EMPLOYEE
BENEFITS GUIDE
March 1, 2024 to
February 28, 2025

Wendy's

Classic Food, Inc.
March 1, 2024 - February 28, 2025
Employee Benefits Guide

If you have questions regarding...	Call	Click
Classic Foods, Inc. 1585 N Skyline Dr. *Idaho Falls, ID 83402*		office@wendysidaho.com
Medical/Vision Blue Cross Group #	(888) 675-6570	www.bluecross.com
Dental Delta Dental of Idaho Group #2309	(208) 489-3582	www.deltadentalidaho.com
Open Enrollment, Escalated Claims & Benefits Questions GBS Benefits of Idaho	(208) 529-3541	aj.argyle@gbsbenefits.com magen.smith@gbsbenefits.com
HRA NBS	(800) 274-0503	service@nbsbenefits.com

This communication highlights some of your benefit plans. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the plan documents will prevail. We reserve the right to change any benefit plan without notice. Benefits are not a guarantee of employment.

Table of Contents

What's Inside
This guide provides information for consideration when newly enrolling, changing your elections, or reenrolling in our benefit programs.

Classifications

Class III - Hourly Crew

Class II - Hourly Management / Shift Manager

Class I - Owners and Salaried Management

Important Information

Wendy’s of Idaho

Wendy's of Idaho's Benefits and You

Welcome

We are committed to providing our employees with quality benefits programs that are comprehensive, flexible and affordable. Giving our employees the best in benefit plans is one way we can show you that as an employee, YOU are our most important asset. Eligible employees have many benefit plans to choose from, so we ask that you read this benefits guide carefully to help you make the benefit elections that are the best fit for you and your family.

Know Your Benefits

Making wise decisions about your benefits requires planning. By selecting benefits that provide the best care and coverage, you can optimize their value and minimize the impact to your budget. The best thing you can do is "shop" for benefits carefully, using the same type of decision-making process you use for other major purchases.

- **Take Advantage Of The Tools Available**
  That includes this guide, access to plan information, provider directories, and enrollment materials. For up to date information, visit www.wendysidaho.com

- **Be a Smart Shopper**
  If you were buying a car or purchasing a home, you would do a lot of research beforehand. You should do the same for benefits.

- **Don't Miss the Deadline and Keep Record of Your Enrollment**
  Pay attention to the enrollment deadline and be sure to provide us with your benefit elections in a timely manner. It is important to review your paycheck to ensure the accuracy of payroll deductions. Notify us immediately if there are any discrepancies. **Remember:** Once the enrollment period has ended, you may not make or change your benefit elections, unless you experience a qualified life event.

Summary of Benefits and Coverage (SBC) and Uniform Glossary

In addition to the plan information in this Benefits Guide, you can also review a Summary of Benefits and Coverage for each medical plan. This requirement of the ACA standardizes health plan information so that you can better understand and compare plan features. We will automatically provide you a copy of the SBC annually during open enrollment.

For the most up-to-date information regarding the ACA, please visit www.healthcare.gov.

Enrollment & Eligibility

Who is Eligible?

If you are hired as a full-time Class III employee working 30 or more hours per week, coverage will begin on the first day of the month following 12 months of qualified employment. If you are hired as a full-time Class II employee working 30 or more hours per week, coverage will begin on the first day of the month following 60 days of qualified employment If you are hired as a Class I employee, coverage will begin on date of hire. You may also enroll your eligible dependents in the same plans you choose for yourself.

Eligible dependents include your legal spouse and your natural, adopted or step-child(ren). The dependent age limit for children on your medical plan is age 26, but may vary for other benefits offered.

When to Enroll

You can enroll for coverage as a new hire, or during our annual open enrollment period. Outside of the annual open enrollment period, the only time you can change your coverage is if you experience a qualifying life event.

How to Make Changes

Once you enroll in or decline benefits, you will not be able to make any changes to your elections until our next annual open enrollment period, unless you experience a qualified life event. Qualified life events include, but are not limited to:

- Change in your legal marital status
- Birth, adoption, placement for adoption or legal guardianship of a child
- Death of a dependent
- Change in child's dependent status
- You or your dependent(s) become eligible or lose eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
- Change in your dependent's employment resulting in loss or gain of eligibility for employer coverage
- A court or administrative order

If your qualified life event is due to loss or gain of Medicaid or CHIP coverage, you have 60 days to complete the necessary enrollment forms and return them to us. All other qualified life events must be reported to us within 30 days of the event. It is your responsibility to notify us when you have a qualified life event and would like to make changes to your benefit elections. Please do not miss this important deadline!

When Coverage Ends

For most benefits, coverage will end on the last day of the month in which your regular work schedule is reduced to fewer than 30 hours per week, your employment ends, or you stop paying your share of the coverage. Your dependent(s) coverage ends when your coverage ends, or the last day of the month in which the dependent is no longer eligible. Certain benefits may terminate on the date of event.

Stretching Your Rx Dollar

GoodRx Comparison Tool

Stop paying too much for your prescriptions! With the GBS Benefits Rx Comparison Tool, you can compare drug prices at over 70,000 pharmacies, and discover free coupons and savings tips.

Isn't health insurance all I need?

Your health insurance provides valuable prescription and other health benefits, but a smart consumer can save much more, especially for drugs that are not covered by health insurance (weight-loss medications, some antihistamines, etc.), drugs that have limited quantities, drugs that can be found for less than your copay, or drugs with a lower priced generic.

How can I find these savings?

The GoodRx Comparison Tool provides you with instant access to current prices on more than 6,000 drugs at virtually every pharmacy in America.

› **On the Web:** https://www.goodrx.com/
Instantly look up current drug prices at CVS, Walgreens, Walmart, Costco, and other local pharmacies.
Please Note:
- Prescription drug pricing displayed on the GoodRx Comparison Tool may be more or less than your insurance drug card.
- Please be sure to compare all discount pricing options before you purchase.
- Check your insurance carrier's pharmacy benefit before purchasing a 90-day supply.

› **On Your Phone**
Available on the app store or with Android on Google play. Or, just go to m.goodrx.com from any mobile phone.

Generic Prescriptions

$4 30-Day Supply or a $10 90-Day Supply

These programs may assist you in paying a reduced amount for generic medications, as well as, reducing utilization of the medical prescription benefits.

Did You Know?

Even if the generic substitute for one of your prescription drugs is not on one of the $4 lists, generic drugs are often 80% less expensive than brand name drugs, so switching to a generic will have a large impact on your pocketbook whether you switch pharmacies or not. To see if you would benefit from a switch to a generic drug, do some comparison shopping. One of the better places to do this is at www.crbestbuydrugs.org, a Consumer Reports site.

