Regence BlueShield of Idaho, Inc. Policy

Individual Group Number: 38001001

2019 Medical Benefits

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 HSA 2500

This Schedule of Benefits provides You with information regarding Your costs for Covered Services and how Provider choice affects Your out-of-pocket costs. This Schedule of Benefits is part of Your Policy. Please read the entire Policy to understand the benefits, limitations, exclusions, defined terms and provisions of this Policy.

	Insured Responsibility	
	In-Network Provider	**Out-of-Network Provider**
Coinsurance	20%	50%
Deductible per Calendar Year • The entire Deductible must be met before benefits begin for any Insured of the Family, except for any Insured of the Family that meets the $6,750 maximum amount for the In-Network Out-of-Pocket Maximum as described below.	$2,500 Single Coverage $5,000 Family Coverage	$15,000 Single Coverage $30,000 Family Coverage
Out-of-Pocket Maximum per Calendar Year • The In-Network Out-of-Pocket Maximum for any Insured on Family Coverage is not to exceed $6,750, including the In-Network Deductible. If an Insured reaches this maximum amount prior to satisfying the In-Network Family Out-of-Pocket Maximum, including the In-Network Deductible, benefits will be paid at 100 percent of the Allowed Amount for that Insured.	$6,750 Single Coverage $13,500 Family Coverage	$200,000 per Insured

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 count 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 of the Policy 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**
Office Visits – Illness or Injury	20%	50%
Preventive Care and Immunizations	0%, Deductible waived	50%
Other Professional Services	20%	50%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Ambulance Services • Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum	20%	
Ambulatory Surgical Center	10%	50%
Blood Bank • Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum	20%	
Dental Hospitalization • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	20%	50%
Detoxification • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	20%	50%
Diabetic Education	0%	50%
Dialysis • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	20%	50%
Durable Medical Equipment	20%	50%
Emergency Room • Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum	20%	
Family Planning	20%	50%

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 – 20%	50%
Genetic Testing	20%	50%
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	20%	50%
Home Health Care	20%	50%
Hospice Care • 14 inpatient or outpatient respite days per Lifetime	20%	50%
Hospital Care – Inpatient and Outpatient • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	20%	50%
Maternity Care • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	20%	50%
Medical Foods	20%	50%

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	20%	50%
Newborn Care • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $1,500 per day	20%	50%
Nutritional Counseling • 3 visits per Calendar Year	20%	50%
Orthotic Devices	20%	50%
Palliative Care • 30 visits per Calendar Year	20%	50%
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	
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 for VSP Doctor	Examination – 50%, Deductible waived
	Hardware – 0%, Deductible waived for VSP Doctor	Hardware – 50%, Deductible waived
	Contact Lens Evaluation and Fitting Examination – 0%, Deductible waived for VSP Doctor	Contact Lens Evaluation and Fitting Examination – 50%, Deductible waived
	Low Vision Supplemental Testing – 0%, Deductible waived for VSP Doctor	Low Vision Supplemental Testing – 0%, Deductible waived
	Low Vision Supplemental Aids – 0%, Deductible waived for VSP Doctor	Low Vision Supplemental Aids – 0%, Deductible waived

<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>In-Network Provider</th><th>Out-of-Network Provider</th></tr>
<tr><td rowspan="6">Prescription Medications – from a Pharmacy
• *5% discount on Prescription Medications filled at a Preferred Pharmacy
• Deductible waived for medications specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medications list. To obtain this list visit Our 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</td><td colspan="2">*20% for each Preferred Generic Medication on the Drug List</td></tr>
<tr><td colspan="2">*25% 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>50% for each Preferred Specialty Medication on the Drug List from a Nonparticipating Pharmacy</td></tr>
<tr><td colspan="2">50% for each Specialty Medication on the Drug List</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">15% for each Preferred Generic Medication on the Drug List</td></tr>
<tr><td colspan="2">20% 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>
<tr><td>Prosthetic Devices</td><td>20%</td><td>50%</td></tr>
<tr><td>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</td><td>20%</td><td>50%</td></tr>
</table>

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	**Insured Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Repair of Teeth • Treatment must be provided within 12 months from the date of Injury	20%	50%
Retail Clinic Office Visits	20%	50%
Skilled Nursing Facility (SNF) Services • 30 inpatient days per Calendar Year	20%	50%
Spinal Manipulations • 18 spinal manipulations per Calendar Year	20%	50%
Telehealth	20%	50%
Telemedicine	20%	50%
Termination of Pregnancy • Allowed only for certain circumstances, refer to the Medical Benefits Section	20%	50%
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	20%	50%

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

As You read this Policy, please keep in mind that references to "You" and "Your" refer to both the Policyholder and Enrolled Dependents. 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 under a Regence BlueShield of Idaho health insurance Policy, and whose name appears on the records of Regence BlueShield of Idaho as the individual to whom this Policy was issued. Policyholder does not mean a dependent under this Policy. Other terms are defined in the Definitions Section at the back of this Policy or where they are first used and are designated by the first letter being capitalized.

POLICY

This Policy describes benefits effective **January 1, 2019** , 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 under 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 including 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

If You have questions, would like to learn more about Your Policy or would like to request written or electronic information regarding any other plan that We offer, talk with one of Our Customer Service representatives. Phone lines are open Monday-Friday 5 a.m. - 8 p.m. and Saturday 8 a.m. - 4:30 p.m. Pacific Time.

Customer Service: 1 (877) 508-7359
(TTY: 711)

Or visit Our Web site at: **regence.com**

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

Pediatric Vision Services. If You have Provider or benefit questions specific to Your pediatric vision coverage, call Vision Service Plan (VSP) at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance), Monday-Friday 5 a.m. - 8 p.m.; Saturday 7 a.m. - 8 p.m.; and Sunday 7 a.m. - 7 p.m. You may also visit VSP's Web site at **www.vsp.com**.

BlueCard® Program. Call Customer Service to learn how to have access to care through the 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.

Sean M. Robbins
President
Regence BlueShield of Idaho

Using Your Policy

YOUR PARTNER IN HEALTH CARE

Regence BlueShield of Idaho is pleased that You have chosen Us as Your partner in health care. It's important to have continued protection against unexpected health care costs. Thanks to the purchase of this Policy, You have coverage that's affordable and provided by a partner You can trust in times when it matters most.

YOU SELECT YOUR PROVIDER AND CONTROL YOUR OUT-OF-POCKET EXPENSES

This Policy allows You to control Your out-of-pocket expenses, such as Copayments and Coinsurance, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your Provider under two choices called: "In-Network" and "Out-of-Network."

- **In-Network.** You choose to see an In-Network Provider and save the most in Your out-of-pocket expenses. Choosing this provider option means You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network.** You choose to see an Out-of-Network Provider and Your out-of-pocket expenses will generally be higher than an In-Network Provider. Also, choosing this provider option means You may be billed for balances beyond any Deductible and/or Coinsurance. This is sometimes referred to as balance billing.

For each benefit in this Policy, We indicate in the Schedule of Benefits Your payment amount for each provider option. In-Network and Out-of-Network are also in the Definitions Section of this Policy. You can go to **regence.com** for further Provider network information.

ADDITIONAL MEMBERSHIP ADVANTAGES

When You purchased this Policy, You were provided with more than just great coverage. You also acquired Regence membership, which offers additional valuable services. The advantages of Regence membership include access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to **regence.com**, an interactive environment that can 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.** It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar. Have Your member card handy to log on. Use the secure member 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.**

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Understanding Your Benefits

In this section, You will discover information to help You understand what We mean by Your Maximum Benefits, Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximum. Other terms are defined in the Definitions Section at the back of this Policy or where they are first used and are designated by the first letter being capitalized.

While this Understanding Your Benefits Section defines these types of cost-sharing elements, You need to refer to the Schedule of Benefits to see exactly how they are applied and to which benefits they apply.

An important feature of this high deductible health plan is how the single and Family coverage works. The key is understanding the difference between "single" and "family" coverage. Single Coverage means only one person has coverage under this Policy. A Policyholder who is the only one in his or her Family who has coverage under this Policy, and an Enrolled Dependent who is continuing insurance coverage on his or her own are examples of Single Coverage. Family Coverage, on the other hand, means two or more members of the same Family have coverage under this Policy under a single application.

MAXIMUM BENEFITS

Some benefits for Covered Services may have a specific Maximum Benefit. For those Covered Services, We will provide benefits until the specified Maximum Benefit (which may be a number of days, visits, services, supplies or specified time period) has been reached. Allowed Amounts for Covered Services that are applied toward any applicable Deductible are also applied to any specific Maximum Benefit that is expressed in this Policy. Refer to the Schedule of Benefits to determine if a Covered Service has a specific Maximum Benefit.

DEDUCTIBLES

We will begin to pay benefits for Covered Services in any Calendar Year only after an Insured satisfies any applicable Calendar Year Deductible. There are two Deductible amounts: one for In-Network benefits and another for Out-of-Network benefits. The Schedule of Benefits describes this more fully, but in this Policy, the term is referred to simply as the "Deductible." An Insured satisfies the Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible. An Insured's Deductible amount paid toward Covered Services listed in the Schedule of Benefits for ambulance, blood bank, emergency room services and Prescription Medications will apply toward the In-Network Deductible amount.

There are two Family Calendar Year Deductible amounts: one for In-Network benefits and another for Out-of-Network benefits. The Family Calendar Year Deductible is satisfied when some or all covered Family members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount.

We do not pay for services applied toward the Deductible. Refer to the Schedule of Benefits to see if a particular service is subject to any Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not count toward the Deductible.

COPAYMENTS

A Copayment means a fixed dollar amount that You must pay directly to a Provider for services or supplies, including medications, each time You receive a specified service or medication (as applicable). A Provider may or may not request any applicable Copayment at the time of service. The Copayment will be the lesser of the fixed dollar amount or the Allowed Amount for the service or medication. Refer to the Schedule of Benefits to understand what Copayments You may be responsible for.

PERCENTAGE PAID UNDER THIS POLICY (COINSURANCE)

Once You have satisfied any applicable Deductible and any applicable Copayment, We pay a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When Our payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). Your Coinsurance will be based upon the lesser of the billed charges or the Allowed Amount. The percentage We pay varies, depending on the kind of service or supply You received and who rendered it.

