Regence BlueCross BlueShield of Utah Policy

Individual Group Number: 38004001

2018 Medical Benefit

NONDISCRIMINATION NOTICE

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

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

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

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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 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 http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

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

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

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

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

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

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

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

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

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (**መስማት ለተሳናቸው**:- 711)**::**

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)

SCHEDULE OF BENEFITS

Silver 3000 EPO

This Schedule of Benefits provides You with information regarding Your costs for Covered Services and how Provider choice affects Your out-of-pocket costs. This Schedule of Benefits is part of Your Policy. Please read the entire Policy to understand the benefits, limitations, exclusions, defined terms and provisions of this Policy.

	Insured Responsibility In-Network Provider Only
Coinsurance	30%
Deductible per Calendar Year	$3,000 per Insured $6,000 per Family
Out-of-Pocket Maximum per Calendar Year	$7,350 per Insured $14,700 per Family

EXCLUSIVE PROVIDERS

Be aware that this Plan requires You to receive Covered Services from In-Network Providers. There is no coverage for Out-of-Network Providers except for Covered Services as specified below. When permitted services are received from Out-of-Network Providers, the Insured is responsible for paying the difference between the amount billed by the Out-of-Network Provider and the Allowed Amount. Rural Residents are entitled to Out-of-Network Covered Services by an Independent Hospital, a Credentialed Staff Member at an Independent Hospital or his Local Practice Location, or a Federally Qualified Health Center, as further described in the Policy and Claims Administration Section.

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies	
Benefit	**Insured Responsibility In-Network Provider Only**
Office or Urgent Care Facility Visits – Illness or Injury • The Copayment applies until the Out-of-Pocket Maximum is met.	Primary Physician or Practitioner – $20 Copayment, Deductible waived Specialist (including urgent care facility) – $60 Copayment, Deductible waived
Preventive Care and Immunizations	0%, Deductible waived
Other Professional Services	30%
Ambulance Services • Out-of-Network services are covered and apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum.	30%
Ambulatory Surgical Center	20%
Autism Spectrum Disorder Services	30%
Blood Bank • Out-of-Network services are covered and apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum.	30%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies	
Benefit	**Insured Responsibility In-Network Provider Only**
Cardiac and Pulmonary Rehabilitation – Outpatient • 5 visits combined per Calendar Year	30%
Clotting Factor Products – Outpatient	30%
Detoxification	30%
Diabetic Education	0%, Deductible waived
Dialysis – Inpatient	30%
Dialysis – Outpatient Initial Outpatient Treatment Period • Services for the initial outpatient treatment period of 120 days for hemodialysis, peritoneal dialysis and hemofiltration services. • Out-of-Network services are covered and apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum.	30%
Dialysis – Outpatient Supplemental Outpatient Treatment Period for Dialysis (Following Initial Outpatient Treatment Period) • If Our agreement with the Provider expressly specifies that its terms supersede the benefits (or this benefit) of this Policy, We pay 100% of the Allowed Amount. Otherwise, We pay 125% of the Medicare allowed amount at the time of service. • Out-of-Network services are covered and apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum.	0%
Durable Medical Equipment • Additional limitations apply, refer to the Durable Medical Equipment Appendix.	30%
Emergency Room • Out-of-Network Provider services are covered the same as In-Network Provider services.	30%
Family Planning	30%
Habilitation Services • 30 inpatient days per Calendar Year • 20 outpatient combined visits per Calendar Year	30%
Home Health Care • 30 visits per Calendar Year	30%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies	
Benefit	**Insured Responsibility In-Network Provider Only**
Hospice Care • 14 inpatient or outpatient respite days per Lifetime	30%
Hospital Care – Inpatient and Outpatient	30%
Maternity Care/Adoption Benefit • $4,000 per pregnancy for adoption expenses	30%
Medical Foods (PKU)	30%
Mental Health or Substance Use Disorder Services	30%
Newborn Care	30%
Nutritional Counseling • Limited to nutritional counseling and therapy for diabetic counselling only.	30%
Palliative Care • 30 visits per Calendar Year	30%
Prescription Medications – Pharmacy • **Nonparticipating Pharmacies are not covered** • Copayment is based on each 30-day supply • *$5 or 5% discount on Prescription Medications filled at a Preferred Pharmacy. • 30-day supply for Specialty Medications • 90-day supply for Prescription Medications (even if the packaging includes a larger supply) • Multiple-month dispensing: the largest allowed quantity is the smallest multiple-month supply as packaged by the manufacturer. • **Nonparticipating Specialty Pharmacies are not covered** • For Specialty Medications (including those on the Specialty Select Drug List) to be covered after the initial fill, they must be filled at a Specialty Pharmacy. However, some Specialty Medications must have the first and subsequent fills at a Specialty Pharmacy.	*$10 Copayment, Deductible waived for each Preferred Generic Medication on the Essential Formulary
	*25%, Deductible waived for each Non-Preferred Generic Medication on the Essential Formulary
	*30% for each Preferred Brand-Name Medication on the Essential Formulary
	*50% for each Non-Preferred Brand-Name Medication on the Essential Formulary
	40% for each Preferred Specialty Medication on the Essential Formulary from a Specialty Pharmacy
	50% for each Non-Preferred Specialty Medication on the Essential Formulary from a Specialty Pharmacy
	30% for each Self-Administrable Cancer Chemotherapy Medication on the Essential Formulary; refer to Policy for Special Provisions for a Cancer Drug Treatment Regimen
Prescription Medications – Mail-Order Supplier • **Nonparticipating Mail-Order Suppliers are not covered**	$20 Copayment, Deductible waived for each Preferred Generic Medication on the Essential Formulary
	20%, Deductible waived for each Non-Preferred Generic Medication on the Essential Formulary