Tips

- When you receive a prescription from your doctor, ask if a generic equivalent is available.
- The member must present the written prescription to the pharmacist and request the $4-Generic price.
- The member should not present the medical ID card. The pharmacy will not submit a claim to the insurance carrier.

How can I find out if my prescription is on the $4-Generic Drug List?

Most of the generic programs offer approximately 150 to 300 generic drugs at a discounted price. The generic drugs offered cover most diseases and most chronic conditions such as arthritis, heart disease, high blood pressure, depression and diabetes.
You may search for the generic medication on the pharmacy's website or contact the pharmacy to inquire if the generic medication the provider prescribed is on the pharmacy's $4-Generic Drug List.

Medical

Blue Cross

Medical Plan Comparison

Plan Design			
Provider Network			
	In-Network You Pay (Must submit claims to NBS to receive the $1,000 Buy Down and $5,850 out of pocket)		**Out-of-Network You Pay**
Annual Deductible	$4,500 / Individual $9.000 / Family		$8.800 / Individual $17,600 / Family
Annual Out-of-Pocket Maximum	$9.000 / Person $18,000 / Family		$17,600 / Person $35,200 / Family
Coinsurance	30% AD		50% AD
Coverage Levels	**Choice Doctors**	**All Other In-Network**	**Out-of-Network**
Office Visits			
Primary Care	$20	$40	50% AD
Specialist	$40	$60	50% AD
Urgent Care	$40 copay	$60 Copay	
Diagnostic Imaging	30% AD		50% AD
Pediatric Physician Office Visit (Under 18 years old, Includes Urgent Care visits)	Covered at 100%		50% AD
Ambulance	30% AD		50% AD
Hospital Services			
Inpatient /Outpatient	30% AD		50% AD
Emergency Room - Facility	$350 AD		$350 AD
Pharmacy - Retail	**RX Deductible $500**		
Tier 1 - Preferred Generic	$15		
Tier 2 - Non-Preferred Generic	$25		
Tier 3 - Preferred Brand Name	$45		
Tier 4 - Non-Preferred	$60 AD		
Tier 5 - Preferred Specialty & Generic Specialty	30% AD		
Tier 6 - Non-Preferred Specialty	50% AD		
ACA Preventative	No Charge		

HRA

NBS

CLASSIC FOODS BUY-DOWN PROGRAM

What is the purpose of the Buy-Down Program?

The most important purpose of the plan is to provide medical deductible expenses reimbursement to employees and dependents in a way that allows the benefits to be excluded from gross income for federal income tax.

How do you join the plan?

If you are currently enrolled in medical benefits PPO Blue Cross plan, you will automatically be enrolled.

How do I receive reimbursements from Buy-Down program for my deductible expenses?

Claims for benefits under the Classic Foods, LLC plan are based on the Explanation of Benefits (EOB's) you receive from your insurance carrier (Blue Cross of Idaho) after medical services. To receive reimbursements, you will need to make sure you turn in **ALL** your Explanation of Benefits from your health carrier to the Buy-Down Administrator NBS with a claim form. Explanations of Benefits are mailed to you after your medical provider submits claims to your insurance carrier. You can also call the 1-800-627-1188 on back of your health insurance card and request claims printouts periodically.

How do I submit a claim?

You can go online and do it through the participant portal at mynbsbenefits.com
You can email your claim form and EOB's to service@nbsbenefits.com
Instruction on how to do so are available from GBS of Idaho or are located in your Benefit Guide, provided by Classic Foods.

How will benefits be paid to you?

NBS will reimburse you by check, or they offer direct deposit as claims are processed.

What happens if I do not submit my Explanation of Benefits from the health carrier?

If you do not submit your Explanation of Benefits to MERP administrator your deductible will be $4,500 individual instead of $1,000.

What is the cost of the Buy-Down Program?

There is no additional cost to participate in the Buy-Down Program. It is an added benefit your employer has provided to keep your health plan deductible low.

Will all my submitted health information be privacy protected?

Yes. Your Classic Foods, LLC HIPAA privacy officer will follow all privacy laws to ensure your private health information is protected. The administrator of the program also has thorough HIPAA compliance training.

Can I view my claims online?

Yes, if you follow the participant portal instructions available on the NBS website.

Do you have a mobile app?

Yes, NBS Benefits Mobile.

Savings For You and Your Employees

1. Lower insurance premiums
2. Tax savings
3. Extra money for out-of-pocket healthcare expenses
4. Rollover options for amounts not used

Help Make Medical Costs Painless.

Find out more at
info@nbsbenefits.com

nbs national benefit services

8523 South Redwood Road
West Jordan, Utah 84088
1-855-399-3035
info@nbsbenefits.com

What is a Health Reimbursement Account (HRA)?

Health Reimbursement Arrangement (HRA)

What is a Health Reimbursement Arrangement (HRA)?

HRAs go by many names, such as personal care accounts, or consumer-driven healthcare plans. Whatever label you give them, HRAs allow an employer to fund an account to pay employees' healthcare expenses that are not covered by insurance.

An HRA account may pay any or all of the same expenses as a Section 125 Health Flexible Spending Account (FSA). Unlike an FSA, only employers can make contributions to an HRA.

What Happens to the Money that an Employer Puts into the HRA?

Once you establish an HRA, the plan pays for eligible expenses incurred by participants. Unlike an FSA, there is no requirement that the entire annual allocation be available on the first day of the plan year. HRA funds can be made available all at once or in equal portions throughout the year. Employers can allow employees to carry over unused dollars to the next year, or have unused balances forfeited at the end of each year.

HRA Plan Design Options

Bridge: The Bridge Plan complements a higher-deductible insurance product. It pays only for deductible items covered by insurance and provides a "bridge" between out of-pocket expenses and insurance coverage.

Comprehensive: The Comprehensive Plan pays all medical expenses that are not covered by insurance. These expenses include, but are not limited to, dental and vision fees, chiropractic services, copays, deductibles, and insurance premiums. Over-the-counter drugs may also be paid through your plan. This plan could be coupled with a higher-deductible limited coverage insurance arrangement or as a stand-alone employee benefit.

Limited: A limited HRA covers only a group of expenses, such as dental or vision. It can also be restricted to a single medical expense, such as prescriptions.

Insurance Only: The Insurance Only Plan allows employees to pay the premiums for employer provided insurance, individual dental and vision-only insurance, or long-term care insurance.

Account access is easy

Get account information from our easy-to-use online portal and mobile app. See your account balance, contributions and account history in real time.

