

Regence BlueShield of Idaho, Inc. Policy

Individual Group Number: 37000101

2024 Medical Benefits



Regence BlueShield of Idaho is an Independent Licensee
of the BlueCross and BlueShield Association

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

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

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

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

NONDISCRIMINATION NOTICE

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

Regence:

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

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

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

- Qualified interpreters
- Information written in other languages.

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

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

Customer Service

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

Medicare Customer Service

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

VSP Customer Service

Phone: 1-844-299-3041
TTY: 1-800-428-4833

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

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

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

Language assistance

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

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

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

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

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

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

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

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

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' 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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល 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 ሊያገለግሉት ተዘጋጅተዋል፤ የሚከተለው 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 नि:शुल्क 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)

ໂບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຈະມີມີພ້ອມໃຫ້ທ່ານ. ໂທ 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 فاذا ذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)

SCHEDULE OF BENEFITS

SLHP Gold 1500 (including Tribal Greater than 300)

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

	Insured Responsibility	
	In-Network Provider	Out-of-Network Provider
Coinsurance	20%	50%
Deductible per Calendar Year <ul style="list-style-type: none"> • Except as noted with "Deductible waived," all benefits are subject to the Deductible and the Deductible must be met before benefits begin for any Insured. No one Family member may contribute more than their individual Deductible amount toward the Family Deductible. 	\$1,500 per Insured \$3,000 per Family	\$16,300 per Insured \$32,600 per Family
Out-of-Pocket Maximum per Calendar Year	\$9,450 per Insured \$18,900 per Family	\$81,500 per Insured \$163,000 per Family

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

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

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	Insured Responsibility	
	In-Network Provider	Out-of-Network Provider
Preventive Care and Immunizations	0%, Deductible waived	50%
Preventive Care – Expanded Immunizations	20%	50%
Office or Urgent Care Visits – Illness or Injury	Primary Physician or Practitioner Office Visits – \$10 Copayment, Deductible waived	Office Visits – 50%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	Insured Responsibility	
	In-Network Provider	Out-of-Network Provider
<ul style="list-style-type: none"> Out-of-Network urgent care visits apply to the In-Network Out-of-Pocket Maximum 	Specialist Office Visits – \$70 Copayment, Deductible waived	
	Urgent Care Visits – \$70 Copayment, Deductible waived	
Other Professional Services	20%	50%
Acupuncture <ul style="list-style-type: none"> 18 visits per Calendar Year 	\$10 Copayment, Deductible waived	50%
Ambulance Services <ul style="list-style-type: none"> Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum 	20%	
Blood Bank <ul style="list-style-type: none"> Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum 	20%	
Dental Hospitalization <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	20%	50%
Detoxification <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	20%	50%
Diabetic Education	0%, Deductible waived	50%
Dialysis <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	20%	50%
Durable Medical Equipment	20%	50%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	Insured Responsibility	
	In-Network Provider	Out-of-Network Provider
Emergency Room <ul style="list-style-type: none"> Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum 	20%	
Gene Therapy and Adoptive Cellular Therapy <ul style="list-style-type: none"> 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 \$2,000 per day 	Centers of Excellence facility – 20%	50%
Gene Therapy and Adoptive Cellular Therapy – Travel Expenses <ul style="list-style-type: none"> \$7,500 per course of treatment, including companion(s), for transportation and lodging expenses Additional limitations apply, refer to the Medical Benefits Section 	100% of all expenses. Your travel expenses may be reimbursed subject to Your In-Network Deductible and travel expense limit.	
Habilitation Services <ul style="list-style-type: none"> 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 \$2,000 per day 	20%	50%
Hearing Loss <ul style="list-style-type: none"> 1 hearing aid device per ear every 36 months 45 outpatient speech and language therapy visits within 12 months from the receipt of a hearing aid, bone conduction device or cochlear implant Additional limitations apply, refer to the Medical Benefits Section 	20%	50%
Home Health Care	20%	50%
Hospice Care	20%	50%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	Insured Responsibility	
	In-Network Provider	Out-of-Network Provider
Hospital Care – Inpatient, Outpatient and Ambulatory Surgical Center <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	20%	50%
Infusion Therapy	20%	50%
Maternity Care <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	20%	50%
Medical Foods	20%	50%
Mental Health or Substance Use Disorder Services <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	Inpatient services – 20%	50%
	Outpatient office/psychotherapy visits – \$10 Copayment, Deductible waived All other outpatient services – 20%	
Newborn Care <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	20%	50%
Nutritional Counseling <ul style="list-style-type: none"> 3 visits per Calendar Year 	20%	50%
Orthotic Devices	20%	50%
Palliative Care <ul style="list-style-type: none"> 30 visits per Calendar Year 	20%	50%
Prosthetic Devices	20%	50%
Provider-Administered Specialty Drugs	20%	50%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	Insured Responsibility	
	In-Network Provider	Out-of-Network Provider
Rehabilitation Services <ul style="list-style-type: none"> 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 \$2,000 per day 	20%	50%
Repair of Teeth <ul style="list-style-type: none"> Treatment must be provided within 12 months from the date of Injury 	20%	50%
Skilled Nursing Facility <ul style="list-style-type: none"> 30 inpatient days per Calendar Year 	20%	50%
Spinal Manipulations <ul style="list-style-type: none"> 18 spinal manipulations per Calendar Year 	\$10 Copayment, Deductible waived	50%
Termination of Pregnancy <ul style="list-style-type: none"> Allowed only for certain circumstances, refer to the Medical Benefits Section 	20%	50%
Transplants <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	20%	50%
Transplants – Travel Expenses <ul style="list-style-type: none"> 14 days per transplant episode (limit is combined for Insured and companion(s)) Covered Services apply to the In-Network Deductible and/or In-Network Out-of-Pocket Maximum Additional limitations apply, refer to the Medical Benefits Section 	100% of all expenses. Your travel expenses may be reimbursed subject to Your In-Network Deductible and travel expense limit.	
Virtual Care – Store and Forward Services	0%, Deductible waived	50%
Virtual Care – Telehealth	\$10 Copayment, Deductible waived	50%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	Insured Responsibility	
	Participating Pharmacy	Nonparticipating Pharmacy
Prescription Medications – from a Pharmacy <ul style="list-style-type: none"> • Deductible waived when You fill a prescription for Preferred Brand-Name insulin and for medications specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medications list. To obtain this list visit Our website or contact Customer Service. Contact Information is available in the Introduction Section. • You are not responsible for any Deductible, Copayment and/or Coinsurance when You fill prescriptions for medications intended to treat opioid overdose that are on the Naloxone Value List. To obtain this list visit Our website or contact Customer Service. Contact Information is available in the Introduction Section. • Out-of-Network services apply to the In-Network Deductible and/or In-Network Out-of-Pocket Maximum • 90-day supply for Prescription Medications Copayment is based on each 30-day supply • 30-day supply for Specialty Medications • Cost-sharing for Preferred Brand-Name insulin will not exceed \$100 per 30-day supply 	\$10 Copayment, Deductible waived for each Generic Medication on the Drug List	
	20% for each Preferred Brand-Name Medication on the Drug List	
	50% for each Brand-Name Medication on the Drug List	
	50% for each Specialty Medication on the Drug List from a Participating Specialty Pharmacy	60% for each Specialty Medication on the Drug List from a Nonparticipating Specialty Pharmacy
Prescription Medications – from a Home Delivery Supplier <ul style="list-style-type: none"> • Out-of-Network services apply to the In-Network Deductible and/or In-Network Out-of-Pocket Maximum • 90-day supply for Prescription Medications • Cost-sharing for Preferred Brand-Name insulin will not exceed \$300 per 90-day supply 	\$30 Copayment, Deductible waived for each Generic Medication on the Drug List	
	20% for each Preferred Brand-Name Medication on the Drug List	
	50% for each Brand-Name Medication on the Drug List	

**Covered Services (per Insured)
Unless Otherwise Noted the Deductible Applies**

Benefit	Insured Responsibility	
	VSP Doctor	Out-of-Network Provider
Pediatric Vision (under age 19) <ul style="list-style-type: none"> • 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 • Services do not accrue to any Out-of-Pocket Maximum • Low vision supplemental examination (testing) and supplemental aids every 2 Calendar Years • Additional limitations apply, refer to the Pediatric Vision Services Section 	Examination – 0%, Deductible waived	Examination – 100% of billed charges; 50% of Your payment may be reimbursed based upon the Allowed Amount, Deductible waived
	Hardware – 0%, Deductible waived	Hardware – 100% of billed charges; 50% of Your payment may be reimbursed based upon the Allowed Amount, Deductible waived
	Contact Lens Evaluation and Fitting Examination – 0%, Deductible waived	Contact Lens Evaluation and Fitting Examination – 100% of billed charges; 50% of Your payment may be reimbursed based upon the Allowed Amount, Deductible waived
	Low Vision Supplemental Examination (Testing) – 0%, Deductible waived	Low Vision Supplemental Examination (Testing) – 100% of billed charges; 100% of Your payment may be reimbursed based upon the VSP Doctor Allowed Amount, Deductible waived
	Low Vision Supplemental Aids – 0%, Deductible waived	Low Vision Supplemental Aids – 100% of billed charges; 100% of Your payment may be reimbursed based upon the VSP Doctor Allowed Amount, Deductible waived

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	Insured Responsibility	
	In-Network Dentist	Out-of-Network Dentist
Pediatric Dental (under age 19) <ul style="list-style-type: none"> • Out-of-Network services apply to the In-Network Out-of-Pocket Maximum • Additional limitations apply, refer to the Pediatric Dental Services Section 	Preventive and Diagnostic Services – 0%, Deductible waived	
	Basic Services – 20%, Deductible waived	
	Major Services – 50%, Deductible waived	

Introduction

Regence BlueShield of Idaho, Inc.

Street Address:
1602 21st Avenue
Lewiston, ID 83501

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

POLICY

This Policy describes benefits effective **December 1, 2024**, for the Policyholder and Enrolled Dependents. This Policy provides the evidence and a description of the terms and benefits of coverage. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your Provider before receiving care.

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 according to the requirements established by YHI, including any provisions pertaining to a grace period and in further consideration of the application and statements submitted through YHI 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 upon payment of the monthly premium when due or within the grace period.

EXAMINATION OF POLICY

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

ESSENTIAL HEALTH BENEFITS

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

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services (including behavioral health treatment);
- prescription drugs;
- rehabilitation and habilitation services and devices;
- laboratory services;
- preventive and wellness services and 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 website listed below.

CONTACT INFORMATION

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

Phone lines are open Monday – Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m., Pacific Time.

Contact Customer Service:

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

Mail Your medical or pediatric dental claims to the following address:

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

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

P.O. Box 1827, MS CS B32B
Medford, OR 97501-9884

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

VSP phone lines are open Monday – Saturday, 6 a.m. – 5 p.m., Pacific Time.

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

Mail Your VSP Doctor vision claims to the following address:

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

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

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

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

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

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

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



Mark H. Ruszczyk
President
Regence BlueShield of Idaho

Using Your Policy

ACCESSING PROVIDERS

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

NOTE: If You are a Native American enrolled in this Policy, You may also choose an Indian Health Care Provider (IHCP), such as Indian Health Services, an Indian Tribe, Tribal Organizations or an Urban Indian Organization.