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies	
Benefit	**Insured Responsibility In-Network Provider Only**
• 90-day supply for Prescription Medications (even if the packaging includes a larger supply) • Multiple-month dispensing: the largest allowed quantity is the smallest multiple-month supply as packaged by the manufacturer.	25% for each Preferred Brand-Name Medication on the Essential Formulary
	45% for each Non-Preferred Brand-Name Medication on the Essential Formulary
	30% for each Self-Administrable Cancer Chemotherapy Medication on the Essential Formulary; refer to Policy for Special Provisions for a Cancer Drug Treatment Regimen
Prosthetic Devices • Artificial prosthetic eye prosthetics limited to once every 5 years per site	30%
Rehabilitation Services • 30 inpatient days per Calendar Year combined with Skilled Nursing Facility services • 20 outpatient combined visits per Calendar Year	30%
Skilled Nursing Facility (SNF) Services • 30 inpatient days per Calendar Year combined with inpatient Rehabilitation Services	30%
Spinal Manipulations • 10 spinal manipulations per Calendar Year	30%
Telehealth	$10 Copayment, Deductible waived
Telemedicine	30%
Termination of Pregnancy	30%
Transplants	30%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit – Pediatric Dental (under age 19)	**Insured Responsibility**	
	Participating Dentist	**Nonparticipating Dentist**
Preventive and Diagnostic Services • Additional limitations apply, refer to the Medical Benefits Section.	0%, Deductible waived	0%, Deductible waived

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit – Pediatric Vision (under age 19)	**Insured Responsibility**	
	VSP Doctor	**Out-of-Network Provider**
• 1 routine eye examination per Calendar Year • 1 frame per Calendar Year • 1 pair of lenses (2 lenses) per Calendar Year • Contacts may be selected (once per Calendar Year) instead of frames and lenses • Low vision supplemental testing and supplemental aids every 2 Calendar Years • Coinsurance amounts for Out-of-Network Providers do not accrue to the Out-of-Pocket Maximum. • Additional limitations apply, refer to the Medical Benefits Section.	Examination – 0%, Deductible waived	Examination – 25%, Deductible waived
	Otis and Piper Collection Frames – 0%, Deductible waived	Frames – 25%, Deductible waived
	Lenses – 0%, Deductible waived	Lenses – 25%, Deductible waived
	Contact Lens Evaluation and Fitting Examination – 0%, Deductible waived	Contact Lens Evaluation and Fitting Examination – 25%, Deductible waived
	Low Vision Supplemental Testing – 0%, Deductible waived	Low Vision Supplemental Testing – 25%, Deductible waived
	Low Vision Supplemental Aids – 0%, Deductible waived	Low Vision Supplemental Aids – 25%, Deductible waived

