2016 BOOKLET FOR:

HIGHLAND JOINT SCHOOL DISTRICT 305

Group Number: 10028361

Regence Group Direct Gold HSA

Introduction

Regence BlueShield of Idaho

Street Address:
1602 21st Avenue
Lewiston, ID 83501

Claims Address:
P.O. Box 31603
Salt Lake City, UT 84131-0603

Customer Service/Correspondence Address:
P.O. Box 1271, M/S C7A
Portland, OR 97207-1271

Appeals Address:
P.O. Box 4208
Portland, OR 97208-4208

This Booklet provides the evidence and a description of the terms and benefits of coverage. The agreement between the Group and Regence BlueShield of Idaho (called the "Contract") contains all the terms of coverage. Your plan administrator has a copy.

This Booklet describes benefits effective **September 1, 2016**, or the date after that on which Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Us and makes it void.

As You read this Booklet, please keep in mind that references to "You" and "Your" refer to both the Enrolled Employee and Enrolled Dependents (except that in the eligibility and continuation of coverage sections, the terms "You" and "Your" mean the Enrolled Employee only). The terms "We," "Us" and "Our" refer to Regence BlueShield of Idaho and the term "Group" means the organization whose employees may participate under this coverage. Other terms are defined in the Definitions Section at the back of this Booklet or where they are first used and are designated by the first letter being capitalized.

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 habilitative services and devices; laboratory services; preventive and wellness services including chronic disease management; and pediatric services, including oral and vision care. There is no annual or lifetime maximum applicable to these services.

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

CONTACT INFORMATION

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

And visit Our Web site at: **www.Regence.com**

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

Using Your Regence Group Direct Gold HSA Booklet

YOUR PARTNER IN HEALTH CARE

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

Regence Group Direct Gold HSA provides You with great benefits that are quickly accessible and easy to understand, thanks to access to Providers and innovative tools. With Regence Group Direct Gold HSA health care coverage, You will discover the personal freedom to make informed health care decisions, as well as the assistance You need to navigate the health care system.

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

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

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

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

ADDITIONAL MEMBERSHIP ADVANTAGES

When Your Group purchased Regence Group Direct Gold HSA, You were provided with more than just great coverage. You also acquired Regence membership, which offers additional valuable services. The advantages of Regence membership include access to 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 **www.Regence.com**, an interactive environment that can help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE.**

- **Go to www.Regence.com.** It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar. Have Your Member card handy to log on. Use the secure Member Web site to:

    - view recent claims, benefits and coverage;
    - find a contracting Provider;
    - participate in online wellness programs and use tools to estimate upcoming healthcare costs;
    - identify Participating Pharmacies;
    - find alternatives to expensive medicines;
    - learn about prescriptions for various Illnesses; and
    - compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

GUIDANCE AND SERVICE ALONG THE WAY

This Booklet was designed to provide information and answers quickly and easily. Be sure to understand Your benefits before You need them. You can learn more about the unique advantages of Regence Group Direct Gold HSA health care coverage and the rewards of Regence membership throughout this

Booklet, some of which are highlighted here. We realize that You may still have some questions about Your Regence Group Direct Gold HSA coverage, so please contact Us if You do.

- **Learn more and receive answers about Your coverage or any other plan that We offer.** Just call 1 (877) 508-7359 to talk with one of Our Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. - 6 p.m. You may also visit Our Web site at: **www.Regence.com**.
- **Case Management.** You can request that a case manager be assigned or You may be assigned a case manager to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. Call Case Management at 1 (866) 543-5765 .
- **BlueCard® Program.** Learn how to have access to care through the BlueCard Program. This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world.

Employee Wellness Reward

Employees may qualify for a $100 gift card reward per Contract Year. To qualify, You, the employee:

- Must be enrolled in the Group's health plan by the 90th day of the Contract Year;
- Must have completed within the first six months of the Contract Year
    - a Biometric Screening from an approved Provider and
    - Our General Health Assessment tool; and
- Must still be enrolled in the Group's health plan as of the later of the date of completion of the Biometric Screening and the date of completion of the General Health Assessment tool.

Biometric screening by a health care Provider can assist You in assessing Your health risks and identifying changes to improve Your health by providing information about Your blood pressure, glucose, cholesterol and body mass. Approved Providers for the Biometric Screening are identified on Our Web site at **www.Regence.com** or by calling Our Customer Service department at 1 (877) 508-7359.

A General Health Assessment is a tool You complete, describing Your health practices. The General Health Assessment is found online at **www.Regence.com** or You may contact Customer Service at 1 (877) 508-7359.

The Employee Wellness Reward is only available to employees. Some participating employees may be contacted by a health coach, offering assistance in health improvement. **THIS EMPLOYEE WELLNESS REWARD IS A COMPLEMENT TO THE GROUP HEALTH PLAN, BUT IS NOT INSURANCE.**

Table of Contents

Understanding Your Benefits

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

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

MAXIMUM BENEFITS

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

OUT-OF-POCKET MAXIMUM

An important feature of this high deductible health plan is how the single and Family Out-of-Pocket Maximums work. The key is understanding the difference between "single" and "family" coverage. Single Coverage means only one person has coverage under this Booklet. An employee who is the only one in his or her Family who has coverage under this Booklet, a husband and wife who both work for the Group and have each filled out an application and are Enrolled Employees on separate coverages, and an Enrolled Dependent who is continuing insurance coverage on his or her own are examples of Single Coverage. Family Coverage, on the other hand, means two or more members of the same Family have coverage under this Booklet under a single application.

Members can meet the Out-of-Pocket Maximum by payments of Deductible and Coinsurance as specifically indicated in the Medical Benefits Section. There are two Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits. The Medical Benefits Section describes this more fully, but in this Booklet, the term is referred to simply as "the Out-of-Pocket Maximum." A Member's payment of any Deductible and Coinsurance for emergency room services, Prescription Medications, pediatric dental, pediatric vision hardware and benefits listed in the Medical Benefits Section that show under the Provider "All" will apply toward the In-Network Out-of-Pocket Maximum amount. Additionally, services provided by a Provider that has an effective participating contract with Us or one of Our Affiliates but is not designated as an In-Network Provider (as further defined in the Definitions Section at the back of this Booklet) will apply to the In-Network Out-of-Pocket Maximum amount. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach this Booklet's Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum, benefits will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. The Coinsurance for some benefits in this Booklet does not change to a higher payment level or apply to the Out-of-Pocket Maximum. Those exceptions are specifically noted in the Medical Benefits Section in this Booklet. Additionally, the benefits provided for EAP do not apply to the Out-of-Pocket Maximum or change to a higher payment level.

There are two Family Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits. The Family Out-of-Pocket Maximum for a Calendar Year is satisfied when some or all Family Members' Deductibles and Coinsurance for Covered Services for that Calendar Year total and meet the Family Out-of-Pocket Maximum amount.

PERCENTAGE PAID UNDER THE CONTRACT (COINSURANCE)

Once You have satisfied any applicable Deductible, We pay a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When Our payment is less than 100 percent,

You pay the remaining percentage (this is Your Coinsurance). Your Coinsurance will be based upon the lesser of the billed charges or the Allowed Amount. The percentage We pay varies, depending on the kind of service or supply You received and who rendered it.

We do not reimburse Providers for charges above the Allowed Amount. However, an In-Network Provider will not charge You for any balances for Covered Services beyond Your Deductible and/or Coinsurance amount. Out-of-Network Providers, however, may bill You for any balances over Our payment level in addition to any Deductible and Coinsurance amount. See the Definitions Section for descriptions of Providers.

DEDUCTIBLES

We will begin to pay benefits for Covered Services in any Calendar Year only after a Member satisfies the Calendar Year Deductible. There are two Deductible amounts: one for In-Network benefits and another for Out-of-Network benefits. The Medical Benefits Section describes this more fully, but in this Booklet, the term is referred to simply as "the Deductible." A Member who is enrolled on Single Coverage satisfies the Single Coverage Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total and meet the Single Coverage Deductible.

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

A Member's Deductible amount paid toward Covered Services listed in the Medical Benefits Section for emergency room services, Prescription Medications and Covered Services that show under the Provider "All" will apply toward the In-Network Deductible amount. Additionally, services provided by a Provider that has an effective participating contract with Us or one of Our Affiliates but is not designated as an In-Network Provider (as further defined in the Definitions Section at the back of this Booklet) will apply to the In-Network Deductible amount.

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

HOW CALENDAR YEAR BENEFITS RENEW

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

Some benefits in this Booklet have a separate Maximum Benefit based upon a Member's Lifetime and do not renew every Calendar Year. Those exceptions are specifically noted in the benefits sections in this Booklet.

Medical Benefits

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

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

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

If benefits in this Booklet 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.

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

In-Network

The maximum Out-of-Pocket for any Member on Family Coverage is not to exceed $6,850 including the In-Network Deductible. If a Member reaches this maximum amount prior to satisfying the In-Network Family Out-of-Pocket Maximum, benefits will be paid at 100 percent of the Allowed Amount for that Member.

Single Coverage: $3,000
Family Coverage: $6,000

Out-of-Network

Single Coverage: $10,000
Family Coverage: $20,000

Be aware that Your actual costs for Covered Services provided by an Out-of-Network Provider may exceed this Booklet's Out-of-Network Out-of-Pocket Maximum amount. Also, Your costs for Specialty Medications do not accumulate toward any Out-of-Pocket Maximum amount if delivered by a Nonparticipating Specialty Pharmacy. In addition, Out-of-Network Providers and Nonparticipating Specialty Pharmacies can bill You for the difference between the amount charged and Our Allowed Amount and that amount does not count toward any Out-of-Pocket Maximum.

