2026 Benefit Summary and Vision Program Document

J.R. Simplot Company
Group Health and Welfare Plan
Vision Program

Contract Administrator: Blue Cross of Idaho Health Service, Inc.

Voluntary Vision

Effective Date: January 1, 2026

Benefit Period: January 1 through December 31

SIMPLOT VISION PROGRAM BENEFITS OUTLINE AND PROGRAM DOCUMENT

IMPORTANT INFORMATION ABOUT THIS OUTLINE

This booklet is a description of the benefits covered by the J.R. Simplot Company Group Health and Welfare Plan Vision Program and serves as the Vision Program Document. This Document, together with the J.R. Simplot Company Group Health and Welfare Plan Summary Plan Description Booklet (SPD), constitute the summary plan description for the Vision Program. Together, they describe in detail the rights and obligations of both the Participant and the Plan. It is important that you read the SPD and this Vision Program Document carefully. If you receive this document electronically, you may request a paper copy at any time at no additional charge by contacting the Contract Administrator (Blue Cross of Idaho) Customer Service.

Throughout this Document references to Blue Cross of Idaho (BCI) are referring to the Contract Administrator. For Covered Services under the terms of the Vision Program, Maximum Allowance is the amount established by the Vision Care Services Vendor as the highest level of compensation for a Covered Service.

ELIGIBILITY AND ENROLLMENT
Please refer to the J.R. Simplot Company Group Health and Welfare Plan's Summary Plan Description Booklet for information regarding Eligibility and Enrollment.

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate, exclude or treat less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex.

Blue Cross of Idaho:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho Civil Rights Coordinator at 1-800-627-1188 (TTY: 711).

If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance at:

Civil Rights Coordinator
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: ***grievancesandappeals@bcidaho.com***
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf***, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at ***https://www.hhs.gov/ocr/complaints/index.html***.

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY:711).

Arabic انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1-800-627-1188 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY：711)。

Farsi توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (711:TTY).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188（TTY:711）まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

Nepali: ध्यान दनिुहोस्: तपाईंले नेपाली बोलनुहुनछ भने तपाईंको नमिर्ता भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिविइ: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711).

Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

VOLUNTARY VISION CARE BENEFITS*
BENEFITS OUTLINE

Visit our Website at www.bcidaho.com to locate a Participating Provider

*The In-Network VSP Provider is responsible for verifying benefits with VSP prior to rendering services. A Participant must provide the VSP In-Network Provider sufficient information to verify eligibility. Failure of the Participant to provide sufficient information may delay services and may affect benefit payment under the Vision Program.

For Covered Providers and Services • Copayment	Participant pays $10 per Frame and/or Lenses	
Service Frequency Limitations	Participant may receive: • one (1) eye exam every twelve (12) months. • one (1) pair of spectacle Lenses or Contact Lenses every twelve (12) months. • one (1) Frame every twelve (12) months.	
	In-Network Provider* ***Payment for Services Rendered and Allowances:***	**Out-of-Network Provider[1]** ***Reimbursement Allowances:***
Professional Fees • Eye Exam	No charge	Up to $50
Lenses per pair • Single vision • Bifocal • Trifocal • Progressive	No charge after Copayment	Up to $30 Up to $50 Up to $65 Up to $50
Frame	Up to $150, after Copayment[2]	Up to $70
Contact Lenses – per pair *(evaluation, materials and fittings only)*	Up to $150[3]	Up to $105

*Benefits for Covered Services received from an In-Network Provider will be paid in full, after any required Copayment, up to the Maximum Allowance for standard lenses and/or Frame.

[1] If a Participant chooses an Out-of-Network Provider, the Participant may be responsible for any charges that exceed the Maximum Allowance.
[2] If a Participant chooses a frame valued at more than the allowance, a 20% discount will be applied to the out-of-pocket costs for frames purchased from an In-Network Provider.
[3] The Contact Lens allowance applies to the cost of the Contact Lens exam and Contact Lenses. A 15% savings off the cost of the Contact Lens exam will apply when services are received from an In-Network Provider.

Blue Cross of Idaho

An Independent Licensee of the Blue Cross and Blue Shield Association

J.R. SIMPLOT COMPANY GROUP HEALTH AND WELFARE PLAN
VISION PROGRAM DOCUMENT

Blue Cross of Idaho has been hired as the Contract Administrator by the Plan Administrator to perform claims processing and other specified administrative services in relation to the Plan. Blue Cross of Idaho is a trade name for Blue Cross of Idaho Health Service, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

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HOW TO SUBMIT CLAIMS

A Participant must submit a claim to the Vision Program's designated Vision Care Services Vendor, Vision Service Plan (VSP) in order to receive benefits for Covered Services. There are two (2) ways for a Participant to submit a claim:

1. The vision service Provider can file the claim for the Participant. In-Network (Participating) Providers will submit a claim on a Participant's behalf if the Participant shows them the identification card before services are rendered and tells them they have coverage through VSP.

2. The Participant can send the claim to VSP.

To File a Participant's Own Claims

In-Network Providers will submit a claim for the Participant. This will ensure the Participant receives the highest benefits from the Plan. If the Participant receives services from an Out-of-Network Provider, the Participant can file the claim directly to VSP. To submit an Out-of-Network claim:

1. The Participant can visit VSP's Website at www.vsp.com and sign in as a Member. Click on the "Benefits" link and then the "Submit a Claim" under the heading "Oops! Did You Go Out of Network" Instructions for completing the form are described. Once completed, mail the form to VSP at the address listed below.