We do not reimburse Providers for charges above the Allowed Amount. An In-Network Provider will not charge You for any balances for Covered Services beyond Your applicable Deductible, Copayment and/or Coinsurance amount. Out-of-Network Providers, however, may bill You for any balances over Our

payment level in addition to any Deductible, Copayment and/or Coinsurance amount. See the Definitions Section for descriptions of Providers.

OUT-OF-POCKET MAXIMUM

You can meet the Out-of-Pocket Maximum by Your payments of any Deductible, Copayments and Coinsurance as specifically indicated in the Schedule of Benefits. There are two Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits. The Schedule of Benefits describes this more fully, but in this Policy, the term is referred to simply as the "Out-of-Pocket Maximum." An Insured's payment of any Deductible, Copayments and 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 does not count 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 will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. The Coinsurance for some benefits in this Policy does not change to a higher payment level or apply to the Out-of-Pocket Maximum. Those exceptions are specifically noted in the Schedule of Benefits.

The In-Network Family Out-of-Pocket Maximum for a Calendar Year is satisfied when some or all 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. 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

Many provisions in this Policy (for example, Deductibles, Out-of-Pocket Maximum and certain benefit maximums) are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again.

Some benefits in this Policy have a separate Maximum Benefit based upon an Insured's Lifetime and do not renew every Calendar Year. Those exceptions are specifically noted in the Schedule of Benefits.

Medical Benefits

In this section, You will learn about Your Policy's benefits. There are no referrals required before You can use any of the benefits of this coverage, including women's health care services. For Your ease in finding the information regarding benefits most important to You, We have listed these benefits alphabetically, with the exception of Office Visits, Preventive Care and Immunizations and Other Professional Services benefits.

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. To be covered, medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Also, a Provider practicing within the scope of his or her license must render the service. Please see the Definitions Section in the back of this Policy for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

Reimbursement may be available under Your Policy for some medical supplies, equipment and devices when purchased new from a Provider or from an approved Commercial Seller, even though that seller is not a Provider. New medical supplies, equipment and devices, such as a breast pump or wheelchair, 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, please 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.**

A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service in this Policy.

OFFICE VISITS - ILLNESS OR INJURY

We cover office visits for treatment of 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 under this benefit. For example, We will pay for a surgical procedure performed in the office according to the Other Professional Services benefit.

PREVENTIVE CARE AND IMMUNIZATIONS

We cover preventive care services provided by a professional Provider, facility or Retail Clinic such as:

- routine well-baby care, routine physical examinations, routine well-women's care and routine health screenings;
- Provider counseling and Prescription Medications prescribed for tobacco use cessation. See the Prescription Medications benefit in this Policy for a description of how to obtain Prescription Medications;
- immunizations for adults and children according to, and as recommended by, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- one new non-Hospital grade breast pump (including its accompanying supplies) per pregnancy at the In-Network benefit level when obtained from a Provider (including a Durable Medical Equipment supplier). Alternatively, 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; and
- United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods for women in accordance with HRSA recommendations. These include 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.

Benefits will be covered under this Preventive Care and Immunizations benefit, not any other provision in this Policy, if services are in accordance with 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 CDC. In the event any of these bodies adopts a new or revised recommendation, this plan has up to one year before coverage of the related services must be available and effective under this benefit. For a list of services covered under this benefit, including information about obtaining a new breast pump from an approved Commercial Seller, please visit Our Web site or contact Customer Service.

NOTE: Covered Services that do not meet these criteria (for example, diagnostic colonoscopies or immunizations for the purpose of travel, occupation or residency in a foreign country) will be covered the same as any other Illness or Injury.

OTHER PROFESSIONAL SERVICES

We cover services and supplies provided by a professional Provider subject to any specified limits as explained in the following paragraphs:

Medical Services and Supplies

We cover professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider, that are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury. Services and supplies also include those to treat a Congenital Anomaly and foot care associated with diabetes.

Additionally, We cover 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, please visit Our Web site or contact Customer Service.

Professional Inpatient

We cover 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. Please contact Customer Service for further information and guidance.

Radiology and Laboratory

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

Diagnostic Procedures

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

Surgical Services

We cover surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist.

Therapeutic Injections

We cover therapeutic injections and related supplies when given in a professional Provider's office.

A selected list of Self-Administrable Injectable Medications is covered under the Prescription Medications benefit in this Policy.

AMBULANCE SERVICES

We cover ambulance services to the nearest Hospital equipped to provide treatment, when any other

form of transportation would endanger Your health and the purpose of the transportation is not for personal or convenience purposes. Covered ambulance services include licensed ground and air ambulance Providers.

AMBULATORY SURGICAL CENTER

We cover outpatient services and supplies of an Ambulatory Surgical Center (including services of staff Providers) for Injury and Illness.

APPROVED CLINICAL TRIALS

We cover Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating subject to the Deductible, Coinsurance and/or Copayments, the maximum Allowed Amount for inpatient non-emergency admission at a Nonparticipating Facility and Maximum Benefits as specified in the Schedule of Benefits. Additional specified limits are as further defined. If an In-Network Provider is participating in the Approved Clinical Trial and will accept You as a trial participant, these benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If the 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.

Definitions

In addition to the definitions in the Definitions Section, 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; or
- Conducted under an investigational new drug application reviewed by the Food and Drug Administration 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

We cover the services and supplies of a blood bank, excluding storage costs.

DENTAL HOSPITALIZATION

We cover inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia), if hospitalization in an Ambulatory Surgical Center or Hospital is necessary to safeguard

Your health.

DETOXIFICATION
We cover Medically Necessary detoxification.

DIABETES SUPPLIES AND EQUIPMENT
We cover supplies and equipment for the treatment of diabetes. Please refer to the Other Professional Services, Diabetic Education, Durable Medical Equipment, Orthotic Devices or Prescription Medications benefits for coverage details of such covered supplies and equipment.

DIABETIC EDUCATION
We cover services and supplies for diabetic self-management training and education. Nutritional therapy is covered under the Nutritional Counseling benefit.

DIALYSIS
We cover services and supplies for inpatient and outpatient dialysis (including outpatient hemodialysis, peritoneal dialysis and hemofiltration).

DURABLE MEDICAL EQUIPMENT
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. Examples include oxygen equipment and wheelchairs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

Additionally, We cover new Durable Medical Equipment that is 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, please visit Our Web site or contact Customer Service.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)
We cover emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. For the purpose of this benefit, "stabilization" means to provide Medically Necessary treatment: 1) 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 2) in the case of a covered female Insured, who is pregnant, to perform the delivery (including the placenta). Emergency room services do not need to be pre-authorized. 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. Please contact Customer Service for further information and guidance. See the Hospital Care benefit for coverage of inpatient Hospital admissions.

FAMILY PLANNING
We cover certain professional Provider contraceptive services and supplies, including, but not limited to, vasectomy. See the Prescription Medications benefit for coverage of prescription contraceptives.

Please see the Preventive Care and Immunizations benefit for coverage of women's contraceptive methods, sterilization procedures and patient education and counseling services in accordance with any frequency guidelines according to, and as recommended by HRSA.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY
We cover gene therapies, adoptive cellular therapies as well as associated services and supplies 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, please contact Our Customer Service, as the lists are subject to change.

Travel Expenses
We cover transportation, lodging and meal expenses incurred only as required for travel to one of Our Centers of Excellence facilities for treatment 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, We cover local ground transportation within the treatment area to and from the Centers of Excellence facility 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. Please contact Our Customer Service for further information and guidance.

GENETIC TESTING
We cover Medically Necessary services for genetic testing.

HABILITATION SERVICES
We cover inpatient and outpatient habilitation services. Habilitation services are health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical, occupational and speech therapy and other services for an Insured with disabilities. Outpatient habilitation visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

HOME HEALTH CARE
We cover home health care 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 under the Durable Medical Equipment benefit.

HOSPICE CARE
We cover hospice care 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: We cover respite care 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 under the Durable Medical Equipment benefit.

HOSPITAL CARE - INPATIENT AND OUTPATIENT
We cover inpatient and outpatient services and supplies of a Hospital for Injury and Illness (including services of staff Providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. See the Emergency Room benefit for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

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

MATERNITY CARE
We cover prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or elective cesarean), complications of pregnancy and related conditions for all female Insureds. There is no limit for the mother's length of inpatient stay. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit to see how the care of Your newborn is covered.

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

MEDICAL FOODS
We cover medical foods for inborn errors of metabolism including, but not limited to, formulas for

Phenylketonuria (PKU). For the purpose of this benefit, "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

We cover Mental Health and Substance Use Disorder Services for the treatment of Mental Health Conditions or Substance Use Disorders.

We also cover applied behavioral analysis (ABA) therapy services 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 both a Board Certified Behavioral Analysis (BCBA) certification issued by the Behavioral Analyst Certification Board and a Habilitative Interventionist certification issued by the Idaho Department of Health and Welfare (IDHW).

Definitions

In addition to the definitions in the Definitions Section, 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 means 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 in this Policy. Mental disorders that accompany an excluded diagnosis are covered.

Substance Use Disorders means 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

We cover services and supplies, under the newborn's own coverage, in connection with nursery care for the natural newborn or newly adoptive child. The Newborn Child must be eligible and enrolled as explained later in the Who Is Eligible, How to Apply and When Coverage Begins Section. There is no limit for the newborn's length of inpatient stay. For the purpose of this benefit, "newborn care" means the medical services provided to a Newborn Child following birth including well-baby Hospital nursery charges, the initial physical examination and a PKU test.

NUTRITIONAL COUNSELING

We cover nutritional counseling and diabetic counseling. Nutritional counseling visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. For diabetic education coverage, refer to the Diabetic Education benefit.

ORTHOTIC DEVICES

We cover Medically Necessary orthotics, except when related to the feet, including, but not limited to, braces, back or special surgical corsets, splints for extremities and trusses.

Additionally, We cover certain orthotic devices that are new and 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, please visit Our Web site or contact Customer Service.

We may elect to provide benefits for a less costly alternative item. We do not cover 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 or other foot support devices.

PALLIATIVE CARE

We cover palliative care when a Provider has assessed that an Insured is in need of palliative services for serious Illness (including remission support), life-limiting Injury or end-of-life. For the purpose of this benefit, "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.