COINSURANCE

Coinsurance is listed in the tables for Covered Services for each applicable benefit.

CALENDAR YEAR DEDUCTIBLES

In-Network

Single Coverage: $1,400
Family Coverage: $2,800 (entire Deductible must be met before benefits begin, except for any Member of the Family that meets the $6,850 maximum amount for the In-Network Out-of-Pocket Maximum as described above.)

Out-of-Network

Single Coverage: $1,400

Family Coverage: $2,800 (entire Deductible must be met before benefits begin, except for any Member of the Family that meets the $6,850 maximum amount for the In-Network Out-of-Pocket Maximum as described above.)

You do not need to meet any Deductible before receiving benefits for:

- In-Network Preventive Care and Immunizations;
- Pediatric Dental Services; and
- Pediatric Vision Services.

Furthermore, You do not need to meet any Deductible when You fill prescriptions for Generic Medications or Brand-Name Medications on the Essential Formulary specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List found at **www.Regence.com** or by calling Customer Service at 1 (877) 508-7359.

PREVENTIVE CARE AND IMMUNIZATIONS

Benefits will be covered under this Preventive Care and Immunizations benefit, not any other provision in this Booklet, if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA) or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). In the event any of these bodies adopts a new or revised recommendation, this plan has up to one year before coverage of the related services must be available and effective under this benefit. For a list of services covered under this benefit, please visit **www.Regence.com** or contact Customer Service at 1 (877) 508-7359. NOTE: Covered Services that do not meet these criteria will be covered the same as any other Illness or Injury.

In addition to Covered Services for Preventive Care and Immunizations by an In-Network Provider, Covered Services for Preventive Care and Immunizations provided by a Provider that has any form of participating contract to provide services and supplies to Our Members in accordance with the provisions of this coverage, will be covered as an In-Network benefit as explained below.

Provider: In-Network	Provider: Out-of-Network
Payment: We pay 100% of the Allowed Amount.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover preventive care services provided by a professional Provider or facility. Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, routine immunizations and routine health screenings. Also included is Provider counseling for tobacco use cessation and Generic Medications prescribed for tobacco use cessation. See the Prescription Medications benefit in this Booklet for a description of how to obtain Generic Medications. Coverage for all such services is provided only for preventive care as designated above (which designation may be modified from time to time). Covered expenses do not include immunizations if the Member receives them only for the purpose of travel, occupation or residency in a foreign country.

Additionally, We cover all United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods for women in accordance with HRSA recommendations. These include female condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill, and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products), intrauterine devices (both copper and those with progestin), implantable contraceptive rod, surgical implants, and surgical sterilization. Please see Our Web site at **www.Regence.com** for Our preferred contraceptive products covered under the Prescription Medications benefit.

PROFESSIONAL SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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

Medical Services

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

Office or Urgent Care Facility Visits
We cover office and urgent care facility visits for treatment of Illness or Injury.

Professional Inpatient
We cover professional inpatient visits for Illness or Injury, including services for cardiac and pulmonary rehabilitation. If pre-arranged procedures are performed by an In-Network Provider and You are admitted to an In-Network Hospital, We will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by an Out-of-Network Provider at the In-Network benefit level. However, You may be billed for balances beyond any Deductible and/or Coinsurance. Please contact Customer Service for further information and guidance.

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

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

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

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

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

AMBULANCE SERVICES

Provider: All
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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

APPROVED CLINICAL TRIALS
We cover Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating subject to the Deductible, Coinsurance and Maximum Benefits as specified in the Medical Benefits and Prescription Medications benefits in this Booklet. Additional specified limits are as further defined. If an In-Network Provider is participating in the Approved Clinical Trial and will accept You as a trial participant, these benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If the Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care.

Definitions
In addition to the definitions in the Definitions Section, the following definitions apply to this Approved Clinical Trials benefit:

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

- Approved or funded by one or more of:

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

- Conducted under an investigational new drug application reviewed by the Food and Drug Administration or that is a drug trial exempt from having an investigational new drug application.

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

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

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

BLOOD BANK

Provider: All
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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

DENTAL HOSPITALIZATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia), if hospitalization in an Ambulatory Surgical Center or Hospital is necessary to safeguard Your health. Benefits are not available for services received in a Dentist's office.

DETOXIFICATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover Medically Necessary detoxification.

DIABETES SUPPLIES AND EQUIPMENT

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

DIABETIC EDUCATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: four visits per Member per Calendar Year	

We cover services and supplies for diabetic self-management training and education. Diabetic education visits that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services.

DURABLE MEDICAL EQUIPMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Member's home. Examples include oxygen equipment and wheelchairs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After In-Network Deductible, We pay 80% of the Allowed Amount and You pay balance of billed charges. Your 20% payment of the Allowed Amount will be applied toward the In-Network Out-of-Pocket Maximum.

We cover emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be pre-authorized. See the Hospital Care benefit in this Medical Benefits Section for coverage of inpatient Hospital admissions.

FAMILY PLANNING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover certain professional Provider contraceptive services and supplies, including, but not limited to, vasectomy. See the Prescription Medications benefit in this Medical Benefits Section for coverage of prescription contraceptives.

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

GENETIC TESTING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

HOME HEALTH CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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

HOSPICE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 14 inpatient or outpatient respite care days per Member Lifetime	

We cover hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and his or her family during the final stages of Illness. Respite care: We cover respite care to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member. Respite days that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered under the Durable Medical Equipment benefit in this Booklet.

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER

Inpatient and Outpatient

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Ambulatory Surgical Center

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover the inpatient and outpatient services and supplies of a Hospital or the outpatient services and supplies of an Ambulatory Surgical Center for Injury and Illness (including services of staff Providers billed

by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. However, You may be billed for balances beyond any Deductible and/or Coinsurance. Please contact Customer Service for further information and guidance. See the Emergency Room benefit in this Medical Benefits Section for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

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

MATERNITY CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or elective cesarean), complications of pregnancy and related conditions for all female Members. There is no limit for the mother's length of inpatient stay. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit in this Medical Benefits Section to see how the care of Your newborn is covered. NOTE: Certain services such as screening for gestational diabetes, breastfeeding support, supplies and counseling are covered under Your Preventive Care benefit.

MEDICAL FOODS (PKU)

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover medical foods for inborn errors of metabolism including, but not limited to, formulas for Phenylketonuria (PKU).

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Mental Health or Substance Use Disorder Services benefit:

Mental Health or Substance Use Disorder Services mean Medically Necessary outpatient services, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is determined by Us to be Medically Necessary).

Mental Health Conditions means mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association except

as otherwise excluded in this Booklet. Mental disorders that accompany an excluded diagnosis are covered.

Residential Care means care received in an organized program which is provided by a residential facility, Hospital, or other facility licensed, for the particular level of care for which reimbursement is being sought, by the state in which the treatment is provided.

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

NEWBORN CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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

NUTRITIONAL COUNSELING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: three visits per Member per Calendar Year (diabetic counseling is subject to this limit). Nutritional counseling visits that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services. For diabetic education coverage, refer to the Diabetic Education benefit in this Medical Benefits Section.	

ORTHOTIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover benefits for the purchase of braces, splints, orthopedic appliances and orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body. We may elect to provide benefits for a less costly alternative item. We do not cover shoes (unless permanently attached to a brace), orthopedic shoes, arch supports and off-the-shelf shoe inserts.

PALLIATIVE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 30 visits per Member per Calendar Year	

We cover palliative care when a Provider has assessed that a Member is in need of palliative services. For the purpose of this benefit, "palliative care" means specialized services received from a Provider in a home setting for counseling and home health aide services for activities of daily living. Palliative care visits that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services.

PEDIATRIC DENTAL SERVICES

We cover benefits for Dental Services for Members under the age of 19. Coverage will be provided for a Member until the last day of the monthly period in which the Member turns 19 years of age. Please note that the BlueCard Program detailed in the Contract and Claims Administration Section does not apply to dental benefits provided under this Pediatric Dental benefit. We will pay benefits under this Pediatric Dental benefit, not any other provision in this Booklet, if a service or supply is covered under both.

Preventive And Diagnostic Dental Services

Provider: In-Network Dentist	Provider: Out-of-Network Dentist
Payment: We pay 100% of the Allowed Amount.	**Payment:** We pay 100% of the Allowed Amount and You pay balance of billed charges.

For Members under the age of 19, We cover the following preventive and diagnostic Dental Services, as indicated:

- Bitewing x-ray series, limited to two per Member per Calendar Year.
- Complete intra-oral mouth x-rays and panoramic x-rays, limited to once per Member in a three-year period; cephalometric x-rays.
- Preventive oral examinations, limited to two per Member per Calendar Year.
- Diagnostic oral examinations, limited to two per Member per Calendar Year.
- Cleanings, limited to two per Member per Calendar Year.
- Preventive resin restoration in a moderate to high caries risk patient, permanent tooth, limited to one sealant per tooth in a three-year period.
- Sealants for permanent molars, limited to once in a three-year period per tooth.
- Topical fluoride application, excluding cleanings, limited to two treatments per Member per Calendar Year.
- Topical fluoride varnish, limited to two treatments per Member per Calendar Year.
- Space maintainers.