NBS mobile app

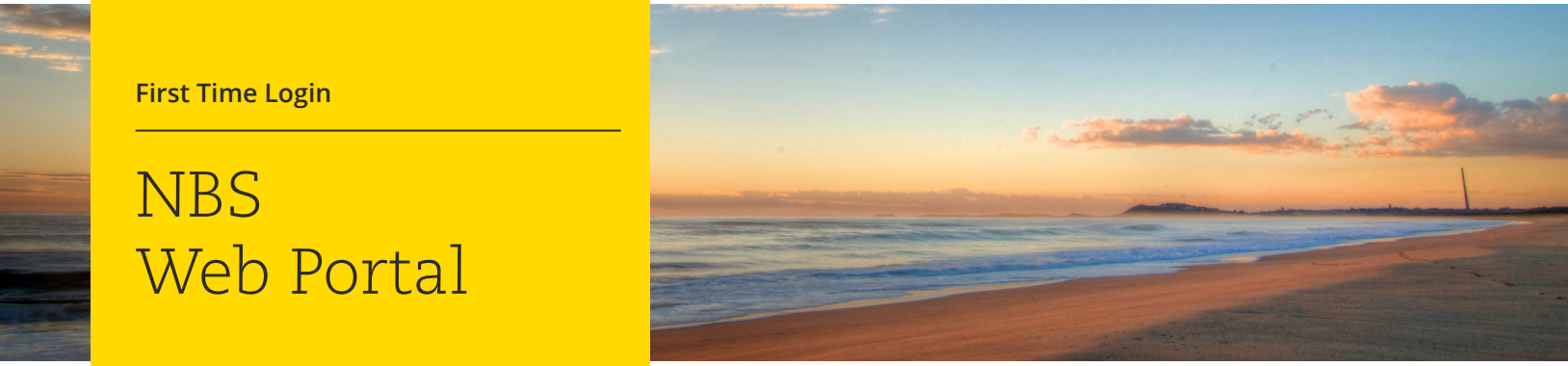
- View account balances
- View claims
- View plan information
- Contact us
- Submit claims
- Edit personal information
- View reimbursement history
- Pay providers

Download on the App Store

GET IT ON Google Play

First Time Login

NBS Web Portal



How Do I Access My Online Account?

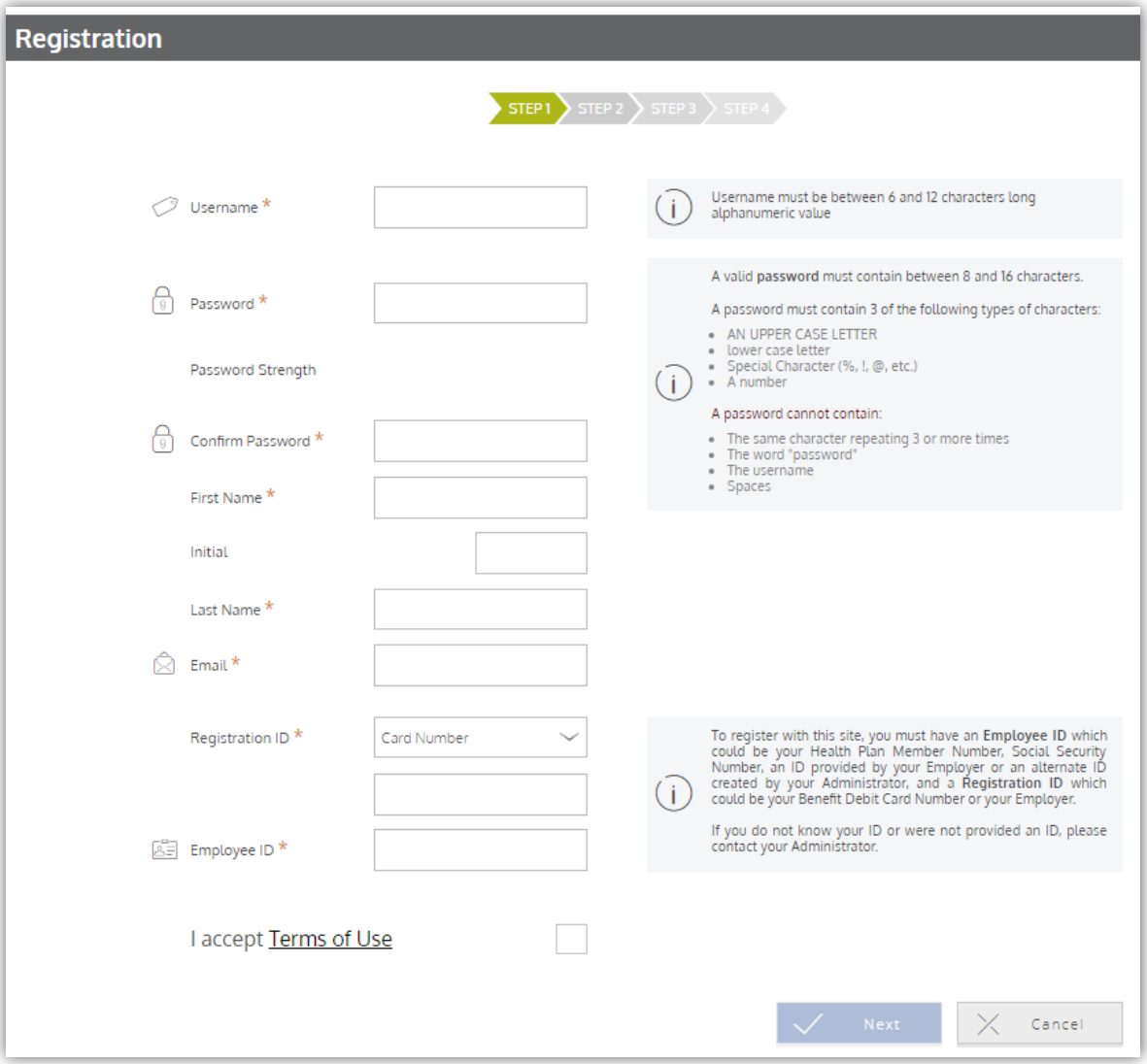
Registering for and logging into your account online is easy. Just follow the instructions below.

1 Get to the website

- Using your Internet browser, navigate to: http://my.nbsbenefits.com
- Click “Register” on the home page. (Highlighted in red below.)

2 Complete the required fields of the registration form

- Username and password
- Personal information - name and email address
- Employee ID: Please enter your **Social Security Number**
- Employer ID OR NBS Benefits Card Number.
  - Employer ID is a 9 digit code given to you in your welcome email from NBS, or may be obtained through your employer or by contacting NBS at (855) 399-3035
- Accept the Terms of Use
- After completing all required fields, click “Register”



Making it Easy

NBS Mobile App

When you're on the go, save time and hassle with the NBS Mobile App.