2. Include a copy of the itemized billing statement or receipts and be sure to include the following information:
   a. Doctor's name or office name
   b. Name of patient
   c. Date of Service
   d. Each service received and the amount paid

   Mail to:
   Vision Service Plan
   Attention: Claims Services
   PO Box 385018
   Birmingham, AL 35238-5018

For assistance with claims the Participant can call VSP Customer Service at 1-844-348-0848 Monday through Friday 6 a.m. – 7 p.m. MT.

How the Participant is Notified

If the Participant receives services from an In-Network Provider, the Provider will provide a statement explaining the cost of the services. If the Participant receives services from an Out-of-Network Provider, VSP will provide a statement of costs to the Participant with a reimbursement check. See the Inquiry and Appeals Procedures section for additional information on how to appeal a determination on cost of services.

CONTACT INFORMATION

For assistance with claims or benefit information, please contact VSP Customer Service.

Phone:	1-844-348-0848 Monday through Friday 6 a.m. – 7 p.m. MT.
Mail:	VSP P O Box 385018 Birmingham, AL 35238-5018
Online:	www.vsp.com

VISION CARE BENEFITS SECTION

This section specifies the benefits a Participant is entitled to receive for the Covered Services described, subject to the other provisions of the Vision Program.

I. Copayment and Limitations on Frequency of Services

The Copayment amount and limitations on frequency of services are shown in the Benefits Outline.

II. Covered Providers

The following are Covered Providers under this section:

- Optometrist (OD)
- Ophthalmologist (MD)

III. Procedures for Obtaining Covered Services

A. In-Network: A Participant must contact the In-Network Provider to make an appointment to receive Covered Services. No preauthorization or special benefit form is required. The doctor is responsible for verifying eligibility and obtaining the necessary authorization from VSP prior to the delivery of service. Each authorization is valid for fifteen (15) days, as long as the Participant is still covered by the Vision Program and the Benefit Period has not ended. A Participant must provide the In-Network Provider sufficient information to verify eligibility. Failure of the Participant to provide sufficient information may delay services and may affect benefit payment under the Vision Program.

B. Out of Network: If a Participant receives Covered Services from an Out-of-Network Provider, the Participant must pay the Provider in full and file a claim with VSP for reimbursement.

IV. Covered Services

When rendered by a Covered Provider, benefits are provided for the following services:

A. Eye Examination
B. Frame
C. Single Vision Lenses
D. Lined Bifocal Lenses
E. Lined Trifocal Lenses
F. Contact Lens fitting and evaluation and Contact Lenses in place of eyeglasses

A. Eye Examination

A routine vision examination may, include but not is not limited to, the following services:
(NOTE: A Provider may not perform each test for every patient.)

1. **Comprehensive Examination**—evaluation of the complete visual system with or without cycloplegia or mydriasis.
2. **Intermediate Examination**—brief or limited routine check-up or vision survey.
3. **Vision Analysis**—various tests for prescription Lenses.
4. **Tonometry**—measurement of eye tension for glaucoma.
5. **Biomicroscopy**—examination of the living eye tissue.
6. **Central and/or Peripheral Field Study**—measurement of visual acuity in the central and/or peripheral field of vision.
7. **Dilation**—allows for a better view inside the eye, i.e., optic nerve blood vessels, etc.

B. Prescribed Lenses and Frames

When an eye examination indicates that new Lenses or a new Frame or both are necessary for the proper visual health and welfare of a Participant, they will be supplied, together with such professional services as necessary, which include but are not limited to:

1. Prescribing and ordering proper Lenses.
2. Assisting in the selection of a Frame.
3. Verifying the accuracy of the finished Lenses.
4. Proper fitting and adjustment of the eyeglasses.

VSP reserves the right to limit the cost of Frames provided by an In-Network Provider. The allowance is published periodically by VSP to its Providers and is set at a level to cover the majority of Frames in common use. If a Participant wishes to select a more expensive Frame than allowed in this section, the difference in cost is not the responsibility of VSP or the Vision Program.

C. Contact Lenses

1. **Medically Necessary Contact Lenses**—Medically Necessary Contact Lenses are covered for Participants when specific benefit criteria are satisfied and when prescribed by Participant's doctor. When the In-Network Provider receives prior approval for such cases, they are fully covered by the Vision Program and are in place of the benefits described for Prescribed Lenses and Frames.

   Medically Necessary Contact Lenses may be prescribed only for certain medical conditions.
2. **Elective Contact Lenses**—if a Participant chooses Contact Lenses from an In-Network Provider for reasons other than those mentioned above, benefits are provided as follows: The initial basic examination will be covered in full (as described under Eye Examination) and an allowance will be paid toward a contact lens evaluation fee, fitting costs, and materials in place of the benefits described for Prescribed Lenses and Frames. The allowance amount is shown in the Benefits Outline.
3. **Reimbursement Allowance**—For Covered Services rendered by an Out-of-Network Provider, reimbursement allowances for Medically Necessary and Elective Contact Lenses include a Contact Lens evaluation fee, fitting costs, and materials and is in place of all other benefits for materials, including eyeglass Lenses and Frame.

V. Additional Amount of Payment Provisions

A. The Participant will pay the Copayment, if any, to the In-Network Provider for Covered Services and will pay for any additional services received not covered by the Vision Program. VSP, on behalf of the Plan Administrator, will pay the In-Network Provider directly in accordance with the agreement between VSP and the In-Network Provider.

Subject to the applicable Copayment(s), VSP shall pay or otherwise secure the discharge of the cost of Covered Services rendered by an In-Network Provider. An In-Network Provider shall not make an additional charge to a Participant for amounts in excess of the Vision Program's payment except for Copayments, noncovered services, amounts above the allowance for elective Contact Lenses, and Frames that are more expensive than the VSP allowance.