- **IHCP.** Choosing an IHCP means Your Covered Services will not be subject to any Deductible, Copayment and/or Coinsurance. Choosing to see an In-Network Provider or an Out-of-Network Provider through a referral from an IHCP also means Your Covered Services will not be subject to any Deductible, Copayment and/or Coinsurance. However, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. This is referred to as balance billing. Refer to the notice "Your Rights and Protections Against Surprise Medical Bills" attached to this Policy for information regarding reimbursement and balance billing applicable to Out-of-Network Providers for certain services.
- **In-Network.** Choosing In-Network Providers saves You the most in Your out-of-pocket expenses. In-Network Providers will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network.** Choosing Out-of-Network Providers means Your out-of-pocket expenses will be higher than choosing an In-Network Provider. Also, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. This is referred to as balance billing. Refer to the notice "Your Rights and Protections Against Surprise Medical Bills" attached to this Policy for information regarding reimbursement and balance billing applicable to Out-of-Network Providers for certain services. If a Covered Service is not available from an In-Network Provider, You may be able to receive coverage from an Out-of-Network Provider at the In-Network benefit level. Refer to the Prior Approval of Out-of-Network Provider Services provision in the Policy and Claims Administration Section for further information.

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

ADDITIONAL ADVANTAGES OF MEMBERSHIP

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

- **Go to regence.com or Our mobile application.** You can use these secure applications to:
 - view recent claims, benefits and coverage;
 - find a contracting Provider or identify Participating Pharmacies;
 - use tools to estimate upcoming health care costs and otherwise help You manage health care expenses;
 - get suggestions to improve or maintain wellness and participate in self-guided motivational online wellness programs;
 - learn about prescriptions for various Illnesses;
 - compare medications based upon performance and cost and get assistance in switching to less costly, equally effective alternative medications, if You wish; and
 - access information about Regence Advantages. Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services. We have contracted with several program partners, listed on the secure applications, to offer discounts on their products and services, such as hearing care, health and wellness products and vision care.*

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is

covered by Your 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

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

MAXIMUM BENEFITS

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

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

DEDUCTIBLES

The Deductible is the amount You must pay each Calendar Year before We will provide payments for Covered Services. Only Allowed Amounts for Covered Services are applied to satisfy the Deductible. There is an individual Deductible amount and a Family Deductible amount for In-Network benefits and also for Out-of-Network benefits.

The Family Deductible is satisfied when any combination of Family members' payments toward each of their individual Deductibles total the Family Deductible amount. No one Family member may contribute more than their individual Deductible amount toward the Family Deductible in a Calendar Year. A Family member does not have to satisfy their individual Deductible if the Family Deductible has already been satisfied.

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

COPAYMENTS

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

COINSURANCE (PERCENTAGE YOU PAY)

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

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the most You could pay in a Calendar Year for Covered Services. Your payments of any Deductible, Copayments and/or Coinsurance apply to the Out-of-Pocket Maximum,

unless specified otherwise. There is an individual Out-of-Pocket Maximum amount and a Family Out-of-Pocket Maximum amount for In-Network benefits and also for Out-of-Network benefits.

The Family Out-of-Pocket Maximum is satisfied when any combination of Family members' payments of their cost-shares for Covered Services total the Family Out-of-Pocket Maximum. No one Family member may contribute more than their individual Out-of-Pocket Maximum amount toward the Family Out-of-Pocket Maximum in a Calendar Year. A Family member does not have to satisfy their individual Out-of-Pocket Maximum if the Family Out-of-Pocket Maximum has already been satisfied.

An Insured's payment of any Deductible, Copayments and/or Coinsurance for ambulance, blood bank, emergency room services, Prescription Medications (including any applicable separate Prescription Medication Deductible) 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. In addition, the difference in cost between a Brand-Name Medication and its generic equivalent (or a Specialty Medication and its Specialty Biosimilar Medication) does not apply toward the Out-of-Pocket Maximum. Further, any reduction in Your cost-sharing for Prescription Medications resulting from the use of any discount or a drug manufacturer coupon may not apply toward the Out-of-Pocket Maximum. If You do not fill Your Prescription Medication through a Specialty Pharmacy, You are required to notify Us of Your use of a drug manufacturer coupon. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach any applicable Out-of-Pocket Maximum.

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

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 \$2,000 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 \$2,000 per day maximum Allowed Amount.

HOW CALENDAR YEAR BENEFITS RENEW

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

Medical Benefits

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

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

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

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

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

CASE MANAGEMENT

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

PREAUTHORIZATION

Contracted Providers

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

Non-Contracted Providers

Outpatient Services

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

Inpatient Services

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

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

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

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

PREVENTIVE VERSUS DIAGNOSTIC SERVICES

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

Your Provider's classification of the service as either preventive or diagnostic and any other terms in this Policy will determine the benefit that applies. For example, colonoscopies and mammograms are covered in the Preventive Care and Immunizations benefit if Your Provider bills them as preventive and they fall within the recommendations identified in that benefit. Otherwise, colonoscopies and mammograms are covered the same as any other illness or injury. You may want to ask Your Provider why a Covered Service is ordered or requested.

PREVENTIVE CARE AND IMMUNIZATIONS

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

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

- vaginal ring;
- contraceptive shot/injection;
- emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products);
- intrauterine devices (both copper and those with progestin);
- implantable contraceptive rod;
- surgical implants; and
- surgical sterilization procedures for women.

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

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

Expanded Immunizations

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

OFFICE OR URGENT CARE VISITS – ILLNESS OR INJURY

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

OTHER PROFESSIONAL SERVICES

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

Medical Services and Supplies

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

Services and supplies also include:

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

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

Diagnostic Procedures

Services for diagnostic procedures including cardiovascular testing, pulmonary function studies, stress

tests, sleep studies and neurology/neuromuscular procedures.

Office or Urgent Care Visits – After Upfront Benefit Limits (if applicable)

After any Upfront office visit limits are exhausted, office or urgent care visits for treatment of Illness or Injury are covered as specified in the Schedule of Benefits.

Professional Inpatient

Professional inpatient visits for treatment of 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. Contact Customer Service for further information and guidance.

Radiology and Laboratory

Diagnostic services for treatment of Illness or Injury. This includes Medically Necessary genetic testing and diagnostic mammography services not covered in the Preventive Care and Immunizations benefit.

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

Surgical Services

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

Treatment of varicose veins is only covered when there is:

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

Therapeutic Injections

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

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

ACUPUNCTURE

Acupuncture is covered. Acupuncture visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

AMBULANCE SERVICES

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

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

APPROVED CLINICAL TRIALS

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

Definitions

The following definitions apply to this Approved Clinical Trials benefit:

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

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

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

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

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

BLOOD BANK

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

DENTAL HOSPITALIZATION

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

DETOXIFICATION

Medically Necessary detoxification is covered.

DIABETIC EDUCATION

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

DIALYSIS

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

DURABLE MEDICAL EQUIPMENT

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

Additionally, new Durable Medical Equipment is covered when obtained from an approved Commercial Seller. Benefits for eligible new Durable Medical Equipment will be covered up to the In-Network benefit

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

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

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

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

"Stabilization" means to provide Medically Necessary treatment:

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

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

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

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

To be covered at the Centers of Excellence (COE) benefit level, gene therapy and/or adoptive cellular therapy must be received from one of Our COE facilities that is expressly identified as a COE for that therapy. However, if a COE has not been identified for a covered gene therapy and/or adoptive cellular therapy, that therapy must be received from an In-Network Provider to be covered at the COE benefit level. Receiving therapy from one of Our COE facilities will save the most in Your out-of-pocket expenses. For a list of covered therapies or to identify a COE facility, contact Our Customer Service, as the lists are subject to change.

Travel Expenses

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

- based on the generally accepted course of treatment in the United States, the therapy would require an overnight stay of seven or more consecutive nights away from home and within reasonable proximity to the treatment area;
- if a COE has been identified for the specified covered therapy, covered treatment must be received from the COE;
- if a COE has not been identified for the specified covered therapy, covered treatment must be received from an In-Network Provider;
- coverage is for the Insured and one companion (or two companions if the Insured is under the age of 19);
- commercial lodging expenses are limited to the IRS medical expense allowances (currently \$50 per night for the Insured, not to exceed \$100 per night for the Insured and companion(s) combined; and
- covered transportation expenses to and from the treatment area include only:
 - commercial coach class airfare;
 - commercial coach class train fare; or
 - documented auto mileage (calculated per IRS medical expense allowances).

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

Coverage does not include meals or expenses outside of transportation and lodging.

HABILITATION SERVICES

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

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

HEARING LOSS

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

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

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

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

Covered Services do **not** include:

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

HOME HEALTH CARE

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

HOSPICE CARE

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

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

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER

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

INFUSION THERAPY

Inpatient, outpatient and home therapy services, supplies (including infusion pumps) and medications for infusion therapy are covered. Covered Services also include parenteral and enteral therapy. Certain medications for outpatient infusion therapy that are provided to treat chronic, complex conditions are otherwise covered in the Provider-Administered Specialty Drugs benefit. Contact Customer Service for further information and guidance.

MATERNITY CARE

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

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

MEDICAL FOODS

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

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES

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

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

Definitions

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

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

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

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

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

NEWBORN CARE

Services and supplies in connection with nursery care for the natural newborn or newly adoptive child are covered by the newborn's own coverage. The Newborn Child must be eligible and enrolled as explained

in the Eligibility and Enrollment Section. There is no limit for the newborn's length of inpatient stay. "Newborn care" means the medical services provided to a Newborn Child following birth including Hospital nursery charges, the initial physical examination and a PKU test.

NUTRITIONAL COUNSELING

Services for nutritional counseling and nutritional therapy, such as diabetic counseling, discussions on eating habits, lifestyle choices and dietary interventions are covered for all conditions, including obesity. Nutritional counseling visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

ORTHOTIC DEVICES

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

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

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

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

- custom or off-the-shelf shoes or boots (unless permanently attached to a brace) including any adjustments or additions;
- orthopedic shoes;
- lifts;
- arch supports;
- splints for aligning the toes; and
- any other foot support devices or orthotics related to the feet.

PALLIATIVE CARE

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

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

PREVENTIVE CARE FOR SPECIFIED CHRONIC CONDITIONS

Services and supplies are covered when used to treat an Insured diagnosed with the associated chronic condition and prescribed to prevent either exacerbation of the chronic condition or the development of a secondary condition. Covered Services as specified below are not subject to any applicable Deductible for In-Network services:

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

PROSTHETIC DEVICES

Prosthetic devices for functional reasons are covered to replace a missing body part, including artificial

limbs, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. Covered Services include voice boxes to replace all, part of or a surgically removed larynx. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered in the appropriate facility benefit. Additionally, the repair or replacement of a prosthetic device due to normal use or growth of a child is covered.