Additional Benefit - Refer to this Policy for details on this program
Accidental Death Benefit

Introduction

Regence BlueCross BlueShield of Utah

Street Address:
2890 East Cottonwood Parkway
Salt Lake City,UT 84121

Medical/Pediatric Dental Claims Address:
P.O. Box 30272
Salt Lake City,UT 84130-0272

Pediatric Vision Claims Address:
Vision Service Plan
P.O. Box 385020
Birmingham, AL 35238-5020

Medical/Pediatric Dental Customer Service/Correspondence Address:
P.O. Box 1827, MS CS B32B
Medford, OR 97501-9884

Pediatric Vision Customer Service/Correspondence Address:
Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100

Medical/Pediatric Dental Appeals Address:
P.O. Box 1408
Lewiston, ID 83501
Pediatric Vision Appeals Address:
Vision Service Plan
Attention: Complaint and Grievance Unit
P.O. Box 997100
Sacramento, CA 95899-7100

As You read this Policy, please keep in mind that references to "You" and "Your" refer to both the Policyholder and Enrolled Dependents. The terms "We," "Us" and "Our" refer to Regence BlueCross BlueShield of Utah and the term "Policyholder" means a person who is enrolled for coverage under a Regence BlueCross BlueShield of Utah health insurance Policy, and whose name appears on the records of Regence BlueCross BlueShield of Utah as the individual to whom this Policy was issued. Policyholder does not mean a dependent under this Policy. Other terms are defined in the Definitions Section at the back of this Policy or where they are first used and are designated by the first letter being capitalized.

POLICY

This Policy describes benefits effective **December 1, 2018**, for the Policyholder and Enrolled Dependents. This Policy provides the evidence and a description of the terms and benefits of coverage.

Regence BlueCross BlueShield of Utah, an independent licensee of the Blue Cross and Blue Shield Association domiciled in Utah, agrees to provide benefits for Medically Necessary services as described in this Policy, subject to all of the terms, conditions, exclusions and limitations in this Policy, including endorsements affixed hereto. This agreement is in consideration of the premium payments hereinafter stipulated and in further consideration of the application and statements currently on file with Us and signed by the Policyholder for and on behalf of the Policyholder and/or any Enrolled Dependents listed in this Policy, which are hereby referred to and made a part of this Policy.

GUARANTEED RENEWABILITY OF POLICY

This Policy is renewable at the option of the Policyholder upon payment of the monthly premium when due or within the grace period, except in cases of intentional misrepresentation of material fact or fraud in connection with the coverage, Our decision to cease offering this Policy to individual Policyholders, or Our decision to cease offering coverage in the individual market. No modification or amendment will be effective until 30 days (or longer, as required by law) after written notice has been given to the Policyholder (except for modification of premium, which shall not be effective until 45 days after written notice has been given to the Policyholder), and modification must be uniform within the product line and at the time of renewal. Please refer to the Guaranteed Renewability and Policy Termination and the Modification of Policy provisions for details.

EXAMINATION OF POLICY

If, after examination of this Policy, the Policyholder is not satisfied for any reason with this Policy, the above named Policyholder will be entitled to return this Policy within 10 days after its delivery date. If the Policyholder returns this Policy to Us within the stipulated 10-day period, such Policy will be considered void as of the original Effective Date and the Policyholder generally will receive a refund of premiums paid, if any. (If benefits already paid under this Policy exceed the premiums paid by the Policyholder, We will be entitled to retain the premiums paid and the Policyholder will be required to repay Us for the amount of benefits paid in excess of premiums.)

ESSENTIAL HEALTH BENEFITS

This coverage complies with the essential health benefits in the following ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitation and habilitation services and devices; laboratory services; preventive and wellness services including chronic disease management; and pediatric services, including oral and vision care. There is no annual or Lifetime maximum applicable to these services.

OPEN ENROLLMENT PERIOD

The open enrollment period is the period of time, as designated by law, during which You and/or Your eligible dependents may enroll.