B. If Covered Services are rendered by an Out-of-Network Provider:

1. The Participant is responsible for paying the Provider in full. The Participant will be reimbursed in accordance with the benefits available, if any, as shown in the Benefits Outline.
2. The Out-of-Network Provider is not obligated to accept the Vision Program's payment as payment in full. VSP, the Contract Administrator and the Plan are not responsible for the difference, if any, between the Vision Program's payment and the actual charge; any such difference is the Participant's responsibility.
3. Benefits for Covered Services are subject to the same time limits and Copayments as those described for Covered Services received from an In-Network Provider. Covered Services obtained from an Out-of-Network Provider are in place of obtaining services from an In-Network Provider.

C. The amounts shown in the Benefits Outline under Payment for Services Rendered by an Out-of-Network Provider are maximums. The actual amount paid in reimbursement to the Participant is either the amount indicated in the Benefits Outline or the amount actually charged, or the billed charge, whichever is less.

VI. Enrollee's Options

When a Participant selects any of the following options, the Vision Program pays the basic cost of the allowed Lenses, and the Participant is responsible for paying the additional costs for the following options:

1. Blended Lenses.
2. Contact Lenses, except as provided in this section.
3. Oversize Lenses.
4. Coating of the lens or Lenses.
5. Laminating of the lens or Lenses.
6. A Frame that costs more than VSP's allowance.
7. Cosmetic Lenses.
8. Optional cosmetic processes.
9. UV (ultraviolet) protected Lenses.
10. Photochromic Lenses, tinted lenses except Pink #1 and Pink #2.
11. Polycarbonate Lenses.
12. Certain limitations on low vision care.

13. Low vision aids.
14. Lens materials other than plastic or glass.

DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout this Vision Program Document ("Document"). Other terms may be defined where they appear in this Document. All Providers and Facilities must be licensed, certified, accredited and/or registered, where required, to render Covered Services. For the purposes of this Document, Providers include any facility or individual who provides a Covered Service while operating within the scope of their license, certification, accreditation and/or registration under applicable state law, unless exempted by federal law. Definitions in this Document shall control over any other definition or interpretation unless the context clearly indicates otherwise.

Accidental Injury— an objectively demonstrable impairment of bodily function or damage to part of the body caused by trauma from a sudden, unforeseen external force or object, occurring at a reasonably identifiable time and place, and without a Participant's foresight or expectation, which requires medical attention at the time of the accident. Contact with an external object must be unexpected and unintentional, or the results of force must be unexpected and sudden. The force may be the result of the injured party's actions, but must not be intentionally self-inflicted. Accidental injuries caused by a medical condition or domestic violence are not subject to exclusion under this Program.

Adverse Benefit Determination—any denial, reduction or termination of, or the failure to provide payment for, a benefit for services or ongoing treatment under the Vision Program.

Benefit Period—the specified period of time in which a Participant's benefits for incurred Covered Services accumulate toward annual benefit limits. The Benefit Period for the Plan is a calendar year from January 1 through December 31.

Benefits Outline—a listing of certain Covered Services specifying Cost Sharing, Copayments, Deductibles, and benefit limitations and maximums under the Vision Program.

Blended Lenses—bifocals that do not have a visible dividing line.

Coated Lenses—a substance added to a finished lens on one (1) or both surfaces.

Contact Lenses—ophthalmic corrective Lenses (either glass or plastic, ground or molded). They must be prescribed by an Optometrist or Ophthalmologist/Physician to be directly fitted to the Participant's eye.

Contract Administrator—Blue Cross of Idaho has been hired as the Contract Administrator by the Plan Administrator to perform claims processing and other specified administrative services in relation to the Vision Program. The Contract Administrator is not an insurer of health benefits under the Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Contract Administrator is not responsible for Plan financing and does not guarantee the availability of Plan benefits.

Copayment—a designated dollar and/or percentage amount, separate from Cost Sharing, that a Participant is financially responsible for and must pay to a Provider at the time certain Covered Services are rendered.

Cost Effective—a requested or provided medical service or supply that is Medically Necessary in order to identify or treat a Participant's health condition, illness or injury and that is:

1. Provided in the most cost-appropriate setting consistent with the Participant's clinical condition and the Covered Provider's expertise. For example, when applied to services that can be provided in either an Inpatient hospital setting or Outpatient hospital setting, the Cost Effective setting will generally be the outpatient setting. When applied to services that can be provided in a hospital setting or in a physician office setting, the Cost Effective setting will generally be the physician office setting.
2. Not more costly than an alternative service or supply, including no treatment, and at least as likely to produce an equivalent result for the Participant's condition, Disease, Illness or injury.

Cost Sharing—the percentage of the Maximum Allowance or the actual charge, whichever is less, a Participant pays Out-of-Pocket for Covered Services after satisfaction of any applicable Copayments.

Covered Provider—a Provider licensed to perform Covered Services specified in this Document from whom a Participant must receive Covered Services in order to be eligible to receive benefits.

Covered Service—when rendered by a Covered Provider, a service, supply, or procedure specified in this Document for which benefits will be provided to a Participant.

Disease—any alteration in the body or any of its organs or parts that interrupts or disturbs the performance of vital functions, thereby causing or threatening pain, weakness, or dysfunction. A Disease can exist with or without a Participant's awareness of it, and can be of known or unknown cause(s).

Effective Date—the date when coverage for a Participant begins under the Vision Program.

Eligible Dependent—a person eligible for enrollment under an Enrollee's coverage as specified in the Plan's Summary Plan Description booklet.

Eligible Employee—an employee who is eligible to become an Enrollee.

Employer—J.R. Simplot Company.

Enrollee—an Eligible Employee who has satisfied the Eligibility requirements of the Plan as described in the Plan's Summary Plan Description booklet and who has properly enrolled in the Vision Program of the Plan through a process determined by the J.R. Simplot Company.

Frame—a standard eyeglass Frame adequate to hold Lenses.