Basic Dental Services

Provider: In-Network Dentist	Provider: Out-of-Network Dentist
Payment: We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** We pay 80% of the Allowed Amount and You pay balance of billed charges. Your 20% payment of the Allowed Amount will be applied toward the In-Network Out-of-Pocket Maximum.

We cover the following basic Dental Services:

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

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

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

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

Major Dental Services

Provider: In-Network Dentist	Provider: Out-of-Network Dentist
Payment: We pay 50% and You pay 50% of the Allowed Amount. Your 50% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the In-Network Out-of-Pocket Maximum.

We cover the following major Dental Services:

- Bridges (fixed partial dentures), limited to one per Member in a five-year period. For adjustment and repair coverage, refer to the Basic Dental Services in this Pediatric Dental Services benefit.
- Crowns, inlays and onlays, limited to once per tooth per Member 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 Member Lifetime.
- Dental implant abutment repair limited to one per Member in a five-year period.
- Dentures, full and partial, limited to once per Member in a five-year period. For adjustment and repair coverage, refer to the Basic Dental Services in this Pediatric Dental Services benefit.
- Occlusal guards limited to one in a twelve-month period for Members 13 years of age and older.

Exclusions

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

Adjustments: Adjustment of a denture or bridgework which is done within 6 months after insertion by the same Dentist who installed the denture or bridgework.

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

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

Cone Beam Imaging/MRI Procedures

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

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

Reconstructive means services, procedures or surgery performed on abnormal structures of the body, caused by Congenital Anomalies, developmental abnormalities, trauma, infection, tumors or disease.

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

Decay Prevention: Supplies and materials to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners.

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

Experimental or Investigational Services

Fabrication of Athletic Mouth Guard

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

- those performed by a Dentist who is compensated by a facility for similar Covered Services performed for Member; 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

Oral Sedation

Nitrous Oxide

Oral Hygiene and Dietary Instructions

Orthodontic Dental Services: Except when Medically Necessary, We will not cover services and supplies provided in connection with orthodontics, including the following:

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

Plaque Control Programs

Precision Attachments, Precious Metal Bases and Other Specialized Techniques

Provisional, Temporary and Duplicate Devices or Appliances

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

Sealants: Except as provided for permanent molars.

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

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

Services and Supplies to Alter Vertical Dimension and/or Restore or Maintain the Occlusion: Services and supplies to alter vertical dimension and/or restore or maintain the occlusion, including the following:

- equilibration;

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

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

Services Provided by Certain Entities: Services and treatment received from a Dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration Hospital or similar person or group.

Specialized Procedures and Techniques

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

Topical Medicament Center

Definitions

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

Allowed Amount means:

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

Charges in excess of Allowed Amount are not considered Reasonable Charges and are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, please contact Us.

Covered Service means those services or supplies that are required to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues and are Dentally Appropriate. These services must be performed by a Dentist or other Provider practicing within the scope of his or her license.

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 Member's condition; and
- not primarily for the convenience of the Member, Member's Family or Provider.

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

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

In-Network Dentist means a Dentist who has an effective participating contract with Us to provide services and supplies to Members in accordance with the provisions in this Booklet.

Out-of-Network Dentist means a Dentist who does not have an effective participating contract with Us to provide services and supplies to Members, or any other Dentist that does not meet the definition of an In-Network Dentist in this Booklet.

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

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

Out-of-Network Dentist Claims
In order for Covered Services to be paid, You or the Dentist must first send Us a claim. Be sure the claim is complete and includes the following information:

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

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

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

Freedom of Choice of Dentist
Nothing contained in this Booklet is designed to restrict You in selecting the Dentist of Your choice for dental care or treatment.

PEDIATRIC VISION SERVICES
We cover benefits for vision care for Members under the age of 19. Coverage will be provided for a Member until the last day of the monthly period in which the Member turns 19 years of age. Covered Services must be rendered by a Physician or optometrist practicing within the scope of his or her license. We will pay benefits under this Pediatric Vision benefit, not any other provision in this Booklet, if a service or supply is covered under both.

Vision Examination

Provider: In-Network	Provider: Out-of-Network
Payment: We pay 100% of the Allowed Amount.	**Payment:** We pay 100% of the Allowed Amount and You pay balance of billed charges.
Limit: one routine eye examination per Member per Calendar Year	

Vision Hardware

Provider: All
Payment: We pay 50% of the Allowed Amount and You pay 50% of the Allowed Amount. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Lenses limit: one pair of lenses (two lenses) per Member per Calendar Year **Frames limit:** one standard frame per Member per Calendar Year **Contacts limit:** contacts may be selected instead of frames and lenses

We cover hardware including frames, contacts and lenses. Coverage is limited to frames and lenses or contacts, but not both in a Calendar Year period. Separate charges for fittings, prism lens and any hardware not Medically Necessary will not be covered.

PRESCRIPTION MEDICATIONS

We cover Prescription Medications listed under the Essential Formulary on Our Web site. To view this Essential Formulary visit Our Web site at **www.Regence.com**.

After You meet the In-Network Deductible, You are responsible for paying the following Coinsurance amounts (at the time of purchase, if the Pharmacy submits the claim electronically). (See below for information on claims that are not submitted electronically and for information on maximum quantities.) Your Coinsurance will be applied toward the In-Network Out-of-Pocket Maximum, except as indicated below for Prescription Medications from a Nonparticipating Specialty Pharmacy.

You do not need to meet any Deductible when You fill prescriptions for Generic Medications or Brand-Name Medications on the Essential Formulary specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List found at **www.Regence.com** or by calling Customer Service at 1 (877) 508-7359.

For Prescription Medications from a Pharmacy

- 10% for each Category 1 Generic Medication on the Essential Formulary

A Member can receive a 5% discount if filled at a Preferred Pharmacy

- 20% for each Category 2 Generic or Category 1 Brand-Name Medication on the Essential Formulary

A Member can receive a 5% discount if filled at a Preferred Pharmacy

- 50% for each Category 2 Brand-Name Medication on the Essential Formulary

A Member can receive a 5% discount if filled at a Preferred Pharmacy

For Prescription Medications from a Mail-Order Supplier

- 5% for each Category 1 Generic Medication on the Essential Formulary
- 15% for each Category 2 Generic or Category 1 Brand-Name Medication on the Essential Formulary
- 40% for each Category 2 Brand-Name Medication on the Essential Formulary

For Prescription Medications from a Participating Specialty Pharmacy

- 50% for each Specialty Medication on the Essential Formulary. The first fill is allowed at a Pharmacy. Additional fills must be provided at a Specialty Pharmacy.

For Prescription Medications from a Nonparticipating Specialty Pharmacy

- 75% for each Specialty Medication on the Essential Formulary. The first fill is allowed at a Pharmacy. Additional fills must be provided at a Specialty Pharmacy. Your Coinsurance does not apply toward any Out-of-Pocket Maximum.

Essential Formulary Changes

Any removal of a Prescription Medication from Our Essential Formulary will be posted at **www.Regence.com** 30 days prior to the effective date of that change unless the removal is done on an emergency basis or if an equivalent Generic Medication becomes available without prior notice. In the case of an emergency removal, the change will be posted as soon as practicable.

If You are taking a Prescription Medication while it is removed from the Essential Formulary 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 substitution 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.

Substitution Process

Non-formulary medications are not routinely covered under Your Prescription Medications benefit; however, a Prescription Medication not on the Essential Formulary may be covered under certain circumstances. Non-formulary means those self-administered Prescription Medications not listed in the Essential Formulary for Your coverage at **www.Regence.com**.

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

- You are not able to tolerate a covered Prescription Medication on the Essential Formulary; or
- Your Provider determines that the Prescription Medication on the Essential Formulary is not therapeutically efficacious for treating Your covered condition; or
- Your Provider determines that a dosage required for efficacious treatment of Your covered condition differs from the Prescription Medication on the Essential Formulary dosage limitation.

The specific medication policy criteria to determine if a Prescription Medication not on the Essential Formulary is Medically Necessary are available at **www.Regence.com**. You or Your Provider may request preauthorization by calling Customer Service at 1 (877) 508-7359 or by completing and submitting the form available at **www.Regence.com**.

Once preauthorization has been approved, the Prescription Medication not on the Essential Formulary will be available for coverage at the Substituted Medication on the Essential Formulary Coinsurance level determined by Your benefit.

Covered Prescription Medications

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

- diabetic supplies (including test strips, glucagon emergency kits, insulin and insulin syringes, but not insulin pumps and their supplies), when obtained with a Prescription Order (insulin pumps and their supplies are covered under the Durable Medical Equipment benefit);
- Prescription Medications;
- certain preventive medications (including, but not limited to, aspirin, fluoride, iron and medications for tobacco use cessation, except for Brand-Name Medications not on the Essential Formulary) according to, and as recommended by, the USPSTF, when obtained with a Prescription Order;
- FDA-approved women’s prescription and over-the-counter (if presented with a prescription) contraception methods as recommended by the HRSA. These include female condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill, and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, and emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products);
- immunizations for adults and children according to, and as recommended by, the CDC;
- growth hormones, when preauthorized;
- Specialty Medications;
- Self-Administrable Cancer Chemotherapy Medication; and
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Compound and Injectable Medications).

