# 2021 BOOKLET FOR:

# CITY OF LEWISTON EMPLOYEE BENEFIT PLAN TRUST
# PLAN SPONSOR: CITY OF LEWISTON

## Group Number: 10006006

## Vision Benefits

**This is a self-funded Plan and is not insurance and does not participate in the Idaho Life and Guaranty Association.**

Regence

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

# Introduction

**NOTE: THIS BOOKLET PROVIDES VISION BENEFITS ONLY.**

This Booklet provides the written description of the terms and benefits of coverage available under the Plan. Your Plan is managed by the City of Lewiston Employee Benefit Plan Trust (hereafter referred to as the "Trust"). The administrative services contract between the Trust and Regence BlueShield of Idaho, Inc. (called the "Agreement") contains all the terms of coverage. Your employer has a copy.

This Booklet describes benefits effective **January 1, 2021**, or the date Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Regence BlueShield of Idaho and makes it void. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your Provider before receiving care.

In this Booklet, the term "Claims Administrator" refers to Regence BlueShield of Idaho, Inc. (hereafter referred to as "Regence BlueShield of Idaho") and the term "Plan Sponsor" refers to Your employer. References to "You" and "Your" refer to the Participant and/or Beneficiaries. The Trust may also be referred to as "Plan Administrator." Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized.

## EMPLOYER PAID BENEFITS

This self-funded group health plan (hereafter referred to as "Plan") is an employer-paid benefits plan administered by the Claims Administrator. The Plan Sponsor contributes to the Trust to pay for Your covered vision services and supplies. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. This means that the Trust, on behalf of the Plan Sponsor, not Regence BlueShield of Idaho, pays for Your covered vision services and supplies. Your claims will be paid only after the Trust provides the Claims Administrator with the funds to pay Your benefits and pay all other charges due under the Plan.

The Claims Administrator has contracted with Vision Service Plan (VSP) for the delivery of certain claims processing and related services.

This employee benefit plan may be governed by the Employee Retirement Income Security Act (ERISA). Throughout the Booklet, references to "ERISA" will apply only if the Plan is part of an employee welfare benefit plan regulated under ERISA.

**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

**Our Customer Service:** 1 (866) 240-9580
(TTY: 711)

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

Contact Our Customer Service:

- if You have membership questions;
- if You would like to learn more about Your coverage;
- if You would like to request written or electronic information regarding any other plan that the Claims Administrator offers;
- to talk with one of the Claims Administrator's Customer Service representatives;
- via the Claims Administrator's Web site, **regence.com**, to chat live with a Customer Service representative;
- to request a copy of Your identification card (or print a copy via the Claims Administrator's Web site); or
- for assistance in a language other than English.

**VSP:** 1 (844) 299-3041
(hearing impaired: 1 (800) 428-4833)

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

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

# Using Your Booklet

## ACCESSING PROVIDERS

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

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

For each benefit, the Provider You may choose and Your payment amount for each provider option is indicated. See the Definitions Section for a complete description of VSP Doctor and Out-of-Network Provider. You can go to **www.vsp.com** for further Provider network information.

## ADDITIONAL ADVANTAGES OF PARTICIPATION

The Claims Administrator provides access to discounts on select items and services, personalized health/vision care planning information, health-related events and innovative health/vision-decision tools, as well as a team dedicated to Your personal vision care needs. You also have access to **regence.com** to help You navigate Your way through treatment decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE PLAN.**

- **Go to regence.com.** You can use the Claims Administrator's secure Web site to:
    - participate in online wellness programs and use tools to estimate upcoming healthcare costs; and
    - discover discounts on select items and services*.

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by this Plan, that also may create savings or administrative fees for the Claims Administrator. **ANY SUCH DISCOUNTS OR COUPONS ARE COMPLEMENTS TO THE PLAN.**

# Table of Contents

# Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits, Deductibles, Copayments and Cost-Sharing. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the Vision Benefits Section to see what Your benefits are.

## MAXIMUM BENEFITS

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

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

## DEDUCTIBLES

The Deductible is the amount You must pay each Calendar Year before the Plan will provide payments for Covered Services. The Deductible is satisfied by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible.

The Plan does not pay for services applied toward the Deductible. Refer to the Vision Benefits Section to see what Covered Services are subject to the Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not apply toward the Deductible.

## COPAYMENTS

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

## COST-SHARING (PERCENTAGE YOU PAY)

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

## HOW CALENDAR YEAR BENEFITS RENEW

The Deductible and certain Maximum Benefits are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again.

The Agreement is renewed each Plan Year. A Plan Year is the 12-month period following either the Agreement's original Effective Date or subsequent renewal date. If the Agreement renews on a day other than January 1 of any year, any Deductible You satisfied before the Agreement's renewal date will carry over into the next Plan Year. If the Deductible amount increases during the Calendar Year, You will need to meet the new requirement minus any amount already satisfied from the previous Agreement during the same Calendar Year.

# Vision Benefits

This section explains Your benefits for Covered Services.