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

PROVIDER-ADMINISTERED SPECIALTY DRUGS

Provider-Administered Specialty Drugs are covered under this plan at the Specialty Pharmacy for Provider-Administered Specialty Drugs benefit level only when a Provider-Administered Specialty Drug has been preauthorized and obtained by the administering Provider through the designated Specialty Pharmacy for Provider-Administered Specialty Drugs. Even if the administering Provider is an In-Network Provider (whose services are otherwise covered in the Other Professional Services benefit), it does not guarantee coverage for Provider-Administered Specialty Drugs if they are not obtained through the Specialty Pharmacy for Provider-Administered Specialty Drugs. An exception may be available when the administering Provider obtains a Provider-Administered Specialty Drug from a source other than a Specialty Pharmacy for Provider-Administered Specialty Drugs. Contact Customer Service for further information and guidance.

When Provider-Administered Specialty Drugs are received outside the service area that We or one of Our Affiliates serves, coverage is provided in the Infusion Therapy benefit and not in this Provider-Administered Specialty Drugs benefit.

Definitions

The following definitions apply to this Provider-Administered Specialty Drugs benefit:

Provider-Administered Specialty Drug(s) means medications used to treat chronic, complex conditions that typically require special handling, administration, or monitoring and that are included in the Provider-Administered Specialty Drug List.

Provider-Administered Specialty Drug List means Our list of selected Provider-Administered Specialty Drugs. The Provider-Administered Drug List is routinely reviewed and updated. It is available on Our website or by calling Customer Service.

Specialty Pharmacy for Provider-Administered Specialty Drugs means an approved Provider or Pharmacy that specializes in the distribution and medication management services of certain injectables and Provider-Administered Specialty Drugs. A Specialty Pharmacy for Provider-Administered Specialty Drugs must also agree to submit claims for Provider-Administered Specialty Drugs to Our designated claims administrator. For more information about Specialty Pharmacies for Provider-Administered Specialty Drugs, visit Our website or contact Customer Service.

REHABILITATION SERVICES

Inpatient and outpatient rehabilitation services and accommodations are covered as appropriate and necessary to restore or improve lost function caused by Illness or Injury. Rehabilitation for neurodevelopmental purposes by a Physician or Practitioner is also covered. "Rehabilitation services" mean physical, occupational and speech therapy services only, including associated services such as massage when provided as a therapeutic intervention. Rehabilitation for neurodevelopmental purposes also includes maintenance services, if significant deterioration of the Insured's condition would result without the service.

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

REPAIR OF TEETH

Services and supplies for treatment required as a result of damage to or loss of sound natural teeth are

covered when such damage or loss is due to an Injury.

SKILLED NURSING FACILITY

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

Skilled Nursing Facility days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

SPINAL MANIPULATIONS

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

TERMINATION OF PREGNANCY

Termination of pregnancy (abortion) is covered, to the extent such services are permitted under applicable law, for all Insureds only when:

- an abortion is necessary to save the life of the pregnant Insured per the recommendation of one consulting Physician; or
- the Insured is pregnant as a result of rape (as defined in Idaho Code §18-6101) or incest as determined by the courts.

TRANSPLANTS

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

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

For a list of covered transplants, contact Our Customer Service, as the list is subject to change. Gene and/or adoptive cellular therapies are covered in the Gene Therapy and Adoptive Cellular Therapy benefit. Any organ or tissue which is procured outside the United States and any transplant procedure performed outside the United States are not covered.

Donor Organ Benefits

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

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

Travel Expenses

Transportation and lodging expenses are covered when approved through case management, subject to the following specified limits:

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

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of the treatment. We will reimburse You for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Travel expenses that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Contact Our Customer Service for further information and guidance.

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

VIRTUAL CARE

Virtual care services are covered for the use of telehealth or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment or management of a covered medical condition. Some Providers may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share. To learn more about how to access virtual care services or Providers that may offer lower-cost services, visit Our website or contact Customer Service.

Store and Forward Services

Store and forward services are covered for primary care, urgent care, Mental Health Conditions or Substance Use Disorders as specified in the Schedule of Benefits. All other Covered Services for an Insured receiving store and forward services will be covered the same as any other Illness or Injury.

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

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

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

Telehealth

Telehealth services are covered for primary care, urgent care, Mental Health Conditions or Substance Use Disorders as specified in the Schedule of Benefits. All other Covered Services for an Insured receiving telehealth services will be covered the same as any other Illness or Injury.

"Telehealth" means Your live services (real-time audio-only or audio and video communication) with a

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

Prescription Medications

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

Prescription Medications listed on the Drug List are covered. Prescription Medications not on the Drug List may be covered as described in the Drug List Exception Process provision. The Drug List may be viewed on Our website or by contacting Customer Service.

COVERED PRESCRIPTION MEDICATIONS

Prescription Medication benefits are available for the following:

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

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

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

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

If Your Provider believes that Our covered preventive medications, including contraceptives, are medically inappropriate for You, You may request an equivalent preventive medication by contacting Customer Service. For additional information on covered Prescription Medications, visit Our website or contact Customer Service.

PRESCRIPTION MEDICATIONS CLAIMS AND ADMINISTRATION

Preauthorization

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

Drug List Changes

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

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

Drug List Exception Process

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

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

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

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

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

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

Your Responsibility for Cost Differences of Chosen Medications

You will be responsible for the applicable Copayment and/or Coinsurance for the Brand-Name Medication or Specialty Medication at the time of purchase. You will also be responsible for paying excess costs

above Your applicable cost-share if either of the following occur:

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

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

Pharmacy Network Information

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

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

Claims Submitted Electronically

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

Claims Not Submitted Electronically

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

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

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

Home Delivery

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

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

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

- a completed prescription home delivery form;
- any Deductible, Copayment and/or Coinsurance; and

- the original Prescription Order.

Prescription Medications Dispensed by Excluded Pharmacies

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

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

Refills

Refills obtained from:

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

However, if You:

- choose to refill Your Prescription Medications sooner, You will be responsible for the full cost of the Prescription Medication and those costs will not apply toward any Deductible and/or Out-of-Pocket Maximum.
- feel You need a refill sooner than allowed, a refill exception will be considered on a case-by-case basis. You may request an exception by calling Customer Service.

Discounts or Manufacturer Coupons

Any reduction in Your cost-sharing resulting from the use of any discount or a drug manufacturer coupon may not apply toward the Deductible (including any applicable separate Prescription Medication Deductible) or Out-of-Pocket Maximum. If You do not fill Your Prescription Medication through a Specialty Pharmacy, You are required to notify Us of Your use of a drug manufacturer coupon.

LIMITATIONS

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

Prescription Medication Supply Limits

- **30-Day Supply Limit:**

- **Specialty Medications** – the largest allowable quantity for a Specialty Medication purchased from a Specialty Pharmacy, is a 30-day supply. Specialty Medications are not allowed through Home Delivery Suppliers.

The first fill of Specialty Medications for hemophilia is allowed at a Pharmacy. Additional fills must be provided by a Specialty Pharmacy or Specialty Pharmacy designated as a Hemophilia Treatment Center (HTC).

- **90-Day Supply Limit:**

- **Pharmacy** – the largest allowable quantity of a Prescription Medication purchased from a Pharmacy is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities. The Copayment and/or Coinsurance is based on each 30-day supply.
- **Home Delivery Supplier** – the largest allowable quantity of a Prescription Medication purchased from a Home Delivery Supplier is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
- **Multiple-Month Supply** – the largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Pharmacy is a 90-day supply (even if the packaging includes a larger supply). The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The Copayment and/or Coinsurance is based on the Prescription Order up to a 34-day supply within

that multiple-month supply.

- **Maximum Quantity Limit**

- For certain Prescription Medications, We establish maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. We use information from the FDA and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service.
- For certain Self-Adminstrable Cancer Chemotherapy Medications, due to safety factors and the Insured's ability to tolerate these medications, the Prescription Medication may be reduced to an initial 14-day or 15-day supply before larger quantities are dispensed.
- Any amount over the established maximum quantity is not covered, except if the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

EXCLUSIONS

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

Biological Sera, Blood or Blood Plasma

Bulk Powders

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

Cosmetic Purposes

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

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

Devices or Appliances

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

Diagnostic Agents

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

Digital Therapeutics

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

Foreign Prescription Medications

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

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

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

General Anesthetics

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

Medical Foods

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

Medications that are Not Considered Self-Administrable

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

Nonprescription Medications

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

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

Nonprescription medications include, but are not limited to:

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

Prescription Medications Dispensed in a Facility

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

Prescription Medications Found to be Less than Effective under Drug Efficacy Safety Implementation (DESI)**Prescription Medications Not Approved by the FDA****Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order****Prescription Medications Not on the Drug List**

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

Prescription Medications Not within a Provider's License

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

Prescription Medications with Therapeutic Alternatives

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

Prescription Medications without Examination

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

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

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

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

DEFINITIONS

The following definitions apply to this Prescription Medications Section:

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

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

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

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

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

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

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

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

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

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

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

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.

Prescription Medications and Prescribed Medications mean medications and biologicals that:

- relate directly to the treatment of an Illness or Injury;
- legally cannot be dispensed without a Prescription Order;
- by law must bear the legend, "Prescription Only"; or
- are specifically included on Our Drug List.

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

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

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

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

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

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

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

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

Pediatric Vision Services

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

This pediatric vision coverage is provided by Us, in collaboration with Vision Service Plan Insurance Company (VSP), which coordinates the pediatric vision benefits and associated claims processing. VSP is a separate company that provides vision benefit services.

Accessing Providers

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

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

VISION EXAMINATION

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

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

VISION HARDWARE

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

Frames

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

Lenses

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

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

Any of the following lens enhancements:

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

*Contact lenses are limited to one of the following:

- for elective contact lenses:
 - standard (one pair annually);

- monthly (six-month supply);
 - bi-weekly (three-month supply); or
 - dailies (three-month supply).
- for Necessary Contact Lenses, a Calendar Year supply if You have a specific condition for which contact lenses provide better visual correction.

Necessary Contact Lenses and elective 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 or other types of lenses again until the next Calendar Year.

CONTACT LENS EVALUATION AND FITTING EXAMINATION

Services and supplies for contact lens evaluation and fitting examinations are covered.

LOW VISION BENEFIT

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

Supplemental Examinations (Testing)

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

Supplemental Aids

Low vision aids, including, but not limited to:

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

DISCOUNTS FROM VSP DOCTORS

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

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

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

Discounts do **not** apply to:

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

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

PEDIATRIC VISION CLAIMS AND REIMBURSEMENT

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

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

Submit the claim to:

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

Concerns about Claim Denial or Other Action

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

EXCLUSIONS

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

Certain Contact Lens Expenses

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

Corneal Refractive Therapy (CRT)

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

Corrective Vision Treatment of an Experimental Nature

Costs for Services and/or Supplies Exceeding Benefit Allowances

Lens Enhancements

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

- anti-reflective coating;

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

Medical or Surgical Treatment of the Eyes

Medical or surgical treatment of the eyes, including reversals or revisions of surgical procedures of the eye.

Orthoptics or Vision Training

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

Plano Lenses (Less Than a $\pm .50$ Diopter Power)

Replacements

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

Two Pair of Glasses in Lieu of Bifocals

DEFINITIONS

The following definitions apply to this Pediatric Vision Services Section:

Allowed Amount means:

- For VSP Doctors, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Providers, the amount determined to be reasonable charges for Covered Services. The Allowed Amount may be based upon billed charges for some services.