Submit claims, check your balances, view transactions, and submit documentation using your device's camera.

Easy and secure

- Shares user authentication with the NBS portal. Registered users can download the app and log in immediately to gain access to their benefit accounts, with no need to register their phone or your account.
- No sensitive account information is ever stored on your mobile device and all transmissions use encryption.

Includes virtual assistant 'Emma'

- The first voice-activated intelligent assistant for consumer-driven healthcare.
- Ask Emma questions about your account such as:
  - How much is my account balance?
  - What is the annual contribution limit?
  - Can I change my election amount?

Mobile app features

The NBS mobile app supports a wide variety of features, empowering you to proactively manage your account.

- View account balances
- View claims
- View reimbursement history
- Submit claims
- Submit documentation using your device's camera
- Pay providers
- Setup a variety of SMS alerts
- Edit your personal information
- View contribution details
- View plan information
- View calendar deadlines
- Contact a service representative
- View Benefits Card information
- Eligible Expense Barcode Scanner

Download on the App Store

GET IT ON Google Play

Salt Lake City, UT - Headquarters | Dallas, TX | San Diego, CA | Honolulu, HI
(800) 274-0503 | service@nbsbenefits.com | www.nbsbenefits.com

nbs national benefit services

Manual Claims

Congratulations on your new Benefit with NBS! We look forward to serving you!

With your NBS benefit, paying out of pocket for your qualified medical expenses does not have to be inconvenient. Our simple processes and fast adjudication means you can file within seconds and can receive your reimbursement within 3 business days.

Methods of Filing

- **Your Personal Online Account –** log into your NBS Benefits account, where you can file the claim online.
- **Your Mobile App –** once you have established an online account, the same user name and password grants you access to our mobile app. Filing a manual claim is as easy as taking a picture of your EOB or receipt, filling in a few details about the transactions, and submitting the claim.
- **Email –** you may complete and sign a manual claim form, then email it to us at service@nbsbenefits.com.
- **Fax –** you may complete and sign a manual claim form, then fax it to us at (844) 438-1496.
- **Postal Service –** you may complete and sign a manual claim form, then send it to us at NBS Claims, PO Box 6980, West Jordan, UT 84084.

Manual forms need to be completed in accordance with the instructions on the top of the form. The form must be itemized, signed, and accompanied by the appropriate supporting documentation. If manual claim forms are received incomplete or without proper documentation, we will contact you to request necessary items and your reimbursement will be delayed.

Claim reimbursements are processed daily and will be completed within 2 business days of receipt. Please allow 5-7 business days to receive your reimbursement. To receive your funds faster, sign up for direct deposit through your online account.

If you have questions regarding your Benefit or claim reimbursement, please contact our Service Center to speak with a Customer Representative.

Thank you and Welcome!

Multiple Resources to Help You

Manage Your Account

Does managing your new HSA, FSA, or HRA sound complicated? Don't worry, our dedicated service center is available to help with any of your individual needs including accessing your account or requesting new debit cards.

We look forward to serving you!

Hours of Operation: 6:00 a.m. - 6:00 p.m. MST Mon - Fri
Phone: (800) 274-0503
Fax: (844) 438-1496
Email: service@nbsbenefits.com

Our IVR is accessible 24/7 for account balance information.

For Self-Service

Visit my.nbsbenefits.com

- View account balances
- Access transaction history
- Submit Claims
- Send receipts for debit card transactions
- Pay Providers
- Report and re-issue lost or stolen Benefits Cards