**VISION EXAMINATION AND HARDWARE**

| Provider: VSP Doctor | Provider: Out-of-Network |
|---|---|
| **Payment:** No charge. | **Payment:** You pay 100% of the billed charges; Your payment may be reimbursed up to the Out-of-Network Provider limit. |
| **Examination Frequency Period:** one examination every Calendar Year | |
| **Frame Frequency Period:** one pair of frames every Calendar Year | |
| **Lens Frequency Period:** one pair of lenses every Calendar Year | |
| **Examination limit:** $45 for Out-of-Network Provider | |
| **Frame limit:** $350 for VSP Doctor; $190 for VSP approved wholesale/retail vendor; $70 for Out-of-Network Provider | |
| **Lens limit:**<br>VSP Doctor:<br>• $350 elective contacts*<br>Out-of-Network Provider:<br>• $30 single vision<br>• $50 lined bifocal or standard progressive lenses<br>• $65 lined trifocal<br>• $100 lenticular<br>• $105 elective contacts*<br>• $210 Necessary Contact Lenses* | |

### Vision Examination

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

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

### Vision Hardware

Hardware including frames, contacts and lenses is covered. Lenses are limited to standard glass or plastic lenses for one of the following:

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

*Elective contact lenses are in lieu of all other frame and lens benefits. When You receive elective contact lenses, You will not be eligible for any frames or other types of lenses again until the next Calendar Year. A VSP Doctor can only submit one claim on Your behalf per Calendar Year. If that claim does not exhaust Your elective contact allowance, then You can pay up front and submit additional claims to VSP until that allowance is exhausted.

**Necessary Contact Lenses are available with a Calendar Year supply if You have a specific condition for which contact lenses provide better visual correction. Necessary Contact Lenses are in lieu of all other frame and lens benefits. When You receive Necessary Contact Lenses, You will not be eligible for any frames or other types of lenses again until the next Calendar Year.

## CONTACT LENS EVALUATION AND FITTING EXAMINATION

| Provider: VSP Doctor | Provider: Out-of-Network |
|---|---|
| **Payment:** You pay $60 Copayment. | **Payment:** You pay 100% of the billed charges; Your payment may be reimbursed up to the Out-of-Network Provider limit. |
| **Frequency Period:** one contact lens evaluation and fitting examination every Calendar Year | |

Services and supplies for contact lens evaluation and fitting examinations are covered. For an Out-of-Network Provider, the Contact Lens Evaluation and Fitting Examination benefit and elective or Necessary Contact Lenses combined, will not exceed the limit indicated above in the Vision Hardware benefit.

## LOW VISION BENEFIT

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

### Supplemental Examinations (Testing)

| Provider: VSP Doctor | Provider: Out-of-Network |
|---|---|
| **Payment:** No charge. | **Payment:** You pay 100% of the billed charges; Your payment may be reimbursed up to $125. |
| **Frequency Period:** every two Calendar Years | |
| **Limit:** $1,000 for up to two Supplemental Examination (Testing) and Supplemental Aids combined | |

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

### Supplemental Aids

| Provider: VSP Doctor | Provider: Out-of-Network |
|---|---|
| **Payment:** You pay 25% of the Allowed Amount. | **Payment:** You pay 100% of the billed charges; Your payment may be reimbursed up to 75% of a VSP Doctor's Allowed Amount. |
| **Frequency Period:** every two Calendar Years | |
| **Limit:** $1,000 for up to two Supplemental Examinations (Testing) and all Supplemental aids combined | |

Low vision aids, including, but not limited to:

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

## DISCOUNTS FROM VSP DOCTORS

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

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

Discounts are applied to the VSP Doctor's usual and customary fees and are unlimited for 12 months on or following the date of the patient's last eye examination. Professional judgment will be applied when evaluating prescriptions written by an Out-of-Network Provider.

Discounts do **not** apply to:

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

**THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THIS VISION BENEFIT.**

# General Exclusions

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

### SPECIFIC EXCLUSIONS

The following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**, are not covered. However, these exclusions will not apply with regard to a Covered Service for an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law.

### Certain Contact Lens Expenses

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

### Conditions Caused by Active Participation in a War or Insurrection

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

### Conditions Incurred in or Aggravated During Performances in the Uniformed Services

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

### Corneal Refractive Therapy (CRT)

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

### Corrective Vision Treatment of an Experimental Nature

### Cosmetic Services and Supplies

Except for Medically Necessary services and supplies to treat a Congenital Anomaly, cosmetic services and supplies are not covered, including, but not limited to:

- beautification;
- cosmetic purposes;
- aesthetic purposes; or
- optional cosmetic processes.

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

### Expenses Before Coverage Begins or After Coverage Ends

Services and supplies incurred before Your Effective Date under the Plan or after Your termination under the Plan.

### Facility Charges

Services and supplies provided in connection with facility services.

### Fees, Taxes, Interest

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

- charges for shipping and handling, postage, interest or finance charges that a Provider might bill;
- excise, sales or other taxes;

- surcharges;
- tariffs;
- duties;
- assessments; or
- other similar charges whether made by federal, state or local government or by another entity.

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

Additionally, except as required by law for emergency services, government facilities or government facilities outside the service area are not covered.