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

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

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

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

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

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

Pediatric Dental Services

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

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

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

- The following services are limited to two per Insured per Calendar Year:

- bitewing x-ray sets;
- preventive oral examinations;
- diagnostic oral examinations;
- topical fluoride application (excluding cleanings);
- topical fluoride varnish treatments; and
- cleanings.*

*A third cleaning may be covered, in the same Calendar Year, for an Insured with one or more of the following conditions:

- coronary atherosclerosis;
- diabetes;
- hypertensive heart disease; or
- pregnancy.

- The following services are limited to one per Insured in a three-year period:

- complete intra-oral mouth x-rays;
- panoramic x-rays;
- sealants for permanent molars, limited to one per tooth; and
- preventive resin restoration in a moderate to high caries risk patient, limited to one per permanent tooth.

- Cephalometric x-rays.

- Space maintainers.

BASIC DENTAL SERVICES

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

- Complex oral surgery procedures including:

- surgical extractions of teeth;
- impaction;
- alveoloplasty;
- vestibuloplasty; and
- residual root removal.

- Emergency treatment for pain relief. Restorative treatment on the same date of service as emergency treatment is not covered.

- Endodontic services including:

- Apicoectomy;
- Pulpotomy; and
- root canal treatment.

- Fillings consisting of composite and amalgam restorations.

- General dental anesthesia or intravenous sedation administered for:

- extractions of partially or completely bony impacted teeth; or
- to safeguard the Insured's health (for example, a child under seven years of age).
- Uncomplicated oral surgery procedures including:
 - removal of teeth;
 - biopsy;
 - incision; and
 - drainage.
- Periodontal services including:
 - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery) limited to once per Insured per quadrant in a three-year period;
 - gingivectomy and gingivoplasty limited to once per Insured per quadrant in a three-year period;
 - scaling and root planing limited to once per Insured per quadrant in a two-year period; and
 - periodontal maintenance limited to four per Insured per Calendar Year in lieu of preventive cleanings.
- Adjustment and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within six months of insertion.
 - reline procedures, limited to once per Insured in a three-year period; and
 - rebase procedures, limited to once per Insured in a three-year period.

MAJOR DENTAL SERVICES

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

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

PEDIATRIC DENTAL CLAIMS AND REIMBURSEMENT

In-Network Dentist Claims and Reimbursement

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

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

Out-of-Network Dentist Claims and Reimbursement

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

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

- the group number.

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

EXCLUSIONS

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

Adjustments

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

Aesthetic Dental Procedures

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

Bone Grafts

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

Cone Beam Imaging/MRI Procedures

Cosmetic/Reconstructive Services and Supplies

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

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

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

Decay Prevention

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

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

Duplicate Services

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

Experimental or Investigational Services

Fabrication of Athletic Mouth Guard

Facility Expenses

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

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

Failure to Comply

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

Gold-Foil Restorations**Nitrous Oxide****Oral Hygiene and Dietary Instructions****Oral Sedation****Orthodontic Dental Services**

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

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

Plaque Control Programs**Precision Attachments, Personalization, Precious Metal Bases and Other Specialized Techniques****Provisional, Temporary and Duplicate Devices or Appliances****Replacements**

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

Sealants

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

Separate Charges

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

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

Services and Supplies to Alter Vertical Dimension and/or Restore or Maintain the Occlusion

Services and supplies to alter vertical dimension and/or restore or maintain the occlusion are not covered, including, but not limited to:

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

Services and Supplies Which the Insured Would Have No Legal Obligation to Pay in the Absence of this Coverage**Services and Treatment Not Prescribed By or Under the Direct Supervision of a Dentist**

Services Provided by Certain Entities

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

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

Specialized Procedures and Techniques

Temporomandibular Joint (TMJ) Disorder Treatment

Services and supplies provided in connection with TMJ disorder treatment.

Topical Medicament Center

DEFINITIONS

The following definitions apply to this Pediatric Dental Services Section:

Allowed Amount means:

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

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

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

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

A Dental Service may be Dentally Appropriate yet not be a Covered Service in this Policy.

Dentist means an individual who is duly licensed to practice dentistry in all of its branches (including a doctor of medical dentistry, doctor of dental surgery or a denturist) or to practice as a dental hygienist who is permitted by their 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 them as a Dentist of Your network, to provide services and supplies to Insureds in accordance with the provisions of this coverage.

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

General Exclusions

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

SPECIFIC EXCLUSIONS

The following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**, are not covered. However, these exclusions will not apply with regard to a Covered Service for:

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

Activity Therapy

The following activity therapy services are not covered:

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

Adventure, Outdoor, or Wilderness Interventions and Camps

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

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

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

Assisted Reproductive Technologies

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

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer;
- other artificial means of conception; or
- any associated surgery, medications, testing or supplies.

Aviation

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

Breast Reduction

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

Certain Therapy, Counseling and Training

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

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

Conditions Caused by Active Participation in a War or Insurrection

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

Conditions Incurred in or Aggravated During Performances in the Uniformed Services

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

Cosmetic/Reconstructive Services and Supplies

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

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

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

Counseling in the Absence of Illness

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

Custodial Care

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

Dental Services

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

Elective Abortions

Elective abortions are not covered.

"Elective abortion" means an abortion for any reason other than when:

- an abortion is necessary to save the life of the pregnant Insured per the recommendation of one consulting Physician; or
- the Insured is pregnant as a result of rape (as defined in Idaho Code §18-6101) or incest as determined by the courts.

Coverage for non-elective abortions is provided in the Termination of Pregnancy benefit.

Facilities Without a Provider Legally Required to be on Duty

Admission and treatment in a setting where neither a Physician nor licensed nurse is legally required to be on duty at all times that a patient is admitted.

Family Counseling

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

Fees, Taxes, Interest

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

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

Government Programs

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

Additionally, except as listed below, government facilities or government facilities outside the Service Area are not covered:

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

Hearing Aids and Other Devices

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

Hypnotherapy and Hypnosis Services

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

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

Illegal Activity

Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by an Insured's **voluntary participation in** an activity where the Insured is found guilty of an illegal activity in a criminal proceeding or is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty or a no contest plea. If benefits already have been paid before the finding of guilt

or liability is reached, We may recover the payment from the person We paid or anyone else who has benefited from it.

Illegal Services, Substances and Supplies

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

Individualized Education Program (IEP)

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

Infertility

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

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

Investigational Services

Except as provided in the Approved Clinical Trials benefit, Investigational services are not covered, including, but not limited to:

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

Liposuction for the Treatment of Lipedema

Motor Vehicle Coverage and Other Available Insurance

When motor vehicle coverage, other available insurance or contract is either issued to, or makes benefits available to an Insured (whether or not the Insured makes a claim with such coverage), expenses are not covered for services and supplies that are payable by any:

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

Further, the Insured is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits in such contract or insurance are exhausted or considered to no longer be Injury-related by the no-fault provisions of the contract, benefits will be provided accordingly.

Non-Direct Patient Care

Except as provided in the Virtual Care benefit, non-direct patient care services are not covered, including, but not limited to:

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

Non-Therapeutic Continuous Glucose Monitors

Obesity or Weight Reduction/Control

Except as provided in the Nutritional Counseling benefit, as required by law or for treatment of obesity-related comorbid medical conditions (for example, diabetes, high blood pressure and heart disease), services or supplies that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered, including, but not limited to:

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

Orthognathic Surgery

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

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

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

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

Over-the-Counter Contraceptives

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

Personal Items

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

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

Physical Exercise Programs and Equipment

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

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

Private-Duty Nursing

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

Provider-Administered Specialty Drugs

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

Reversals of Sterilizations

Services and supplies related to reversals of sterilization.

Routine Foot Care

Routine Hearing Examinations

Self-Help, Self-Care, Training or Instructional Programs

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

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

Services and Supplies Provided by a Member of Your Family

Services and supplies provided to You by a member of Your immediate family are not covered.

"Immediate family" means:

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

Services and Supplies That Are Not Medically Necessary

Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Services Required by an Employer or for Administrative or Qualification Purposes

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

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

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

Sexual Dysfunction

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

Temporomandibular Joint (TMJ) Disorder Treatment

Services and supplies provided for TMJ disorder treatment.

Third-Party Liability

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

Travel and Transportation Expenses

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

Varicose Vein Treatment

Except as provided in the Other Professional Services benefit, treatment of varicose veins is not covered:

Vision Care

Except as provided in the Pediatric Vision Services Section, vision care services are not covered, including, but not limited to:

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

Wigs

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

Work-Related Conditions

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

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

Policy and Claims Administration

This section explains administration of benefits and claims, including situations that may arise when Your health care expenses are the responsibility of a source other than Us.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

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

In-Network Provider Claims and Reimbursement

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

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

Out-of-Network Provider Claims and Reimbursement

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

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

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

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

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

Timely Filing of Claims

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

Claim Determinations

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

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

Time of Payment of Claims

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

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

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

CONTINUITY OF CARE

You may qualify to receive 90 days of continued coverage (or 90 days from the date You are no longer a continuing care patient, whichever is earlier) at the In-Network benefit level, if Your Provider was a contracted In-Network Provider, but is no longer contracted (this provision does not apply if the contract with the Provider was terminated due to a failure to meet quality standards or for fraud).

To qualify for continued coverage, You must be:

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

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

PRIOR APPROVAL OF OUT-OF-NETWORK PROVIDER SERVICES

If a Covered Service is Medically Necessary, but there is not reasonable access to an In-Network Provider, You may be able to receive coverage for such services from an Out-of-Network Provider. Balance Billing protections may not apply for services provided by these Out-of-Network Providers. Refer to the notice "Your Rights and Protections Against Surprise Medical Bills" attached to this Policy for additional information. To receive coverage, You or the Provider must request prior approval before You receive services. When prior approved, Covered Services received from the Out-of-Network Provider will be reimbursed at the In-Network benefit level.

If the Out-of-Network Provider does not have a contract with Us or the local Blue Cross and/or Blue Shield Licensee, You may be responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount, in addition to any amount You must pay due to any Deductible, Copayment and/or Coinsurance. Any amounts You pay for non-Covered Services or in excess of the Allowed Amount do not apply toward the Deductible or Out-of-Pocket Maximum. Contact Customer Service for further information and guidance.

NOTE: It is Your responsibility to obtain prior approval for any such Out-of-Network Provider services. If You do not obtain prior approval, services will not be covered. The Out-of-Network Provider can bill You directly and You will have to pay the total cost of the services. These costs do not apply toward the Deductible or Out-of-Pocket Maximum.

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), urgent care services and Out-of-Network services We have prior approved when You otherwise would not have reasonable access to an In-Network Provider. Out-of-Area Covered Services will be provided at the In-Network benefit level.

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

BlueCard Program

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

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

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

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.