PEDIATRIC DENTAL SERVICES

We cover benefits for Dental Services 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. Please note that the BlueCard Program detailed in the Contract and Claims Administration Section does not apply to dental benefits provided under this Pediatric Dental benefit. We will pay benefits under this Pediatric Dental benefit, not any other provision in this Policy, if a service or supply is covered under both.

Preventive And Diagnostic Dental Services

We cover the following preventive and diagnostic Dental Services:

- Bitewing x-ray series, limited to twice per Insured per Calendar Year.
- Complete intra-oral mouth x-rays and panoramic x-rays, limited to once per Insured in a three-year period; cephalometric x-rays.
- Preventive oral examinations, limited to twice per Insured per Calendar Year.
- Diagnostic oral examinations, limited to twice per Insured per Calendar Year.
- Cleanings, limited to twice per Insured per Calendar Year.
- 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 once in a three-year period per tooth.
- Topical fluoride application, excluding cleanings, limited to two treatments per Insured per Calendar Year.
- Topical fluoride varnish, limited to two treatments per Insured per Calendar Year.
- Space maintainers.

Basic Dental Services

We cover the following basic Dental Services:

- Complex oral surgery procedures including surgical extractions of teeth, impactions, 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 connection with the extractions of partially or completely bony impacted teeth and 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 consisting of:
    - 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 exams whether periodontal maintenance or preventive 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

We cover the following major Dental Services:

- Bridges (fixed partial dentures), limited to one per Insured in a five-year period. For adjustment and repair coverage, refer to the Basic Dental Services in this Pediatric Dental Services benefit.
- 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 once per Insured in a five-year period. For adjustment and repair coverage, refer to the Basic Dental Services in this Pediatric Dental Services benefit.
- Occlusal guards limited to one in a twelve-month period.

Exclusions

In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Pediatric Dental benefit:

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: Cosmetic and/or reconstructive services and supplies, except for Dentally Appropriate services and supplies to treat a Congenital Anomaly and to restore a physical bodily function lost as a result of Injury or Illness.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance (for example, bleaching of teeth and personalization or characterization of prosthetic appliances).

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, such as 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, including, but not limited to:

- those performed by a Dentist who is compensated by a facility for similar Covered Services performed for 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, We will not cover services and supplies provided in connection with orthodontics, including the following:

- 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: Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.

Sealants: Except as provided for permanent molars.

Separate Charges: Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following:

- 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, including the following:

- 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 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: Dental Services provided by Telehealth or Telemedicine (see the Telehealth and Telemedicine benefits for definitions).

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

Topical Medicament Center

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Pediatric Dental benefits section:

Allowed Amount means:

- With respect to In-Network Dentists, the amount In-Network Dentists have contractually agreed to accept as full payment for Covered Services.
- With respect to Out-of-Network Dentists, reasonable charges for Covered Services.

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, please contact Us.

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 licensed to practice dentistry (including a doctor of medical dentistry, doctor of dental surgery or a denturist). A Dentist also means 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.

In-Network Dentist Claims

You must present Your member card when obtaining Covered Services from an In-Network Dentist. You must also furnish any additional information requested. The In-Network Dentist will furnish Us with the forms and information needed to process Your claim.

In-Network Dentist Reimbursement

An In-Network Dentist will be paid directly for Covered Services. In-Network Dentists have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount is any amount You must pay due to Deductible and/or Coinsurance. An In-Network Dentist may require You to pay Your share at the time You receive care or treatment.

Out-of-Network Dentist Claims

In order for Covered Services to be paid, You or the Dentist must first send Us a claim. 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; and
- the patient's name and the group and identification numbers.

Out-of-Network Dentist Reimbursement

In most cases, the Out-of-Network Dentist will be paid directly for Covered Services he or she provides.

Out-of-Network Dentists have not agreed to accept the Allowed Amount as full compensation for Covered Services. So, 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 Deductible and/or Coinsurance. For Out-of-Network Dentists, the Allowed Amount may be based upon the billed charges for some services, if required by law.

PEDIATRIC VISION SERVICES

We cover benefits for vision care 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. Please note that the BlueCard Program detailed in the Contract and Claims Administration Section does not apply to vision benefits provided under this Pediatric Vision benefit. Covered Services must be rendered by a Physician or optometrist practicing within the scope of his or her license. We will pay benefits under this Pediatric Vision benefit, not any other provision in this Policy, if a service or supply is covered under 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

Your Pediatric Vision benefit allows You to control Your out-of-pocket expenses, such as Copayments and Coinsurance, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your vision Provider under two choices called: "VSP Doctor" and "Out-of-Network Provider."

- **VSP Doctor.** You choose to see a VSP Doctor and save the most in Your out-of-pocket expenses. Choosing this vision Provider option means You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services
- **Out-of-Network Provider.** You choose to see an Out-of-Network Provider that does not have a contract with VSP and Your out-of-pocket expenses will generally be higher than a VSP Doctor. Also, choosing this vision Provider option means You may be billed for balances beyond any Deductible and/or Coinsurance. This is sometimes referred to as balance billing.

Vision Examination

We cover professional complete medical eye examination or visual analysis, 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

We cover hardware including frames, contacts and lenses. Coverage is limited to frames and lenses or contacts, but not both in a Calendar Year.

Frames

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

Lenses

We cover the following standard lenses in either glass or plastic:

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

Additionally, We cover lens enhancements, including 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 is covered if You have a specific condition for which contact lenses provide better visual correction.

Contact Lens Evaluation and Fitting Examination
We cover services and supplies for contact lens evaluation and fitting examinations.

Low Vision Benefit
In addition to the pediatric vision benefits described above, We cover low vision benefits for Insureds if vision loss is sufficient enough to prevent reading and performing daily activities. If You fall within this category (check with Your Provider), You will be entitled to professional services as well as ophthalmic materials, subject to the frequency and benefit limitations of these Low Vision Benefits. Consult Your VSP Doctor for more details.

Supplemental Testing
We cover 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
We cover low vision aids, including, but not limited to, optical and non-optical aids and the associated training.

Limitations
These pediatric vision benefits are designed to cover visual needs rather than cosmetic materials. If You select any of the following extras, We will pay the basic cost of the allowed lenses and You will pay any additional costs for these options:

- optional cosmetic processes;
- anti-reflective coating;
- color coating;
- mirror coating;
- blended lenses;
- cosmetic lenses;
- laminated lenses;
- oversize lenses;
- standard, premium and custom progressive multifocal lenses;
- certain limitations on low vision care; and
- contact lenses not previously described as covered.

Additional Discount
You are entitled to receive a 20 percent discount toward the purchase of non-covered materials from any VSP Doctor when a complete pair of glasses is dispensed. You are also entitled to receive a 15 percent discount off of contact lens examination services from any VSP Doctor, beyond the covered exam. Professional judgment will be applied when evaluating prescriptions written by an Out-of-Network Provider. VSP Doctors may request an additional exam at a discount.

Discounts are applied to the VSP Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye examination. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THIS PEDIATRIC VISION BENEFIT, BUT ARE NOT INSURANCE.**

Discount Limitations
- Discounts do not apply to vision care benefits obtained from Out-of-Network Providers.
- 20 percent discount applies only when a complete pair of glasses is dispensed.
- Discounts do not apply to sundry items, for example, contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

Exclusions
In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this

Pediatric Vision benefit:

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): Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia) or reversals or revisions of surgical procedures which alter the refractive character of the eye.

Corrective Vision Treatment of an Experimental Nature

Costs for Services and/or Supplies Exceeding Benefit Allowances

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 under the Low Vision benefit, We do not cover orthoptics or vision training and any associated supplemental testing.

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

Replacement of Lenses and Frames: Except at the normal intervals when services are otherwise available, We do not cover replacement of lenses and frames furnished under this Policy which are lost or broken.

Two Pair of Glasses in Lieu of Bifocals

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Pediatric Vision benefits section:

Allowed Amount means:

- For VSP Doctors (see definition of "VSP Doctor" below), the amount that these Providers have contractually agreed to accept as payment in full for a service or supply.
- For Out-of-Network Providers (see definition of "Out-of-Network Provider" below), the billed amount for listed services and supplies.

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, please contact Us.

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 are contact lenses that are prescribed by Your VSP Doctor or Out-of-Network Provider for other than cosmetic purposes. Benefit Authorization is not required for You to be eligible for Necessary Contact Lenses, however, certain benefit criteria, as defined by VSP, must be satisfied in order for contact lenses to be covered as Necessary Contact Lenses.

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.

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.

General Information

Submission of Claims and Reimbursement

When You visit a VSP Doctor, the VSP Doctor will submit the claim directly to VSP for payment. If You visit an Out-of-Network Provider, however, You will need to pay the Provider his or her full fee at the time You receive the service or supply. You will need to submit a claim to VSP for reimbursement according to the benefits in this Policy, less any Copayment and/or Coinsurance. THERE IS NO ASSURANCE THAT PAYMENT WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR HARDWARE. Be sure the claim is complete and includes the following information:

- copy of claim receipt from the Provider, including Provider's name, address, date of service, and services performed. You may access Out-of-Network Reimbursement under My Benefits on VSP's Web site, **www.vsp.com**, to get a claim form to assist in submission of Out-of-Network Provider claims;
- Your name, date of birth, address and member ID number; and
- patient's name, date of birth and relation to You.

Send 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 under these Pediatric Vision benefits and wish to have it reviewed, You may Appeal. See the Appeal Process in this Policy 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.

PRESCRIPTION MEDICATIONS

We cover Prescription Medications listed under the Drug List, which can be viewed on Our Web site.

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 practicable.

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 routinely covered under Your Prescription Medications benefit; however, a Prescription Medication not on the Drug List may be covered under certain circumstances. Non-Drug List means those self-administered Prescription Medications not listed in the Drug List for Your coverage.

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:

- You are not able to tolerate a covered Prescription Medication on the Drug List; or
- Your Provider determines that the Prescription Medication on the Drug List is not therapeutically efficacious for treating Your covered condition; or
- Your Provider determines that a dosage required for efficacious 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 on the Drug List Copayment and/or Coinsurance level determined by Your benefit.