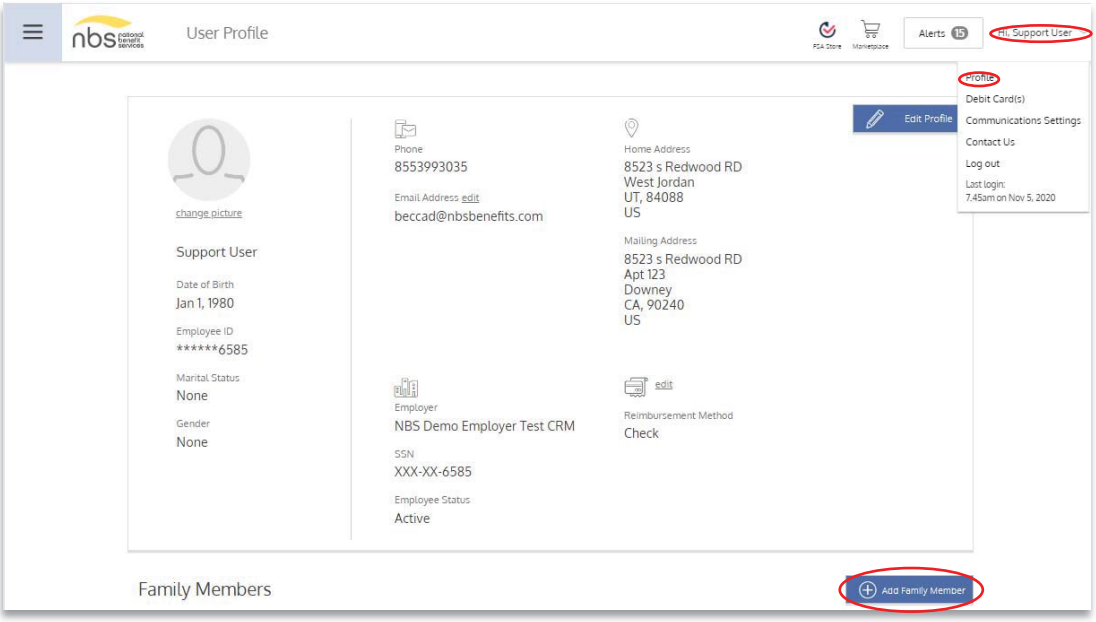
Or download the NBS Mobile App

Download on the App Store

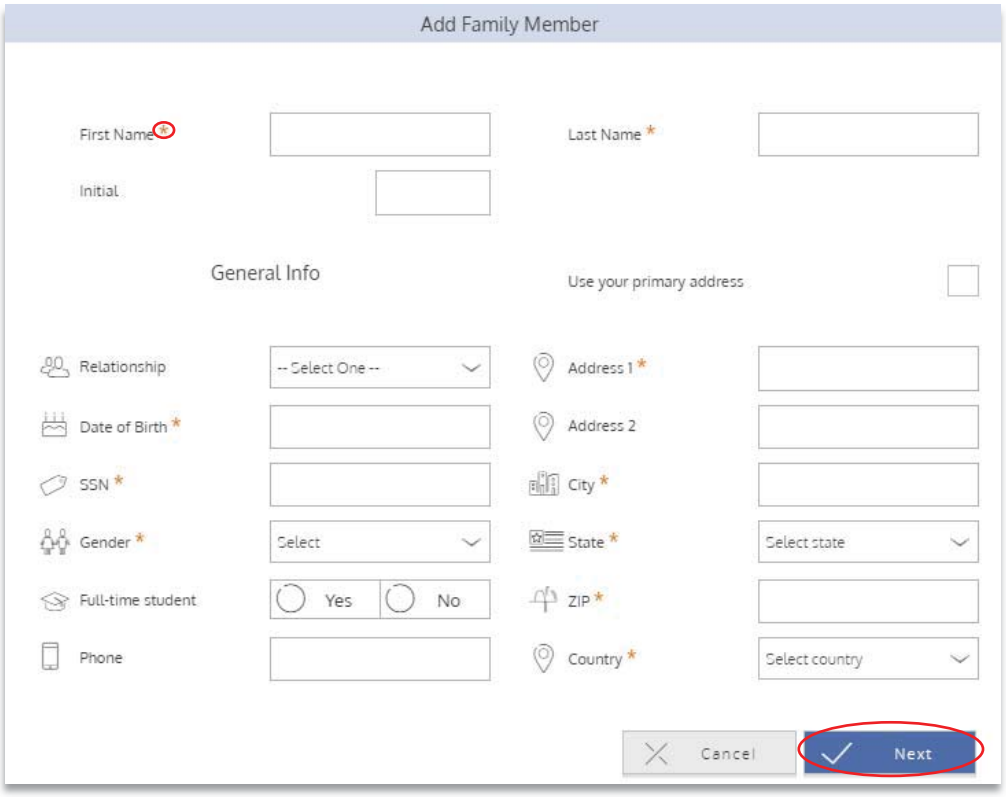
GET IT ON Google Play

How to add a Dependent to your account:

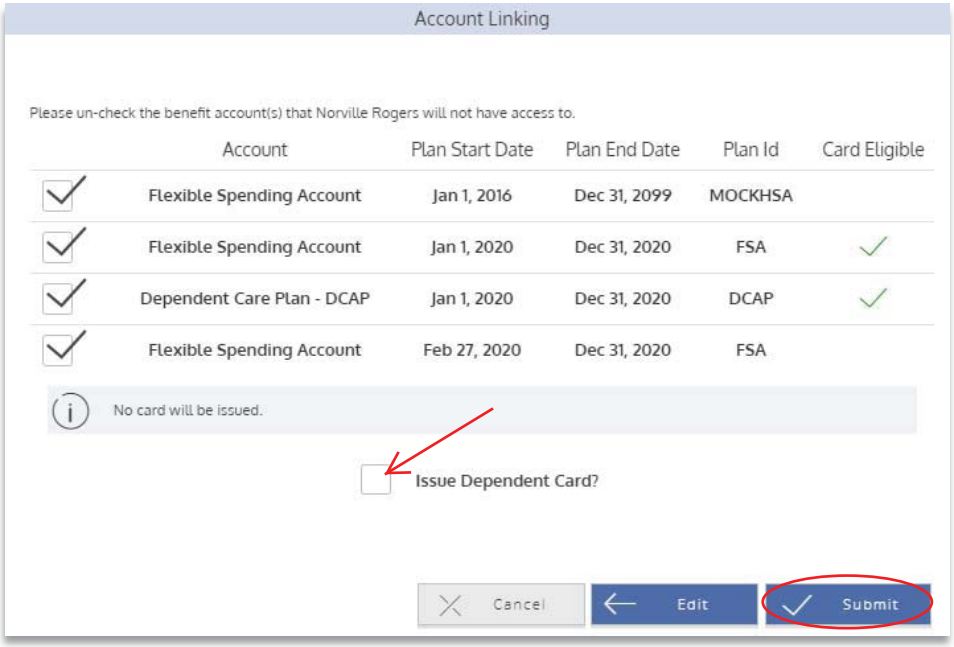
Step 1: Click on your name on the upper right corner of the Personal Dashboard
Step 2: Click on Profile
Step 3: Click on Add Family Member



Step 4: Complete all the required sections (*), then click Next



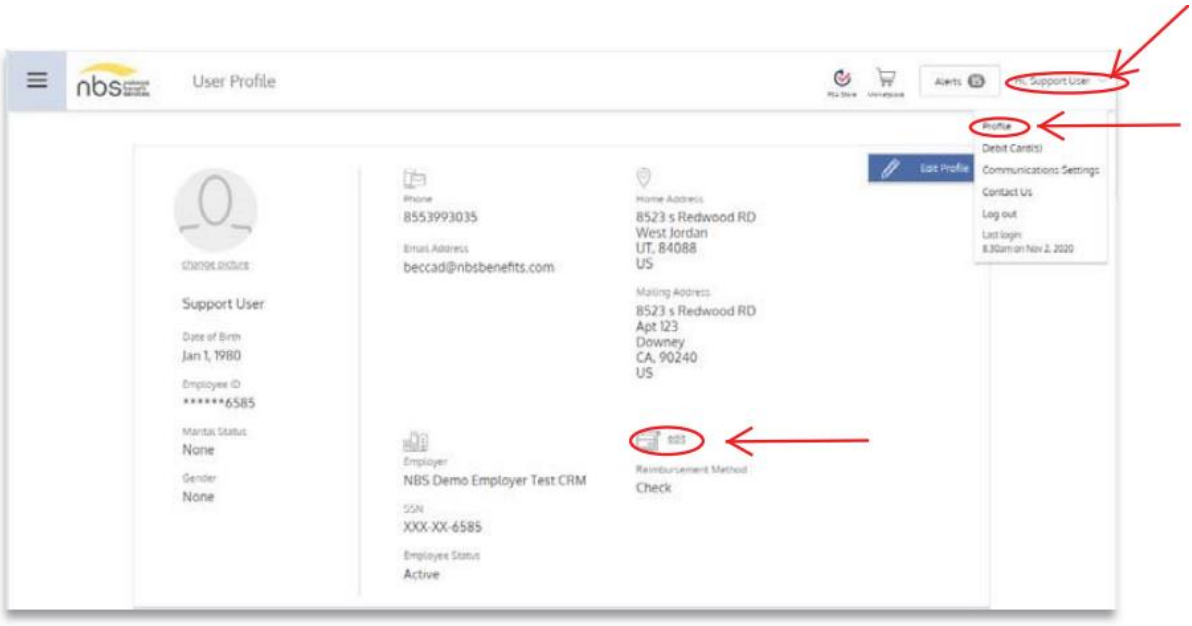
Step 5: Select or De-Select the accounts that you would like to add for this dependent. If you would like to issue a card for them, then check Issue Dependent Card? box. Then click Submit.