Illness—a deviation from the healthy and normal condition of any bodily function or tissue. An Illness can exist with or without a Participant's awareness of it, and can be of known or unknown cause(s).

Injury—damage to a part of the body caused by trauma from a sudden, unforeseen outside force or object, occurring at an identifiable time and place, and without the Participant's foresight or expectation.

In-Network Provider—a Provider that has entered into a written agreement with VSP regarding payment for Covered Services rendered to a Participant under the Vision Program.

In-Network Services—Covered Services provided by an In-Network Provider.

Investigational—any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes such as length of life, quality of life, and functional ability. A technology is considered investigational if, as determined by VSP, on behalf of the Plan Administrator, it fails to meet any one of the following criteria:

- The technology must have final approval from the appropriate government regulatory body. This applies to drugs, biological products, devices, and other products/procedures that must have approval from the U.S. Food and Drug Administration (FDA) or another federal authority before they can be marketed. Interim approval is not sufficient. The condition for which the technology is approved must be the same as that VSP is evaluating.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of current published medical literature and investigations published in peer-reviewed journals. The quality of the studies and consistency of results will be considered. The evidence should demonstrate that the technology can measure or alter physiological changes related to a Disease, Injury, Illness, or condition. In addition, there should be evidence that such measurement or alteration affects health outcomes.
- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives.
- The technology must show improvement that is attainable outside the investigational setting. Improvements must be demonstrated when used under the usual conditions of medical practice.

If a technology is determined to be investigational, all services specifically associated with the technology, including but not limited to associated procedures, treatments, supplies, devices, equipment, facilities or drugs will also be considered investigational.

Lenses—ophthalmic corrective lenses (either glass or plastic, ground or molded). They must be prescribed by an Optometrist or Ophthalmologist/Physician to improve visual acuity or performance and to be fitted to a Frame. Amounts payable are based on a lens blank not more than sixty-one (61) millimeters in diameter, tinted no darker than the equivalent of Pink #1 or #2 and without photosensitive or anti-reflective properties.

Maximum Allowance—for Covered Services under the terms of this Document, Maximum Allowance is the lesser of the billed charge or the amount established as the highest level of compensation for a Covered Service as established by VSP.

Medicaid—Title XIX (Grants to States for Medical Assistance Programs) of the United States Social Security Act as amended.

Medically Necessary (or Medical Necessity)—the Covered Service or supply recommended by the treating Covered Provider to identify or treat a Participant's condition, Disease, Illness or Accidental Injury and which is determined by VSP, on behalf of the Plan Administrator, to be:

1. The most appropriate supply or level of service, considering potential benefit and harm to the Participant.
2. Proven to be effective in improving health outcomes:
   a. For new treatment, effectiveness is determined by peer reviewed scientific evidence; or
   b. For existing treatment, effectiveness is determined first by peer reviewed scientific evidence, then by professional standards, then by expert opinion.
3. Not primarily for the convenience of the Participant or Covered Provider.
4. Cost Effective for this condition.

The fact that a Covered Provider may prescribe, order, recommend, or approve a service or supply does not, in and of itself, necessarily establish that such service or supply is Medically Necessary under the Vision Program.

The term Medically Necessary as defined and used in this Document is strictly limited to the application and interpretation of this Document, and any determination of whether a service is Medically Necessary hereunder is made solely for the purpose of determining whether services rendered are Covered Services.

In determining whether a service is Medically Necessary, the Contract Administrator considers the medical records and, the following source documents: Blue Cross Blue Shield Association's Evidence Positioning System assessments, the Blue Cross and Blue Shield Association Medical Policy Reference Manual as adopted by the Contract Administrator, and Blue Cross of Idaho Medical Policies. The Contract Administrator also considers, current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

Medicare—Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

Ophthalmologist—a doctor of medicine (M.D.) who is both a medical doctor and a surgeon. The ophthalmologist is licensed to exam, diagnose and treat disorders and diseases of the eye and visual system of the brain, as well as prescribe corrective lenses (glasses or contacts).

Optometrist—a person who is licensed and specializes in optometry to examine, measure and treat certain visual defects by means of corrective lenses or other methods that do not require a license as a physician.

Orthoptics—the teaching and training process for improvement of visual perception and coordination of the two (2) eyes for efficient and comfortable binocular vision.

Out-of-Network Provider—a Provider that has not entered into a written agreement with VSP regarding payment for Covered Services rendered to a Participant under the Vision Program.

Out-of-Network Services—any Covered Services rendered by an Out-of-Network Provider.

Outpatient—a Participant who receives services or supplies while not an inpatient.

Participant—an Enrollee or an enrolled Eligible Dependent covered under the Vision Program.

Photochromic Lenses—lenses that change color with intensity of sunlight.

Physician—a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) licensed to practice medicine.

Plan—J.R. Simplot Company Group Health and Welfare Plan.

Plan Administrator—the Plan Administrator, J.R. Simplot Company, the sole fiduciary of the Plan, has all discretionary authority to interpret the provisions and control the operation and administration of the Plan within the limits of the law.

Plan Sponsor—J.R. Simplot Company.

Plano Lenses—lenses with refractive correction of less than ± .50 diopter.

Post-Service Claim—any claim for a benefit under the Plan that does not require prior authorization before services are rendered.

Pre-Service Claim—any claim for a benefit under the Plan that requires prior authorization before services are rendered.

Provider—a person or entity that is licensed, certified, accredited and/or registered, where required, to render Covered Services. For the purposes of the Vision Program of the Plan, Providers include only Ophthalmologist/Physicians and Optometrists

Surgery—within the scope of a Provider's license, the performance of:

1. Generally accepted operative and cutting procedures.
2. Invasive procedures using specialized instruments.
3. Customary preoperative and postoperative care.