You are not responsible for any applicable Deductible and/or Coinsurance when You fill prescriptions at a Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications, women's contraceptives or for immunizations, as specified above. For a list of such medications, please visit **www.Regence.com** or contact Customer Service at 1 (877) 508-7359. Also, if your Provider believes that Our covered preventive medications, including women's contraceptives, are medically inappropriate for You, You may request a coverage exception for a different preventive medication by contacting Customer Service at this same number.

Pharmacy Network and Mail-Order Information

A nationwide network of Participating Pharmacies is available to You. Pharmacies that participate in this network submit claims electronically. You must present Your Member card at a Participating Pharmacy for the claim to be submitted electronically. You must pay any required Deductible and/or Coinsurance at the time of purchase.

You can also use mail-order services to purchase covered Prescription Medications. Mail-order coverage applies only when Prescription Medications are purchased from a Mail-Order Supplier and the claim is submitted electronically. Not all Prescription Medications are available from Mail-Order Suppliers. You may also obtain mail-order coverage for covered Prescription Medications at a Pharmacy, if the Pharmacy agrees to the same terms and conditions as those provided by a Mail-Order Supplier.

To buy Prescription Medications through the mail, simply send all of the following items to a Participating Mail-Order Supplier at the address shown on the prescription mail-order form available on Our Web site at **www.Regence.com** (which also includes refill instructions):

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

Nonparticipating Pharmacies are covered as further detailed below.

Nonparticipating Pharmacies that are registered and agree to dispense covered Prescription Medications under the same terms and conditions as those provided by a Participating Pharmacy will be covered in the same manner as covered Prescription Medications dispensed by a Participating Pharmacy, except for Specialty Medications which shall be covered as specified in the payment tables above. If a Nonparticipating Pharmacy provides Your Prescription Medication, per the exception above, and submits the claim electronically, We will pay the Nonparticipating Pharmacy directly. You will be responsible for any Deductible and/or Coinsurance shown electronically to the Nonparticipating Pharmacy at the time of purchase. This provision also applies to a Nonparticipating Mail-Order Supplier and a Nonparticipating Specialty Pharmacy.

Nonparticipating Pharmacies that are registered, but do not agree to dispense covered Prescription Medications under the same terms and conditions as those provided by a Participating Pharmacy are also covered. However, You will be required to make full payment for covered Prescription Medications at the time of purchase. You will be responsible for filing claims directly with Us. We will reimburse You based on the Covered Prescription Medication Expense, less any applicable Deductible and/or Coinsurance that would have been required had the medication been purchased from and submitted electronically by a Participating Pharmacy. We will send payment directly to You. This provision also applies to a Nonparticipating Mail-Order Supplier and a Nonparticipating Specialty Pharmacy.

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

Your Member card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as a Member with Regence BlueShield of Idaho, a Participating Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find Participating Pharmacies and a Pharmacy locator on Our Web site at **www.Regence.com** or by contacting Customer Service at 1 (877) 508-7359.

It is best to use a Participating Pharmacy, Participating Mail-Order Supplier or Participating Specialty 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 and/or Coinsurance.

Preauthorization

Preauthorization may be required to establish that a Prescription Medication is Medically Necessary before it is dispensed and as indicated under the Substitution Process above. We publish a list of those medications that currently require preauthorization. You can see the list on Our Web site at **www.Regence.com** or contact Customer Service at 1 (877) 508-7359. In addition, We notify participating Providers, including Pharmacies, which Prescription Medications require preauthorization. The prescribing Provider must provide the medical information necessary to establish Medical Necessity of Prescription Medications that require preauthorization.

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

Limitations

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

- **Maximum 30-Day or Greater Supply Limit**

  - **Injectable Medications and 30-Day Supply.** The largest allowable quantity for Self-Administrable Injectable Medications purchased from a Pharmacy or Mail-Order Supplier, is a 30-day supply. The Coinsurance for Self-Administrable Injectable Medications purchased from a Mail-Order Supplier will be the same as if the medication was purchased from and the claim was submitted by a Pharmacy.
  - **Specialty Medications and 30-Day Supply.** The largest allowable quantity for a Specialty Medication purchased from a Specialty Pharmacy, is a 30-day supply. For Specialty Medications to be covered after the initial fill, they must be filled at a Specialty Pharmacy.
  - **Mail-Order and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Mail-Order Supplier is a 90-day supply. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities. Self-Administrable Injectable Medications are limited to a 30-day supply as indicated above.
  - **Pharmacy and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Pharmacy is a 90-day supply. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities. The Coinsurance is based on each 30-day supply.
  - **Pharmacy and 90-Day 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 the smallest multiple-month supply packaged by the manufacturer for dispensing by Pharmacies. The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The maximum supply covered for these products is a 90-day supply (even if the packaging includes a larger supply). The Coinsurance is based on each 30-day supply within that multiple-month supply. However, a Pharmacy that agrees to the same terms and conditions as those provided by a Mail-Order Supplier will be covered as detailed in the Mail-Order and 90-Day Supply provision above.

- **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 Member card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service at 1 (877) 508-7359. We do not cover any amount over the established maximum quantity, except if the amount is Medically Necessary. The prescribing Provider must provide medical

information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

- **Refills**

We will cover refills from a Pharmacy when You have taken 75 percent of the previous prescription. Refills obtained from a Mail-Order Supplier are allowed after You have taken all but 20 days of the previous Prescription Order. If You choose to refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward Your Deductible (if applicable) or Out-of-Pocket Maximum. If You feel You need a refill sooner than allowed, a refill exception will be considered by Us on a case-by-case basis. You may request an exception by calling Customer Service at 1 (877) 508-7359.

- **Prescription Medications Dispensed by Excluded Pharmacies**

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

Exclusions

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

Biological Sera, Blood or Blood Plasma

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

Cosmetic Purposes: Prescription Medications used for cosmetic purposes, including, but not limited to: removal, inhibition or stimulation of hair growth; retardation of aging; or repair of sun-damaged skin.

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

Foreign Prescription Medications: Except for Prescription Medications associated with an Emergency Medical Condition while You are traveling outside the United States, or Prescription Medications You purchase while residing outside the United States, We do not cover foreign Prescription Medications. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.

Insulin Pumps and Pump Administration Supplies: Coverage for insulin pumps and supplies is provided under the Diabetic Supplies and Equipment benefit of this Medical Benefits Section.

Medications We Don't Consider Self-Administrable: Coverage for these medications may otherwise be provided under this Medical Benefits Section.

Nonprescription Medications: Medications that by law do not require a Prescription Order and which are not included in Our definition of Prescription Medications, shown below, unless included on Our Essential Formulary.

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

Prescription Medications for Treatment of Infertility

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

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

Prescription Medications Used for Sexual Dysfunction or Enhancement

Prescription Medications without Examination: Except as provided under the Telehealth and Telemedicine benefits in this Medical Benefits Section, We do not cover prescriptions made by a Provider without recent and relevant in-person examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. For purposes of this exclusion, an examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

Professional Charges for Administration of Any Medication

Travel Immunizations: Immunizations for purposes of travel, occupation or residency in a foreign country.

Definitions

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

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.

Category 1 Generic Medication means a lower cost, established generic medication that has been on the market beyond the initial 180-day exclusivity period and there are multiple manufacturers of the medication.

Category 1 Brand-Name Medication means all preferred brand medications that are not a Specialty Medication.

Category 2 Generic Medication means a higher cost generic and/or an available less costly generic alternative medication that is new to the market.

Category 2 Brand-Name Medication means other Brand-Name Medications used to treat the same or similar medical conditions either at a higher cost or determined to be of lesser value than preferred Brand-Name Medications and that are not Specialty Medications.

Compound Medication means two or more medications that are mixed together by the Pharmacist. To be covered, Compound Medications must contain a Prescription Medication that has been approved by the FDA.

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

Essential Formulary means Our list of selected Prescription Medications. We established Our Essential Formulary and We review and update it routinely. It is available on Our Web site at **www.Regence.com** or by calling Customer Service at 1 (877) 508-7359. Medications are reviewed and selected for inclusion in Our Essential Formulary 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. For the purpose of this definition, "equivalent" means the FDA ensures that the Generic Medication has the same active ingredients, meets the same manufacturing and testing standards, and is as safe and as effective as the Brand-

Name Medication. 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.

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

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

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed. A Participating Pharmacy or Preferred Pharmacy means either a Pharmacy with which We have a contract or a Pharmacy that participates in a network for which We have contracted to have access. Participating or Preferred Pharmacies have the capability of submitting claims electronically. To find a Preferred Pharmacy, please visit Our Web site at **www.Regence.com** or contact Customer Service at 1 (877) 508-7359. A Nonparticipating Pharmacy means a Pharmacy with which We neither have a contract nor have contracted access to any network it belongs to. Nonparticipating Pharmacies may not be able to or choose not to submit claims electronically.

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

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

Self-Administrable Prescription Medications (also Self-Administrable Medications, Self-Administrable Injectable Medication or Self-Administrable Cancer Chemotherapy Medication) means, a Prescription Medication (including, for Self-Administrable Cancer Chemotherapy Medication, oral Prescription Medication used to kill or slow the growth of cancerous cells), which can be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician office or clinic) and that does not require administration by a Provider.

Specialty Medications means medications used for patients with complex disease states, such as but not limited to, multiple sclerosis, rheumatoid arthritis, cancer and hepatitis C. For a list of some of these medications, please visit Our Web site at **www.Regence.com** or contact Customer Service at 1 (877) 508-7359.