### Investigational Services
Investigational services are not covered, including, but not limited to:

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

### Lens Enhancements
Lens enhancements are not covered, including, but not limited to:

- anti-reflective coating;
- color coating;
- mirror coating;
- scratch coating;
- blended lenses;
- cosmetic lenses;
- laminated lenses;
- oversize lenses;
- premium and custom progressive multifocal lenses;
- photochromic lenses;
- tinted lenses, except Pink #1 and Pink #2; or
- UV (ultraviolet) protected lenses.

### Medical or Surgical Treatment of the Eyes
Medical or surgical treatment of the eyes, including reversals or revisions of surgical procedures of the eye.

### Motor Vehicle Coverage and Other Available Insurance
When motor vehicle coverage, other available insurance or contract is either issued to, or makes benefits available to a Claimant (whether or not the Claimant makes a claim with such coverage), expenses are not covered for services and supplies that are payable by any:

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

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

### Non-Direct Patient Care
Non-direct patient care services are not covered, including, but not limited to:

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

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

### Personal Items
Items that are primarily for comfort, convenience, cosmetics, contentment, hygiene, aesthetics or other nontherapeutic purposes.

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

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

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

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

### Self-Help, Self-Care, Training or Instructional Programs
Except for services provided without a separate charge in connection with Covered Services that train or educate a Claimant, self-help, non-vision self-care and training or instructional programs are not covered.

### Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family are not covered.

"Immediate family" means:

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

### Services and Supplies That Are Not Medically Necessary
Services and supplies that are not Medically Necessary for the treatment of the diagnosis or correction of visual acuity.

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

**Travel and Transportation Expenses**

**Two Pair of Glasses in Lieu of Bifocals**

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

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

# Claims Administration

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

## SUBMISSION OF CLAIMS AND REIMBURSEMENT

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

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

Submit the claim to:

Vision Service Plan
Attention: Claim Services (Out-of-Network)
P.O. Box 385018
Birmingham, AL 35238-5018

### Timely Filing of Claims

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

### Claim Determinations

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

If the Claims Administrator requires additional information to process the claim, the Claims Administrator must allow You at least 45 days to provide it to them. If the Claims Administrator does not receive the requested information within the time allowed, the Claims Administrator will deny the claim.

## CLAIMS RECOVERY

If the Plan pays a benefit to which You or Your Beneficiaries were not entitled, or if the Plan pays a person who is not eligible for benefits at all, the Trust has the right to recover the payment from the

person the Plan paid or anyone else who benefited from it, including a Provider of services. The Trust's right to recovery includes the right to deduct the mistakenly paid amount from future benefits the Plan would provide the Participant or any of his or her Beneficiaries, even if the mistaken payment was not made on that person's behalf.

The Claims Administrator regularly works 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.). The Plan will be credited all amounts recovered.

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

## SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former Claimants who incur claims and are or have been covered by the Plan. No adult Claimant hereunder, may assign any rights that he or she may have to recover expenses from any tortfeasor or other person or entity to any minor child or children of said adult Claimant without the prior express written consent of the Plan. These provisions will apply to all claims arising from Your Illness, Injury or condition, including, but not limited to, wrongful death, survival or survivorship claims brought on Your, Your estate's or Your heirs' behalf, regardless of whether medical expenses were or could be claimed. "You" or "Your" includes anyone on whose behalf the Plan pays benefits.

The Plan's Right of Subrogation or reimbursement, as set forth below, extend to all insurance coverage available to You due to an Illness, Injury or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

This Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage, excess coverage or similar contract or insurance.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until this Plan's subrogation and reimbursement interest are fully satisfied.

### Subrogation

The "Right of Subrogation" means the Plan is entitled to pursue any claims that You may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of Your rights of recovery with respect to any claim or potential claim against any party, due to an Illness, Injury or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

### Reimbursement

If You receive any payment as a result of an Illness, Injury or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that Illness, Injury or condition, up to and including the full amount of Your recovery. Benefit payments made under the Plan are conditioned upon Your agreement to reimburse the Plan in full from any recovery You receive for Your Illness, Injury or condition.

### Constructive Trust

By accepting benefits (whether the payment of such benefits is made to You or made on Your behalf to any Provider) You agree that if You receive any payment as a result of an Illness, Injury or condition, You will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of Your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until this Plan's subrogation and reimbursement interest are fully satisfied.

### Lien Rights
Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the Illness, Injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any Illness, Injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, You, Your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

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

### First-Priority Claim
By accepting benefits from the Plan, You acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before You receive any recovery for Your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make You whole or to compensate You in part or in whole for the damages sustained. The Plan is not required to participate in or pay Your court costs or attorney fees to any attorney You hire to pursue Your damage claim.

### Applicability to All Settlements and Judgments
The terms of this entire Subrogation and Right of Recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than expenses provided by the Plan. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to Your own negligence.