Tinted Lenses—Lenses that have an additional substance added to produce constant tint.

Vision Care Services Vendor—an entity contracting with the Contract Administrator, on behalf of the Plan Administrator, to provide Vision Care Services to its Participants. Vision Service Plan (VSP) is the Vision Care Services Vendor for the Vision Program.

Vision Program—the self-funded program of the J.R. Simplot Group Health and Welfare Plan that provides vision benefits for eligible Participants on the terms and conditions set forth in this Vision Program Document and in the Plan's Summary Plan Description booklet.

EXCLUSIONS AND LIMITATIONS SECTION

The following exclusions and limitations apply to the entire Vision Program, unless otherwise specifically listed as a Covered Service.

I. General Exclusions and Limitations

There are no benefits for services, supplies, drugs or other charges that are:

A. In excess of the Maximum Allowance.

B. Not prescribed by or upon the direction of an Optometrist or Ophthalmologist or other professional Provider; or which are furnished by any individuals or facilities other than Physicians, and other Providers.

C. Investigational in nature.

D. Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Participant is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Participant claims such benefits or compensation or recovers losses from a third party.

E. Provided or paid for by any federal governmental entity or unit except when payment under the Vision Program is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefore would vary, or are or would be affected by the existence of coverage under the Vision Program.

F. Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.

G. Furnished by a Provider who is related to the Participant by blood or marriage and who ordinarily dwells in the Participant's household.

H. Received from a vision, or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.

I. Rendered prior to the Participant's Effective Date

J. For telephone consultations, and all computer or Internet communications; for failure to keep a scheduled visit or appointment; for completion of a claim form; for interpretation services; or for personal mileage, transportation, food or lodging expenses or for mileage, transportation, food or lodging expenses billed by a Provider.

K. For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.

L. For treatment or other health care of any Participant in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Participant to Covered Services under the Vision Program, if and to the extent those benefits are payable to or due the Participant under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's, or other similar policy of insurance, contract, or underwriting plan.

In the event the Vision Program for any reason makes payment for or otherwise provides benefits excluded by the above provisions, the Plan shall succeed to the rights of payment or reimbursement of the compensated Provider, the Participant, and the Participant's heirs and personal representative against all insurers, underwriters, self-insurers or other such obligors contractually liable or obliged to the Participant, or their estate for such services, supplies, drugs or other charges so provided by the Vision Program in connection with such Illness, Disease, Accidental Injury or other condition.

M. For which a Participant would have no legal obligation to pay in the absence of coverage under the Vision Program or any similar coverage; or for which no charge or a different charge is usually made in the absence of health coverage or insurance coverage or charges in connection with work for compensation or charges; or for which reimbursement or payment is contemplated under an agreement with a third party.

N. Provided to a person enrolled as an Eligible Dependent, but who no longer qualifies as an Eligible Dependent due to a change in eligibility status that occurred after enrollment.

O. Provided outside the United States, which if had been provided in the United States, would not be a Covered Service.

P. Furnished by a Provider or caregiver that is not listed as a Covered Provider.

Q. For the purchase of Therapy or Service Dogs/Animals and the cost of training/maintaining said animals.

R. Orthoptics or other vision training and any associated supplemental testing.

S. Plano Lenses.

T. Two (2) pair of eyeglasses in place of bifocals.

U. Replacement of Lenses, Frames or Contact Lenses furnished hereunder that are lost or broken (Lenses, Frames or Contact Lenses are only replaced at the normal intervals when Covered Services are otherwise available).

V. Medical or surgical treatment of the eye(s).

W. Any eye examination or any corrective eyewear required by an employer as a condition of employment.

X. Solutions and/or cleaning products for eyeglasses or Contact Lenses.

Z. Contact lens insurance policies or service agreements.

AA. Refitting of Contact Lenses after the initial ninety (90) day fitting period.

AB. Contact lens modification, polishing or cleaning.

AC. Local, state and/or federal taxes, except where the Vision Program is required by law to pay.

AD. Professional services associated with Corneal Refractive Therapy (CRT), Orthokeratology, or myopia management.

GENERAL PROVISIONS SECTION

I. Participant/Provider Relationship

A. The choice of a Provider is solely the Participant's.

B. VSP and the Contract Administrator do not render Covered Services but only make payment for Covered Services received by Participants. VSP, the Contract Administrator and the Plan Administrator are not liable for any act or omission or for the level of competence of any Provider, and have no responsibility for a Provider's failure or refusal to render Covered Services to a Participant.

C. The use or nonuse of an adjective such as Participating or Nonparticipating is not a statement as to the ability of the Provider.

II. Coordination of Benefits

The intent of this Coordination of Benefits provision is to provide that the sum of benefit payments from all "Other Plans" and the Vision Program will not exceed the normal benefit allowance from Vision Program when no Other Plan(s) are involved.

A. Definitions, as used in this section:

1. **This Plan** will mean the Vision Program.
2. **Other Plans** will mean any medical or dental expense benefits provided under:
   a. Any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association;
   b. Any program required or established by federal or state law, including Medicare Parts A, B, C and D; and
   c. Any program sponsored by or arranged through a school or other educational agency. (Note: the term “Other Plan” will not include benefits provided under a student accident policy, nor will the term “Other Plan” include benefits provided under a state medical assistance program where eligibility is based on financial need.)

   If the Other Plan contains several programs and some of those programs dictate rules for Coordination of Benefits and other programs do not dictate rules for Coordination of Benefits, Coordination of Benefits will apply separately.
3. **Primary Plan/Secondary Plan** describes the order of how payments are made according to benefit determination rules when more than one plan covers the person. When this Plan is Primary, its benefits are determined before those of any Other Plan and without considering any Other Plan’s benefits. When this Plan is Secondary, its benefits are determined after those of any Other Plan and may be reduced because of the Primary.
4. **Allowable Expense** will mean a health care Covered Service or expense, including Deductibles and Copayments, if any, that is covered at least in part by any of the plans covering the person for whom benefits are claimed. When a plan provides benefits in the form of Services, the reasonable cash value of each Service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an Allowable Expense.