Covered Prescription Medications

Benefits under this Prescription Medications benefit are available for the following:

- diabetic supplies (including test strips, glucagon emergency kits, insulin syringes, but not insulin pumps or continuous glucose monitors and their supplies), when obtained with a Prescription Order (insulin pumps or continuous glucose monitors and their supplies are covered under the Durable Medical Equipment benefit);
- Prescription Medications;
- certain preventive medications (including, but not limited to, aspirin, fluoride, iron and medications for tobacco use cessation, except for Brand-Name Medications not on the Drug List) according to, and as recommended by, the USPSTF, when obtained with a Prescription Order;
- FDA-approved women's prescription and over-the-counter (if presented with a Prescription Order) contraception methods as recommended by the HRSA. These include 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);
- immunizations for adults and children according to, and as recommended by, the CDC;
- immunizations for purposes of travel, occupation or residency in a foreign country;
- growth hormones, when preauthorized;
- Specialty Medications;
- certain Prescription Medications that are administered by Your Provider as determined by the Pharmacy and Therapeutics (P&T) Committee;
- Self-Administrable Cancer Chemotherapy Medication; and
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Injectable Medications).

You are not responsible for any applicable Deductible, Copayment and/or Coinsurance when You fill prescriptions at a Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications, women's contraceptives or for immunizations, as specified above. For a list of such medications, please visit Our Web site or contact Customer Service. Also, if Your Provider believes that Our covered preventive medications, including women's contraceptives, are medically inappropriate for You, You may request a coverage exception for a different preventive medication by contacting Customer Service.

Pharmacy Network Information

A nationwide network of Participating Pharmacies is available to You. Pharmacies that participate in this network submit claims electronically.

Your member card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as Our Insured, a Participating Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find Participating Pharmacies and a Pharmacy locator on Our Web site or by contacting Customer Service.

Claims Submitted Electronically

You must present Your member card at a Pharmacy for the claim to be submitted electronically. You must pay any required Deductible, Copayment and/or Coinsurance at the time of purchase. 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

When a claim is not submitted electronically, You must pay for the Prescription Medication in full at the time of purchase. For reimbursement, simply complete a Prescription Medication claim form and mail the form and receipt to Us. We will reimburse You based on the Covered Prescription Medication Expense, less the applicable Deductible, Copayment and/or Coinsurance that would have been required had the medication been purchased from and submitted electronically by a Participating Pharmacy. We will send payment directly to You.

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 any Deductible, Copayment and/or Coinsurance.

Mail-Order

You can also use mail-order services to purchase covered Prescription Medications. Mail-order coverage applies only 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 under 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, simply send all of the following items to a Mail-Order Supplier at the address shown on the prescription mail-order form available on Our Web site (which also includes refill instructions):

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

Preauthorization

Preauthorization may be required to establish that a Prescription Medication is Medically Necessary before it is dispensed and as indicated under the Drug List Exception Process above. We publish a list of those medications that currently require preauthorization. If You have any questions regarding the list of medications that require preauthorization, You can contact Customer Service or You can view the list on Our Web site. In addition, We notify participating Providers, including Pharmacies, which Prescription Medications require preauthorization. The prescribing Provider must provide the medical information necessary to establish Medical Necessity of Prescription Medications that require preauthorization.

Coverage for preauthorized Prescribed Medications begins on the date We preauthorize them. If Your Prescription Medication requires preauthorization and You purchase it before We preauthorize it or without obtaining the preauthorization, the Prescription Medication may not be covered, even if purchased from a Participating Pharmacy.

Limitations

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

- **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. We do not cover any amount over the established maximum quantity, 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.

- **Refills**
  We will cover refills from a Pharmacy when You have taken 75 percent of the previous prescription (however, Schedule II or III controlled substance medications may be refilled only after You have taken 85 percent of the previous prescription). Refills obtained from a Mail-Order Supplier are allowed after You have taken all but 20 days of the previous Prescription Order. If You choose to refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward any applicable Deductible or Out-of-Pocket Maximum. If You feel You need a refill sooner than allowed, a refill exception will be considered by Us on a case-by-case basis. You may request an exception by calling Customer Service.

- **Prescription Medications Dispensed by Excluded Pharmacies**
  A Pharmacy may be excluded if it has been investigated by the Office of the Inspector General (OIG) and appears on the OIG's exclusion list. If You are receiving medications from a Pharmacy that is later determined by the OIG to be an excluded Pharmacy, You will be notified, after Your claim has been processed, that the Pharmacy has been excluded, so that You may obtain future Prescription Medications from a non-excluded Pharmacy. We do not permit excluded Pharmacies to submit claims after the excluded Pharmacies have been added to the OIG list.

- **Manufacturer Coupons**
  Any reduction in Your cost-sharing resulting from the use of a drug manufacturer coupon does not count toward the Out-of-Pocket Maximum.

Exclusions

In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Prescription Medications benefit:

Biological Sera, Blood or Blood Plasma

Brand-Name Medications not on the Drug List: Except as provided through the Drug List Exception Process in this Prescription Medications benefit, We do not cover Prescription Medications as defined below for Brand-Name Medications that are not on the Drug List also defined below.

Bulk Powders: Except for those included on Our Drug List that are presented with a Prescription Order, We do not cover bulk powders.

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: Devices or appliances of any type, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Durable Medical Equipment benefit).

Diagnostic Agents: Except for diagnostic agents that may otherwise be provided under this Medical Benefits Section, We do not cover medications used to aid in diagnosis rather than treatment.

Foreign Prescription Medications: Except for 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, We do not cover foreign Prescription Medications. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.

General Anesthetics: Coverage may otherwise be provided under this Medical Benefits Section.

Insulin Pumps and Pump Administration Supplies: Coverage for insulin pumps and supplies is provided under the Durable Medical Equipment benefit.

Medical Foods: Coverage for these products may otherwise be provided under this Medical Benefits Section.

Medications We Don't Consider Self-Administrable: Coverage for these medications may otherwise be provided under this Medical Benefits Section or as specifically indicated in this Prescription Medications benefit.

Nonprescription Medications: Except for medications included on Our Drug List, approved by the FDA or a Prescription Order by a Physician or Practitioner, We do not cover medications that by law do not require a Prescription Order, for example, over-the-counter medications, including vitamins, minerals, food supplements, homeopathic medicines, nutritional supplements and 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 under 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 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 under the Telehealth and Telemedicine benefits, We do not cover prescriptions made by a Provider without recent and relevant in-person examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. For purposes of this exclusion, 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. Additionally, this exclusion does not apply to a Provider or Pharmacist who may prescribe: 1) an opioid antagonist to an Insured who is at risk of experiencing an opiate-related overdose; or 2) an epinephrine auto-injector to an Insured who is at risk of experiencing anaphylaxis.

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Prescription Medications benefit:

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 Pharmacy that is able to provide Prescription Medications using a mail-order program. A Participating Mail-Order Supplier means a mail-order Pharmacy with which We have contracted for mail-order services and which has the capability of submitting claims electronically. A Nonparticipating Mail-Order Supplier means a mail-order Pharmacy with which We have not contracted

for mail-order services and which may not be able to or chooses not to submit claims electronically.

Pharmacist means an individual licensed to dispense Prescription Medications, counsel a patient about how the medication works and its 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. A 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. Participating or Preferred Pharmacies have the capability of submitting claims electronically. To find a Preferred Pharmacy, please visit Our Web site or contact Customer Service. A Nonparticipating Pharmacy means a Pharmacy with which We neither have a contract nor have contracted access to any network it belongs to. Nonparticipating Pharmacies may not be able to or choose not to submit claims electronically.

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

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. For the purpose of this definition, "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 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, please visit Our Web site or contact Customer Service.

Prescription Medications (also Prescribed Medications) means medications and biologicals that relate directly to the treatment of an Illness or Injury, legally cannot be dispensed without a Prescription Order and by law must bear the legend: "Prescription Only," or as specifically included on Our Drug List.

Prescription Order means a written prescription or oral 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). For purposes of this definition, 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. A Participating Specialty Pharmacy means a Specialty Pharmacy for which We have contracted to have access and which has the capability of submitting claims electronically. A Nonparticipating Specialty Pharmacy means a Specialty Pharmacy with which We have not contracted and which may not be able to or chooses not to submit claims

electronically. To find a Specialty Pharmacy, please 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.

PROSTHETIC DEVICES

We cover prosthetic devices for functional reasons to replace a missing body part, including artificial limbs, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. 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 covered only for voice boxes to replace all, part or a surgically removed larynx. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility benefit (Hospital Care or Ambulatory Surgical Center). We will cover repair or replacement of a prosthetic device due to normal use or growth of a child.

REHABILITATION SERVICES

We cover inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services) and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness or for neurodevelopmental purposes. Outpatient rehabilitation visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. We do not cover outpatient cardiac and pulmonary rehabilitation. See the Other Professional Services and Hospital Care benefits for coverage of inpatient cardiac and pulmonary rehabilitation.

REPAIR OF TEETH

We cover services and supplies for treatment required as a result of damage to or loss of sound natural teeth when such damage or loss is due to an Injury.

RETAIL CLINIC OFFICE VISITS

We cover office visits in a Retail Clinic for treatment of Illness or Injury. All other professional services performed in the Retail Clinic, not billed as an office visit, are not considered an office visit under this benefit. For example, We will pay for a surgical procedure performed in the Retail Clinic according to the Other Professional Services benefit.

SKILLED NURSING FACILITY (SNF) SERVICES

We cover the inpatient services and supplies of a Skilled Nursing Facility 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

We cover spinal manipulations performed by any Provider. Manipulations of extremities are covered under the Rehabilitation Services benefits. Spinal manipulations that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

TELEHEALTH

We cover telehealth (live audio-only communication, audio and video communication and store and forward services, as permitted by law) between the patient and a telehealth Provider.

For purposes of this benefit:

"Audio-only communication" is a secure telephonic communication. Audio-only communication is covered if there is a previously established patient-Provider relationship. An audio-only communication must take the place of an in-person visit that would be billable by the Provider.

"Store and forward technology" is secure one-way electronic transmission (sending) of a patient's medical information from an originating site to a Provider at a distant site, which is later used by the Provider for

diagnosis and medical management of the patient. Store and forward technology does not include telephone, fax or e-mail communication.

