specialized Techniques

Provisional, Temporary and Duplicate Devices or Appliances

Replacements
Replacement of any lost, stolen or broken dental appliance, including but not limited, dentures or retainers.

Sealants
Except as provided for permanent molars, sealants are not covered.

Separate Charges
Services and supplies that may be billed as separate charges (services that should be included in the billed procedure) are not covered, including, but not limited to:

- any supplies;
- local anesthesia; and
- sterilization (office infection control charges).

Services and Supplies to Alter Vertical Dimension and/or Restore or Maintain the Occlusion
Services and supplies to alter vertical dimension and/or restore or maintain the occlusion are not covered, including, but not limited to:

- equilibration;
- periodontal splinting;
- full mouth rehabilitation; and
- restoration for misalignment of teeth.

Services and Supplies Which the Insured Would Have No Legal Obligation to Pay in the Absence of this Coverage

Services Provided by Certain Entities
Services and treatment are not covered when received from a dental or medical department maintained by or on behalf of:

- an employer;
- mutual benefit association;
- labor union;
- trust;
- Veterans Administration Hospital; or
- similar person or group.

Specialized Procedures and Techniques

Teledentistry
Virtual care Dental Services are not covered.

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided in connection with TMJ disorder treatment.

Topical Medicament Center

Eligibility and Enrollment

To be eligible to apply, You must reside in Regence BSI's Service Area (and not elsewhere) and not be enrolled in Medicare. If You intend to reside in Regence BSI's Service Area, You may apply, but You would not be eligible for coverage until You physically reside in Regence BSI's Service Area. Service Area means the state of Idaho.

If You or Your spouse or domestic partner is covered (or will be eligible to be covered) by a group insurance plan, You are not eligible for coverage with one of Regence BSI's individual health insurance plans.

OPEN ENROLLMENT PERIOD

The open enrollment period is the period of time, as designated by law, during which You and/or Your eligible dependents may enroll.

ENROLLMENT

After carefully reading this brochure and deciding to apply for coverage, You should complete the Idaho Individual Health Insurance Application and the Individual Application Cover Sheet and return it to Regence BSI. Premiums are determined by the age, location in the Service Area and tobacco use of the individual(s) covered by the Policy. Regence BSI relies on the information You provide for Yourself and Your dependents, so the information must be complete and accurate for each person to be enrolled.

SPECIAL ENROLLMENT

Submit a completed application if You and/or Your eligible dependents have one of the following qualifying events. You (unless already enrolled) and Your eligible dependent(s) are eligible to enroll (except as specified otherwise below) for coverage under the Policy within 60 days from the date of the qualifying event:

- if You, Your spouse or domestic partner gain a new dependent child or, for a child, become a dependent child by birth, adoption or Placement for adoption;
- if You, Your spouse or domestic partner gain a new dependent child or, for a spouse or domestic partner or child, become a dependent through marriage or beginning a domestic partnership;
- unintentional, inadvertent or erroneous enrollment or non-enrollment resulting from an error, misrepresentation or inaction by an officer, employee or agent of Your Health Idaho or U.S. Department of Health and Human Services;
- can adequately demonstrate that a qualified health plan has substantially violated a material provision of Your contract with regard to You and/or Your eligible dependents;
- become newly eligible or newly ineligible for advance payment of premium tax credits or have a change in eligibility for cost-sharing reductions;
- lose eligibility for group coverage due to: death of a covered employee, an employee's termination of employment (other than for gross misconduct), child status or certain employer bankruptcies;
- permanently move to a new Service Area; or
- loss of minimum essential coverage.

A qualifying event due to loss of minimum essential coverage does not include a loss because You failed to timely pay Your portion of the premium on a timely basis (including COBRA) or when termination of such coverage was because of rescission. It also doesn't include Your decision to terminate coverage.

For the above qualifying events coverage will be effective on the first of the calendar 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.

POLICY EFFECTIVE DATE

Your coverage Effective Date will be assigned on the first day of the month after Your application has been reviewed and accepted. If there is a delay in accepting Your application and the Effective Date is postponed, You will be notified. Your premium payment must be received in order for Your coverage to become effective.

TERMINATION

Coverage will terminate in the event of:

- failure to pay premiums;
- establishment of residence outside Regence BSI's Service Area;
- intentional misrepresentation of material fact or fraud; or
- loss of dependent eligibility.