Out-of-Network Providers Outside Our Service Area

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

- **Exceptions.** In certain situations, We may use other payment methods, such as billed covered charges, the payment We would make if the health care services had been obtained within Our service area, or a special negotiated payment to determine the amount We will pay for services provided by Out-of-Network Providers. In these situations, You may be liable for the difference between the amount that the Out-of-Network Provider bills and the payment We will make for the Out-of-Area Covered Services as set forth in this Policy.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

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

If You need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, You should call the service center at 1 (800) 810-BLUE or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

- **Inpatient Services**
In most cases, if You contact the service center for assistance, Hospitals will not require You to pay for covered inpatient services, except for Your applicable Deductible, Coinsurance, etc. In such cases, the Hospital will submit Your claims to the service center to begin claims processing. However, if You paid in full at the time of services, You must submit a claim to receive reimbursement for Out-of-Area Covered Services.
- **Outpatient Services**
Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require You to pay in full at the time of services. You must submit a claim to obtain reimbursement for Out-of-Area Covered Services.
- **Submitting a Blue Cross Blue Shield Global Core Claim**
When You pay for Out-of-Area Covered Services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from the service center or online at www.bcbsglobalcore.com. If You need assistance with Your claim submission, You should call the service center at 1 (800) 810-BLUE or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week.

CLAIMS RECOVERY

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

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

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

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

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

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

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

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

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

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

Advancement of Benefits

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

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

- the health care expenses are itemized or expressly excluded in the recovery; or
 - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered in this Policy.
- We will not reduce Our reimbursement or subrogation due to Your not being made whole. Our right to reimbursement or subrogation, however, will not exceed the amount of recovery.
 - By accepting benefits under this Policy, You or Your representative agrees to notify Us promptly (within 30-days) and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to third-party Injuries sustained by You.
 - You and Your representative must cooperate with Us and do whatever is necessary to secure Our rights of subrogation and reimbursement under this Policy. We may require You to sign and deliver all legal papers and take any other actions requested to secure Our rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third-party or other source). If We ask You to sign a trust agreement or other document to reimburse Us from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.
 - You must agree that nothing will be done to prejudice Our rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by Us. You will also cooperate fully with Us, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify Us of any facts that may impact Our right to reimbursement or subrogation, including, but not necessarily limited to, the following:
 - the filing of a lawsuit;
 - the making of a claim against any third-party;
 - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
 - intent of a third-party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Illness or Injury that gives rise to Our right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).
 - You and/or Your agent or attorney must agree to serve as constructive trustee and keep any recovery or payment of any kind related to Your Illness or Injury which gave rise to Our right of subrogation or reimbursement segregated in its own account, until Our right is satisfied or released.
 - In the event You and/or Your agent or attorney fails to comply with any of these conditions, We may recover any such benefits advanced for any Illness or Injury through legal action.
 - Any benefits We have provided or advanced are provided solely to assist You. By paying such benefits, We are not acting as a volunteer and are not waiving any right to reimbursement or subrogation.

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

Motor Vehicle Coverage

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

Workers' Compensation

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

- You must notify Us in writing within five days of any of the following:

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

Fees and Expenses

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

Future Medical Expenses

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

COORDINATION OF BENEFITS

If You are covered by any other Plan (as defined below), the benefits in this Policy and those of the other Plan will be coordinated in accordance with the provisions of this section.

Definitions

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

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

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

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

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

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

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

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

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

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

Plan does **not** include:

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

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

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

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

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

Order of Benefit Determination

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

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

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

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

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

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

- If a court decree specifies that one of Your parents is responsible for Your health care expenses or health care coverage and that parent's Plan has actual knowledge of that term of the decree, the Plan of that parent is primary to the Plan of Your other parent. If the parent with responsibility has no health care coverage for Your health care expenses, but that parent's spouse does, that parent's spouse's Plan is the Primary Plan. If benefits have been paid or provided by a Plan before it has actual knowledge of the term in the court decree, these rules do not apply until that Plan's next 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 their Plan longer shall be primary to the Plan of the parent who has been covered by their Plan for a shorter period.
- If there is no court decree allocating responsibility for Your health care expenses or health care coverage:
 - The Plan covering the Custodial Parent shall be primary to the Plan covering Your Custodial Parent's spouse.
 - The Plan of Your Custodial Parent's spouse shall be primary to the Plan covering Your noncustodial parent.
 - Then the Plan covering Your noncustodial parent shall be primary to the Plan of Your noncustodial parent's spouse.

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

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

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

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

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

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

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

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

Primary Health Plan Benefits

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

Secondary Health Plan Benefits

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

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

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

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

Any payment made by any other Plan(s) may include an amount that should have been paid by this Policy. If so, We may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this coverage. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

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

Appeal Process

If You or Your Representative wish to seek review of a claim denial or other dispute that is identified below, You may appeal. There is one appeal to Us, as well as an additional voluntary external review that You may pursue. Certain situations requiring a faster decision may qualify for an expedited appeal as described below.

For pediatric vision benefits, We have delegated the appeal process to VSP, though We retain ultimate responsibility over the appeal process. The terms "We," "Us" and "Our" for the purpose of pediatric vision appeals refer to VSP. If You believe a policy, action, or decision is incorrect, contact the VSP Customer Service department.

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

INTERNAL APPEAL

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

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

What You May Appeal – Internal Appeal

You may appeal disputes regarding:

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

Voluntary External Review – Independent Review Organization (IRO)

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

INTERNAL EXPEDITED APPEAL

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

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

What You May Appeal – Internal Expedited Appeal

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

- the application of regular appeal time frames on a Pre-Service or concurrent care claim either:
 - could jeopardize Your life, health or ability to regain maximum function; or

- according to a Provider with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment; or
- the treatment would be significantly less effective if not promptly initiated.

Voluntary Expedited Review – IRO

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

FILING AN INTERNAL APPEAL

For pediatric vision benefits, Appeals can be initiated with VSP using any of the following methods:

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

For all other benefits in this coverage, both internal and internal expedited appeals can be initiated with Us using any of the following methods:

Method of Request	Contact Information
Secure Online Account	Sign-in to Your account at regence.com , navigate to appeals and complete an appeal request
E-mail	MemberAppeals@regence.com
Fax	1 (888) 496-1542
Phone	Call the Customer Service phone number on Your identification card
Mail	Attn: Appeals Coordinator Regence BlueShield of Idaho P.O. Box 1408 Lewiston, ID 83501

INTERNAL APPEAL DETERMINATION TIMING

We will send Our decision on Your internal appeal as follows:

Type of Appeal	How and When to Expect a Response
Post-Service appeal	In writing, within 30 days of Our receipt of the appeal.
Pre-Service appeal for preauthorization	In writing, within 15 days of Our receipt of the appeal.
Expedited appeal	By phone, fax or e-mail within 72 hours of Our receipt of the appeal, followed by written notice within 3 working days.

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW – NOTICE

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

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

Filing an External Review Request

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

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

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

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

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

What You May Appeal – Voluntary Standard External Review Request

If We issue a final adverse benefit determination of Your request to provide or pay for a health care

service or supply that is a Covered Service, You may have the right to have Our decision reviewed by health care professionals who have no association with Us. You have this right only if Our denial decision involved:

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

Voluntary Standard External Review Request Timing

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

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

What You May Appeal – Voluntary Expedited External Review Request

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

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

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

Voluntary Expedited External Review Request Timing

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

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

Binding Nature of the External Review Decision

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

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

DEFINITIONS

The following definitions apply to this Appeal Process Section:

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

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

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

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

Eligibility and Enrollment

NOTE: Eligibility requirements, applications for coverage and coverage effective dates are determined by YHI. However, some information concerning these matters is included in this Policy. Contact YHI for additional information, including details about special enrollment periods.

This section explains some of the terms of eligibility under this Policy for a Policyholder and any eligible dependents. Payment of any corresponding monthly premium is required for coverage to begin and continue.

WHEN COVERAGE BEGINS

You will be entitled to apply for coverage for Yourself and Your eligible dependents through YHI per the eligibility requirements as stated in the following paragraphs and as further determined by YHI. Coverage for You and Your applying eligible dependents will begin on the date assigned by YHI.

Residency Requirement

A Policyholder must meet the residency requirements as determined by YHI and provide appropriate documentation as requested.

Policyholder

An applicant must meet the Residency Requirement provision above, not be enrolled in Medicare, enroll through YHI and agree to the terms of this Policy. The application used in establishing coverage will be a part of this Policy. Any applications and statements made on the application will be binding on both the applicant and dependents.

Dependents

You may enroll Your eligible dependents by completing the enrollment process for them established by YHI. Eligible 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, stepchild, adopted child or child legally Placed with You (or Your spouse or Your domestic partner) for adoption;
 - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; or
 - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).

- Your (or Your spouse's or Your domestic partner's) child who is age 26 or over and incapable of self-support because of intellectual disability or physical handicap that began before the child's 26th birthday. The child must also meet the requirements of a Disabled Dependent as defined in the Definitions Section below, and either:
 - the child is an enrolled child immediately before their 26th birthday; or
 - the child's 26th birthday preceded Your Effective Date and the child has been continuously covered as a dependent on either a parent's or legal guardian's group coverage or an individual plan issued by Us since that birthday.

NEWLY ELIGIBLE DEPENDENTS

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

Enrollment will be effective from:

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

SPECIAL ENROLLMENT

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

- if You, Your spouse or domestic partner gain a new dependent child or, for a child, become a dependent child by birth, adoption or Placement for adoption;
- if You, Your spouse or domestic partner gain a new dependent child or, for a spouse or domestic partner or child, become a dependent through marriage or beginning a domestic partnership;
- unintentional, inadvertent or erroneous enrollment or non-enrollment resulting from an error, misrepresentation or inaction by an officer, employee or agent of YHI 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);
 - an employee's reduction in working hours;
 - an employee's divorce or legal separation;
 - an employee's entitlement to Medicare;
 - loss of dependent child status; or
 - certain employer bankruptcies.
- newly gain access to an individual coverage health reimbursement arrangement (ICHRA) or are newly provided a qualified small employer health reimbursement arrangement (QSEHRA);
- an individual (not previously lawfully present) gains status as a citizen, national or lawfully present individual in the U.S.;
- permanently move to a new Service Area;
- loss of minimum essential coverage; or
- other exceptional circumstances as YHI may provide.

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

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

If You are classified as an "Indian" under federal law, You may move between qualified health plans one time per month.

DOCUMENTATION OF ELIGIBILITY

You must promptly provide (or coordinate) any necessary and appropriate information to determine the eligibility of a dependent. Such information will be required before a person can be enrolled as a dependent in this Policy.

DEFINITIONS

The following definitions apply to this Eligibility and Enrollment Section:

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

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

When Coverage Ends

NOTE: Coverage termination dates are determined by YHI. However, some information concerning these matters is included in this Policy. Contact YHI for additional information.

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

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

GUARANTEED RENEWABILITY AND POLICY TERMINATION

This Policy is guaranteed renewable, at the option of the Policyholder, upon payment of the monthly premium when due or within the requirements established by YHI, including any provisions pertaining to a grace period.

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

In addition, if We choose to discontinue offering coverage in the individual market, We will provide 180-days prior written notice to the Policyholder and all Enrolled Dependents on their renewal dates. 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 date assigned by YHI.

MILITARY SERVICE

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

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your Enrolled Dependents on the date assigned by YHI.

Nonpayment of Premium and Grace Period

Except as provided below for a Policyholder receiving advance payments of the premium tax credit, a grace period of 30 days will be granted for the payment of the regular monthly premium. During this grace period this Policy shall not be terminated. However, if the premium has not been received during the grace period, this Policy shall be terminated at the end of the month for which premium has been paid, not at the end of the grace period.