### Cooperation
You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is Your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your Illness, Injury or condition. You and Your agents agree to provide the Plan or its representatives notice of any recovery You or Your agents obtain prior to receipt of such recovery funds or within five days if no notice was given prior to receipt of recovery funds. Further, You and Your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and Your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery You receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of Your health benefits or the institution of court proceedings against You.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the Illness, Injury or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

### Workers' Compensation
If the entity providing workers' compensation coverage denies Your claim and You have filed an appeal, benefits may be advanced for Covered Services if You agree to hold any recovery obtained in a segregated account for the Plan.

### 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 the Plan would normally provide benefits. However, the amount of any Covered Services excluded in this provision will not exceed the amount of Your recovery.

### Interpretation
In the event that any claim is made that any part of this Subrogation and Right of Recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator shall have the sole authority to resolve all disputes regarding the interpretation of this provision.

### Jurisdiction
By accepting benefits from the Plan, You agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, You hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of Your present or future domicile. By accepting such benefits, You also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to per this provision.

## COORDINATION OF BENEFITS
If You are covered by any other Plan (as defined below), the benefits in this Booklet and those of the other Plan will be coordinated in accordance with the provisions of this section. NOTE: This Section refers to a broad range of benefits, even though this Plan is a Vision only Plan.

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

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

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

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

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

Closed Panel Plan means a Plan that provides health benefits to a Claimant 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 Claimant uses a non-panel provider, except for emergency services or authorized referrals that are provided by the Primary Plan.

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

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

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

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

Plan does **not** include:

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

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

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

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

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

### Order of Benefit Determination

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

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

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

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

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

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

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

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

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

**Continuation coverage:** A Plan which covers You as an employee or retired employee, or as an employee's or retired employee's dependent, will be primary to a Plan that is providing continuation coverage (pursuant to COBRA or a right of continuation by state or other federal law). If the other Plan

does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply. This paragraph does not apply if an order of benefit determination can be made by the non-dependent coverage paragraph above.

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

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

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

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

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

### Primary Health Plan Benefits

When, in accordance with the order of benefit determination, this coverage is the Primary Plan, the Plan will pay the benefits in this coverage 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 Plan will be calculated as follows:

The Claims Administrator will calculate the benefits that the Plan would have paid for a service if this coverage were the Primary Plan. The Claims Administrator will compare the Allowable Expense in this Plan for that service to the Allowable Expense for it with the other Plan(s) by which You are covered. This Plan 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 the Plan would have paid for the service if this coverage were the Primary Plan.

Deductibles, Cost-Sharing and Copayments in this coverage will be used in the calculation of the benefits that the Plan 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. The Plan's 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 the Plan will credit toward any Deductible in this coverage 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 Plan, this Plan will pay its 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 the Claims Administrator with the information necessary for the Claims Administrator to determine the Plan's appropriate secondary benefits payment within a reasonable time after their request, the Claims Administrator shall assume their benefits are identical to this Plan's and the Plan will pay benefits accordingly, subject to adjustment upon receipt of the information requested from the other Plan(s) within two years of this Plan's payment.

Nothing contained in this Coordination of Benefits provision requires this Plan to pay for all or part of any service that is not covered by this coverage. Further, in no event will this Coordination of Benefits provision operate to increase the Plan's payment over what the Plan 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. The Claims Administrator has the right to decide which facts they need. The Claims Administrator 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 the Claims Administrator any information necessary or appropriate to administer this Coordination of Benefits provision. Receipt of such information by the Claims Administrator will be a condition precedent to this Plan's obligation to provide benefits in this Booklet.

### Facility of Payment

Any payment made by any other Plan(s) may include an amount that should have been paid by this coverage. If so, the Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this coverage. The Plan 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 the Plan provides benefits to or on behalf of You in excess of the amount that would have been payable in this Plan by reason of Your coverage with any other Plan(s), the Claims Administrator 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 under the Plan and wishes to have it reviewed, You (or he or she) may Appeal.

### FILING APPEALS

Appeals can be initiated through written or verbal request. The Claims Administrator has delegated certain activities, including Appeals, to VSP, though the Claims Administrator retains ultimate responsibility over these activities. A written request can be made by completing the form available on **www.vsp.com** or by sending the written request by mail to VSP at: Vision Service Plan, Attention: Complaint and Grievance Unit, P.O. Box 997100, Sacramento, CA 95899-7100. Verbal requests can be made by calling VSP.

Each level of Appeal must be pursued within 180 days of Your receipt of the determination (or, in the case of the first level, within 180 days of Your receipt of the original adverse decision that You are Appealing). If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum. When an Appeal request is received, You will be sent written acknowledgement.

### First-Level Appeals

In Appeals that involve issues requiring medical judgment, the decision is made by an internal 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 Post-Service Appeals involving a service or supply determined to be Investigational, written notice of the decision will be sent within 20 working days of receipt of the Appeal.

### Panel-Level (Second-Level) Appeals

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 Post-Service Appeals involving a service or supply determined to be Investigational, written notice of the decision will be sent within 20 working days of receipt of the Appeal.

### INFORMATION

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

### DEFINITIONS

The following definitions apply to this Appeal Process Section:

Appeal means a written or verbal request from a Claimant or, if authorized by the Claimant, the Claimant's Representative, to change a previous decision 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 Claimant and the carrier;
- rescission of Your benefit coverage; and
- other matters as specifically required by state law or regulation.