"Store and forward services" are the Provider's diagnosis and medical management of the patient that result from the use of store and forward technology. You must have engaged in a live (in-person or synchronous audio and video communication) visit with Your Provider before engaging in subsequent, related store and forward services with that Provider. Coverage of store and forward services is limited to the services We have specifically contracted with that Provider to provide.

TELEMEDICINE

We cover telemedicine (audio and video communication) services between a distant-site Practitioner and a patient at an originating site. Originating sites include facilities such as Hospitals, rural health clinics, Physician's offices and community mental health centers.

We also cover store and forward technology. For the purpose of this benefit, "store and forward technology" is secure one-way electronic transmission (sending) of a patient's medical information from an originating site to a Provider at a distant site, which is later used by the Provider for diagnosis and medical management of the patient. Store and forward technology does not include telephone, fax or e-mail communication.

TERMINATION OF PREGNANCY

We cover termination of pregnancy (abortion) for all female Insureds only when necessary to preserve the life of the female Insured on whom the abortion is performed.

TRANSPLANTS

We cover transplants, including transplant-related services and supplies for covered transplants. Covered travel expenses are limited to transportation, lodging and food costs, when approved through case management. Covered travel expenses that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. A transplant recipient who is covered under this Policy and fulfills Medically Necessary criteria will be eligible for the following transplants: 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, for example, either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions). This list of transplants is subject to change. Insureds can contact Us for a current list of covered transplants. We do not cover any organ or tissue which is procured outside the United States and any transplant procedure performed outside the United States.

NOTE: Gene and/or adoptive cellular therapies are covered under the Gene Therapy and Adoptive Cellular Therapy benefit and not under this Transplants benefit.

Donor Organ Benefits

We cover donor organ procurement costs if the recipient is covered for the transplant under this Policy. 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.

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 under 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 under 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 under this benefit.

GENERAL PROVISIONS

Notice of Claim

Written notice of any loss resulting in a claim being filed under 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

In addition to the definitions in the Definitions Section, 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 in this Policy. Other provision specific exclusions (for example, Pediatric Dental or Pediatric Vision services) may apply and, if so, will be described elsewhere in this Policy.

SPECIFIC EXCLUSIONS

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise Covered Service for preventive service as specified under the Preventive Care and Immunizations or the Prescription Medications benefits.

Activity Therapy

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 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 associated surgery, drugs, testing or supplies, regardless of underlying condition or circumstance.

Aviation

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

Breast Reduction

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

Certain Therapy, Counseling and Training

Educational, vocational, social, image, milieu or marathon group therapy, premarital or marital counseling, Individual Assistance Program (IAP) services, except as provided under the IAP Section, if applicable; 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

Cosmetic and/or reconstructive services and supplies, except in the treatment of the following:

- to treat a Congenital Anomaly;
- to restore a physical bodily function lost as a result of Injury or Illness; 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 in this Policy.

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, We do not cover counseling in the absence of Illness.

Custodial Care
Except as provided under the Palliative Care benefit, We do not cover non-skilled care and helping with activities of daily living.

Dental Services
Except as provided under the Pediatric Dental Services or the Repair of Teeth benefits, We do not cover Dental Services 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.

Elective Abortions
We do not cover elective abortions. By "elective abortion," We mean 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 under 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 family counseling is part of the treatment for a child or adolescent with a covered diagnosis, We do not cover family counseling.

Fees, Taxes, Interest
Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. We also do not cover 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, unless required by law.

Government Programs
Benefits that are covered, or would be covered in the absence of this Policy, by any federal, state or government program, except for facilities that contract with Us and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. We do not cover government facilities outside the Service Area (except for 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, We do not cover hearing aids (externally worn or surgically implanted) or other hearing devices.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses, including, but not limited to, use of such services for the 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 under state or federal law.

Individualized Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids and supports as provided under 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, We do not cover treatment of infertility, including, but not limited to, surgery, fertility drugs and medications.

Investigational Services
Except as provided under the Approved Clinical Trials benefit, We do not cover Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section in this Policy.

Motor Vehicle Coverage and Other Available Insurance
Expenses for services and supplies that are payable under any automobile medical, personal injury protection (PIP), or automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, the Coordination of Benefits provision in this Policy shall apply); underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to an Insured, whether or not the Insured makes a claim under such coverage. Further, the Insured is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, We will provide benefits according to this Policy.

Non-Direct Patient Care
Services that are not direct patient care, including:

- 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), except as provided under the Telehealth and Telemedicine benefits.

Obesity or Weight Reduction/Control
Except as provided under the Nutritional Counseling benefit or as required by law, We do not cover medical treatment, medications, surgical treatment (including treatment of complications, revisions and reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions. This exclusion does not apply to reversals or revisions of surgery for obesity when required to correct a life-endangering condition. This exclusion also does not apply to treatment of obesity-related comorbid medical conditions; for example: diabetes, high blood pressure and heart disease.

Orthognathic Surgery
Except for orthognathic surgery due to an Injury, sleep apnea or Congenital Anomaly, We do not cover services and supplies for orthognathic surgery. By "orthognathic surgery," We mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones.

Over-the-Counter Contraceptives
Except as provided under the Prescription Medications benefit or as required by law, We do not cover over-the-counter contraceptive supplies.

Personal Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, We do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps, light boxes and therapy or service animals, including the cost of training and maintenance.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment, including hot tubs or membership fees at spas, health clubs or other such facilities. This exclusion applies even if the program, equipment or membership is recommended by the Insured's Provider.

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 for treatment of an Illness, Injury or condition caused by an Insured's **voluntary participation in** a riot, armed invasion or aggression, insurrection or rebellion or sustained by an Insured arising directly from 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
Self-help, non-medical self-care and training programs, including:

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

This exclusion does not apply to services for training or educating an Insured when provided without separate charge in connection with Covered Services or when specifically indicated as a Covered Service (for example, nutritional counseling and diabetic education).

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "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
Except for preventive care benefits provided in this Policy, We do not cover 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, such as laboratory or similar tests, primarily for administrative or qualification purposes. Such purposes include, but are not limited to, admission to or remaining in a school, camp, sports team, the military or other institution; athletic training evaluation; legal proceedings, such as establishing paternity or custody; qualification for employment, marriage, insurance, occupational injury benefits, licensure or certification; or immigration or emigration.

Sexual Dysfunction
Except for covered Mental Health Services, We do not cover treatment, services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause.

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided for temporomandibular joint (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
Travel and transportation expenses other than covered ambulance services or as otherwise provided in this Policy.

Varicose Vein Treatment
Except when there is associated venous ulceration or persistent or recurrent bleeding from ruptured veins, We do not cover treatment of varicose veins.

Vision Care
Except as provided under the Pediatric Vision Services benefit, We do not cover routine eye exam, 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
Expenses for services and supplies incurred as a result of any work-related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. We may require You or one of Your eligible dependents to file a claim for workers' compensation benefits before providing any benefits under this coverage. We do not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers' compensation benefit. The only exception is if You or one of Your eligible dependents are exempt from state or federal workers' compensation law.

Policy and Claims Administration

This section explains a variety of matters related to administering benefits and/or claims, including situations that may arise when Your health care expenses are the responsibility of a source other than Us.

PREAUTHORIZATION

Contracted Providers

Contracted Providers may be required to obtain preauthorization from Us in advance for certain services provided to You. You will not be penalized if the contracted Provider does not obtain those approvals from Us in advance and the service is determined to be not covered in this Policy.

Non-Contracted Providers

Outpatient Services

Non-contracted Providers are not required to obtain preauthorization from Us in advance for outpatient services. You may be liable for costs if You elect to seek services from non-contracted Providers and those services are not considered Medically Necessary and not covered in this Policy. You may request that a non-contracted Provider preauthorize outpatient services on Your behalf to determine Medical Necessity prior to the service being rendered.

Inpatient Services

While We do not require non-contracted Providers to obtain preauthorization from Us in advance for inpatient services, We do require preauthorization in advance of receiving these services. You are responsible for obtaining preauthorization from Us in advance of inpatient services received 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 in this Policy.

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

MEMBER CARD

When You, the Policyholder, enroll with Us, You will receive a member card. It will include important information such as Your identification number and Your name.

It is important to keep Your member card with You at all times. Be sure to present it to Your Provider before receiving care.

If You lose Your card, or if it gets destroyed, You can get a new one by contacting Customer Service. You can also view or print an image of Your member card by visiting Our Web site on Your PC or mobile device. If coverage under this Policy terminates, Your member card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

We have the sole right to 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.

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. Please refer to Your Blue plan network where supplies were received for coverage of shipped Durable Medical Equipment.

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. Please

refer to Your Blue plan network where the referring Provider is located for coverage of independent clinical laboratory services.

You will be responsible for the total billed charges for benefits in excess of Maximum Benefits, if any, and for charges for any other service or supply not covered under this Policy, regardless of the Provider rendering such service or supply.

Timely Filing of Claims
Written proof of loss must be received within one year after the date of service for which a claim is made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. We will deny a claim that is not filed in a timely manner unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. You may, however, Appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner.

Freedom of Choice of Provider
Nothing contained in this Policy is designed to restrict You in selecting the Provider of Your choice for pediatric dental care or treatment, pediatric vision care or treatment or for care or treatment of an Illness or Injury.

In-Network Provider Claims
You must present Your member card when obtaining Covered Services from an In-Network Provider. You must also furnish any additional information requested. The Provider will furnish Us with the forms and information We need to process Your claim.

In-Network Provider Reimbursement
We will pay an In-Network Provider directly for Covered Services. These Providers have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount is any amount You must pay due to any Deductible, Copayment and/or Coinsurance. These Providers may require You to pay Your share at the time You receive care or treatment.

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

Out-of-Network Providers have not agreed to accept the Allowed Amount as full compensation for Covered Services. So, 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 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.

Ambulance Claims
When You or Your Provider forwards a claim for ambulance services to Us, it must show where the patient was picked up and where he or she was taken. It should also show the date of service, the patient's name and the patient's identification number.