NOTICE OF PRIVACY PRACTICES

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

CONTACT INFORMATION

If You have questions, would like to learn more about Your Policy or would like to request written or electronic information regarding any other plan that We offer, talk with one of Our Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. – 6 p.m. Pacific Time.

Customer Service: 1 (888) 231-8424
(TTY: 711)

Or visit Our Web site at: **regence.com**

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

Pediatric Vision Services. If You have Provider or benefit questions specific to Your pediatric vision coverage, call Vision Service Plan (VSP) at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance), Monday-Friday 5 a.m. – 8 p.m.; Saturday 7 a.m. – 8 p.m.; and Sunday 7 a.m. – 7 p.m. You may also visit VSP's Web site at **www.vsp.com**.

BlueCard® Program. You have limited access to care through the BlueCard Program, which enables You to access Hospitals and Physicians when traveling outside the four-state area Regence BlueCross BlueShield of Utah serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Such access is further described in the Out-of-Area Services provision of

this Policy. You can also contact Customer Service to learn about access to care through the BlueCard Program.

James Swayze
President
Regence BlueCross BlueShield of Utah

Using Your Policy

YOUR PARTNER IN HEALTH CARE

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

EXCLUSIVE PROVIDERS

Except for those Covered Services specified for Out-of-Network Providers in the Medical Benefits Section or the Schedule of Benefits, this Policy requires that You receive Covered Services from In-Network Providers. An exception for Rural Residents is described in the Policy and Claims Administration Section. You can go to Our Web site for further Provider network information.

ADDITIONAL MEMBERSHIP ADVANTAGES

When You purchased this Policy, You were provided with more than just great coverage. You also acquired Regence membership, which offers additional valuable services. The advantages of Regence membership include access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to **regence.com**, an interactive environment that can help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE INDIVIDUAL POLICY, BUT ARE NOT INSURANCE.**

- **Go to regence.com.** It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar. Have Your member card handy to log on. Use the secure member Web site to:
    - view recent claims, benefits and coverage;
    - find a contracting Provider;
    - participate in online wellness programs and use tools to estimate upcoming healthcare costs;
    - discover discounts on select items and services*;
    - identify Participating Pharmacies;
    - find alternatives to expensive medicines;
    - learn about prescriptions for various Illnesses; and
    - compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by this Policy, that also may create savings for Us. Any such discounts or coupons are complements to the individual Policy, but are not insurance.

Table of Contents

Understanding Your Benefits

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

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

MAXIMUM BENEFITS

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

DEDUCTIBLES

We will begin to pay benefits for Covered Services in any Calendar Year only after an Insured satisfies any applicable Calendar Year Deductible. An Insured satisfies the Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible.

The Family Calendar Year Deductible is satisfied when some or all covered Family members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount. One Insured may not contribute more than the individual Deductible amount.

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

COPAYMENTS

A Copayment means a fixed dollar amount that You must pay directly to a provider of services or supplies, including medications or, each time You receive a specified service or medication (as applicable). The Copayment will be the lesser of the fixed dollar amount or the Allowed Amount for the service or medication. Refer to the Schedule of Benefits to understand what Copayments You may be responsible for.

PERCENTAGE PAID UNDER THIS POLICY (COINSURANCE)

Once You have satisfied any applicable Deductible and any applicable Copayment, We pay a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When Our payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). Your Coinsurance will be based upon the lesser of the billed charges or the Allowed Amount. The percentage We pay varies, depending on the kind of service or supply You received and who rendered it.

We do not reimburse Providers for charges above the Allowed Amount. However, an In-Network Provider will not charge You for any balances for Covered Services beyond Your applicable Deductible, Copayment and/or Coinsurance amount. We do not cover services provided by Out-of-Network Providers, except as specified in the Medical Benefits Section or the Schedule of Benefits. For eligible Covered Services received from an Out-of-Network Provider, the Out-of-Network Provider may bill You for any balances over Our payment level in addition to any Deductible, Copayment and/or Coinsurance amount. See the Definitions Section for descriptions of Providers.