Post-Service means any claim for benefits.

Representative means someone who represents You for the Appeal. The Representative may be an attorney, Your authorized Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the Appeal. No authorization is required from the parent(s) or legal guardian of a Claimant who is an unmarried and dependent child and is less than 13 years old. 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 Representative or Your treating Provider only.

# Eligibility and Enrollment

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible or during an annual enrollment period. It describes when coverage under the Plan begins for You and/or Your eligible dependents. Payment of any corresponding monthly costs is required for coverage to begin on the indicated dates.

## INITIALLY ELIGIBLE AND WHEN COVERAGE BEGINS

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

If You and/or Your eligible dependents do not enroll for coverage under the 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 Plan Sponsor long enough to satisfy any probationary period required by the Plan Sponsor.

### Dependents

Your Beneficiaries are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when the Claims Administrator has enrolled them in coverage under the Plan. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your (or Your spouse's) child who is under age 26 and who meets any of the following criteria:
    - Your (or Your spouse's) natural child, stepchild, adopted child or child legally Placed with You (or Your spouse) for adoption;
    - a child for whom You (or Your spouse) have court-appointed legal guardianship; or
    - a child for whom You (or Your spouse) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your spouse's) child who is age 26 or over and incapable of self-support because of intellectual disability or physical handicap that began before his or her 26th birthday. You must complete and submit the Claims Administrator's 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 a Beneficiary 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.

    The Claims Administrator's affidavit of dependent eligibility form is available by visiting their Web site or calling Customer Service.

## NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request and the appropriate payment (if any) is received by the Claims Administrator within 31 days of the date the monthly payment invoice is received by the Plan Sponsor and a notice of payment (if any) is provided to You by the Plan Sponsor.

Enrollment will be effective from:

- the moment of birth for a Newborn Child if a completed enrollment form is received within 60 days following the date of birth; or

- Placement of a Newly Adopted Child with the Participant for 60 days, but will continue from then on only if a completed enrollment form is received within 60 days following Placement with the Participant.

If the date of birth for the Newborn Child or date of Placement for the Newly Adopted Child is on or before the 15th of the month, the payment will be billed for the entire month. If date of birth or date of Placement is after the 15th, the payment will commence with the first day of the month following birth or Placement.

## ANNUAL ENROLLMENT PERIOD

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

## DOCUMENTATION OF ELIGIBILITY

You must promptly provide (or coordinate) any necessary and appropriate information to determine the eligibility of a dependent. The Claims Administrator must receive such information before enrolling a person as a dependent under the Plan.

## RETIREES

If You meet the eligibility criteria described below at the time of Your retirement, You and Your eligible dependents will have access to City of Lewiston Retiree Medical coverage until You become eligible for Medicare. After You or Your covered dependents become Medicare eligible for any reason (for example, because of reaching age 65 or becoming disabled), Your and Your dependents' participation in this Plan will end.

This Booklet provides general information about the Plan's Retiree Medical coverage, such as who is eligible, how to enroll, who pays for the coverage and Plan administrative information. Specific information about covered services, cost-sharing, limitations and exclusions is also included.

This Booklet describes the terms of the Plan as in effect on January 1, 2021, and supersedes all prior Plan documents and communications.

## INITIALLY ELIGIBLE AND WHEN COVERAGE BEGINS

You are eligible to participate in this Plan if You are a Participant who satisfies the following conditions at the time of Your retirement:

- You were hired before May 1, 2005 or You were rehired after May 1, 2005 with a break in service of less than 12 months,
- You and any dependents You wish to cover were participating in medical coverage through City of Lewiston while You were an active employee through Your retirement date,
- You retire from City of Lewiston at age 55 or later, and have at least 15 years of vesting service; or retire from City of Lewiston at age 50 or later and have at least 15 years of vesting service in Public Safety, and,
- You are not eligible for Medicare.

You are required to enroll in other employer sponsored healthcare program if eligible. If You retire from City of Lewiston and You are employed by another organization that offers employee benefits, You are required to enroll in that medical plan as a primary benefit program.

If You choose to enroll in the City of Lewiston Retiree medical plan, the retiree benefits offered by City of Lewiston will be the secondary coverage plan.

**When You become eligible for Medicare (because You reach age 65 or become disabled), You are no longer eligible to participate in this Plan.**

## DEPENDENTS

If You are eligible to participate in this Plan, You may also enroll Your Beneficiaries in City of Lewiston retiree medical coverage if certain conditions are satisfied. The dependent eligibility rules under this Plan are slightly different than the dependent eligibility rules for active employees.

For purposes of this Plan, eligible dependents must satisfy two requirements. First, the dependent must have been covered under the City of Lewiston Medical Plan at the time of Your retirement. Second, the dependent must be one of the following:

- Your spouse.
- Your dependent prior to age 65 if the dependent is described in one of the following three eligibility groups.