B. Order of Benefit Determination

Benefits payable by a plan that does not have a Coordination of Benefits provision as described in this section will be determined before a plan that does have such a provision except as described below in the “Medicare Exception—Order of Benefit Determination” subsection. In all other instances, the order of determination will be:

1. Non-Dependent/Dependent. The benefits of a plan that covers the person for whom benefits are claimed as an Enrollee (non-dependent) are determined before the benefits of a plan that covers the person as an Eligible Dependent.
2. Dependent Child
   a. Parents not Separated or Divorced—The benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the plan that covered a parent longer are determined before those of the plan that covered the other parent for a shorter period of time. However, if another plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a

result, the plans do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.

b. Separated or Divorced Parents—Single Custody. If two or more plans cover an Eligible Dependent child of divorced or separated parents, benefits for the child are determined in this order:
   1) First, the plan of the parent with custody of the child;
   2) Then, the plan of the spouse of the parent with custody of the child; and
   3) Finally, the plan of the parent not having custody of the child.
   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any period during which any benefits are actually paid or provided before the entity has that actual knowledge.

c. Separated or Divorced Parents—Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules for Eligible Dependent children of parents who are not separated or divorced.

d. Active/Inactive Employee. The benefits of a plan that covers a person as an Enrollee who is neither laid off nor retired, or as that active Enrollee's Eligible Dependent, are determined before the benefits of a plan that covers that person as a laid-off or retired Enrollee or as that inactive Enrollee's Eligible Dependent. 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.

e. Continuation of Coverage. If coverage is provided for a person under a right of continuation according to federal or state law and the person is also covered under the Other Plan, the following will be the order of benefit determination:
   1) First, the benefits of a plan covering the person as an active (non-COBRA participant (or as that person's dependent);
   2) Second, the benefits under the continuation coverage.
   3) If the Other Plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

f. Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the plan that covered a person longer are determined before those of the plan that covered that person for the shorter time.

g. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the plans. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

C. Medicare Exception—Order of Benefit Determination

This Plan will be primary over Medicare only when federal law requires it to be primary. This Plan will be secondary to Medicare to the fullest extent allowed by federal law.

The rules governing coordination of benefits with Medicare are set by the federal government and are quite complex. The summary that follows is not a comprehensive account of those rules nor is it intended to change the basic Medicare rule described in the previous paragraph.

1. Medicare is primary for a person who is eligible for Medicare on the basis of age or disability unless the person is covered under this Plan because of his/her current employment status or that of their spouse. COBRA continuation coverage is not considered coverage based on current employment status, i.e., Medicare is primary for a person who is eligible for Medicare on the basis of age or disability and has COBRA continuation coverage under this Plan.

2. Medicare is primary for a person who is eligible for Medicare on the basis of end stage renal disease (ESRD) after the thirtieth (30) month of Medicare eligibility unless Medicare was already primary on the basis of age or disability on the date the person became eligible on the basis of ESRD.

When this Plan would be secondary to Medicare, it will reduce benefits based on what Medicare would pay under Part A and Part B, even if you or your Dependent are not enrolled in Part A or Part B. The Claims

Administrator may make a good faith estimate of the amount Medicare would pay. This estimate will be deemed a benefit paid for purposes of determining benefits.

D. Effect on Benefits

Benefits payable by this Plan will not duplicate benefits already paid by any Other Plan(s) for Allowable Expenses.

Benefits payable under this Plan will be adjusted appropriately by the benefits payable under the Other Plan(s), if the Other Plan(s) benefits are determined to be primary payers before this Plan.

When this Plan is secondary, the regular benefit payment will be calculated. If the Other Plan's payment is less than this Plan's normal benefit allowance, then this Plan will pay the difference up to the normal benefit allowance for this Plan.

Example 1:	**Allowable Expense**	**Plan Pays**	**Benefit**
Other Plan (Primary Plan)	$100	70%	$70
This Plan (Secondary Plan)	$100	80%	$80
Difference Paid by Simplot Plan		$10	

If the Other Plan's payment is equal to or more than this Plan's normal benefit allowance, then this Plan pays no additional benefits.

Example 2:	**Allowable Expense**	**Plan Pays**	**Benefit**
Other Plan (Primary Plan)	$100	80%	$80
This Plan (Secondary Plan)	$100	80%	$80
Difference Paid by this Plan		$0	

Deductibles, maximums and other benefit limits of this Plan will be adjusted as if benefits had been paid.

E. General Coordination of Benefits Provisions

1. Exchange of Information. Any person who claims benefits under this Plan is required, upon request, to provide all information that is needed to coordinate benefits. In addition, all information that is needed to coordinate benefits may be exchanged with other companies, organizations, or persons.
2. Plan Reimbursement. The Plan may reimburse any Other Plan if:
   a. Benefits were paid by that Other Plan; but
   b. Should have been paid under this Plan in accordance with this section.
   In such instances, the reimbursement amounts will be considered benefits paid under this Plan and, to the extent of those amounts, will discharge this Plan from liability.
3. Integration with Individual Medical Expense Automobile Policies. The amount payable under this Plan for covered medical and dental expenses shall be reduced by the amounts payable for such Services under an individual medical expense automobile policy.
4. Right of Recovery. If it is determined that benefits paid under this Plan should have been paid by any Other Plan or policy, this Plan will have the right to recover those payments from:
   a. The person to or for whom the benefits were paid; and/or
   b. The other companies or organizations liable for the benefit payments.