OUT-OF-POCKET MAXIMUM

You can meet the Out-of-Pocket Maximum by payments of any Deductible, Copayments and Coinsurance as specifically indicated in the Schedule of Benefits. An Insured's payment of any Deductible, Copayments and Coinsurance for Covered Services listed in the Schedule of Benefits will apply toward the Out-of-Pocket Maximum amount. Any amounts You pay for non-Covered Services, Out-of-Network Pediatric Vision Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach any applicable Out-of-Pocket Maximum.

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

The Family Out-of-Pocket Maximum for a Calendar Year is satisfied when some or all Family members' Deductibles, Copayments and Coinsurance for Covered Services for that Calendar Year total and meet the Family Out-of-Pocket Maximum amount. One Insured may not contribute more than the individual Out-of-Pocket Maximum amount. One Insured may not contribute more than the individual In-Network Out-of-Pocket Maximum amount.

HOW CALENDAR YEAR BENEFITS RENEW

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

Some benefits in this Policy have a separate Maximum Benefit based upon an Insured's Lifetime and do not renew every Calendar Year. Those exceptions are specifically noted in the Schedule of Benefits.

Medical Benefits

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

All covered benefits are subject to the limitations, exclusions and provisions of this Policy. In some cases, We may limit benefits or coverage to a less costly and Medically Necessary alternative item. To be covered, medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Also, a Provider practicing within the scope of his or her license must render the service. **Additionally, only those services specified as covered for Out-of-Network Providers in this Medical Benefits Section or the Schedule of Benefits can be received from Out-of-Network Providers.** Please see the Definitions Section in the back of this Policy for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

Reimbursement may be available under Your Policy for some medical supplies, equipment and devices You purchase from a Provider or from an approved Commercial Seller, even though that seller is not a Provider. Medical supplies, equipment and devices, such as a breast pump or wheelchair, purchased through an approved Commercial Seller are covered at the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item or the retail market value for that item. To learn more about how to access reimbursable retail medical supplies, equipment and devices, please visit Our Web site or contact Customer Service.

NOTE: If You choose to access medical supplies, equipment and devices through Our Web site, We may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are a complement to Your individual Policy, but are not insurance.

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

OFFICE OR URGENT CARE FACILITY VISITS – ILLNESS OR INJURY

When Your office visit is performed by a Primary Physician or Practitioner, Your out-of-pocket expenses will be lower. On the other hand, when Your office visit is performed by a Specialist or at an urgent care facility, Your out-of-pocket expenses will be higher. See the Definitions Section at the back of this Policy for a description of Primary Physician or Practitioner and Specialist. For In-Network office or urgent care facility visits, You will not be responsible for any Coinsurance. The Copayment applies to In-Network office or urgent care facility visits in the office, home or Hospital outpatient department only.

PREVENTIVE CARE AND IMMUNIZATIONS

We cover preventive care services provided by a professional Provider or facility such as:

- routine well-baby care, routine physical examinations, routine well-women's care and routine health screenings;
- nutritional counseling and Provider counseling and Prescription Medications prescribed for tobacco use cessation. See the Prescription Medications benefit in this Policy for a description of how to obtain Prescription Medications;
- immunizations for adults and children according to, and as recommended by, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- one non-Hospital grade breast pump (including its accompanying supplies) per pregnancy at the In-Network benefit level when obtained from a Provider (including a Durable Medical Equipment supplier). Alternatively, a comparable breast pump may be obtained from an approved Commercial Seller in lieu of a Provider. Benefits for a comparable breast pump obtained from an approved Commercial Seller will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value; and

- United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods for women in accordance with HRSA recommendations. These include female condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products), intrauterine devices (both copper and those with progestin), implantable contraceptive rod, surgical implants and surgical sterilization.

Benefits will be covered under this Preventive Care and Immunizations benefit, not any other provision in this Policy, if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). In the event any of these bodies adopts a new or revised recommendation, this plan has up to one year before coverage of the related services must be available and effective under this benefit. For a list of services covered under this benefit, including information about obtaining a breast pump from an approved Commercial Seller, please visit Our Web site or contact Customer Service.

NOTE: Covered Services that do not meet these criteria will be covered the same as any other Illness or Injury. In addition, covered expenses do not include immunizations if the Insured receives them only for the purpose of travel, occupation or residency in a foreign country.