    - Your unmarried children from birth to age 26. From age 19-26 the child must be a full-time student (with certain exceptions for certain medical leaves of absence as discussed under the heading **Michelle's Law**). From birth to age 26, the child must reside with You (except in certain divorce situations) and cannot provide over half of his or her own support. If Your child does not reside with You and **does not** live with a foster parent, stepparent, grandparent, sibling, aunt or uncle, or if the child is age 25, the child may still be Your dependent if **You** provide over half of the child's support.
    - Your unmarried children 26 and older who are physically or mentally disabled, if they reside with You, (except in certain divorce situations) and do not provide over half of their own support. If Your disabled child does not reside with You and does not live with a foster parent, stepparent, grandparent, sibling, aunt or uncle, the child may still be Your dependent if You provide over half of the child's support. The child must have been disabled and covered under the Plan (or another health plan) prior to age 19. Coverage may be continued as long as the child remains disabled and You remain enrolled in the Plan. Proof of disability may be required.
    - Your children, including:

        - stepchildren;
        - legally adopted children;
        - children placed with You for adoption by You; and
        - any children for whom You are legally responsible to provide support and maintenance.

Children does not include children for whom You are a temporary guardian.

If You have questions regarding whether an individual qualifies as an eligible dependent, contact Human Resources.

**When Your covered Beneficiaries become eligible for Medicare (because they reach age 65 or become disabled), they will no longer be eligible to participate in this Plan. If You become eligible for Medicare before Your covered Beneficiaries become eligible for Medicare, Your Beneficiaries may continue to participate in this Plan as long as they continue to satisfy the eligibility requirements of this Plan. If Your covered Beneficiaries become eligible for Medicare before You become eligible for Medicare, You may continue to participate in this Plan as long as You continue to satisfy the eligibility requirements of this Plan.**

### Michelle's Law

If Your dependent child is enrolled and covered under the Plan as a full time student from age 19 to 26 and he or she experiences a serious illness or injury that requires a medical leave of absence from school or a medically necessary change in enrollment status from full-time to part-time, the child may be eligible for up to a one-year extension of eligibility for retiree medical coverage, provided that the serious illness or injury causing the leave of absence or change in enrollment status is adequately documented by a physician and such documentation is provided to the medical plan in which You are enrolled. If eligible, Your dependent will continue to be covered as an eligible dependent for 12 months after the leave of absence or medically necessary change in enrollment status begins despite the fact that he or she is not a full-time student. However, the 12 months will not extend coverage beyond another independent event that would otherwise end dependent status, such as marriage or attainment of age 26.

### Qualified Medical Child Support Orders (QMCSO)

In certain circumstances a court may order that You enroll a child under this Plan by filing a "QMCSO" with the City of Lewiston. A "QMCSO" may only be filed with respect to a retiree who enrolls in the Plan and may only cover a child who meets age and student status criteria described previously. For more

information or for a copy of the Plan's QMCSO procedures, contact Human Resources. This information is available at no charge.

## HOW TO ENROLL IN THE PRE-65 RETIREE COVERAGE

If You want retiree medical coverage through the City of Lewiston, You must enroll in retiree medical coverage within 31 days of the date Your City of Lewiston coverage as an active employee would otherwise end. As long as You enroll within 31 days, Your City of Lewiston retiree medical coverage will be effective as of the first of the month following the month in which You retire. If You want retiree medical through another retiree health plan (such as through a spouse's plan), or an individual insurance policy, You must enroll in that coverage as soon as possible.

## RETIREE MEDICAL OPTIONS

If You retire on or after January 1, 2020 and meet the eligibility requirements, You can enroll in the company medical plan. Until You become eligible for Medicare, You and Your Beneficiaries will have access to retiree medical coverage options under this Plan. When You or Your Beneficiaries become eligible for Medicare (based on reaching age 65 or disability), You or Your Beneficiaries will no longer be eligible to participate in this Plan.

The retiree medical options are reviewed each year and any material changes will be communicated to You before their effective date.

There is no annual enrollment for this Plan.

### Tiers of Coverage

When You enroll in City of Lewiston retiree medical and dental coverage, You will choose from the following types of coverage:

- Participant only;
- Participant plus spouse;
- Participant plus one child;
- Participant plus two or more children;
- Participant plus spouse and one child; or
- Participant plus spouse and two or more children.

Once You have made Your initial election, the only change You can make in Your coverage level is to lower Your level of coverage (for example, from couple to single). If You return to work at the City of Lewiston as an active employee, Your Retiree Plan coverage will be frozen until Your active employment ends.

### Payment for Coverage

You pay the full cost of Your medical coverage as a retiree. There is no subsidy from the City of Lewiston. If You enroll in the City of Lewiston retiree medical coverage, You will receive cost-share payment instructions from the company when You retire. You must pay Your cost-share on a timely basis. Failure to pay cost-shares on a timely basis may result in cancellation of Your retiree medical coverage.

### Death of a Participant

If You are enrolled in the City of Lewiston retirement benefits when You die, Your Beneficiaries will continue to have access to retiree medical coverage through the City of Lewiston. They must continue to pay all required Cost-Shares.

# When Coverage Ends

This section describes the situations when coverage will end for You and/or Your Beneficiaries. You must notify the Claims Administrator within 30 days of the date on which a Beneficiary is no longer eligible for coverage.