Specialty Pharmacy means a Pharmacy that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. A Participating Specialty Pharmacy means a Specialty Pharmacy for which We have contracted to have access and which has the capability of submitting claims electronically. A Nonparticipating Specialty Pharmacy means a Specialty Pharmacy with which We have not contracted and which may not be able to or chooses not to submit claims electronically. To find a Specialty Pharmacy, please visit Our Web site at **www.Regence.com** or contact Customer Service at 1 (877) 508-7359.

Substituted Medication means a Generic Medication or a Brand-Name Medication not on the Essential Formulary that is approved for coverage at the Category 2 Brand-Name Medication benefit level. Substituted Medication also means a Specialty Medication not on the Essential Formulary that is approved for coverage at the Specialty Medication benefit level.

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover prosthetic devices for functional reasons to replace a missing body part, including artificial limbs, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. Synthesized, artificial speech or communications output device, appliance, system or computer system designed to provide speech output or to aid an inoperative or unintelligible voice are covered only for voice boxes to replace all, part or a surgically removed larynx. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility benefit (Hospital inpatient care or Hospital outpatient and Ambulatory Surgical Center care) in this Medical Benefits Section. We will cover repair or replacement of a prosthetic device due to normal use or growth of a child.

REHABILITATION AND HABILITATION SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Inpatient limit: unlimited **Outpatient limit:** 20 visits combined per Member per Calendar Year	

We cover inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services) and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness. We cover inpatient and outpatient habilitation services. Habilitation services are health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical, occupational and speech therapy and other services for a Member with disabilities. Outpatient rehabilitation and habilitation visits that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services. We do not cover outpatient cardiac and pulmonary rehabilitation. See the Professional Services and Hospital Care benefits in this Medical Benefits Section for coverage of inpatient cardiac and pulmonary rehabilitation.

REPAIR OF TEETH

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: treatment must be provided within 12 months from the date of Injury.	

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

SKILLED NURSING FACILITY (SNF) SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 30 inpatient days per Member per Calendar Year	

We cover the inpatient services and supplies of a Skilled Nursing Facility for Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is necessary. Skilled Nursing Facility days that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services. Ancillary services and supplies, such as physical therapy, Prescription Medications, and radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward the Maximum Benefit limit on Skilled Nursing Facility care.

SPINAL MANIPULATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 18 spinal manipulations per Member per Calendar Year	

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

TELEHEALTH

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 25% of the Allowed Amount and You pay balance of billed charges. Your 75% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover telehealth (audio and video communication) office visits for primary care services and equivalent behavioral health services between the patient and a telehealth Provider. To find an approved In-Network telehealth Provider or for additional information on Covered Services, please visit Our Web site at **www.Regence.com** or contact Customer Service at 1 (877) 508-7359. NOTE: Telehealth services are prohibited in some states and therefore You will not be covered for these services if You attempt to access them while in one of those states. Please contact Customer Service for further information and guidance. Coverage is not provided under this benefit for all non-real-time delivery methods, including, but not limited to, store and forward solutions, e-mail or secure message exchange.

TELEMEDICINE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover telemedicine (audio and video communication) services between a distant-site Physician, the patient and a consulting Practitioner when the originating (distant) site is a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services.

TERMINATION OF PREGNANCY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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

TRANSPLANTS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: travel expenses for the patient and care giver are limited up to 14 days per Member per Calendar Year. Reimbursable expenses require case management approval.	

We cover transplants, including transplant-related services and supplies for covered transplants. Covered travel expenses are limited to transportation, lodging and food costs, when approved through case management. Covered travel expenses that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services. A transplant recipient who is covered under this plan and fulfills Medically Necessary criteria will be eligible for the following transplants: heart, lung, kidney, pancreas, liver, cornea, multivisceral, small bowel, islet cell and hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors, for example, either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions). This list of transplants is subject to change. Members can contact Us for a current list of covered transplants. We do not cover any organ or tissue which is procured outside the United States and any transplant procedure performed outside the United States.

Donor Organ Benefits

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

Employee Assistance Program (EAP)

In this section, You will learn how Your EAP coverage works. The explanation includes information about Maximum Benefits and Covered Services.

All terms and conditions in this Booklet apply to this EAP Section, except as otherwise noted.

This EAP is an important component of Your preventive care package. The EAP provides short-term, confidential counseling at no out-of-pocket expense to You. The EAP is available to You and Your immediate family, including family members living in Your home (who may or may not be enrolled in this coverage). Please contact Us for more information regarding EAP coverage and for contact information.

SERVICES PROVIDED
The following services are provided as part of the EAP package:

24-Hour Crisis Counseling
The EAP hotline number is answered by professional counselors 24 hours a day, 7 days per week.

Short-Term Counseling
If the problem can be resolved within the scope of the EAP, the counselor provides this service to the individual(s). Up to four counseling sessions will be allowed per incident. An "incident" means a discrete event or events occurring in the client's life. We will allow each family member affected by an incident a total of four counseling sessions. If two or more members of the same family are seen together in a conjoint session, the session is counted as one visit for each attending family member. Eligible family members are those individuals living in the same residence with You.

Referral
If the counselor and client determine the problem cannot be handled in short-term counseling, the counselor will refer the individual to community resources that are best suited to address the issue.

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

General Exclusions

The following are the general exclusions from coverage in this Booklet. Other provision specific exclusions (for example, Pediatric Dental or Pediatric Vision services) may apply and, if so, will be described elsewhere in this Booklet.

SPECIFIC EXCLUSIONS

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise Covered Service for: 1) an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law; or 2) a preventive service as specified under the Preventive Care and Immunizations or the Prescription Medications benefits in the Medical Benefits Section.

Acupuncture

Applied Behavior Analysis (ABA) Therapy

Breast Reduction

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

Conditions Caused By Active Participation In a War or Insurrection

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

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

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

Cosmetic/Reconstructive Services and Supplies

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

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

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

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

Counseling in the Absence of Illness

Except as provided in this Booklet or as required by law, We do not cover counseling in the absence of Illness, for example: educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; Employee Assistance Program (EAP) services, except as provided under the EAP Section; wilderness programs; premarital or marital counseling; and family counseling (however family counseling will be covered when the identified patient is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment when Mental Health Services are covered benefits in this Booklet).

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

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

Elective Abortions
We do not cover elective abortions. By "elective abortion," We mean an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed. Coverage for non-elective abortions is provided under the Termination of Pregnancy benefit in this Booklet.

Expenses Before Coverage Begins or After Coverage Ends
Services and supplies incurred before Your Effective Date under the Contract or after Your termination under the Contract.

Fees, Taxes, Interest
Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. We also do not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Government Programs
Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or government program, except for facilities that contract with Us and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. We do not cover government facilities outside the service area (except for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).

Hearing Care
Routine hearing examinations, programs or treatment for hearing loss, including, but not limited to, hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion does not apply to cochlear implants.

Infertility
Except to the extent Covered Services are required to diagnose such condition, We do not cover treatment of infertility. Non-covered treatment includes, but is not limited to, all assisted reproductive technologies (for example, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception), fertility drugs and medications, and other artificial means of conception.

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

Mental Health Treatment For Certain Conditions
We do not cover Mental Health Conditions for treatment of paraphilias or paraphilic disorders (except gender identity disorder in children or gender identity disorder in adolescents or adults). Additionally, We do not cover any V code diagnoses, except for Medically Necessary treatment for children ages five and under for parent-child problems, neglect, abuse or bereavement. By "V code," We mean codes for additional conditions that may be a focus of clinical attention, as described in the most recent edition of the DSM, that describe relational problems, problems related to abuse or neglect or other issues that may be the focus of assessment or treatment. This includes, but is not limited to, such issues as occupational or academic problems.

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

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

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

Obesity or Weight Reduction/Control
Except as provided under the Nutritional Counseling benefit in this Booklet, We do not cover medical treatment, medication, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions. This exclusion does not apply to reversals or revisions of surgery for obesity when required to correct a life-endangering condition.

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

Over-the-Counter Contraceptives
Except as provided under the Prescription Medications benefit in this Booklet, We do not cover over-the-counter contraceptive supplies.

Personal Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, We do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps and light boxes.

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

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

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

Riot, Rebellion and Illegal Acts
Services and supplies for treatment of an Illness, Injury or condition caused by a Member's **voluntary participation in** a riot, armed invasion or aggression, insurrection or rebellion or sustained by a Member arising directly from an act deemed illegal by an officer or a court of law.

Routine Foot Care

Self-Help, Self-Care, Training or Instructional Programs
Self-help, non-medical self-care, training programs, including:

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

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

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a Member of Your immediate family. For purposes of this provision, "immediate family" means:

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

Services and Supplies That Are Not Medically Necessary
Except for preventive care benefits provided in this Booklet, We do not cover services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Sexual Dysfunction
Except for counseling services provided by covered, licensed Practitioners, We do not cover services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause.

Sexual Reassignment Surgery

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

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

Travel and Transportation Expenses
Travel and transportation expenses other than covered ambulance services or as otherwise provided in this Booklet.

Vision Care
Except as provided under the Pediatric Vision Services benefit in this Booklet, We do not cover routine eye exam and vision hardware.

Visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.