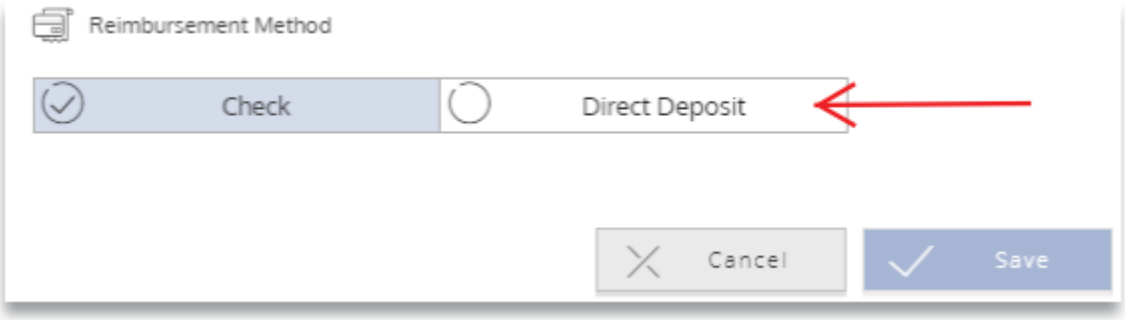
If you have further questions, feel free to reach out to us via phone at 855-399-3035 or email at service@nbsbenefits.com

Adding Direct Deposit Information Online

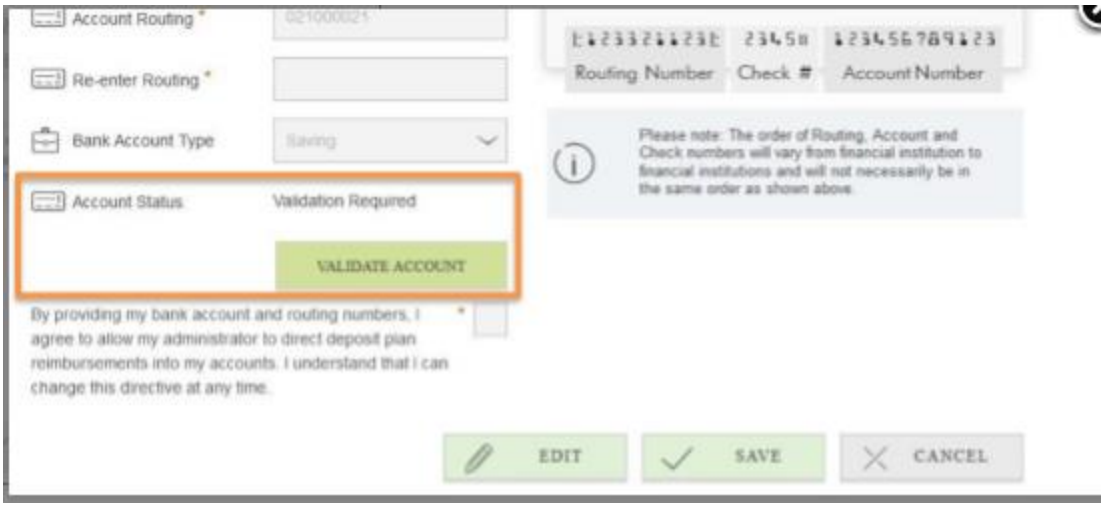
Navigate to the Reimbursement method section of the portal by clicking on the drop down next to your username. Then click Profile followed by Edit above the Reimbursement Method section.

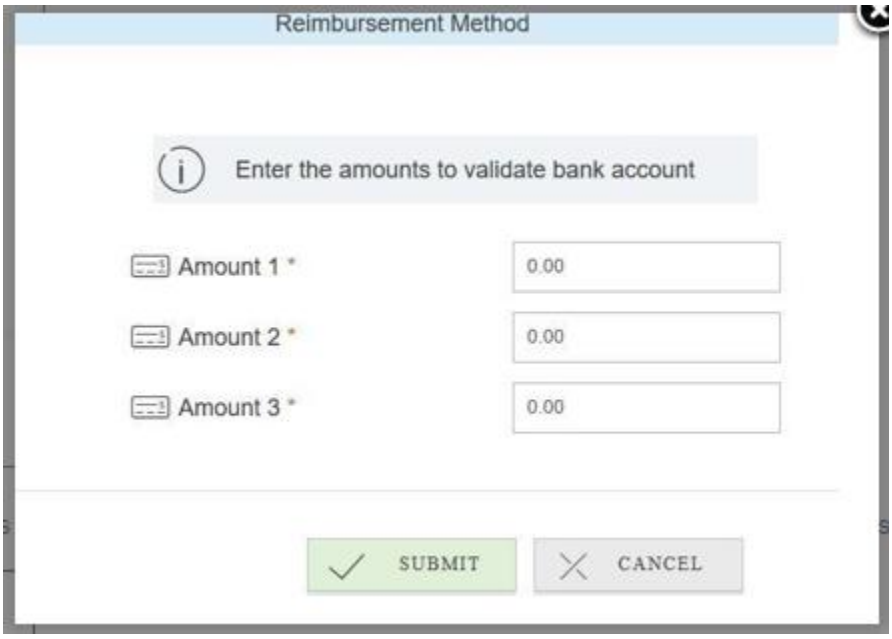


On the popup window, click on Direct Deposit. This will take you to a screen to add your account details.



Please read the terms and conditions, check the Certification box, and then you will need to validate your account. Validation will include two small credits and one offsetting withdrawal to your bank account. You will validate your account by selecting the “Validate Account” box.





Once you enter in the correct amounts you will get a message letting you know that your validation was successful. Your direct deposit account status will then show as active.

If you have further questions, feel free to reach out to us via phone at 855-399-3035 or email at service@nbsbenefits.com

HRA Claim Form

Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must include a date, description, and amount of the service
- Please list one expense per line
- Please print in blue or black ink when using this form
- Please allow 2 business days for claims to be processed

For Account Balance:
Go to my.nbsbenefits.com
or call (855) 399-3035

1 Personal Information

Employee Name (First Name, Last Name) _____ Company Name _____

Street Address _____ City _____ State _____ Zip Code _____ ☐No ☐Yes Address Change?