Claims Determinations
Within 30 days of Our receipt of a claim, We will notify You of the action We have taken on it. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When We cannot take action on the claim due to circumstances beyond Our control, We will notify You within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when We expect to act on the claim.
- When We cannot take action on the claim due to lack of information, We will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

We must allow You at least 45 days to provide Us with the additional information if We are seeking it from You. If We do not receive the requested information to process the claim 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 under 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 ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("nonparticipating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

BlueCard Program

Under 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. Please 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 nonparticipating Providers, the amount You pay for such services will normally be based on either the Host Blue's nonparticipating 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 nonparticipating 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 nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating 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.

NONASSIGNMENT AND NONASSIGNMENT OF VOTING RIGHTS

Only You are entitled to benefits under 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.

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 under 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 other-party liability provision in this Policy and Claims Administration Section for additional information.

LEGAL ACTION

No action at law or in equity will be brought to recover under this Policy prior to the expiration of 60 days after written proof of loss has been furnished 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 furnished.

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. Please contact Our Customer Service department 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.

LIMITATIONS ON LIABILITY

In all cases, 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.

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 under 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 under 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 under 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 Injury or Illness 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 Injury or Illness 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 under 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 under this provision will not exceed the amount of Your recovery.

COORDINATION OF BENEFITS
If You are covered under 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.

Coordination of Benefits Under a Health Savings Account (HSA) Plan
This high deductible health plan was designed for use in conjunction with an HSA, but can be maintained without an HSA. Laws strictly limit the types of other coverages that an HSA participant may carry in addition to his or her high deductible health plan. The benefits of maintaining an HSA are jeopardized if impermissible types of other coverages are maintained. We will coordinate benefits according to this Coordination of Benefits provision, regardless of whether other coverage is permissible under HSA law or not. It is Your responsibility to ensure that You do not maintain other coverage that might jeopardize any HSA tax benefit that You plan to claim.

Benefits Subject to this Provision
All of the benefits provided in this Policy are subject to this Coordination of Benefits provision.

Definitions
In addition to the definitions in the Definitions Section, the following are definitions that apply to this

Coordination of Benefits Section:

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 under 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.
- When this Policy restricts coordination of benefits to certain types of coverage or benefits, any expenses for other types of coverage or benefits. See the Benefits Subject to this Provision paragraph, above, for restrictions on the types of coverage or benefits to which coordination applies.
- 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, for purposes of these Coordination of Benefits provisions, 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 (as defined in IDAPA 18.01.30);
- Medicare supplement coverage;
- A state plan under Medicaid; 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 under this provision; or
- Both Plans use the order of benefit determination provision included herein and under 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 under 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, for purposes of this Coordination of Benefits provision, 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 applies:

Non-dependent Coverage: A Plan that covers You other than as a dependent will be primary to a Plan under 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 or 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 under 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 under 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 over a Plan that is providing continuation coverage (pursuant to COBRA or under a right of continuation under 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 under 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 under a Plan, two Plans will be treated as one if You were eligible under 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 under a Plan is measured from Your first date of coverage under 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 under 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 under 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 under 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 under 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 under any other Plan(s) may include an amount that should have been paid under 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 under this Policy. 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 under 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 under 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, please contact the VSP Customer Service department. 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's Customer Service department at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance). For the purpose of Appeals for pediatric vision benefits, references to "We," "Us" and "Our" in this Appeal Process Section refer to VSP.

For all other benefits under this Policy, if You believe a policy, action or decision of Ours is incorrect, please contact Our Customer Service department. 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 under the regular Appeal process, You or Your treating Provider may specifically request an expedited Appeal. Please 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

Please 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 under 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 in this Policy, 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 under the Expedited External Review Request provision below.

No later than four months from the date We issue a final notice of denial, You may submit a 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.

By "urgent care request," We mean 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.

Under Idaho law, the IRO is immune from any claim relating to its opinion rendered or acts or omissions

performed within the scope of its duties unless performed in bad faith or involving gross negligence.

INFORMATION

For pediatric vision benefits, if You have any questions about the Appeal Process outlined here, You may contact VSP's Customer Service department at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance), Monday-Friday 5 a.m. - 8 p.m., Saturday 7 a.m. - 8 p.m., and Sunday 7 a.m. - 7 p.m.

For all other benefits under this Policy, if You have any questions about the Appeal Process outlined here, You may call Our Customer Service department or You can write to Our Customer Service department at the following address: Regence BlueShield of Idaho, P.O. Box 1827, MS CS B32B, Medford, OR 97501-9884.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

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 in this Policy that is not considered Pre-Service.

Pre-Service means any claim for benefits in this Policy 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 purpose of 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 purpose of 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.

Who Is Eligible, How to Apply and When Coverage Begins

This section contains the terms of eligibility under this Policy for a Policyholder and his or her dependents. It also describes when coverage under this Policy begins for You and/or Your eligible dependents. Of course, payment of any corresponding monthly premium is required for coverage to begin on the indicated dates.

WHEN COVERAGE BEGINS

Subject to meeting the eligibility requirements as stated in the following paragraphs, You will be entitled to apply for coverage for Yourself and Your eligible dependents. 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

To be eligible to apply, as a Policyholder, for coverage in this Policy, You 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.

If You move and are no longer a Resident in Our Service Area, notify Us without delay. 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 considered to be a part of this Policy. Applicants are eligible to apply under this Policy if they are not enrolled in Medicare and meet the Residency Requirement provision 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; and
  - 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) otherwise eligible 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, if You 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) to Us. A Newborn Child's enrollment will be effective from the moment of birth if a completed application is received within 60 days following the date of birth 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 for a Newly Adopted Child will be effective from Placement 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 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. See also the Special Enrollment provision below.

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

SPECIAL ENROLLMENT

If You and/or Your eligible dependents have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children 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 (see also the Newly Eligible Dependents provision above);
- 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 the Exchange 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.

Note that 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, if enrollment is requested as specified, coverage will be effective on the first of the calendar month following the date of the qualifying event, except that where 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 furnish or cause to be furnished to Us any information necessary and appropriate to determine the eligibility of a dependent. We must receive such information before enrolling a person as a dependent in this Policy.

DEFINITIONS SPECIFIC TO WHO IS ELIGIBLE, HOW TO APPLY AND WHEN COVERAGE BEGINS 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: 1) incapable of self-sustaining employment by reason of intellectual disability or physical handicap; and 2) 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 in this Policy 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 under 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, Your and Your Enrolled Dependents' coverage ends 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.

GRACE PERIOD

A grace period of 30 days will be granted for the payment of the regular monthly premium, as prescribed by Us, after payment of the first 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.

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 under this Policy according to the provisions

below.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), 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.

If You Die

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 after the Effective Date (including 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), 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. 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

- For an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the calendar month in which the child exceeds the dependent age limit so long as premium has been received for the calendar month.
- For an enrolled child who is no longer eligible due to disruption of Placement before legal adoption and who is removed from Placement, eligibility ends on the date the child is removed from Placement.
- For an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the calendar month in which the child is no longer a dependent 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:

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

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

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 monthly period through which premiums are paid or such later date as is 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.

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 under this benefit plan that include the right to Appeal, review by an Independent Review Organization and civil action.

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 30 days (or longer, as required by law) after written notice has been given to the Policyholder, and 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.

NOTICES

Any notice to Insureds required in this Policy will be considered to be 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 form (COA) 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 given by mail addressed to: Regence BlueShield of Idaho, P.O. Box 31603, Salt Lake City, UT 84130-0603; provided, however that any 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 under this Policy and to make an autopsy in case of death where it is not forbidden by law.

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 the purpose of 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.

WE ARE NOT RESPONSIBLE FOR HSA FINANCIAL OR TAX ARRANGEMENTS

While this high deductible health plan was designed for use in conjunction with an HSA, We do not assume any liability associated with Your contribution to an HSA during any period that this high deductible health plan does not qualify for use with an HSA. An HSA is a tax-exempt account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible but in order to qualify for and make contributions to an HSA, You must be enrolled in a qualified high deductible health plan (and generally not be enrolled in other coverage). You are solely responsible to ensure that this plan qualifies, and continues to qualify, for use with any HSA that You choose to establish and maintain. Please note that the tax references contained in this Policy relate to federal income tax only. The tax treatment of HSA contributions and distributions under Your state's income tax laws may differ from the federal tax treatment and differs from state to state.

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

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered in this Policy, 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 used in this Policy. 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 (see definition of "In-Network" below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For Out-of-Network Providers (see definition of "Out-of-Network" below) who are not accessed through the BlueCard Program, the reasonable charges for Covered Services or supplies. 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 (see definition of "Out-of-Network" below) 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 with in 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, please contact Us.

Ambulatory Surgical Center means a distinct facility or that portion of a facility that operates exclusively for the purpose of providing 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. For the purpose of this definition, the term "significant deviation" is defined to be a deviation which impairs the function of the body and includes, but is not limited to, the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers or defects of metabolism and other conditions that are medically diagnosed to be Congenital Anomalies.

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

Custodial Care means care that is for the purpose of 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 for the purpose of separating the patient from others or preventing self-harm.

Dental Services 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.

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 under the terms in this Policy by Us.

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, Injury, genetic or Congenital Anomaly, pregnancy or 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 under 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 under the direction of registered nurses. A Hospital under 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 to be 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 caused by 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 as Injuries.

In-Network means a Provider that has an effective participating contract with Us that designates him, her or it as a Provider of Your network, to provide services and supplies to Insureds in accordance with the provisions of this coverage. In-Network also means a Provider of Your network that has an effective participating contract with one of Our Affiliates 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 under 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 efficacious 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, Injury or Illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

Lifetime means the entire length of time an Insured is continuously covered under 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 for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
- 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.

For these purposes, "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.

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. Reimbursement of Out-of-Network Provider services will be provided at the Out-of-Network benefit level and You may be billed for balances over Our payment level in addition to any Deductible, Copayment and/or Coinsurance amount.

Physician means an individual who is duly licensed to practice medicine and surgery in all of its branches or to practice as an osteopathic Physician and 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 podiatrists, psychologists, certified nurse midwives, certified registered nurse anesthetists, dentists (doctor of medical dentistry or doctor of dental surgery, or denturist; and 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, Skilled Nursing Facility, Ambulatory Surgical Center, Physician, 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, or an Ambulatory Surgical Center, urgent care center or facility, Hospital, Pharmacy, rehabilitation facility or 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. Generally, there will also be no Coinsurance amount required for an Upfront Benefit, however, a Copayment or Coinsurance may still 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 a Deductible, Copayment and/or Coinsurance. Refer to the Upfront Benefit in the Schedule of Benefits to determine coverage.