Work-Related Conditions

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

Contract and Claims Administration

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

PREAUTHORIZATION

Contracted Providers may be required to obtain preauthorization from Us in advance for certain services provided to You. You will not be penalized if the contracted Provider does not obtain those approvals from Us in advance and the service is determined to be not covered in this Booklet. Non-contracted Providers are not required to obtain preauthorization from Us in advance for services so You may be liable for costs if You elect to seek services from non-contracted Providers and those services are not considered Medically Necessary and not covered in this Booklet. You may request that a non-contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to the services being rendered.

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 resource use. 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.

ALTERNATIVE BENEFITS

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

MEMBER CARD

When You, the Enrolled Employee, enroll with Regence BlueShield of Idaho, You will receive a Member card. It will include important information such as Your identification number, Your Group number and Your name.

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

If You lose Your card, or if it gets destroyed, You can get a new one by simply calling Our Customer Service department at 1 (877) 508-7359. You can also view or print an image of Your Member card by visiting Our Web site at **www.Regence.com** on Your PC or mobile device. If coverage under the Contract terminates, Your Member card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

We have the sole right to decide whether to pay You, the Provider or You and the Provider jointly. We may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child.

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

Claims for independent clinical laboratory services will be submitted to the Blue plan in the locale in which the specimen was drawn or otherwise acquired, regardless of where the examination of the specimen occurred. Please refer to Your Blue plan network where the specimen was drawn for coverage of independent clinical laboratory services.

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

Calendar Year and Contract Year

The Deductible and Out-of-Pocket Maximum provisions are calculated on a Calendar Year basis. This Contract is renewed, with or without changes, each Contract Year. A Contract Year is the 12-month period following either the Contract's original Effective Date or subsequent renewal date. A Contract Year may or may not be the same as a Calendar Year. When Your Contract renews on other than January 1 of any year, any Deductible or Out-of-Pocket Maximum amounts You satisfied before the date the Contract renews will be carried over into the next Contract Year. If the Deductible and/or Out-of-Pocket Maximum amount increases during the Calendar Year, You will need to meet the new requirement minus any amount You already satisfied under the previous Contract during that same Calendar Year.

Timely Filing of Claims

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

Freedom of Choice of Provider

Nothing contained in this Booklet is designed to restrict You in selecting the Provider of Your choice for care or treatment of an Illness or Injury.

In-Network Provider Claims

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

In-Network Provider Reimbursement

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

Out-of-Network Provider Claims

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

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

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

Out-of-Network Provider Reimbursement

In most cases, We will pay You directly for Covered Services provided by an Out-of-Network Provider.

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

Reimbursement Examples by Provider

Here is an example of how Your selection of In-Network or Out-of-Network Providers affects Our payment to Providers and Your cost sharing amount. For purposes of this example, let's assume We pay 80 percent of the Allowed Amount for In-Network Providers and 50 percent of the Allowed Amount for Out-of-Network Providers. The benefit table from the Medical Benefits Section (or other benefits section) would appear as follows:

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Now, let's assume that the Provider's charge for a service is $5,000 and the Allowed Amount for that charge is $4,000 for an In-Network Provider. Finally, We will assume that You have met the Deductible and that You have not met the Out-of-Pocket Maximum. Here's how that Covered Service would be paid:

- In-Network Provider: We would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:
  - Amount In-Network Provider must "write-off" (that is, cannot charge You for): $1,000
  - Amount We pay (80% of the $4,000 Allowed Amount): $3,200
  - **Amount You pay** (20% of the $4,000 Allowed Amount): **$800**
  - Total: $5,000
- Out-of-Network Provider: We would pay 50 percent of the Allowed Amount. Because the Out-of-Network Provider does not accept the Allowed Amount, You would pay 50 percent of the Allowed Amount, plus, the $1,000 difference between the Out-of-Network Provider's billed charges and the Allowed Amount, as follows:
  - Amount We pay (50% of the $4,000 Allowed Amount): $2,000
  - **Amount You pay** (50% of the $4,000 Allowed Amount and the $1,000 difference between the billed charges and the Allowed Amount): **$3,000**
  - Total: $5,000

The actual benefits in this Booklet may vary, so please read the benefits sections thoroughly to determine how Your benefits are paid. For example, as explained in the Definitions Section, the Allowed Amount may vary for a Covered Service depending upon Your selected Provider.

Ambulance Claims

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

Claims Determinations

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

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

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

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

OUT-OF-AREA SERVICES

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain health care services outside of Our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Our service area, You will obtain care from health care Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from nonparticipating Providers. Our payment practices in both instances are described below.

BlueCard Program

Under the BlueCard Program, when You access Covered Services within the geographic area served by a Host Blue, We will remain responsible for fulfilling Our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

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

- The billed covered charges for Your 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, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price We use for Your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to Your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, We would then calculate Your liability for any Covered Services according to applicable law.

Negotiated National Account Arrangements

As an alternative to the BlueCard Program, Your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price above) made available to Us by the Host Blue.

Nonparticipating Providers Outside Our Service Area

- Member Liability Calculation. When Covered Services are provided outside of Our service area by nonparticipating Providers, the amount You pay for such services will generally be based on either the Host Blue's nonparticipating Provider local payment or the pricing arrangements required by

applicable state law. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph.

- Exceptions. In certain situations, We may use other payment bases, 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, as permitted under Inter-Plan Programs Policies, to determine the amount We will pay for services rendered by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph.

BLUECARD WORLDWIDE®

We provide BlueCard Worldwide coverage for You. With BlueCard Worldwide, You have more access to inpatient and outpatient Hospital care and Physician services when You're traveling or living outside the United States, as well as medical assistance and claims support services.

When You need health care outside of the United States or its territories, follow these simple steps:

- Always carry Your current Member card.
- If You need emergency medical care outside the United States, go to the nearest Hospital.
- If You are admitted, call the BlueCard Worldwide Service Center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177.
- For non-emergency medical care, call the BlueCard Worldwide Service Center. The Service Center will facilitate hospitalization if necessary at a BlueCard Worldwide Hospital or make an appointment with a Physician. BlueCard Worldwide Service Center staff are available to assist You 24 hours a day, 7 days a week.
- You will only be responsible for out-of-pocket expenses such as any applicable Deductible, Coinsurance and non-Covered Services for Your inpatient care. For outpatient, Hospital care or Physician services, You will be responsible for paying the Hospital or Physician at the time of service and then must complete an international claim form and send it to the BlueCard Worldwide Service Center for reimbursement of Covered Services.

You can obtain an international claim form and find additional information about the BlueCard Worldwide program at **www.bcbs.com**.

NONASSIGNMENT AND NONASSIGNMENT OF VOTING RIGHTS

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

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

CLAIMS RECOVERY

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

We regularly work to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, fraudulent claims, etc.). We will credit all amounts that We recover, less Our reasonable expenses for obtaining the recoveries, to Your Group's

experience or the experience of the pool under which You or Your Group is rated. Crediting reduces claims expense and helps reduce future premium rate increases.

This Claims Recovery provision in no way reduces Our right to reimbursement or subrogation. Refer to the other-party liability provision in the Contract and Claims Administration Section for additional information.

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 calling Our Customer Service department or visiting Our Web site **www.Regence.com**.

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

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

LIMITATIONS ON LIABILITY

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

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

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

We will not provide benefits under this coverage for any medical (or dental and vision, if applicable) or Prescription Medication expenses You incur for treatment of an Injury or Illness if the costs associated with the Injury or Illness may be recoverable from any of the following:

- a third-party;

- worker's compensation; or
- any other source, including automobile medical, personal injury protection (PIP), automobile no-fault, homeowner's coverage, commercial premises medical coverage or similar contract or insurance, when the contract or insurance is either issued to, or makes benefits available to You, whether or not You make a claim under such coverage.

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 if all the following conditions apply:

- By accepting or claiming benefits, You agree that We are entitled to reimbursement of the full amount of benefits that We have paid out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which We have provided benefits.
- In addition to Our right of reimbursement, We may choose, at Our discretion, instead to achieve Our rights through subrogation. We are authorized, but not obligated, to recover any benefits We have paid directly from any party liable to You, upon mailing of a written notice to the potential payer, to You or to Your representative.
- Our rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment or other characterization of the recovery by the Member and/or any third-party or the recovery source. We are entitled to reimbursement from the first dollars received from any recovery. This applies regardless of whether:
    - the third-party or third-party's insurer admits liability;
    - the health care expenses are itemized or expressly excluded in the recovery; or
    - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered in this Booklet.
- We will not reduce Our reimbursement or subrogation due to Your not being made whole, unless applicable state law requires otherwise. Our right to reimbursement or subrogation, however, will not exceed the amount of recovery.
- 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 and that You will cooperate fully with Us, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify Us of any facts that may impact Our right to reimbursement or subrogation, including, but not necessarily limited to, the following:
    - the filing of a lawsuit;
    - the making of a claim against any third-party;
    - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
    - intent of a third-party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Injury or Illness that gives rise to Our right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).
- You and/or Your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to Your benefit or on Your behalf that in any manner relates to the Injury or Illness giving rise to Our right of reimbursement or subrogation, 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.

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

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

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

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

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

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

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

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

Definitions
In addition to the definitions in the Definitions Section, the following are definitions that apply to this Coordination of Benefits Section:

Allowable Expense means, with regard to services that are covered in full or part by this Booklet or any other Plan(s) covering You, the amount on which that Plan would base its benefit payment for a service,

including Coinsurance or copayments and without reduction for any applicable Deductible. In no event shall benefits payable under the Contract and another Plan exceed the allowable charges for such benefits. The following are examples of expenses that are not an Allowable Expense:

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

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

Birthday, for purposes of these Coordination of Benefits provisions, means only the day and month in a Calendar Year and does not include the year in which the Member is born.