A Policyholder receiving advance payments of the premium tax credit will have a grace period of three consecutive months if, during the benefit year, at least one full month's premium is paid. During this grace period this Policy shall not be terminated. However, claims received for services rendered may be pending during the second and third months of the grace period. If the premium has not been received during the grace period, this Policy shall be terminated on the last day of the first month of the three-month grace period, 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 written notice within 14 days to YHI. We will cancel this Policy on the date assigned by YHI. We will refund You any premium received on an Insured's behalf for any period of ineligibility, providing that no benefits were paid during the interim. However, it may be possible for an ineligible dependent to continue coverage with this Policy according to the provisions below.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs, coverage ends for Your Enrolled Dependents on the date assigned by YHI. 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 date assigned by YHI.

Death of the Policyholder

If You die, coverage for Your Enrolled Dependents ends on the date assigned by YHI.

Policy Continuation

In the event that an Insured shall no longer meet eligibility due to divorce, annulment, or death of the Policyholder, such Insured shall have the right to continue the coverage of this Policy.

Termination of Domestic Partnership

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

Loss of Dependent Status

Eligibility ends on the date assigned by YHI when an enrolled child:

- exceeds the dependent age limit;
- is removed from Placement due to disruption of Placement before legal adoption; or
- is no longer an eligible dependent for any other cause not described above.

OTHER CAUSES OF TERMINATION

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

Fraudulent Use of Benefits

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

Fraud or Misrepresentation in Application

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

EXTENSION OF BENEFITS FOR CONTINUOUS LOSS

Termination of this Policy will not discontinue benefits for a continuous loss covered under this Policy if Your continuous loss commenced while this Policy was in force. The extension of benefits for Your continuous loss applies to a single inpatient stay where You are admitted prior to the Policy termination

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

PREGNANCY BENEFIT EXTENSION

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

CERTIFICATES OF CREDITABLE COVERAGE

Requests for and inquiries about required certificates relating to period(s) of creditable coverage under this Policy should be directed to Us at P.O. Box 1106, Lewiston, ID 83501-1106.

General Provisions and Legal Notices

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

CHANGE OF BENEFICIARY

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

CHOICE OF FORUM

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

GOVERNING LAW AND BENEFIT ADMINISTRATION

This Policy will be governed by and construed in accordance with the laws of the United States of America and by the laws of the state of Idaho without regard to its conflict of law rules. We are an insurance company that provides insurance to this benefit plan and makes determinations for eligibility and the meaning of terms subject to Insured rights per this benefit plan that include the right to Appeal, review by an IRO and civil action.

LEGAL ACTION

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

LIMITATIONS ON LIABILITY

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

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

MODIFICATION OF POLICY

We shall have the right to modify or amend this Policy from time to time. However, no modification or amendment will be effective until a minimum of 30 days (or as required by law) after written notice has been given to the Policyholder. The modification must be uniform within the product line and at the time of renewal.

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

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

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

Changes can be made only through a modified Policy, amendment, endorsement or rider authorized and signed by one of Our officers. No other agent or employee of Ours is authorized to change this Policy.

NO WAIVER

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

NONASSIGNMENT AND NONASSIGNMENT OF VOTING RIGHTS

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

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

NOTICES

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

PHYSICAL EXAMINATIONS AND AUTOPSY

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

PREMIUMS

Premiums are to be received by Us on or before the premium due date according to the requirements established by YHI, including any provisions pertaining to a grace period. Failure by the Policyholder to make timely payment of premiums may result in terminating this Policy on the date assigned by YHI.

Premium Payments

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

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

You, on behalf of Yourself and any Enrolled Dependents, expressly acknowledge Your understanding that this Policy constitutes an agreement solely with Regence BlueShield of Idaho, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association), permitting Us to use the Blue Shield Service Mark in the state of Idaho and in Asotin and Garfield counties in the state of Washington and that We are not contracting as the agent of the Association. You, on behalf of Yourself and any Enrolled Dependents, further acknowledge and agree that You have not entered into this Policy based upon representations by any person or entity other than Regence BlueShield of Idaho and that no person or entity other than Regence BlueShield of Idaho will be held accountable or liable to You for any of Our obligations to You created under this Policy. This paragraph will not create any additional

obligations whatsoever on the part of Regence BlueShield of Idaho other than those obligations created under other provisions of this Policy.

REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements You make in an application will be considered representations and not warranties. No statement made for obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

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

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

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

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

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

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

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

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

TAX TREATMENT

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

WHEN BENEFITS ARE AVAILABLE

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

- the person is eligible to be covered according to the eligibility provisions in 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 according to the requirements established by YHI, including any provisions pertaining to a grace period.

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

WOMEN'S HEALTH AND CANCER RIGHTS

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

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

Definitions

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

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

Allowed Amount means:

- For In-Network Providers, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Providers who are not accessed through the BlueCard Program, the amount determined to be reasonable charges for Covered Services. The Allowed Amount may be based upon billed charges for some services or as otherwise required by law. The maximum Allowed Amount for facility charges for an inpatient non-emergency admission at a Nonparticipating Facility will be \$2,000 per day.
- For Out-of-Network Providers accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to Us as the amount on which it would base a payment to that Provider, except that, for an inpatient non-emergency admission at a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day. In exceptional circumstances, such as if the Host Blue does not identify an amount on which it would base payment, We may substitute another payment basis.

The Allowed Amount is based upon many factors, including:

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

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

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

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

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

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

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

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

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

Custodial Care means care for watching and protecting a patient, rather than being a Health Intervention. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily to separate the patient from others or preventing self-harm.

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

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

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

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

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

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

Family means a Policyholder and any Enrolled Dependents.

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

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

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

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

Hospital means a facility that is licensed as a Hospital pursuant to the laws of the state in which the Hospital is located and is primarily and continuously engaged in providing or operating on its premises or in facilities available to the Hospital on a prearranged basis and with the supervision of a staff of licensed Physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made. A Hospital provides continuous 24-hour nursing services by or with the direction of registered nurses. A Hospital per this definition is not,

other than incidentally, a place for rest, a nursing home or a facility for convalescence.

Illness means a bodily disorder or disease other than an Injury. All such bodily disorders existing concurrently, which are due to the same cause or pathologically related causes, shall be considered one Illness. Successive Illnesses resulting from the same cause, or from treatment or complications thereof, shall be considered as the same Illness.

Injury means a physical Injury caused by:

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

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

In-Network means a Provider that has an effective participating contract with Us, that designates the Provider as a member of Your network, to provide services and supplies to Insureds in accordance with the provisions of this coverage. For In-Network Provider reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

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

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

- If a medication or device, the Health Intervention must have final approval from the FDA as being safe and effective for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the medication may be provided when so used.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Illness or Injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved 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 by this Policy with Us.

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

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

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

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

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

Out-of-Network means a Provider that is not In-Network. Out-of-Network also means a Provider outside the area that We or one of Our Affiliates serves, but who have contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program. For Out-of-Network Provider services, You may be billed for balances over Our payment level in addition to any Deductible, Copayment and/or Coinsurance amount for Covered Services provided inside or outside the area that We or one of Our Affiliates serves.

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

Placed or Placement means physical Placement in the care of the adoptive Policyholder. In those circumstances in which such physical Placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Policyholder signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child.

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

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include, but are not limited to:

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

Primary Physician or Practitioner means a Physician, osteopathic Physician or Practitioner who, when acting within the scope of their state license, provides Your primary care or coordinates referral services when needed and is licensed in:

- general practice;
- family practice;
- internal medicine;
- pediatrics;
- geriatrics;
- obstetrics/gynecology (Ob/Gyn);
- preventive medicine;
- adult medicine; or
- women's health care.

Primary Physician or Practitioner also means any Physician assistant, nurse Practitioner or advanced registered nurse Practitioner licensed in one of the above specialties and working under a Physician, osteopathic Physician or Practitioner who is licensed in the same specialty.

Provider means:

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

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

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

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

Service Area means the state of Idaho.

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

Specialist means a Physician or Practitioner who does not otherwise meet the definition of a Primary Physician or Practitioner.

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

Appendix: Value-Added Services

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

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

INDIVIDUAL ASSISTANCE PROGRAM (IAP)

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

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

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

- 24-Hour Crisis Counseling**
The IAP hotline number is answered by professional counselors 24 hours a day, 7 days a week.
- Short-Term Counseling**
An "incident" means a separate event or events occurring in the client's life. Four counseling sessions will be covered per incident. Each client affected by an incident will be eligible for a total of four counseling sessions. If two or more clients are seen together in a joint session, the session is counted as one visit for each attending client.
- Referral**
If the counselor and client determine the problem cannot be handled in short-term counseling, the counselor may refer the client to extended care, community resources or another Provider as best suited to address the issue and referred services will not be part of this IAP. Services not included in this IAP will be subject to the benefits in this Policy.
- Follow-up**
When necessary and appropriate, the counselor may follow up with the client after short-term counseling and/or referral to assess the appropriateness of the referral and to see if this IAP service can be of further assistance.

KIDNEY HEALTH MANAGEMENT

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

NURSE ADVICE

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

PREGNANCY PROGRAM

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

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

REGENCE EMPOWER

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

- earning up to a total of \$100 in gift cards for completion of well-being activities such as an online health risk assessment, health screening(s) and wellness examination(s) (for the Policyholder and their enrolled spouse or domestic partner);
- earning up to a total of \$25 in gift cards for completion of well-being activities (for enrolled dependents, other than a spouse or domestic partner, age 13 and older);
- incentives to reward participation in healthy activities; and
- online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals.



2024 Outline of Coverage

SLHP Gold 1500 (including Tribal Greater than 300)

Regence BlueShield of Idaho, Inc. Medical Benefits

OUTLINE OF COVERAGE

SLHP Gold 1500 (including Tribal Greater than 300)

Introduction

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

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

The pediatric vision benefits are provided by Regence BSI, in collaboration with Vision Service Plan Insurance Company (VSP), which coordinates the pediatric vision benefits and associated claims processing. VSP is a separate company that provides vision benefit services.

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 and chronic disease management; and
- pediatric services including oral and vision care.

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

Notice of Annual Meeting

The annual meeting of Regence BSI contract holders shall be held at 10:00 a.m., Pacific Time on the third Wednesday of April at its corporate headquarters located at 1602 21st Avenue, Lewiston, ID.

ACCESSING PROVIDERS

You control Your out-of-pocket expenses by choosing between "In-Network" and "Out-of-Network" Providers.

NOTE: If You are a Native American enrolled in this Policy, You may also choose an Indian Health Care Provider (IHCP), such as Indian Health Services, an Indian Tribe, Tribal Organizations or an Urban Indian Organization.