If the Policy is terminated for a reason other than an intentional misrepresentation of material fact or fraud, Regence BSI shall refund the unearned amount of the collected premium. If Regence BSI cancels the Policy because of an intentional misrepresentation of material fact or fraud, Regence BSI shall refund all premiums collected minus claims that have been paid.

Your coverage cannot be terminated for health reasons.

Regence BSI has the right to terminate the Policy if Regence BSI:

- Eliminates coverage described in the Policy for all Policyholders (in which case Regence BSI shall provide 90 days prior written notice to all individuals covered by the Policy and shall make available to the Policyholder, without regard to the claims experience or health status of any covered person, the option to purchase any other individual Policy being offered by Regence BSI or an affiliate of Regence BSI for which they qualify); or
- Elects not to renew all health benefit plans issued to individuals in Idaho, in which case, Regence BSI shall provide 180 days prior written notice to all individuals covered by the Policy.

PREGNANCY BENEFIT EXTENSION

In the event Regence BSI cancels or otherwise fails to renew the Policy, Regence BSI shall provide for an extension of benefits for a pregnancy which commenced while the Policy was in force and for which benefits would have been payable had the Policy remained in force.

General Provisions and Legal Notices

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 ("Association"). Whenever You obtain health care services outside Our service area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

We cover health care services received outside of Our service area. As used in this Out-of-Area Services provision, "Out-of-Area Covered Services" means Covered Services obtained outside Our service area. Out-of-Area Covered Services will be provided at the Out-of-Network benefit level specified in the Schedule of Benefits, except emergency care (including ambulance) and urgent care services will be provided at the In-Network benefit level.

When You receive care outside Our service area, You will receive it from one of two kinds of Providers. Most Providers ("In-Network Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Out-of-Network Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

BlueCard Program

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

The BlueCard Program enables You to obtain Out-of-Area Covered Services, as defined above, from a health care Provider participating with a Host Blue, where available. The participating provider will automatically file a claim for the Out-of-Area Covered Services provided to You, so there are no claim forms for You to fill out. You will be responsible for any Out-of-Network Deductible, Coinsurance and Copayments as specified in the Schedule of Benefits. Contact Regence BSI within 24 hours of admission to a Hospital so that We may coordinate Your care.

Emergency Care Services: If You experience an Emergency Medical Condition while traveling outside of Our service area, go to the nearest emergency room.

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

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your health care Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price We have used for Your claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, We will include any surcharge, tax or other fee as part of the claim charge passed on to You.

Nonparticipating Providers Outside Our Service Area

- **Your Liability Calculation.** When Out-of-Area Covered Services are provided by Out-of-Network Providers, the amount You pay for such services will normally be based on either the Host Blue's Out-of-Network Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the Out-of-Network Provider bills and the payment We will make for the Out-of-Area Covered Services as set forth in the Policy. Federal or state law, as applicable, will govern payments for Out-of-Network emergency services.
- **Exceptions.** In certain situations, We may use other payment methods, such as billed covered charges, 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 these situations, You may be liable for the difference between the amount that the Out-of-Network Provider bills and the payment We will make for the out-of-Area Covered Services as set forth in the Policy.

OTHER PARTY LIABILITY

If another party is responsible for Your Illness or Injury, the benefits paid by the Policy may be subject to subrogation. Subrogation means that Regence BSI will recover the amounts it has paid in benefits out of the proceeds of any settlement or judgment that You receive as a recovery from the other party, whether or not You are made whole by the recovery and whether or not the recovery includes any amount for Covered Services.

COORDINATION OF BENEFITS

When You or Your Family members are also enrolled in another health plan, payments for Covered Services will be determined by coordinating the benefits of the two programs. Dual coverage will provide the maximum benefits to which You are entitled while preventing payment duplication. The Primary Health Plan pays the full benefits covered by that plan, and then the Secondary Health Plan may reduce its benefits. In no event will payment be made in excess of expenses incurred.

APPEAL PROCESSES

Fair and well-established multi-level processes are available to You to resolve any complaints or grievances regarding a claim denial or other action by Regence BSI or VSP with internal and external reviews. Refer to the Policy for further information.

MODIFICATION OF POLICY

Regence BSI has the right to modify or amend the Policy from time to time. This right includes Regence BSI's ability to modify or amend premiums, benefits (for example, Deductible, Copayment, Coinsurance, Out-of-Pocket Maximum), exclusions, limitations, Covered Services, eligibility and/or networks. No modification or amendment will be effective until 30 days (or longer, as required by law) after written notice has been given to the Policyholder.