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

### AGREEMENT TERMINATION

If the Agreement is terminated or not renewed by the Plan Sponsor, claims administration by Regence BlueShield of Idaho ends for You and Your Beneficiaries on the date the Agreement is terminated or not renewed. Regence BlueShield of Idaho may administer certain claims for Covered Services that Claimants received before the Agreement termination or nonrenewal, if agreed between the Plan Sponsor and the Claims Administrator.

### WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your Beneficiaries on the last day of the monthly period in which Your eligibility ends. However, it may be possible for You and/or Your Beneficiaries to continue coverage under the Plan according to the COBRA Continuation of Coverage provision.

#### Termination of Your Employment or You are No Longer Eligible

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

#### Nonpayment

If You fail to make required timely contributions to the cost of coverage, coverage will end for You and all Beneficiaries.

### WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs, his or her coverage will end on the last day of the monthly period in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Plan according to the COBRA Continuation of Coverage provision.

#### 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.

#### Death of the Participant

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

#### Loss of Dependent Status

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

## OTHER CAUSES OF TERMINATION

Claimants terminated for the following reason may be able to continue coverage under the Plan according to the COBRA Continuation of Coverage provision.

### Fraud or Misrepresentation

The Plan is issued in reliance upon all information furnished to the Claims Administrator by You or on behalf of You and Your Beneficiaries. No statement made for effecting coverage will void such coverage 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 Plan Sponsor, coverage under the Plan will terminate.

## FAMILY AND MEDICAL LEAVE

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

- You and Your Beneficiaries will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
    - to care for Your Newborn Child;
    - to care for Your spouse, child or parent with a serious health condition;
    - the Placement of a child with You for adoption or foster care; or
    - You suffer a serious physical or mental health condition.

During the FMLA leave, You must continue to make payments for coverage through the Plan Sponsor on time. The provisions described here will not be available if the Plan terminates.

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

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

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to groups that are required by law to comply. The Plan Sponsor must keep the Claims Administrator 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 Plan Sponsor, You can continue coverage for up to three months. Payments must be made through the Plan Sponsor in order to maintain coverage during a leave of absence.

A leave of absence is a Plan Sponsor-granted period off work made at Your request during which You are still considered to be employed and are carried on the Plan Sponsor's employment records. A leave can

be granted for any reason acceptable to the Plan Sponsor. If You are on leave for an FMLA-qualifying reason, You remain eligible under the Plan only for a period equivalent to FMLA leave and may not also continue coverage with a non-FMLA leave.

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

# COBRA Continuation of Coverage

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

If the Plan is subject to COBRA, COBRA continuation is available to Your Beneficiaries 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 Beneficiary 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 Beneficiaries per certain conditions if You are retired and Your Plan Sponsor files for bankruptcy.)

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

### General Rules

You or Your Beneficiaries are responsible for payment of the full cost for COBRA continuation, plus an administration fee, even if the Plan Sponsor contributes toward the cost of those not on COBRA continuation. The administration fee is two percent or, during any period of extension for disability, 50 percent.

In order to preserve Your and Your Beneficiary's rights with COBRA, You or Your Beneficiaries must inform the Plan Sponsor 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 Beneficiary was disabled per Social Security at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that You or Your Beneficiary is no longer disabled per Social Security, You or Your Beneficiary must provide the Plan Sponsor notice of that determination within 30 days of the date it is made.)

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

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

### Notice

The Agreement includes additional details on the COBRA Continuation provisions outlined here and complete details are available from Your Plan Sponsor.

# General Provisions and Legal Notices

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

### CHOICE OF FORUM

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

## GOVERNING LAW AND DISCRETIONARY LANGUAGE

**The Plan will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the state of Idaho without regard to its conflict of law rules. The Plan administrator, the Plan Sponsor, delegates the Claims Administrator discretion for the purpose of paying benefits under this coverage only if it is determined that You are entitled to them and of interpreting the terms and conditions of the 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 a determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the Plan. The Claims Administrator is not the Plan administrator, but does provide claims administration under this Plan, and the court will determine the level of discretion that it will accord determinations.**

### LIMITATIONS ON LIABILITY

You have the exclusive right to choose a health care Provider. The Plan and the Claims Administrator are not responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since the Plan and the Claims Administrator do not provide any health care services, neither can 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 employees nor agents of the Plan or the Claims Administrator.

In addition, the Claims Administrator will not be liable to any person or entity for the inability or failure to procure or provide the benefits in the Plan by reason of epidemic, disaster or other cause or condition beyond the Claims Administrator's control.

### NO WAIVER

The failure or refusal of either party to demand strict performance of the Plan 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 Plan will be considered waived unless such waiver is reduced to writing and signed by one of the Plan Sponsor's authorized officers.

### NONASSIGNMENT AND NONASSIGNMENT OF VOTING RIGHTS

Only You are entitled to benefits under the Plan. 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 the Plan. 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 Plan 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 the Claims Administrator in compliance with the Claims Administrator's bylaws.