- **IHCP.** Choosing an IHCP means Your Covered Services will not be subject to any Deductible, Copayment and/or Coinsurance. Choosing to see an In-Network Provider or an Out-of-Network Provider through a referral from an IHCP also means Your Covered Services will not be subject to any Deductible, Copayment and/or Coinsurance. However, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. This is referred to as balance billing. Refer to the notice "Your Rights and Protections Against Surprise Medical Bills" attached to this Policy for information regarding reimbursement and balance billing applicable to Out-of-Network Providers for certain services.
- **In-Network.** Choosing In-Network Providers saves You the most in Your out-of-pocket expenses. In-Network Providers will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network.** Choosing Out-of-Network Providers means Your out-of-pocket expenses will be higher than choosing an In-Network Provider. Also, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. This is referred to as balance billing. Refer to the notice "Your Rights and Protections Against Surprise Medical Bills" attached to this Policy for information regarding reimbursement and balance billing applicable to Out-of-Network Providers for certain services. If a Covered Service is not available from an In-Network Provider, You may be able to receive coverage from an Out-of-Network Provider at the In-Network benefit level. Refer to the Prior Approval of Out-of-Network Provider Services provision in the Policy and Claims Administration Section for further information.

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

What is Covered

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

PREAUTHORIZATION

Contracted Providers

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

Non-Contracted Providers

Outpatient Services

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

Inpatient Services

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

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

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

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

INPATIENT AND OUTPATIENT HOSPITAL/SKILLED NURSING FACILITY

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

HOME HEALTH CARE

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

OUTLINE OF COVERAGE

PHYSICIAN SERVICES

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

PRESCRIPTION MEDICATIONS

OTHER SERVICES

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

PEDIATRIC VISION SERVICES

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

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

*Contact lenses are in lieu of all other frame and lens benefits.

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

OUTLINE OF COVERAGE

PEDIATRIC DENTAL SERVICES

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

Preventive and Diagnostic Dental Services

- The following services are limited to two per Insured per Calendar Year:

- bitewing x-ray sets;
- preventive oral examinations;
- diagnostic oral examinations;
- topical fluoride application (excluding cleanings);
- topical fluoride varnish treatments; and
- cleanings.*

*A third cleaning may be covered, in the same Calendar Year, for an Insured with one or more of the following conditions:

- coronary atherosclerosis;
- diabetes;
- hypertensive heart disease; or
- pregnancy.

- The following services are limited to one per Insured in a three-year period:

- complete intra-oral mouth x-rays;
- panoramic x-rays;
- sealants for permanent molars, limited to one per tooth; and
- preventive resin restoration in a moderate to high caries risk patient, limited to one per permanent tooth.

- Cephalometric x-rays.
- Space maintainers.

Basic Dental Services

- Complex oral surgery procedures including:

- surgical extractions of teeth;
- impaction;
- alveoloplasty;
- vestibuloplasty; and
- residual root removal.

- Emergency treatment for pain relief. Restorative treatment on the same date of service as emergency treatment is not covered.

- Endodontic services including:

- Apicoectomy;
- Pulpotomy; and
- root canal treatment.

- Fillings consisting of composite and amalgam restorations.

- General dental anesthesia or intravenous sedation administered for:

- extractions of partially or completely bony impacted teeth; or
- to safeguard the Insured's health (for example, a child under seven years of age).

- Uncomplicated oral surgery procedures including:

- removal of teeth;
- biopsy;
- incision; and

- drainage.
- Periodontal services including:
 - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery) limited to once per Insured per quadrant in a three-year period;
 - gingivectomy and gingivoplasty limited to once per Insured per quadrant in a three-year period;
 - scaling and root planing limited to once per Insured per quadrant in a two-year period; and
 - periodontal maintenance limited to four per Insured per Calendar Year in lieu of preventive cleanings.
- Adjustment and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within six months of insertion.
 - reline procedures, limited to once per Insured in a three-year period; and
 - rebase procedures, limited to once per Insured in a three-year period.

Major Dental Services

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

Exclusions

GENERAL EXCLUSIONS

The following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**, are not covered. However, these exclusions will not apply with regard to a Covered Service for:

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

Activity Therapy

The following activity therapy services are not covered:

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

Adventure, Outdoor, or Wilderness Interventions and Camps

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

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

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

Assisted Reproductive Technologies

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

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer;
- other artificial means of conception; or
- any associated surgery, medications, testing or supplies.

Aviation

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

Breast Reduction

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

Certain Therapy, Counseling and Training

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

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

Conditions Caused by Active Participation in a War or Insurrection

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

Conditions Incurred in or Aggravated During Performances in the Uniformed Services

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

Cosmetic/Reconstructive Services and Supplies

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

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

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

Counseling in the Absence of Illness

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

Custodial Care

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

Dental Services

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

Elective Abortions

Elective abortions are not covered.

"Elective abortion" means an abortion for any reason other than when:

- an abortion is necessary to save the life of the pregnant Insured per the recommendation of one consulting Physician; or
- the Insured is pregnant as a result of rape (as defined in Idaho Code §18-6101) or incest as determined by the courts.

Coverage for non-elective abortions is provided in the Termination of Pregnancy benefit.

Facilities Without a Provider Legally Required to be on Duty

Admission and treatment in a setting where neither a Physician nor licensed nurse is legally required to be on duty at all times that a patient is admitted.

Family Counseling

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

Fees, Taxes, Interest

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

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

Government Programs

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

Additionally, except as listed below, government facilities or government facilities outside the Service Area are not covered:

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

Hearing Aids and Other Devices

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

Hypnotherapy and Hypnosis Services

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

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

Illegal Activity

Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by an Insured's **voluntary participation in** an activity where the Insured is found guilty of an illegal

activity in a criminal proceeding or is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty or a no contest plea. If benefits already have been paid before the finding of guilt or liability is reached, We may recover the payment from the person We paid or anyone else who has benefited from it.

Illegal Services, Substances and Supplies

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

Individualized Education Program (IEP)

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

Infertility

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

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

Investigational Services

Except as provided in the Approved Clinical Trials benefit, Investigational services are not covered, including, but not limited to:

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

Liposuction for the Treatment of Lipedema

Motor Vehicle Coverage and Other Available Insurance

When motor vehicle coverage, other available insurance or contract is either issued to, or makes benefits available to an Insured (whether or not the Insured makes a claim with such coverage), expenses are not covered for services and supplies that are payable by any:

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

Further, the Insured is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits in such contract or insurance are exhausted or considered to no longer be Injury-related by the no-fault provisions of the contract, benefits will be provided accordingly.

Non-Direct Patient Care

Except as provided in the Virtual Care benefit, non-direct patient care services are not covered, including, but not limited to:

- appointments scheduled and not kept (missed appointments);
- charges for preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at Regence BSI's request); and

- visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

Non-Therapeutic Continuous Glucose Monitors

Obesity or Weight Reduction/Control

Except as provided in the Nutritional Counseling benefit, as required by law or for treatment of obesity-related comorbid medical conditions (for example, diabetes, high blood pressure and heart disease), services or supplies that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered, including, but not limited to:

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

Orthognathic Surgery

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

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

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

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

Over-the-Counter Contraceptives

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

Personal Items

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

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

Physical Exercise Programs and Equipment

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

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

Private-Duty Nursing

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

Reversals of Sterilizations

Services and supplies related to reversals of sterilization.

Routine Foot Care

Routine Hearing Examinations

Self-Help, Self-Care, Training or Instructional Programs

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

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

Services and Supplies Provided by a Member of Your Family

Services and supplies provided to You by a member of Your immediate family are not covered.

"Immediate family" means:

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

Services and Supplies That Are Not Medically Necessary

Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Services Required by an Employer or for Administrative or Qualification Purposes

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

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

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

- travel, immigration or emigration.

Sexual Dysfunction

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

Temporomandibular Joint (TMJ) Disorder Treatment

Services and supplies provided for TMJ disorder treatment.

Third-Party Liability

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

Travel and Transportation Expenses

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

Varicose Vein Treatment

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

Vision Care

Except as provided in the Pediatric Vision Services Section, vision care services are not covered, including, but not limited to:

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

Wigs

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

Work-Related Conditions

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

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

PRESCRIPTION MEDICATION EXCLUSIONS

Biological Sera, Blood or Blood Plasma

Bulk Powders

Except as included on Regence BSI's Drug List and presented with a Prescription Order, bulk powders are not covered.

Cosmetic Purposes

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

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

Devices or Appliances

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

Diagnostic Agents

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

Digital Therapeutics

Except for those included on Regence BSI's Drug List and presented with a Prescription Order, digital therapeutics are not covered.

Foreign Prescription Medications

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

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

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

General Anesthetics

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

Medical Foods

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

Medications that are Not Considered Self-Administrable

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

Nonprescription Medications

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

- medications included on Regence BSI's Drug List;
- medications approved by the FDA; or
- a Prescription Order by a Physician or Practitioner.

Nonprescription medications include, but are not limited to:

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

Prescription Medications Dispensed in a Facility

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

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

Prescription Medications Not Approved by the FDA

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

Prescription Medications Not on the Drug List

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

Prescription Medications Not within a Provider's License

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

Prescription Medications with Therapeutic Alternatives

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

Prescription Medications without Examination

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

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

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

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

PEDIATRIC VISION EXCLUSIONS

Certain Contact Lens Expenses

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

Corneal Refractive Therapy (CRT)

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

Corrective Vision Treatment of an Experimental Nature

Costs for Services and/or Supplies Exceeding Benefit Allowances

Lens Enhancements

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

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

Medical or Surgical Treatment of the Eyes

Medical or surgical treatment of the eyes, including reversals or revisions of surgical procedures of the eye.

Orthoptics or Vision Training

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

Plano Lenses (Less Than a \pm .50 Diopter Power)

Replacements

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

Two Pair of Glasses in Lieu of Bifocals

PEDIATRIC DENTAL EXCLUSIONS

Adjustments

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

Aesthetic Dental Procedures

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

Bone Grafts

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

Cone Beam Imaging/MRI Procedures

Cosmetic/Reconstructive Services and Supplies

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

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

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

Decay Prevention

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

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

Duplicate Services

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

Experimental or Investigational Services

Fabrication of Athletic Mouth Guard

Facility Expenses

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

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

Failure to Comply

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

Gold-Foil Restorations

Nitrous Oxide

Oral Hygiene and Dietary Instructions

Oral Sedation

Orthodontic Dental Services

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

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

Plaque Control Programs

Precision Attachments, Personalization, Precious Metal Bases and Other Specialized Techniques

Provisional, Temporary and Duplicate Devices or Appliances

Replacements

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

Sealants

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

Separate Charges

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

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

Services and Supplies to Alter Vertical Dimension and/or Restore or Maintain the Occlusion

Services and supplies to alter vertical dimension and/or restore or maintain the occlusion are not covered, including, but not limited to:

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

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

Services and Treatment Not Prescribed By or Under the Direct Supervision of a Dentist

Services Provided by Certain Entities

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

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

Specialized Procedures and Techniques

Temporomandibular Joint (TMJ) Disorder Treatment

Services and supplies provided in connection with TMJ disorder treatment.

Topical Medicament Center

Eligibility and Enrollment

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

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

OPEN ENROLLMENT PERIOD

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

ENROLLMENT

After carefully reading this brochure and deciding to apply for coverage, You may do so via YHI.