NONASSIGNMENT AND NONASSIGNMENT OF VOTING RIGHTS

A Policyholder 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 Regence BSI in compliance with Regence BSI's bylaws.

PREMIUMS

Premium rates for an individual are not based upon the actual or expected variation in claims cost or the actual or expected variation in health status of the individual and his dependents.

Premiums are payable to Regence BSI. If premiums are not fully paid within 30 days after the due date, coverage with the Policy is automatically terminated effective with the due date of the unpaid premiums. You will be notified of any increase or decrease in premiums 30 days in advance of the change. Rate adjustments typically occur once each year on the date of Your renewal, unless state or federal governments mandate benefit changes.

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, Regence BSI 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
- prostheses and treatment of physical complications at all stages of the mastectomy including lymphedemas.

Sean M. Robbins
President
Regence BlueShield of Idaho

This is an overview of benefits, refer to the Policy for a complete list of benefits, Covered Services, limitations and exclusions.

SCHEDULE OF BENEFITS

Silver 3200 POS

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 Policy. Read the entire Policy to understand the benefits, limitations, exclusions, defined terms and provisions of Your coverage.

	Insured Responsibility	
	In-Network Provider	**Out-of-Network Provider**
Coinsurance	30%	60%
Deductible per Calendar Year	$3,200 per Insured $6,400 per Family	$16,300 per Insured $32,600 per Family
Out-of-Pocket Maximum per Calendar Year	$8,150 per Insured $16,300 per Family	$81,500 per Insured $163,000 per Family

Be aware that Your actual costs for Covered Services provided by an Out-of-Network Provider may exceed this Policy's Out-of-Network Out-of-Pocket Maximum Amount. In addition, Out-of-Network Providers and Nonparticipating Pharmacies 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.

NOTE: You are required to obtain preauthorization from Us in advance of all inpatient services received from non-contracted Providers or a penalty will apply. Refer to the Preauthorization provision and Claims Administration Section for requirements and exceptions.

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Preventive Care and Immunizations	0%, Deductible waived	60%
Preventive Care – Expanded Immunizations	30%	60%
Office or Urgent Care Visits – Illness or Injury	Primary Physician or Practitioner – $30 Copayment, Deductible waived Specialist (including urgent care) – $60 Copayment, Deductible waived	60%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Other Professional Services	30%	60%
Ambulance Services • Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum	30%	
Blood Bank • Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum	30%	
Dental Hospitalization • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Detoxification • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Diabetic Education	0%, Deductible waived	60%
Dialysis • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Durable Medical Equipment	30%	60%
Emergency Room • Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum	30%	

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Gene Therapy and Adoptive Cellular Therapy • $7,500 combined for transportation, lodging and meal expenses per course of treatment • Out-of-Network services do not accrue to any Out-of-Pocket Maximum • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	Centers of Excellence facility – 30%	60%
Genetic Testing	30%	60%
Habilitation Services • No limit for inpatient days • 20 outpatient visits per Calendar Year • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Hearing Loss • 1 hearing aid device per ear every 36 months • 45 outpatient speech and language therapy visits within 12 months from the receipt of a hearing aid, bone conduction device or cochlear implant	30%	60%
Home Health Care	30%	60%
Hospice Care	30%	60%
Hospital Care – Inpatient, Outpatient and Ambulatory Surgical Center • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Maternity Care • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Medical Foods	30%	60%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Mental Health or Substance Use Disorder Services • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Newborn Care • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Nutritional Counseling • 3 visits per Calendar Year	30%	60%
Orthotic Devices	30%	60%
Palliative Care • 30 visits per Calendar Year	30%	60%
Prosthetic Devices	30%	60%
Rehabilitation Services • No limit for inpatient days • 20 outpatient visits per Calendar Year • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Repair of Teeth • Treatment must be provided within 12 months from the date of Injury	30%	60%
Retail Clinic Office Visits	$15 Copayment, Deductible waived	60%
Skilled Nursing Facility • 30 inpatient days per Calendar Year	30%	60%
Spinal Manipulations • 18 spinal manipulations per Calendar Year	30%	60%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Termination of Pregnancy • Allowed only for certain circumstances, refer to the Medical Benefits Section	30%	60%
Transplants • 14 days per Calendar Year for travel expenses (for the patient and care giver), after case management approval • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	30%	60%
Virtual Care – Store and Forward Services	0%, Deductible waived	60%
Virtual Care – Telehealth	$10 Copayment, Deductible waived	60%
Virtual Care – Telemedicine	30%	60%