Regence BlueShield of Idaho, Inc.

Medical Benefits
2019 OUTLINE OF COVERAGE

OUTLINE OF COVERAGE
Silver HSA 2500

General Information

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. Please 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.

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 including 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.

What is Covered

Benefits are available for these services and supplies when Medically Necessary. Benefits are subject to all of the applicable exclusions, limitations and requirements of the Policy.

Inpatient and Outpatient Hospital/Skilled Nursing Facility

- Semi-private room accommodations
- Ancillary services and supplies
- Emergency room services
- Dialysis treatment, chemotherapy and radiation therapy
- X-ray and laboratory services
- Inpatient rehabilitation
- Skilled Nursing Facility services limited to 30 inpatient days per Calendar Year

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

- 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

- Ambulatory Surgical Center
- Approved Clinical Trials
- Diabetic Education
- Durable Medical Equipment
- Medical/surgical supplies
- Ambulance services
- Inpatient/outpatient maternity care
- Hospice (inpatient/outpatient and respite. Respite limited to 14 days per Lifetime)
- Nutritional counseling limited to three visits per Calendar Year
- Outpatient habilitation services limited to 20 visits per Calendar Year
- Outpatient rehabilitation services limited to 20 visits per Calendar Year
- Palliative care limited to 30 visits per Calendar Year
- Repair of teeth limited to treatment provided within 12 months from date of Injury
- Telehealth
- Telemedicine
- Spinal manipulations limited to 18 spinal manipulations per Calendar Year

Diabetes Supplies

Diabetes supplies (including needles, syringes, test strips, lancets and other disposable diabetes supplies) are covered under the basic Policy benefit for prescriptions.

Transplants
Coverage is available. Examples for transplants are (but not limited to): kidney, cornea, heart, heart/lung, lung, liver, and pancreas transplants and bone marrow transplants for certain conditions. List of covered transplants is subject to change over time. Contact Regence BSI for an up-to-date list. Travel expenses for patient and caregiver are limited to 14 days per Calendar Year when approved by case management.

Preventive Services
We cover preventive services and immunization 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). In the event any of these bodies adopts a new or revised recommendation, We have up to one year before coverage of the related services must be available and effective.

We cover preventive care services provided by a professional Provider, facility or Retail Clinic such as:

- routine well-baby care, routine physical examinations, routine well-women's care and routine health screenings;
- Provider counseling and Prescription Medications prescribed for tobacco use cessation;
- immunizations for adults and children according to, and as recommended by, the Advisory Committee on Immunization Practices of the CDC;
- one new non-Hospital grade breast pump and accompanying supplies per pregnancy at the In-Network benefit level when obtained from a Provider or an approved Commercial Seller; and
- United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods for women in accordance with HRSA recommendations.

Pediatric Dental Coverage
The following Pediatric Dental benefits 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.

Preventive and Diagnostic Dental Services
- Cleanings: twice per Calendar Year
- Oral Exams - Preventive: twice per Calendar Year
- Oral Exams - Diagnostic: twice per Calendar Year
- Fluoride treatment
    - Topical fluoride varnish: twice per Calendar Year
    - Topical application of fluoride excluding prophylaxis: twice per Calendar Year
- X-Rays
    - Bitewings: twice per Calendar Year
    - Full mouth and panoramic: once in a three-year period
    - Cephalometric
- Sealants
    - One sealant per tooth every three years
    - Preventive resin restoration in a moderate to high caries risk patient - permanent tooth: one sealant per tooth every three years
- Space maintainers

Basic Dental Services
- Fillings
    - Composite or amalgam covered
- Oral surgery
    - Uncomplicated oral surgery procedures and complex oral surgery procedures

  - Osseous and mucogingival surgery: once per quadrant every three years
  - Gingivectomy and gingivoplasty: once per quadrant every three years

- General anesthesia or IV sedation
  - Includes coverage for partial or full bony impactions and children under age seven
- Emergency treatment
  - Covered for emergency treatment for pain relief
- Periodontal maintenance
  - Four per Calendar Year (in lieu of preventive cleaning)
- Scaling and root planning
  - Once in a two-year period per quadrant
- Endodontics (root canal treatment, pulpotomy and apicoectomy)
- Adjustments and repair of dentures/bridges
  - Reline limited to once in a three-year period
  - Rebase limited to once in a three-year period

Major Dental Services

- Crowns, inlays and onlays
  - Once per tooth every seven years
- Recement of crowns, inlays and onlays
- Crown repair or removal (inlay/onlay/veneer repair also covered)
- Dentures (full or partial)
  - Once every five years
- Bridges (fixed partial denture)
  - Once every five years
- Adjustment/repair of dentures and bridges (fixed partial denture)
  - Rebase and reline of dentures covered under Basic Dental Services
- Dental implants
  - Four per Lifetime maximum
- Repair implant abutment
  - Once every five years
- Orthodontia
  - Covered when Medically Necessary
- Occlusal guard
  - Limited to one in 12 months

Pediatric Vision Coverage

The following Pediatric Vision benefits 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. 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.

- Routine Exam: one per Calendar Year
- Frames: one frame per Calendar Year
- Lenses: one pair (two lenses) per Calendar Year
- Contacts may be selected instead of frames and lenses once per Calendar Year
- Low vision supplemental testing and supplemental aids every 2 Calendar Years
- Limitations may apply, refer to the Policy
- Discounts for non-covered services may apply, refer to the Policy.

Accidental Death Benefit

All Regence Individual coverage plans include a death benefit payable when We receive proof of death caused by accidental means. Adult subscribers, 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

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise Covered Service for preventive service as specified under the Preventive Care and Immunizations or the Prescription Medications Benefits in the Policy.

Activity Therapy

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 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 associated surgery, drugs, testing or supplies, regardless of underlying condition or circumstance.

Aviation

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

Breast Reduction

Except when following a Medically Necessary mastectomy, to the extent required by law, We do not cover breast reductions. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice in this Outline of Coverage or in the Policy.

Certain Therapy, Counseling and Training

Educational, vocational, social, image, milieu or marathon group therapy, premarital or marital counseling, Individual Assistance Program (IAP) services, except as provided under the IAP section, if applicable; 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

Cosmetic and/or reconstructive services and supplies, except in the treatment of the following:

- to treat a Congenital Anomaly;
- to restore a physical bodily function lost as a result of Injury or Illness; 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 in this Outline of Coverage or in the Policy.

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, We do not cover counseling in the absence of Illness.

Custodial Care
Except as provided under the Palliative Care benefit, We do not cover non-skilled care and helping with activities of daily living.

Dental Services
Except as provided under the Pediatric Dental Services or the Repair of Teeth Benefits, We do not cover Dental Services 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.

Elective Abortions
We do not cover elective abortions. By "elective abortion," We mean 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 under the Termination of Pregnancy benefit in the Policy.

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 family counseling is part of the treatment for a child or adolescent with a covered diagnosis, We do not cover family counseling.

Fees, Taxes, Interest
Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. We also do not cover 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, unless required by law.

Government Programs
Benefits that are covered, or would be covered in the absence of the Policy, by any federal, state or government program, except for facilities that contract with Us and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. We do not cover government facilities outside the Service Area (except for 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, We do not cover hearing aids (externally worn or surgically implanted) or other hearing devices.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses, including, but not limited to, use of such services for the 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 under state or federal law.

Individualized Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids and supports as provided under 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, We do not cover treatment of infertility, including, but not limited to, surgery, fertility drugs and medications.

Investigational Services
Except as provided under the Approved Clinical Trials benefit, We do not cover Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Policy.

Motor Vehicle Coverage and Other Available Insurance
Expenses for services and supplies that are payable under any automobile medical, personal injury protection (PIP), or automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, the Coordination of Benefits provision in the Policy shall apply); underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to You, whether or not You make a claim under such coverage. Further, You are responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, We will provide benefits according to the Policy.

Non-Direct Patient Care
Services that are not direct patient care, including:

- 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), except as provided under the Telehealth and Telemedicine benefits.

Obesity or Weight Reduction/Control
Except as provided under the Nutritional Counseling benefit or as required by law, We do not cover medical treatment, medications, surgical treatment (including treatment of complications, revisions and reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions. This exclusion does not apply to reversals or revisions of surgery for obesity when required to correct a life-endangering condition. This exclusion also does not apply to treatment of obesity-related comorbid medical conditions; for example: diabetes, high blood pressure and heart disease.

Orthognathic Surgery
Except for orthognathic surgery due to an Injury, sleep apnea or Congenital Anomaly, We do not cover services and supplies for orthognathic surgery. By "orthognathic surgery," We mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones.

Over-the-Counter Contraceptives
Except as provided under the Prescription Medications benefit or as required by law, We do not cover over-the-counter contraceptive supplies.

Personal Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, We do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps, light boxes and therapy or service animals, including the cost of training and maintenance.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment, including hot tubs or membership fees at spas, health clubs or other such facilities. This exclusion applies even if the program, equipment or membership is recommended by Your Provider.

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 for treatment of an Illness, Injury or condition caused by Your **voluntary participation in** a riot, armed invasion or aggression, insurrection or rebellion or sustained by You arising directly from 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
Self-help, non-medical self-care and training programs, including:

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

This exclusion does not apply to services for training or educating You when provided without separate charge in connection with Covered Services or when specifically indicated as a Covered Service (for example, nutritional counseling and diabetic education).

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "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
Except for preventive care benefits provided under this coverage, We do not cover 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, such as laboratory or similar tests, primarily for administrative or qualification purposes. Such purposes include, but are not limited to, admission to or remaining in a school, camp, sports team, the military or other institution; athletic training evaluation; legal proceedings, such as establishing paternity or custody; qualification for employment, marriage, insurance, occupational injury benefits, licensure or certification; or immigration or emigration.

Sexual Dysfunction
Except for covered Mental Health Services, We do not cover treatment, services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause.

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided for temporomandibular joint (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
Travel and transportation expenses other than covered ambulance services or as otherwise provided in

the Policy.