Phone Number _____ Social Security Number _____

2 HRA Claims

	Date of Service MM	DD	YY	Provider	Service Rendered	Person Receiving Service	Amount
1							
2							
3							
4							
5							
6							
7							
8							
9							

Total Health Care Expense _____

3 Eligible Expenses

Please see your current SPD for a summary of your benefit

4 Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan or claimed as a tax deduction.

Employee Signature _____ Date _____

P.O. Box 6980 West Jordan, UT 84084 • (855) 399-3035 • Fax (844) 438-1496 • service@nbsbenefits.com

Dental

Delta Dental

DELTA DENTAL®

Benefit Summary

GENERAL BENEFIT PLAN SUMMARY

Classic Foods, Inc

Group Number: 2309

Contract Effective Date: 03/01/2024

Benefit Overview	PPO	Premier	Non-Participating
Per Person Deductible Excluding Diagnostic and Preventive services per benefit year	$25	$50	$50
Family Deductible Excluding Diagnostic and Preventive services per benefit year	$75	$150	$150
Maximum Benefit Per eligible person per benefit year	$1,000	$750	$500

Services	You pay the % below		
Preventive & Diagnostic Services Examinations, X-rays, teeth cleaning	0%	0%	20%
Basic Services Fillings, root canals, extractions, oral surgery	20%	40%	60%
Major Services Crowns, implants, onlays, bridges, dentures Late enrollee waiting period is 12 months	50%	100%	100%

PARTICIPATING AND NON-PARTICIPATING DENTISTS

If the dentist is a network participating dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Contract Fee. Delta Dental will send payment to the participating dentist and the subscriber will be responsible for any co-payment and/or any non-covered services.

If the dentist is a non-participating dentist, Delta Dental will base payment on the lesser of the Submitted Amount or Delta Dental's non-participating dentist Fee. It is the subscriber's responsibility to make full payment to the non-participating Dentist. For dental services rendered by an out-of-state dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Contract Fee in that area, if the out-of-state dentist is a participating dentist with a Delta Dental plan in the state in which the service is rendered.

DELTA DENTAL®

Benefits and Limitations

Class I Preventive and Diagnostic Services
Periodic exam is allowed 2 times every calendar year.
Single bitewing x-ray is allowed 1 time every 12 months from last date of service.
Full mouth series or panoramic x-rays are allowed 1 time every 5 years from last date of service .
Adult and child cleanings are allowed 2 times every calendar year (restricts against periodontal maintenance within the same time period).
Fluoride treatment is allowed 2 times every 1 year from last date of service through age 18.
Class II Basic Services
Fillings restricted to same tooth/surface are allowed 1 time every 24 months .
Periodontal surgeries per quadrant are allowed 1 time every 3 years from last date of service .
Periodontal scaling and root planing-per quadrant is allowed 1 time every 24 months from last date of service.
Periodontal maintenance procedure is allowed 4 times every 12 months (if patient has had previously treated periodontal disease).
Class III Major Restorative Services
Porcelain, porcelain substrate, and cast restorations are not payable for children less than 12 years of age.
Crowns, stainless steel crowns, onlays, or bridges on same tooth are allowed 1 time every 7 years from last date of service .
Partials or dentures per arch are allowed 1 time every 7 years from last date of service for ages 16 and older.
Implants
Implants are a covered benefit per tooth with a maximum lifetime benefit of $1,200 or the plan's annual maximum, whichever is less. Ages 19 and over.
Dependents
Eligible children must be under age 26.

GENERAL PLAN INFORMATION

1. Optional treatment: If the subscriber or eligible dependent selects a more expensive service than is customarily provided. For example, if teeth can be restored satisfactorily with amalgam or composite material, the cost of inlays, onlays and crowns are not covered and the cost difference between the covered and the non-covered procedure is to be borne by the patient.
2. Payment provisions: The following guidelines will be used to determine the date on which a service shall be paid:
   a. Full dentures or partial dentures: On the date the final impression is taken.

   b. Fixed bridges, crowns, and onlays: On the date the tooth or teeth are prepared.
   c. Root canal therapy: On the date the root canal is initiated.
3. Processing Policies may limit benefits. Processing Policies applied to a claim are noted on the Explanation of Benefits (EOB).
4. Predeterminations: If your dental treatment involves services of $300 or greater, it is advisable to ask your dentist to submit a predetermination of benefits. A statement will be sent to you and your dentist estimating the amount of Delta Dental payment obligation and the amount that you will owe. These estimates will be subject to your continuing eligibility in the plan and the group contract remaining in effect. If claims for other completed dental services are received and processed prior to the completion date of the proposed treatment, this may reduce Delta Dental's estimated payment for the proposed treatment and increase your obligation to the dentist. Predeterminations are valid for ninety (90) days from the date issued by Delta Dental.

WHAT SERVICES ARE NOT COVERED?

No payment will be made by Delta Dental and all charges for the following services will be the responsibility of the subscriber:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Benefits or services that are available from any government agency, political subdivision, community agency, foundation, or similar entity. This provision does not apply to any programs provided under Title XIX Social Security Act, i.e., Medicaid.
2. Service for cosmetic surgery, or dentistry for aesthetic reasons, unless specified otherwise in Benefits and Limitations section above.
3. Services or appliances started before an individual became eligible under the contract.
4. Prescription drugs, pre-medications and/or relative analgesia. General anesthesia and/or intravenous sedation other than for covered oral surgery. Charges for hospitalization, laboratory tests, and examinations and any additional fees charged by the dentist for hospital treatment.
5. Preventive control programs, including home care items.
6. Charges for failure to keep a scheduled visit with the dentist.
7. Repair, relines, or adjustments of occlusal guards.
8. Charges for completion of forms. A participating dentist may not make these charges to a subscriber or eligible dependent.
9. Prosthodontic services (Class III benefits), unless specified as a covered service in the Benefit Summary.
10. Orthodontic services (Class IV benefits), unless specified as a covered service in the Benefit Summary.
11. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances.
12. Services for which no valid dental need can be demonstrated, that are specialized techniques, or that are experimental in nature as determined by the standards of generally accepted dental practice.
13. Appliances, surgical procedures, and restorations for increasing vertical dimension; for restoring occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion. If orthodontic benefits have been selected under this contract, this exclusion will not apply to the orthodontic services.
14. Treatment by other than a dentist, except for services performed by a licensed dental hygienist or denturist within the scope of his or her license.
15. Processing Policies may limit benefits. Processing Policies applied to a claim are noted on the Explanation of Benefits (EOB).
16. Services or supplies for which no charge is made, or for which the patient is not legally obligated to pay. This includes services or supplies furnished by a dentist who is related to the patient by blood or who is related to the patient by blood or marriage and who ordinarily dwells in the patient's household, the dentist providing service to him/her self, or services which would not have a charge in the absence of Delta Dental coverage.