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

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

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

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

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

Plan does not include:

- Hospital indemnity coverage or other fixed indemnity coverage;
- School accident-type coverage that covers students for accidents only, including athletic injuries, either on a 24 hour basis or a "to and from school basis";
- Specified disease or specified accident coverage;
- Accident only coverage;
- Long-term care insurance for non-medical services (such as personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care and Custodial Care) or that pay a fixed daily benefit without regard to actual expenses incurred or services;

- Limited benefit health coverage (as defined in IDAPA 18.01.30);
- Medicare supplement coverage;
- A state plan under Medicaid; or
- A governmental plan that, by law, provides benefits that are excess to those of private insurance or other nongovernmental coverage.

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

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

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

Year, for purposes of this Coordination of Benefits provision, means Calendar Year (January 1 through December 31).

Order of Benefit Determination

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

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

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

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

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

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

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

  - If both parents covering You as a dependent have the same Birthday, the Plan of the parent who has been covered by his or her Plan longer shall be primary to the Plan of the parent who has been covered by his or her Plan for a shorter period.

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

  - The Plan covering the custodial parent shall be primary to the Plan covering Your custodial parent's spouse;
  - The Plan of Your custodial parent's spouse shall be primary to the Plan covering Your noncustodial parent; and then
  - The Plan covering Your noncustodial parent shall be primary to the Plan of Your noncustodial parent's spouse.

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

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

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

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

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

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

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

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

Primary Health Plan Benefits

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

Secondary Health Plan Benefits

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

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

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

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action by Us under the Contract and wishes to have it reviewed, You may Appeal. There are two levels of Appeal, as well as additional voluntary Appeal levels You may pursue. Certain matters requiring quicker consideration may qualify for a level of expedited Appeal and are described separately later in this section.

APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to Us at: Appeals Coordinator, Regence BlueShield of Idaho, P.O. Box 4208, Portland, OR 97208-4208 or facsimile 1 (888) 496-1542. Verbal requests can be made by calling Us at 1 (877) 508-7359.

Each level of Appeal, including expedited Appeals, must be pursued within 180 days of Your receipt of Our determination (or, in the case of the first level, 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 a written acknowledgement.

If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision under the regular Appeal process, You or Your treating Provider may specifically request an expedited Appeal. Please see Expedited Appeals later in this section for more information.

First-Level Appeals

First-level 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. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, We will send a written notice of the decision within 14 days of receipt of the Appeal. For Post-Service Appeals involving a service or supply determined to be Investigational, We will send a written notice of the decision within 20 working days of receipt of the Appeal.

Panel-Level (Second-Level) Appeals

Second-level Appeals are reviewed by a panel, the members of which were not involved in, or subordinate to anyone involved in, the previous decisions. You or Your Representative, on Your behalf, will be given a reasonable opportunity to provide written materials, including written testimony on Your behalf. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, We will send a written notice of the decision within 14 days of receipt of the Appeal. For Post-Service Appeals involving a service or supply determined to be Investigational, We will send a written notice of the decision within 20 working days of receipt of the Appeal.

VOLUNTARY EXTERNAL APPEAL - IRO

For information regarding a Voluntary External Appeal, refer to the Your Right To An Independent External Review - Notice provision below.

EXPEDITED APPEALS

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

- the application of regular Appeal timeframes 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.

Panel-Level (First-Level) Expedited Appeal

The first-level expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. First-level expedited Appeals are reviewed by a panel, the members of which 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 Appeals timeframe) to provide written materials, including written testimony on Your behalf. Verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. This will be followed by written notification within three working days of the verbal notice.

Voluntary Expedited Appeal - IRO

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

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW - NOTICE

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

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

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

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

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

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

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

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

Standard External Review Request

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

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

Expedited External Review Request

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

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

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

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

If Your request is eligible for review, the department will assign an IRO to Your review upon receipt of Our notice. The department will also notify You. The IRO must provide notice of its decision to You, to Us and to the department within 72 hours after the date of receipt of the external review request. The IRO must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses Our denial, We will notify You and the department of Our intent to pay the Covered Service as soon as reasonably practicable, but not later than one working day after receiving notice of the decision.

Binding Nature Of The External Review Decision

This Contract is subject to federal ERISA laws (generally, any plan offered through an employer to its employees). The external review decision by the IRO will be final and binding on Us, but You may have additional review rights provided under federal ERISA laws.

Under Idaho law, the IRO is immune from any legal action against it based upon the opinion rendered by the IRO or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

INFORMATION

If You have any questions about the Appeal Process outlined here, You may contact Our Customer Service department at 1 (877) 508-7359 or You can write to Our Customer Service department at the following address: Regence BlueShield of Idaho, P.O. Box 31603, Salt Lake City, UT 84131-0603.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

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

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

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

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

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary external Appeals and voluntary external expedited Appeals, through an independent contractor relationship with Us and/or through assignment to Us via state regulatory requirements. The IRO is unbiased and is not controlled by Us.

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

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

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

Who Is Eligible, How to Enroll and When Coverage Begins

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

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

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

Except as described under the special enrollment provision, if You and/or Your eligible dependents do not enroll for coverage under the Plan when first eligible or You do not enroll in a timely manner, You and/or Your eligible dependents must wait until the next annual enrollment period to enroll.

Employees

You become eligible to enroll in coverage on the date You have worked for the Group long enough to satisfy any required probationary period.

Dependents

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

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

Our affidavit of dependent eligibility form is available by visiting Our Web site at **www.Regence.com** or by calling Our Customer Service department at 1 (877) 508-7359.

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request to Us. A Newborn Child's enrollment will be effective from the moment of birth if a completed enrollment form is received within 60 days following the date of birth and the appropriate premium (if any) is received by Us within 31 days of the date the monthly premium invoice is received by the Group and a notice of premium (if any) is provided to You by the Group. Enrollment for a Newly Adopted Child will be effective from Placement with the Enrolled Employee for 60 days, but will continue from then on only if a completed enrollment form is received within 60 days following Placement with the Enrolled Employee and the appropriate premium (if any) is received by Us within 31 days of the

date the monthly premium invoice is received by the Group and a notice of premium (if any) is provided to You by the Group.

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

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your eligible dependents, even though You didn't do so when first eligible, and You do not have to wait for an annual enrollment period.

Note that loss of eligibility does not include a loss because You failed to timely pay Your portion of the premium or when termination of coverage was because of fraud. It also doesn't include Your decision to terminate coverage, though it may include Your decision to take another action (for example, terminating employment) that results in a loss of eligibility.

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse and any eligible children are eligible to enroll for coverage under the Contract within 30 days from the date of the qualifying event (except that where the qualifying event is involuntary loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP), You have 60 days from the date of the qualifying event to enroll):

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

For the above qualifying events, if enrollment is requested as specified, coverage will be effective on the day after the prior coverage ended.

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse and any eligible children are eligible to enroll for coverage under the Contract within 60 days from the date of the qualifying event:

- You marry;
- You acquire a new child by birth, adoption or Placement for adoption; or
- You and/or Your dependent(s) become eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP).

For the above qualifying events, if enrollment is requested as specified, coverage will be effective on the first of the calendar month following the date of the qualifying event, except that where the qualifying event is a child's birth, adoption or Placement for adoption, coverage is effective from the date of the birth, adoption or Placement.

ANNUAL ENROLLMENT PERIOD

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

DOCUMENTATION OF ELIGIBILITY

You must promptly furnish or cause to be furnished to Us any information necessary and appropriate to determine the eligibility of a dependent. We must receive such information before enrolling a person as a dependent under the Contract.

When Group Coverage Ends

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

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

CONTRACT TERMINATION

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

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, Your and Your Enrolled Dependents' coverage ends on the last day of the monthly period in which Your eligibility ends. However, it may be possible for You and/or Your Enrolled Dependents to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Contract, Your coverage will end for You and all Enrolled Dependents on the last day of the monthly period in which eligibility ends.

NONPAYMENT OF PREMIUM

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

FAMILY AND MEDICAL LEAVE

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

- You and Your Enrolled Dependents will remain eligible to be enrolled under the Contract during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
    - in order to care for Your newly born child;
    - in order to care for Your spouse, child or parent, if such spouse, child or parent has a serious health condition;
    - the Placement of a child with You for adoption or foster care; or
    - You suffer a serious physical or Mental Health Condition.

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

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

period served before the FMLA leave and You will not have to re-serve any probationary period under the Contract, although You and/or Your Enrolled Dependents will receive no waiting period credits for the period of noncoverage.

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

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

LEAVE OF ABSENCE

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

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

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

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the last day of the monthly period in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

Divorce or Annulment

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

If You Die

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

Loss of Dependent Status

- For an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the monthly period in which the child exceeds the dependent age limit.
- For an enrolled child who is no longer eligible due to disruption of Placement before legal adoption and who is removed from Placement, eligibility ends on the date the child is removed from Placement.
- For an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the monthly period in which the child is no longer a dependent.