Varicose Vein Treatment
Except when there is associated venous ulceration or persistent or recurrent bleeding from ruptured veins, We do not cover treatment of varicose veins.

Vision Care
Except as provided under the Pediatric Vision Services benefit, We do not cover routine eye exam and vision hardware, or visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, 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
Expenses for services and supplies incurred as a result of any work-related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. We may require You or one of Your eligible dependents to file a claim for workers' compensation benefits before providing any benefits under this coverage. We do not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers' compensation benefit. The only exception is if You or one of Your eligible dependents are exempt from state or federal workers' compensation law.

PEDIATRIC DENTAL EXCLUSIONS
Adjustments
Adjustment of a denture or bridgework which is done within 6 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
Cosmetic and/or reconstructive services and supplies, except for Dentally Appropriate services and supplies to treat a Congenital Anomaly and to restore a physical bodily function lost as a result of Injury or Illness.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance (for example, bleaching of teeth and personalization or characterization of prosthetic appliances).

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, such as 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 individual by another Dentist.

Experimental or Investigational Services

Fabrication of Athletic Mouth Guard

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

- those performed by a Dentist who is compensated by a facility for similar Covered Services performed for You; 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, We will not cover services and supplies provided in connection with orthodontics, including the following:

- 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
Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.

Sealants
Except as provided for permanent molars.

Separate Charges
Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following:

- 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, including the

following:

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

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

Services Provided by Certain Entities
Services and treatment 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
Dental Services provided by Telehealth or Telemedicine (see the Telehealth and Telemedicine benefits in the Policy for definitions).

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

Topical Medicament Center

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

Corrective Vision Treatment of an Experimental Nature

Costs for Services and/or Supplies Exceeding Benefit Allowances

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
Orthoptics or vision training and any associated supplemental testing.

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

Replacement of Lenses and Frames
Except at the normal intervals when services are otherwise available, We do not cover replacement of lenses and frames furnished under the Policy which are lost or broken.

Two Pair of Glasses in Lieu of Bifocals

PRESCRIPTION MEDICATION EXCLUSIONS
Biological Sera, Blood or Blood Plasma

Brand-Name Medications not on the Drug List
Except as provided through the Drug List Exception Process in the Prescription Medications benefit, We do not cover Prescription Medications for Brand-Name Medications that are not on the Drug List.

Bulk Powders
Except for those included on Our Drug List that are presented with a Prescription Order, We do not cover bulk powders.

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
Devices or appliances of any type, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Durable Medical Equipment benefit).

Diagnostic Agents
Except for diagnostic agents that may otherwise be provided under the Medical Benefits Section of the Policy, We do not cover medications used to aid in diagnosis rather than treatment.

Foreign Prescription Medications
Except for 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, We do not cover foreign Prescription Medications. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.

General Anesthetics
Coverage may otherwise be provided under the Medical Benefits Section of the Policy.

Insulin Pumps and Pump Administration Supplies
Coverage for insulin pumps and supplies is provided under the Diabetes Supplies and Equipment benefit.

Medical Foods
Coverage for these products may otherwise be provided under the Policy.

Medications We Don't Consider Self-Administrable
Coverage for these medications may otherwise be provided under the Policy.

Nonprescription Medications
Except for medications included on Our Drug List, approved by the FDA or a Prescription Order by a Physician or Practitioner, We do not cover medications that by law do not require a Prescription Order, for example, over-the-counter medications, including vitamins, minerals, food supplements, homeopathic medicines, nutritional supplements and 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 under 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 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 Used for Sexual Dysfunction or Enhancement

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 under the Telehealth and Telemedicine benefits, We do not cover prescriptions made by a Provider without recent and relevant in-person examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. For purposes of this exclusion, 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. Additionally, this exclusion does not apply to a Provider or Pharmacist who may prescribe: 1) an opioid antagonist to an Insured who is at risk of experiencing an opiate-related overdose; or 2) an epinephrine auto-injector to an Insured who is at risk of experiencing anaphylaxis.

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

Eligibility

In general, 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 under one of Our individual health insurance plans.

To be eligible to apply, You must reside in Our Service Area (and not elsewhere) and not be enrolled in Medicare. 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. Service Area means the state of Idaho.

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.

Termination

Coverage will terminate in the event of:

- Failure to pay premiums;
- Establishment of residence outside Idaho;
- Intentional misrepresentation of material fact or fraud; or
- Loss of dependent eligibility

If the Policy is cancelled 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 under the Policy for all Policyholders (in which case Regence BSI shall provide 90 days prior written notice to all individuals covered under 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 under the Policy.

PREGNANCY BENEFIT EXTENSION

In the event We cancel or otherwise fail to renew the Policy, We 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.

PROVIDERS

Regence BSI allows You to control Your out-of-pocket expenses, such as Copayments and Coinsurance, for each Covered Service. You control Your out-of-pocket expenses by choosing Your Provider under two choices called: "In-Network" and "Out-of-Network."

- **In-Network.** You choose to see an In-Network Provider and save the most in Your out-of-pocket expenses. Choosing this Provider option means You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network.** You choose to see an Out-of-Network Provider and Your out-of-pocket expenses will generally be higher than an In-Network Provider. Choosing this Provider option means You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. This is sometimes referred to as balance billing.

For each benefit under the Policy, We indicate in the Schedule of Benefits Your payment amount for each provider option. You can go to **regence.com** for further Provider network information.

You will be responsible for the total billed charges for benefits in excess of Lifetime or Calendar Year benefit maximums, if any, and for charges for any other service or supply not covered under the Policy, regardless of the Provider rendering such service or supply.

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 ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("nonparticipating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

BlueCard Program

Under 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. Please 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 nonparticipating Providers, the amount You pay for such services will normally be based on either the Host Blue's nonparticipating 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 nonparticipating 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 nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment We will make for the out-of-Area Covered Services as set forth in the Policy.

PREAUTHORIZATION

Contracted Providers

Contracted Providers may be required to obtain preauthorization from Us in advance for certain services provided to You. You will not be penalized if the contracted Provider does not obtain those approvals from Us in advance and the service is determined to be not covered in the Policy.

Non-Contracted Providers

Outpatient Services

Non-contracted Providers are not required to obtain preauthorization from Us in advance for outpatient services. You may be liable for costs if You elect to seek services from non-contracted Providers and those services are not considered Medically Necessary and not covered in the Policy. You may request that a non-contracted Provider preauthorize outpatient services on Your behalf to determine Medical Necessity prior to the service being rendered.

Inpatient Services

While We do not require non-contracted Providers to obtain preauthorization from Us in advance for inpatient services, We do require preauthorization in advance of receiving these services. You are responsible for obtaining preauthorization from Us in advance of inpatient services received 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 in the Policy.

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

MEMBER CARD

Your member card is issued after You have been accepted for coverage.

IMPORTANT NOTE: YOUR COVERAGE IS NOT ACTIVE, AND YOU ARE NOT ELIGIBLE TO RECEIVE ANY BENEFITS, PRIOR TO:

- **YOUR PLAN'S EFFECTIVE DATE and**
- **PAYMENT OF YOUR FIRST PREMIUM.**

Once Your coverage is active, if You or Your enrolled family members require medical or Hospital

attention, simply present Your member card. Key information is contained on Your card that assists in proper handling of Your claim.

OTHER PARTY LIABILITY

If another party is responsible for Your Illness or Injury, the benefits paid under this program 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 under its program, and then the Secondary Health Plan may reduce its benefits. In no event will payment be made in excess of expenses incurred.

This high deductible health plan was designed for use in conjunction with a health savings account (HSA), but can be maintained without an HSA. Laws strictly limit the types of other coverages that an HSA participant may carry in addition to his or her high deductible health plan. The benefits of maintaining an HSA are jeopardized if impermissible types of other coverages are maintained. We will coordinate benefits, regardless of whether other coverage is permissible under HSA law or not. It is Your responsibility to ensure that You do not maintain other coverage that might jeopardize any HSA tax benefit that You plan to claim.

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.

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, area and tobacco use of the individual(s) covered under the Policy. We rely on the information You provide for Yourself and Your dependents, so the information must be complete and accurate for each person to be enrolled.

POLICY EFFECTIVE DATE

Your coverage Effective Date will be assigned on the first 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.

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 under 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.

MODIFICATION OF POLICY

We have the right to modify or amend the Policy from time to time. This right includes Our 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.

Special Notices

YOUR SPECIAL ENROLLMENT PERIOD RIGHTS

If You and/or Your eligible dependents have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children 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 the Exchange 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.

Note that 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, if enrollment is requested as specified, coverage will be effective on the first of the calendar month following the date of the qualifying event, except that where 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.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE (WHCRA)

Regence BSI and its subsidiaries are required by law to provide You with the following notice. This does not represent a change in Your coverage. The Women's Health and Cancer Rights Act of 1998 (WHCRA) includes important protections for patients who elect breast reconstruction in connection with mastectomy.

For a covered person who receives benefits in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient 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.

Benefits for the above services will be subject to the same subscriber cost-sharing provisions (for example, Deductible, Copayment and Coinsurance) as may be deemed appropriate and as are consistent with those established for other Covered Services. Your plan is already in compliance with this mandate and provides coverage for this.

WE ARE NOT RESPONSIBLE FOR HEALTH SAVINGS ACCOUNT FINANCIAL OR TAX ARRANGEMENTS

While this high deductible health plan was designed for use in conjunction with an HSA, We do not assume any liability associated with Your contribution to an HSA during any period that this high deductible health plan does not qualify for use with an HSA. An HSA is a tax-exempt account established

under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible, but in order to qualify for and make contributions to an HSA, You must be enrolled in a qualified high deductible health plan (and generally not be enrolled in other coverage). You are solely responsible to ensure that this plan qualifies, and continues to qualify, for use with any HSA that You choose to establish and maintain. Please note that the tax references contained in the Policy relate to federal income tax only. The tax treatment of HSA contributions and distributions under Your state's income tax laws may differ from the federal tax treatment and differs from state to state.

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

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 Us in compliance with Our bylaws.

Sean M. Robbins
President
Regence BlueShield of Idaho

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

For more information call Us at 1 (877) 508-7359 or You can write to Us at 1602 21st Avenue, Lewiston, ID 83501

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