17. Services or supplies received as a result of defect, or injury due to an act of war, declared or undeclared.
18. Services that are covered under a hospital, surgical/medical, or prescription drug program.
19. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
20. Myofunctional therapy.
21. Delta Dental is not obligated to pay claims received more than 12 months after the date of service.
22. Nutritional counseling, tobacco counseling and oral hygiene instruction are not covered benefits except for participants in Delta Dental's Health through Oral Wellness® (HOW®) program.

This is only a general summary of benefits. It provides a brief description about the important features of this policy and does not constitute a contract or guarantee of payment. Full terms and conditions are set forth in the policy provisions. If you have any questions about your plan's benefits or would like to submit a predetermination before services are performed, please call Delta Dental of Idaho customer service advisors at (208) 489-3580 or toll-free at (800) 356-7586. You may also log onto our website, www.deltadentalid.com, for benefit and eligibility information or up-to-date claim status.

Vision

Blue Cross

Vision Plan

Focus $130 (VS3) 01/24

HEALTHY SIGHT FOCUS $130 (CIII)
VISION CARE BENEFITS (VCSV)
BENEFITS OUTLINE

*The Participating Provider is responsible for verifying benefits with the VCSV prior to rendering services. An Insured must provide the Participating Provider sufficient information to verify eligibility. Failure of the Insured to provide sufficient information may delay services and may affect benefit payment under this Policy.

For Covered Providers and Services **Copayment**	Insured pays $0 per eye exam and/or $25 per Frame and Lenses or Medically Necessary Contact Lenses.
Service Frequency Limitations	Insured may receive: • one (1) eye exam every twelve (12) months. • one (1) pair of Lenses or one (1) pair of Medically Necessary Contact Lenses (in lieu of eyeglasses) or one (1) pair of Elective Contact Lenses (in lieu of eyeglasses) every twelve (12) months. • one (1) Frame every twelve (12) months.

In-Network Services (*Participating Providers)
Payment for Services Rendered and Allowances:

Exam—Insured pays Copayment, as applicable, then BCI pays 100% of Maximum Allowance

Prescription Glasses—Insured pays Copayment, as applicable, then BCI pays 100% of Maximum Allowance for Basic Lenses and Medically Necessary Contact Lenses (in lieu of glasses). Includes Frame allowance of $130.

Elective Contact Lenses—Includes a Contact Lens fitting and evaluation and $130 allowance for materials in place of benefits for Prescribed Lenses and Frame.

Out-of-Network Services (Nonparticipating Providers)
Reimbursement Allowances

Professional Fees
Eye Exam: BCI pays up to $45
Materials—Lenses per pair
Frame: BCI pays up to $47
Single Vision Lenses: BCI pays $45
Lined Bifocals Lenses: BCI pays up to $65
Lined Trifocals Lenses: BCI pays up to $90
Progressives Lenses: BCI pays up to $90

Contact Lenses per pair: $120
Medically Necessary, up to Maximum Allowance: $210
Elective Contact Lenses—includes a Contact Lens fitting and evaluation and an allowance for materials in place of benefits for Prescribed Lenses and Frame.

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

Premiums

Premiums Class 1

Medical

Blue Cross of Idaho

Class 1 Silver Choice PPO $4,500 (Including Vision)				
Status	Total Premium Per Month	Employer Contribution Per Month	Employee Cost Per Month	Employee Cost Per Paycheck (26)
Employee	$489.86	$553.37	$61.49	$28.38
Employee & Spouse	$979.72	$1,106.75	$122.97	$56.76
Employee + Children	$926.86	$1,047.92	$116.44	$53.75
Family	$1,416.72	$1,601.30	$177.92	$82.12

Dental

Delta Dental

Class 1 PPO / Premier Provider Network				
Status	Total Premium Per Month	Employer Contribution Per Month	Employee Cost Per Month	Employee Cost Per Paycheck (26)
Employee	$38.24	$33.74	$3.75	$1.73
Employee + Spouse	$75.22	$66.37	$7.38	$3.41
Employee + 1 Child	$68.61	$60.53	$6.73	$3.11
Employee + Children	$117.93	$104.05	$11.57	$5.34
Family	$154.97	$136.74	$15.19	$7.01

Premiums Class 2

Medical

Blue Cross of Idaho

Class 2 Silver Choice PPO $4,500 (Including Vision)				
Status	Total Premium Per Month	Employer Contribution Per Month	Employee Cost Per Month	Employee Cost Per Paycheck (26)
Employee	$489.86	$491.89	$122.97	$56.76
Employee & Spouse	$979.72	$737.83	$491.89	$227.03
Employee + Children	$926.86	$711.69	$452.67	$208.93
Family	$1,416.72	$957.63	$821.59	$379.20

Dental

Delta Dental

Class 2 PPO / Premier Provider Network				
Status	Total Premium Per Month	Employer Contribution Per Month	Employee Cost Per Month	Employee Cost Per Paycheck (26)
Employee	$38.24	$29.99	$7.49	$3.46
Employee + Spouse	$75.22	$44.50	$29.25	$13.50
Employee + 1 Child	$68.61	$41.91	$25.35	$11.70
Employee + Children	$117.93	$61.25	$54.37	$25.10
Family	$154.97	$75.78	$76.15	$35.15

Premiums Class 3

Medical

Blue Cross of Idaho

Class 3 Silver Choice PPO $4,500 (Including Vision)				
Status	Total Premium Per Month	Employer Contribution Per Month	Employee Cost Per Month	Employee Cost Per Paycheck (26)
Employee	$489.86	$491.89	$122.97	$56.76
Employee & Spouse	$979.72	$491.89	$737.83	$340.54
Employee + Children	$926.86	$491.89	$672.47	$310.37
Family	$1,416.72	$491.89	$1,289.33	$595.08

Dental

Delta Dental

Class 3 PPO / Premier Provider Network				
Status	Total Premium Per Month	Employer Contribution Per Month	Employee Cost Per Month	Employee Cost Per Paycheck (26)
Employee	$38.24	$29.99	$7.50	$3.47
Employee + Spouse	$75.22	$29.99	$43.76	$20.20
Employee + 1 Child	$68.61	$29.99	$37.27	$17.21
Employee + Children	$117.93	$29.99	$85.63	$39.53
Family	$154.97	$29.99	$121.94	$56.28


GBS
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