OTHER CAUSES OF TERMINATION

Coverage for the Group may be terminated for the following reason. However, it may be possible for Members to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

Fraud or Misrepresentation

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

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

CERTIFICATES OF CREDITABLE COVERAGE

Requests for and inquiries about required certificates relating to period(s) of creditable coverage under the Contract should be directed to the Group, or to Us at P.O. Box 31603, Salt Lake City, UT 84131-0603.

COBRA Continuation of Coverage

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

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

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

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

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

General Rules

Generally, You or Your Enrolled Dependents are responsible for payment of the full premium for COBRA continuation, plus an administration fee, even if the Group contributes toward the premiums of those not on COBRA continuation. The administration fee is 2 percent or, during any period of extension for disability, 50 percent.

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

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

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

If You or Your Enrolled Dependents do not elect COBRA continuation coverage, coverage under the Contract will end according to the terms of the Contract and We will not pay claims for services provided on and after the date coverage ends. Further, this may jeopardize Your or Your Enrolled Dependents' future eligibility for an individual plan.

Notice

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

Other Continuation Options

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

Availability of Other Coverage

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

Pregnancy

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

Total Disability

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

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

For the purpose of this provision, totally disabled means a condition resulting from Illness or Injury in which, as certified by a Physician:

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

General Provisions

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

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

ERISA (IF APPLICABLE)
This provision applies if the Contract is part of an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA).

The Group intends that the Contract be maintained for the exclusive benefit of the employees.

The Group intends to continue this coverage indefinitely, but it also reserves the right to discontinue or change this coverage at any time. If the Group terminates the Contract for any reason and does not replace the coverage with comparable benefits, employees will receive ample notice. Employees will also receive instructions for converting their coverage to an individual plan.

Rights and Protection
Employees are entitled to certain rights and protection under ERISA. ERISA provides that all employees shall be entitled to:

- Examine without charge, at the plan administrator's office, all policy documents, including insurance policies and copies of certain documents filed by the plan administrator with the U.S. Department of Labor, such as detailed annual reports and policy descriptions.
- Obtain copies of documents governing the operation of the plan upon written request to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- Continue, generally at their own expense, health care coverage of themselves, their spouses and children if coverage ends due to certain qualifying events. Review the summary plan description and governing documents of the coverage for rules and other details about such COBRA continuation rights.

Duties
In addition to creating rights for employees, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries," have a duty to do so prudently and in the interest of employees and their dependents. No one, including the employer, or any other person, may fire an employee or otherwise discriminate against one in any way to prevent an employee from obtaining a welfare benefit or exercising his or her rights under ERISA.

If an employee's claim for a welfare benefit is denied (or ignored) in whole or in part, he or she must receive a written explanation of the reason for the denial. Employees have the rights to obtain copies of related documents without charge and to Appeal any denial within certain time frames. Under ERISA, there are steps they can take to enforce the above rights. For instance, if an employee requests certain materials from the plan administrator in writing and does not receive them within 30 days, the employee may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay an employee up to $110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the plan administrator.

Denied Claims
If an employee has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or federal court. An employee may also do so if he or she disagrees with a decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order. If fiduciaries misuse money, or if an employee is discriminated against for asserting his or her rights, employees may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If an employee is successful, the court may order the person an employee has sued to pay these costs and fees. If an employee loses, the court may

order the employee who sued to pay these costs and fees, for example, if it finds the claim frivolous. If an employee has any questions about the plan, he or she should contact the plan administrator.

If You Need More ERISA Information

If an employee has any questions about this statement or his or her rights under ERISA, or if he or she needs assistance obtaining documents from the plan administrator, the employee should contact the nearest Field Office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in the telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Employees can also obtain publications about their ERISA rights and responsibilities by calling the publications hotline of the Employee Benefits Security Administration.

GOVERNING LAW AND DISCRETIONARY LANGUAGE

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

GROUP IS AGENT

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

MODIFICATION OF CONTRACT

We shall have the right to modify or amend the Contract from time to time. However, no modification or amendment will be effective until 30 days (or longer, as required by law) after written notice has been given to Members or to the Group, and modification must be uniform within the product line and at the time of renewal. Exceptions to this modification provision for circumstances beyond Our control are further addressed in the Contract. No modification or amendment of the Contract will affect the benefits of any Member who is, on the Effective Date of such modification or amendment, confined in a Hospital or other facility on an inpatient basis, until the first discharge from such facility occurring after such Effective Date.

NO WAIVER

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

NOTICES

Any notice to Members or to the Group required in the Contract will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Enrolled Employee or to the Group will be addressed to the Enrolled Employee or to the Group at the last known address appearing in Our records. If We receive a United States Postal Service change of address form (COA) for an Enrolled Employee, We will update Our records accordingly. Additionally, We may forward notice for an Enrolled Employee to the Group administrator if We become aware that We don't have a valid mailing address for the Enrolled Employee. Any notice to Us required in the Contract may be given by mail addressed to: Regence BlueShield of Idaho, P.O. Box 31603, Salt Lake City, UT 84131-0603; provided, however that any notice to Us will not be considered to have been given to and received by Us until physically received by Us.

Notice Of Annual Meeting

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

PREMIUMS

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

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

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

REPLACEMENT

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

REPRESENTATIONS ARE NOT WARRANTIES

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

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

While this high deductible health plan was designed for use in conjunction with a health savings account (HSA), We do not assume any liability associated with Your contribution to an HSA during any period that this high deductible health plan does not qualify for use with an HSA. An HSA is a tax-exempt account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible but in order to qualify for and make contributions to an HSA, You must be enrolled in a

qualified high deductible health plan (and generally not be enrolled in other coverage). You are solely responsible to ensure that this plan qualifies, and continues to qualify, for use with any HSA that You choose to establish and maintain. Please note that the tax references contained in this Booklet relate to federal income tax only. The tax treatment of HSA contributions and distributions under Your state's income tax laws may differ from the federal tax treatment, and differs from state to state.

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

WHEN BENEFITS ARE AVAILABLE

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS

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

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

Definitions

The following are definitions of important terms used in this Booklet. Other terms are defined where they are first used.

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

Allowed Amount means:

- For In-Network Providers (see definition of "In-Network" below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For Out-of-Network Providers (see definition of "Out-of-Network" below) who are not accessed through the BlueCard Program, the amount We have determined to be reasonable charges for Covered Services or supplies. The Allowed Amount may be based upon billed charges for some services, as determined by Us, or as otherwise required by law.
- For Out-of-Network Providers (see definition of "Out-of-Network" below) accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to Us as the amount on which it would base a payment to that Provider.

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

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

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

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

Congenital Anomaly means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. For the purpose of this definition, the term "significant deviation" is defined to be a deviation which impairs the function of the body and includes, but is not limited to, the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers or defects of metabolism and other conditions that are medically diagnosed to be Congenital Anomalies.

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

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

Dental Services means services or supplies (including medications) 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.

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

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

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

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

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

Family means an Enrolled Employee and his or her Enrolled Dependents.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following: disease, Illness, Injury, genetic or Congenital Anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. A Health Intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

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

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

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy. Illness does not include any state of mental health or mental disorder (which is otherwise defined in this Booklet).

Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of Illness or any other cause. An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

In-Network means a Provider that has an effective participating contract with Us that designates him, her or it as a network Provider, who is a member of the employer Group's chosen Provider network, to provide services and supplies to Members in accordance with the provisions of this coverage. In-Network also means a Provider that has an effective participating contract with one of Our Affiliates or a Provider outside the area that We or one of Our Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as an "In-Network" Provider) to provide services and supplies to Members in accordance with the provisions of this coverage. If We or one of Our Affiliates have more than one Provider network from which the employer Group may choose for benefits under the Contract, then the Providers contracted under the network selected by the employer Group will be considered the only In-Network Providers for the purpose of payment of benefits in this Booklet. For In-Network Provider reimbursement, You will not be charged for balances beyond any Deductible and/or Coinsurance for Covered Services.

Investigational means a Health Intervention that We have classified as Investigational. We will review Scientific Evidence from well-designed clinical studies found in peer-reviewed medical literature, if

available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is Investigational. A Health Intervention not meeting all of the following criteria is, in Our judgment, Investigational:

- If a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the medication may be provided when so used.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Injury or Illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

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

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
- not primarily for the convenience of the patient, Physician or other health care Provider, and not more costly than an alternative service or sequence of services or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors.

Member means an Enrolled Employee or an Enrolled Dependent.

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

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

Out-of-Network refers to Providers that are not In-Network. For reimbursement of these Out-of-Network Provider services, You may be billed for balances over Our payment level in addition to any Deductible 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 surgery in all of its branches or to practice as an osteopathic Physician and surgeon.

Placed or Placement means physical Placement in the care of the adoptive Enrolled Employee. In those circumstances in which such physical Placement is prevented due to the medical needs of the

child requiring placement in a medical facility, it means when the adoptive Enrolled Employee signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child.

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include podiatrists, psychologists, certified nurse midwives, certified registered nurse anesthetists, dentists (doctor of medical dentistry or doctor of dental surgery, or denturist; and a dental hygienist who is permitted by his or her respective state licensing board, to independently bill third parties) and other professionals practicing within the scope of his or her respective licenses.

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

Rehabilitation Facility means a facility or distinct part of a facility that is licensed as a Rehabilitation Facility by the state in which it is located and that provides an intensive, multidisciplinary approach to rehabilitation services under the direction and supervision of a Physician.

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

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

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

www.Regence.com

Regence BlueShield of Idaho