F. Prescription Drug Benefit

This Plan shall not pay additional prescription drug benefits secondary to another plan, regardless of whether a claim is made to the primary plan.

III. Inquiry and Appeals Procedures

If the Participant's claim for benefits is denied and an Adverse Benefit Determination, the Participant must first exhaust any applicable internal appeals process described below prior to pursuing legal action. Any legal action must be filed within two (2) years after the final internal appeal decision and must be filed in Federal court in Boise, Idaho.

A. Informal Inquiry

For any initial questions concerning a claim, a Participant should call VSP phone number listed on the back of the Participant's ID card.

B. Formal Appeal

A Participant, or their authorized representative, as defined by the Plan, who wishes to formally appeal a Pre-Service Claim decision may do so through the following process:

1. A Participant may have an authorized representative pursue a benefit claim or an appeal of an Adverse Benefit Determination on their behalf. The Plan Administrator requires that a Participant execute the Contract Administrator's "Appointment of Authorized Representative" form before the Contract Administrator, on behalf of the Plan Administrator, determines that an individual has been authorized to act on behalf of the Participant. The form can be found on the Contract Administrator's Website at www.bcidaho.com.

2. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and the documents in support of such appeals may be submitted by phone or facsimile. The appeal should set forth the reasons why the Participant contends the decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

   A Participant or their authorized representative may submit the appeal to:
   Blue Cross of Idaho
   Attn: Grievances and Appeals Department
   PO Box 7408
   Boise, ID 83707
   Fax to: 208-331-7493

3. After receipt of the appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by a Contract Administrator Medical Director, physician designee, or a VSP designee. For non-urgent claim appeals, the Contract Administrator or a VSP designee will mail a written reply to the Participant within fifteen (15) days after receipt of the written appeal. Urgent claim appeals will be notified orally within seventy-two (72) hours. If the original decision is upheld, the reply will state the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible taking into account the medical exigencies of each claim.

4. Furthermore, the Participant or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.

5. If the original, non-urgent claim decision is upheld upon reconsideration, the Participant or their authorized representative may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within thirty (30) days of the Contract Administrator's (or a VSP designee's) mailing of the initial reconsideration decision. The Contract Administrator Medical Director who is not subordinate to the Medical Director, physician designee, or a VSP designee who decided the initial appeal, will review and make a recommendation to the Plan Administrator who will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt. There are no further internal appeals available for urgent claims.

C.

A Participant, or their authorized representative, as defined by the Plan, who wishes to formally appeal a Post-Service Claims decision may do so through the following process:

1. A Participant may have an authorized representative pursue a benefit claim or an appeal of an Adverse Benefit Determination on their behalf. The Plan Administrator requires that a Participant

execute an “Appointment of Authorized Representative” form before the Contract Administrator, on behalf of the Plan Administrator, determines that an individual has been authorized to act on behalf of the Participant. The form can be found on the Contract Administrator’s Website at www.bcidaho.com.

2. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. This written appeal should set forth the reasons why the Participant contends the decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

3. After receipt of the written appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by a Medical Director or physician designee if the appeal requires medical judgment. The Contract Administrator or a VSP designee shall mail a written reply to the Participant within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will list the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible.

4. Furthermore, the Participant or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.

5. If the original decision is upheld upon reconsideration, the Participant or their authorized representative may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within sixty (60) days of the Contract Administrator’s (or a VSP designee’s) mailing of the initial reconsideration decision. The Plan Administrator will designate that a Medical Director of the Contract Administrator who is not the subordinate to the Medical Director, physician designee, or a VSP designee who decided the initial appeal, will review and make a recommendation to the Plan Administrator who will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within thirty (30) days of its receipt.

IV. Reimbursement of Benefits Paid by Mistake

If VSP or the Contract Administrator, on behalf of the Plan Administrator, mistakenly makes payment for benefits on behalf of an Enrollee or their Eligible Dependent(s) that the Enrollee or their Eligible Dependent(s) is not entitled to under the Vision Program, the Enrollee must reimburse the erroneous payment to VSP or the Contract Administrator, on behalf of the Plan Administrator.

The reimbursement is due and payable as soon as VSP or the Contract Administrator notifies the Enrollee and requests reimbursement. The Contract Administrator, on behalf of the Plan Administrator, may also recover such erroneous payment from any other person or Provider to whom the payments were made. If reimbursement is not made in a timely manner, the Contract Administrator, on behalf of the Plan Administrator, may reduce benefits or reduce an allowance for benefits as a set-off toward reimbursement.

Even though the Contract Administrator, on behalf of the Plan Administrator, may elect to continue to provide benefits after mistakenly paying benefits, the Contract Administrator, on behalf of the Plan Administrator, may still enforce this provision with respect to benefits paid before discovery of the mistake. This provision is in addition to, not instead of, any other remedy the Contract Administrator, on behalf of the Plan Administrator, may have at law or in equity.

V. Subrogation and Reimbursement Rights

The benefits of the Vision Program will be available to a Participant when the Participant is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereinafter referred to as "third party"). To the extent that such benefits for Covered Services are provided or paid for by the Contract Administrator, on behalf of the Plan Administrator under the Vision Program, the Contract Administrator, on behalf of the Plan Administrator shall be subrogated and succeed to the rights of the Participant or, in the event of the Participant's death, to the rights of their heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Services in such an event, the Participant or their personal representative shall furnish the Contract Administrator in writing with the names, addresses, and contact information of the third party or parties that caused or are responsible, or may have caused or may be responsible for such injury, harm or loss, and all facts and information known to the Participant or their personal representative concerning the injury, harm or loss. In addition, the Participant shall furnish the name and contact information of the liability insurer and its adjuster of the third party, including the policy number, of any liability insurance that covers, or may cover, such injury, harm, or loss.