## NOTICES

Any notice to Claimants or to the Plan Sponsor required in the Plan will be considered properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Participant or to the Plan Sponsor will be addressed to the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address (COA) form for a Participant, the Claims Administrator will update their records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Plan Sponsor if they become aware that the Claims Administrator doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be mailed to: Regence BlueShield of Idaho, P.O. Box 2998, Tacoma, WA 98401-2998. However, notice to the Claims Administrator will not be considered to have been given to and received by the Claims Administrator until physically received.

## PLAN SPONSOR IS AGENT

The Plan Sponsor is Your agent for all purposes under the Plan and not the Claims Administrator's agent. You are entitled to health care benefits pursuant to the Agreement between the Claims Administrator and the Plan Sponsor. In the Agreement, the Plan Sponsor agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in this Booklet. You, through the enrollment form signed by the Participant, and as beneficiaries of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Booklet.

## RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Trust on behalf of the Plan Sponsor, itself and its Claimants expressly acknowledges its understanding that the Agreement constitutes an agreement solely between the Trust on behalf of the Plan 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 the Claims Administrator 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 the Claims Administrator is not contracting as the agent of the Association. The Trust on behalf of the Plan Sponsor and its Claimants further acknowledges and agrees that it has not entered into the Agreement 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 Trust on behalf of the Plan Sponsor or the Claimants for any of the Claims Administrator's obligations to the Trust on behalf of the Plan Sponsor or the Claimants created under the Agreement. 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 Agreement.

## REPRESENTATIONS ARE NOT WARRANTIES

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

## RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by the Claims Administrator. 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 the Claims Administrator 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.

The Claims Administrator is required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by visiting the Claims Administrator's Web site or contacting Customer Service.

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

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

## TAX TREATMENT

The Claims Administrator does not provide tax advice. Consult Your financial or tax advisor for information about the appropriate tax treatment of benefit payments and reimbursements.

## WHEN BENEFITS ARE AVAILABLE

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

- the person is eligible to be covered according to the eligibility provisions in the Plan; and
- the person has enrolled in coverage and has been enrolled by the Claims Administrator.

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

# Definitions

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

Allowed Amount means:

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

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

Beneficiary means a Participant's eligible dependent who is listed on the Participant's completed enrollment form and who is enrolled under the Plan.

Benefit Authorization means VSP has approved benefits for You.

Booklet is the description of the benefits by the group vision plan. A group vision plan with different benefit plan options may describe them in one Booklet or in separate Booklet's for each alternative benefit plan option.

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

Claimant means a Participant or a Beneficiary.

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

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

Contribution means the amount paid or payable by the employer or employee, or a postsecondary educational institution or student, into the Trust Fund.

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

Effective Date means the date, following the Claims Administrator's receipt of the enrollment form, as the date coverage begins for You and/or Your Beneficiaries.

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

Frequency Period is the number of Calendar Years, usually one or two, that must pass before benefits renew.

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

- disease;
- Illness or Injury;

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

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

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

Illness means a:

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

Injury means physical damage to the body caused by:

- a foreign object;
- force;
- temperature;
- a corrosive chemical; or
- the direct result of an accident, independent of Illness or any other cause.

An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

Investigational means a Health Intervention that the Claims Administrator has classified as Investigational. The Claims Administrator 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 the Claims Administrator's judgment, Investigational:

- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Illness or Injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

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

- in accordance with generally accepted standards of medical practice. "Generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors.
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease;
- not primarily for the convenience of the patient, Physician or other health care Provider; and

- not more costly than an alternative service or sequence of services or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

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

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

Newly Adopted Children means a child or children under the age of 18 who is Placed for adoption with a Participant 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 Participant.

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

Participant means an employee of the Plan Sponsor who is eligible under the terms of the Agreement, has completed an enrollment form and is enrolled under this coverage.

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

Placed or Placement means physical Placement in the care of the adoptive Participant. 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 Participant 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.

Provider means a Physician, Practitioner or other individual or organization which is duly licensed to provide medical or surgical services.

Scientific Evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of a Health Intervention on Health Outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the Health Intervention and Health Outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

Self-Funded Plan means any single employer plan, public postsecondary educational institution plan, or multiple employer welfare plan, or any other single or multiple employer plan, or any postsecondary educational institution student health benefit plan, other than a plan providing only benefits under title 72, Idaho Code, under which payment for medical, surgical, hospital, and other services for prevention, diagnosis, or treatment of any disease, injury, or bodily condition of an employee is, or is to be, regularly provided for or promised from funds created or maintained in whole or in part by contributions or payments thereto by the employer or employers, or by the employer or employers and the employees, or by a postsecondary educational institution and students at said institution, or students of a postsecondary educational institution, who are not otherwise covered by insurance or contract with a health care service corporation or managed care organization authorized to transact business in this state.

Trust Fund means a Trust Fund established in conjunction with a Self-Funded Plan for receipt of Contributions of employer and employees, postsecondary educational institution and students, and payment of or with respect to health care service costs of beneficiaries.

Trustee means the trustee, whether a single or multiple trustee, of the trust fund.

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

**For more information contact the Claims Administrator at 1 (866) 240-9580 or You can write to P.O. Box 2998, Tacoma, WA 98401-2998**

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