<table>
<tr><th colspan="3">Covered Services (per Insured)
Unless Otherwise Noted the Deductible Applies</th></tr>
<tr><th rowspan="2">Benefit</th><th colspan="2">Insured Responsibility</th></tr>
<tr><th>Participating Pharmacy</th><th>Nonparticipating Pharmacy</th></tr>
<tr><td rowspan="6">Prescription Medications – from a Pharmacy
• *$5 or 5% discount on Prescription Medications filled at a Preferred Pharmacy
• You are not responsible for any Deductible, Copayment and/or Coinsurance when You fill prescriptions for medications intended to treat opioid overdose that are on the Naloxone Value List. To obtain this list visit Our Web site or contact Customer Service. Contact Information is available in the Introduction Section.
• Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum
• 90-day supply for Prescription Medications (even if the packaging includes a larger supply)
• 30-day supply for Specialty Medications
• Multiple-month dispensing: the largest allowed quantity is the smallest multiple-month supply as packaged by the manufacturer
• Copayment is based on each 30-day supply</td><td colspan="2">*$15 Copayment, Deductible waived for each Preferred Generic Medication on the Drug List</td></tr>
<tr><td colspan="2">*25%, Deductible waived for each Generic Medication on the Drug List</td></tr>
<tr><td colspan="2">*30% for each Preferred Brand-Name Medication on the Drug List</td></tr>
<tr><td colspan="2">*50% for each Brand-Name Medication on the Drug List</td></tr>
<tr><td>40% for each Preferred Specialty Medication on the Drug List from a Participating Specialty Pharmacy</td><td>60% for each Preferred Specialty Medication on the Drug List from a Nonparticipating Pharmacy</td></tr>
<tr><td>50% for each Specialty Medication on the Drug List from a Participating Specialty Pharmacy</td><td>60% for each Specialty Medication on the Drug List from a Nonparticipating Pharmacy</td></tr>
<tr><td rowspan="4">Prescription Medications – from a Mail-Order Supplier
• Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum
• 90-day supply for Prescription Medications (even if the packaging includes a larger supply)
• Multiple-month dispensing: the largest allowed quantity is the smallest multiple-month supply as packaged by the manufacturer</td><td colspan="2">$30 Copayment, Deductible waived for each Preferred Generic Medication on the Drug List</td></tr>
<tr><td colspan="2">20%, Deductible waived for each Generic Medication on the Drug List</td></tr>
<tr><td colspan="2">25% for each Preferred Brand-Name Medication on the Drug List</td></tr>
<tr><td colspan="2">45% for each Brand-Name Medication on the Drug List</td></tr>
</table>

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	VSP Doctor	**Out-of-Network Provider**
Pediatric Vision (under age 19) • 1 routine eye examination per Calendar Year • 1 frame per Calendar Year • 1 pair of lenses (2 lenses) per Calendar Year • Contacts may be selected (once per Calendar Year) instead of frames and lenses • Low vision supplemental testing and supplemental aids every 2 Calendar Years • Additional limitations apply, refer to the Medical Benefits Section	Examination – 0%, Deductible waived	Examination – 50%, Deductible waived
	Hardware – 0%, Deductible waived	Hardware – 50%, Deductible waived
	Contact Lens Evaluation and Fitting Examination – 0%, Deductible waived	Contact Lens Evaluation and Fitting Examination – 50%, Deductible waived
	Low Vision Supplemental Testing – 0%, Deductible waived	Low Vision Supplemental Testing – 0%, Deductible waived
	Low Vision Supplemental Aids – 0%, Deductible waived	Low Vision Supplemental Aids – 0%, Deductible waived

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	In-Network Dentist	**Out-of-Network Dentist**
Pediatric Dental (under age 19) • Out-of-Network services apply to the In-Network Out-of-Pocket Maximum • Additional limitations apply, refer to the Medical Benefits Section	Preventive and Diagnostic Services – 0%, Deductible waived	
	Basic Services – 20%, Deductible waived	
	Major Services – 50%, Deductible waived	

Accidental Death Benefit – Refer to this Policy for details on this program	
With proof of death by Accidental Bodily Injury, We pay the following benefit:	
Policyholder (age 18 or older)	$10,000
Enrolled Spouse	$10,000
Enrolled Domestic Partner	$10,000
Enrolled Child	$2,500

For more information call Us at 1 (888) 232-5763

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