SPECIAL ENROLLMENT

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

- if You, Your spouse or domestic partner gain a new dependent child or, for a child, become a dependent child by birth, adoption or Placement for adoption;
- if You, Your spouse or domestic partner gain a new dependent child or, for a spouse or domestic partner or child, become a dependent through marriage or beginning a domestic partnership;
- unintentional, inadvertent or erroneous enrollment or non-enrollment resulting from an error, misrepresentation or inaction by an officer, employee or agent of YHI 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);
 - an employee's reduction in working hours;
 - an employee's divorce or legal separation;
 - an employee's entitlement to Medicare;
 - loss of dependent child status; or
 - certain employer bankruptcies.
- newly gain access to an individual coverage health reimbursement arrangement (ICHRA) or are newly provided a qualified small employer health reimbursement arrangement (QSEHRA);
- an individual (not previously lawfully present) gains status as a citizen, national or lawfully present individual in the U.S.;
- permanently move to a new Service Area;
- loss of minimum essential coverage; or
- other exceptional circumstances as YHI may provide.

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

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

If You are classified as an "Indian" under federal law, You may move between qualified health plans one time per month.

POLICY EFFECTIVE DATE

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

TERMINATION

Coverage will terminate in the event of:

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

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

Your coverage cannot be terminated for health reasons.

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

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

PREGNANCY BENEFIT EXTENSION

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

General Provisions and Legal Notices

OUT-OF-AREA SERVICES

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You obtain health care services outside Our service area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

We cover health care services received outside of Our service area. As used in this Out-of-Area Services provision, "Out-of-Area Covered Services" means Covered Services obtained outside Our service area. Out-of-Area Covered Services will be provided at the Out-of-Network benefit level specified in the Schedule of Benefits, except emergency care (including ambulance) urgent care services and Out-of-Network services We have prior approved when You otherwise would not have reasonable access to an In-Network Provider. Out-of-Area Covered Services will be provided at the In-Network benefit level. Refer to the Policy for further information.

OTHER PARTY LIABILITY

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

COORDINATION OF BENEFITS

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

APPEAL PROCESSES

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

MODIFICATION OF POLICY

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

NONASSIGNMENT AND NONASSIGNMENT OF VOTING RIGHTS

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

PREMIUMS

Premiums are to be received by Us on or before the premium due date according to the requirements established by YHI, including any provisions pertaining to a grace period. Failure by the Policyholder to make timely payment of premiums may result in terminating this Policy on the date assigned by YHI.

WOMEN'S HEALTH AND CANCER RIGHTS

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

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



Mark H. Ruszczyk
President
Regence BlueShield of Idaho

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

SCHEDULE OF BENEFITS

SLHP Gold 1500 (including Tribal Greater than 300)

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

	Insured Responsibility	
	In-Network Provider	Out-of-Network Provider
Coinsurance	20%	50%
Deductible per Calendar Year <ul style="list-style-type: none"> • Except as noted with "Deductible waived," all benefits are subject to the Deductible and the Deductible must be met before benefits begin for any Insured. No one Family member may contribute more than their individual Deductible amount toward the Family Deductible. 	\$1,500 per Insured \$3,000 per Family	\$16,300 per Insured \$32,600 per Family
Out-of-Pocket Maximum per Calendar Year	\$9,450 per Insured \$18,900 per Family	\$81,500 per Insured \$163,000 per Family

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

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

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	Insured Responsibility	
	In-Network Provider	Out-of-Network Provider
Preventive Care and Immunizations	0%, Deductible waived	50%
Preventive Care – Expanded Immunizations	20%	50%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	Insured Responsibility	
	In-Network Provider	Out-of-Network Provider
Office or Urgent Care Visits – Illness or Injury <ul style="list-style-type: none"> Out-of-Network urgent care visits apply to the In-Network Out-of-Pocket Maximum 	Primary Physician or Practitioner Office Visits – \$10 Copayment, Deductible waived	Office Visits – 50%
	Specialist Office Visits – \$70 Copayment, Deductible waived	
	Urgent Care Visits – \$70 Copayment, Deductible waived	
Other Professional Services	20%	50%
Acupuncture <ul style="list-style-type: none"> 18 visits per Calendar Year 	\$10 Copayment, Deductible waived	50%
Ambulance Services <ul style="list-style-type: none"> Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum 	20%	
Blood Bank <ul style="list-style-type: none"> Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum 	20%	
Dental Hospitalization <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	20%	50%
Detoxification <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	20%	50%
Diabetic Education	0%, Deductible waived	50%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	Insured Responsibility	
	In-Network Provider	Out-of-Network Provider
Dialysis <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	20%	50%
Durable Medical Equipment	20%	50%
Emergency Room <ul style="list-style-type: none"> Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum 	20%	
Gene Therapy and Adoptive Cellular Therapy <ul style="list-style-type: none"> 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 \$2,000 per day 	Centers of Excellence facility – 20%	50%
Gene Therapy and Adoptive Cellular Therapy – Travel Expenses <ul style="list-style-type: none"> \$7,500 per course of treatment, including companion(s), for transportation and lodging expenses Additional limitations apply, refer to the Medical Benefits Section 	100% of all expenses. Your travel expenses may be reimbursed subject to Your In-Network Deductible and travel expense limit.	
Habilitation Services <ul style="list-style-type: none"> 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 \$2,000 per day 	20%	50%
Hearing Loss <ul style="list-style-type: none"> 1 hearing aid device per ear every 36 months 45 outpatient speech and language therapy visits within 12 months from the receipt of a hearing aid, bone conduction device or cochlear implant Additional limitations apply, refer to the Medical Benefits Section 	20%	50%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	Insured Responsibility	
	In-Network Provider	Out-of-Network Provider
Home Health Care	20%	50%
Hospice Care	20%	50%
Hospital Care – Inpatient, Outpatient and Ambulatory Surgical Center <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	20%	50%
Infusion Therapy	20%	50%
Maternity Care <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	20%	50%
Medical Foods	20%	50%
Mental Health or Substance Use Disorder Services <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	Inpatient services – 20%	50%
	Outpatient office/psychotherapy visits – \$10 Copayment, Deductible waived All other outpatient services – 20%	
Newborn Care <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	20%	50%
Nutritional Counseling <ul style="list-style-type: none"> 3 visits per Calendar Year 	20%	50%
Orthotic Devices	20%	50%
Palliative Care <ul style="list-style-type: none"> 30 visits per Calendar Year 	20%	50%
Prosthetic Devices	20%	50%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	Insured Responsibility	
	In-Network Provider	Out-of-Network Provider
Provider-Administered Specialty Drugs	20%	50%
Rehabilitation Services <ul style="list-style-type: none"> 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 \$2,000 per day 	20%	50%
Repair of Teeth <ul style="list-style-type: none"> Treatment must be provided within 12 months from the date of Injury 	20%	50%
Skilled Nursing Facility <ul style="list-style-type: none"> 30 inpatient days per Calendar Year 	20%	50%
Spinal Manipulations <ul style="list-style-type: none"> 18 spinal manipulations per Calendar Year 	\$10 Copayment, Deductible waived	50%
Termination of Pregnancy <ul style="list-style-type: none"> Allowed only for certain circumstances, refer to the Medical Benefits Section 	20%	50%
Transplants <ul style="list-style-type: none"> For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is \$2,000 per day 	20%	50%
Transplants – Travel Expenses <ul style="list-style-type: none"> 14 days per transplant episode (limit is combined for Insured and companion(s)) Covered Services apply to the In-Network Deductible and/or In-Network Out-of-Pocket Maximum Additional limitations apply, refer to the Medical Benefits Section 	100% of all expenses. Your travel expenses may be reimbursed subject to Your In-Network Deductible and travel expense limit.	
Virtual Care – Store and Forward Services	0%, Deductible waived	50%
Virtual Care – Telehealth	\$10 Copayment, Deductible waived	50%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	Insured Responsibility	
	Participating Pharmacy	Nonparticipating Pharmacy
Prescription Medications – from a Pharmacy <ul style="list-style-type: none"> • Deductible waived when You fill a prescription for Preferred Brand-Name insulin and for medications specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medications list. To obtain this list visit Our website or contact Customer Service. Contact Information is available in the Introduction Section. • You are not responsible for any Deductible, Copayment and/or Coinsurance when You fill prescriptions for medications intended to treat opioid overdose that are on the Naloxone Value List. To obtain this list visit Our website or contact Customer Service. Contact Information is available in the Introduction Section. • Out-of-Network services apply to the In-Network Deductible and/or In-Network Out-of-Pocket Maximum • 90-day supply for Prescription Medications Copayment is based on each 30-day supply • 30-day supply for Specialty Medications • Cost-sharing for Preferred Brand-Name insulin will not exceed \$100 per 30-day supply 	\$10 Copayment, Deductible waived for each Generic Medication on the Drug List	
	20% for each Preferred Brand-Name Medication on the Drug List	
	50% for each Brand-Name Medication on the Drug List	
	50% for each Specialty Medication on the Drug List from a Participating Specialty Pharmacy	60% for each Specialty Medication on the Drug List from a Nonparticipating Specialty Pharmacy
Prescription Medications – from a Home Delivery Supplier <ul style="list-style-type: none"> • Out-of-Network services apply to the In-Network Deductible and/or In-Network Out-of-Pocket Maximum • 90-day supply for Prescription Medications • Cost-sharing for Preferred Brand-Name insulin will not exceed \$300 per 90-day supply 	\$30 Copayment, Deductible waived for each Generic Medication on the Drug List	
	20% for each Preferred Brand-Name Medication on the Drug List	
	50% for each Brand-Name Medication on the Drug List	

**Covered Services (per Insured)
Unless Otherwise Noted the Deductible Applies**

Benefit	Insured Responsibility	
	VSP Doctor	Out-of-Network Provider
Pediatric Vision (under age 19) <ul style="list-style-type: none"> • 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 • Services do not accrue to any Out-of-Pocket Maximum • Low vision supplemental examination (testing) and supplemental aids every 2 Calendar Years • Additional limitations apply, refer to the Pediatric Vision Services Section 	Examination – 0%, Deductible waived	Examination – 100% of billed charges; 50% of Your payment may be reimbursed based upon the Allowed Amount, Deductible waived
	Hardware – 0%, Deductible waived	Hardware – 100% of billed charges; 50% of Your payment may be reimbursed based upon the Allowed Amount, Deductible waived
	Contact Lens Evaluation and Fitting Examination – 0%, Deductible waived	Contact Lens Evaluation and Fitting Examination – 100% of billed charges; 50% of Your payment may be reimbursed based upon the Allowed Amount, Deductible waived
	Low Vision Supplemental Examination (Testing) – 0%, Deductible waived	Low Vision Supplemental Examination (Testing) – 100% of billed charges; 100% of Your payment may be reimbursed based upon the VSP Doctor Allowed Amount, Deductible waived
	Low Vision Supplemental Aids – 0%, Deductible waived	Low Vision Supplemental Aids – 100% of billed charges; 100% of Your payment may be reimbursed based upon the VSP Doctor Allowed Amount, Deductible waived

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit	Insured Responsibility	
	In-Network Dentist	Out-of-Network Dentist
Pediatric Dental (under age 19) <ul style="list-style-type: none"> • Out-of-Network services apply to the In-Network Out-of-Pocket Maximum • Additional limitations apply, refer to the Pediatric Dental Services Section 	Preventive and Diagnostic Services – 0%, Deductible waived	
	Basic Services – 20%, Deductible waived	
	Major Services – 50%, Deductible waived	

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

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