The Contract Administrator, on behalf of the Plan Administrator, may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

Subrogation is taking over the Participant's right to receive payments from other parties. The Participant or their legal representative will transfer to the Contract Administrator, on behalf of the Plan Administrator any rights the Participant may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Participant. Thus, the Contract Administrator, on behalf of the Plan Administrator, may initiate litigation at the Plan Administrator's sole discretion, in the name of the Participant, against any third party or parties. Furthermore, the Participant shall fully cooperate with the Contract Administrator in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice the Plan's subrogation rights and efforts. The Contract Administrator, on behalf of the Plan Administrator, will be reimbursed in full for all benefits paid even if the Participant is not made whole or fully compensated by the recovery. Moreover, the Contract Administrator and the Plan Administrator are not responsible for any attorney's fees, other expenses or costs incurred by the Participant without the prior written consent of the Contract Administrator and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by the Contract Administrator, on behalf of the Plan Administrator.

Additionally, the Contract Administrator, on behalf of the Plan Administrator may at its option elect to enforce the Plan's right of reimbursement from the Participant, or their legal representative, of any benefits paid from monies recovered as a result of the injury, harm or loss. The Participant shall fully cooperate with the Contract Administrator, on behalf of the Plan Administrator, in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice the Plan's reimbursement rights and efforts.

The Participant shall pay the Contract Administrator, on behalf of the Plan Administrator, as the first priority, and the Contract Administrator, on behalf of the Plan Administrator, shall have a constructive trust and an equitable lien on, all amounts from any recovery by suit, settlement or otherwise from any third party or parties or from any third party's or parties' insurer(s), indemnitor(s) or underwriter(s), to the extent of benefits provided by the Contract Administrator, on behalf of the Plan Administrator under the Plan, regardless of how the recovery is allocated *(i. e.,* pain and suffering) and whether the recovery makes the Participant whole. Thus, the Contract Administrator, on behalf of the Plan Administrator, will be reimbursed by the Participant, or their legal representative, from monies recovered as a result of the injury, harm or loss, for all benefits paid even if the Participant is not made whole or fully compensated by the recovery. Moreover, the Contract Administrator and the Plan Administrator are not responsible for any attorney's fees, other expenses or costs incurred by the Participant without the prior written consent of the Contract Administrator and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by the Contract Administrator, on behalf of the Plan Administrator.

To the extent that the Contract Administrator, on behalf of the Plan Administrator provides or pays benefits for Covered Services, the Contract Administrator's rights of subrogation and reimbursement extend to any right the Participant has to recover from the Participant's insurer, or under the Participant's "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions, and workers' compensation benefits.

The Contract Administrator, on behalf of the Plan Administrator shall have the right, at the Plan Administrator's option, to seek reimbursement from, or enforce its right of subrogation against, the Participant, the Participant's personal representative, a special needs trust, or any trust, person or vehicle that holds any payment or recovery from or on behalf of the Participant including the Participant's attorney.

The Contract Administrator's subrogation and reimbursement rights shall take priority over the Participant's rights both for benefits provided and payments made by the Contract Administrator, on behalf of the Plan Administrator, for Covered Services and for benefits to be provided or payments to be made by the Contract Administrator on behalf of

the Plan Administrator, in the future on account of the injury, harm or loss giving rise to the Contract Administrator's subrogation and reimbursement rights. Further, the Plan's subrogation and reimbursement rights for such benefits and payments provided or to be provided are primary and take precedence over the rights of the Participant, even if there are deficiencies in any recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Participant and the Plan Administrator.

Collections or recoveries made by a Participant for such injury, harm or loss in excess of such benefits provided and payments made shall first be allocated to such future benefits and payments that would otherwise be owed by the Plan on account of the injury, harm or loss giving rise to the Plan's subrogation and reimbursement rights, and shall constitute a special Deductible applicable to such future benefits and payments that would otherwise be owed by the Plan, or any subsequent group health plan provided by the Plan Sponsor. Thereafter, the Contract Administrator, on behalf of the Plan Administrator, shall have no obligation to provide any further benefits or make any further payment until the Participant has incurred medical expenses in treatment of such injury, harm or loss equal to such special Deductible.

VI. Payment of Benefits

The Contract Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

A. The Contract Administrator, on behalf of the Plan Administrator, is authorized by the Participant to make payments directly to Providers rendering Covered Services to the Participant for benefits provided under the Plan. Notwithstanding this authorization, the Contract Administrator, on behalf of the Plan Administrator, reserves and shall have the right to make such payments directly to the Participant. Except as provided by law, the Contract Administrator's right, on behalf of the Plan Administrator, to pay a Participant directly is not assignable by a Participant nor can it be waived without the Contract Administrator's concurrence, on behalf of the Plan Administrator, nor may the right to receive benefits for Covered Services under this Document be transferred or assigned, either before or after Covered Services are rendered. Payments will also be made in accordance with any assignment of rights required by state Medicaid plan.

B. Once Covered Services are rendered by a Provider, the Contract Administrator, on behalf of the Plan Administrator, shall not be obliged to honor Participant requests not to pay claims submitted by such Provider, and the Contract Administrator, on behalf of the Plan Administrator, shall have no liability to any person because of its rejection of such request; however, in its sole discretion, for good cause, the Contract Administrator, on behalf of the Plan Administrator, may nonetheless deny all or any part of any Provider claim.

VII. Notice of Claim

The Contract Administrator must receive a written notice of claim for payment for a Covered Service no later than one year from the date a Covered Service is rendered, except if it is not reasonably possible to give notice of proof within this timeframe. The Contract Administrator will deny any claim not received within this time limit.