OTHER PROFESSIONAL SERVICES

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

Medical Services and Supplies

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

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

Professional Inpatient

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

Radiology and Laboratory

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

Diagnostic Procedures

We cover services for diagnostic procedures including cardiovascular testing, pulmonary function studies, stress tests and neurology/neuromuscular procedures.

Surgical Services

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

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

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

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

AMBULATORY SURGICAL CENTER
We cover outpatient services and supplies of an Ambulatory Surgical Center (including services of staff Providers) for Injury and Illness.

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

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

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

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

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

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

- An Investigational item, device or service that is the subject of the Approved Clinical Trial;
- Items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Insured; or

- A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

AUTISM SPECTRUM DISORDER SERVICES

We cover services for Autism Spectrum Disorder such as diagnosis (including assessments, evaluations or tests) and treatment (including Applied Behavioral Analysis, Behavioral Health, Pharmacy Care, psychiatric care, psychological care, or Therapeutic Care, and related equipment).

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Autism Spectrum Disorder Services benefit:

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorder means pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Behavioral Health means counseling and treatment programs, including Applied Behavior Analysis, that are: necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and provided or supervised by a: board certified behavior analyst; or a person licensed under state law, whose scope of practice includes mental health services.

Pharmacy Care means health-related services to determine the need or effectiveness of Prescription Medications. For coverage of Prescription Medications, refer to the Prescription Medications benefit in this Policy.

Therapeutic Care means services provided by duly licensed or certified speech therapists, occupational therapists, or physical therapists.

BLOOD BANK

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

CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT

We cover Medically Necessary phase II (short-term outpatient) cardiac and pulmonary rehabilitation services associated with a cardiac rehabilitation exercise program. We do not cover phase III (long-term outpatient) and phase IV (outpatient fitness) services.

CLOTTING FACTOR PRODUCTS – OUTPATIENT

We cover plasma-derived and recombinant clotting factor products used in outpatient replacement therapy for hemophilia, Von Willebrand disease, and similar clotting disorders when received from a home infusion provider. This benefit does not cover these products when provided by a Pharmacy.

DETOXIFICATION

We cover Medically Necessary detoxification.

DIABETES SUPPLIES AND EQUIPMENT

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

DIABETIC EDUCATION

We cover services and supplies for diabetic self-management training and education, when requested by the attending physician, if provided by an accredited or certified program. Diabetic counseling is covered under the Nutritional Counseling benefit.

DIALYSIS

Inpatient

We cover inpatient dialysis services and supplies.

Initial Outpatient Treatment Period

When Your Physician prescribes outpatient dialysis, regardless of Your diagnosis, We cover hemodialysis, peritoneal dialysis and hemofiltration services and supplies during an initial treatment period of 120 days, measured from the first day You received dialysis treatment. This initial treatment period is available once for each course of continuous or related dialysis care, even if that course of treatment spans two or more Calendar Years.

We will cover associated services provided by an Out-of-Network Provider at the In-Network benefit level. However, You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance.

Supplemental Outpatient Treatment Period (Following Initial Outpatient Treatment Period)

When Your Physician prescribes outpatient dialysis, regardless of Your diagnosis, for a period that is longer than the initial treatment period, then beginning the first day following completion of the initial treatment period, We cover outpatient hemodialysis, peritoneal dialysis and hemofiltration services and supplies. Your kidney diagnosis may make You Medicare-eligible and, if You are enrolled in additional Medicare Part B on any basis and receive dialysis from a Medicare-participating Provider, You may not be responsible for additional out-of-pocket expenses.

We will cover associated services provided by an Out-of-Network Provider at the In-Network benefit level. However, You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance.

For the purpose of this benefit, "Medicare allowed amount" is the amount that a Medicare-contracted Provider agrees to accept as full payment for a covered service. This is also referred to as the Provider accepting Medicare assignment.

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Insured's home. Examples include oxygen equipment and wheelchairs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item. For further Durable Medical Equipment coverage details, please refer to the Durable Medical Equipment Appendix attached to the end of this Policy.

Additionally, We cover Durable Medical Equipment that is obtained from an approved Commercial Seller. Benefits for eligible Durable Medical Equipment will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible Durable Medical Equipment, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit Our Web site contact Customer Service.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

We cover emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. For the purpose of this benefit, "stabilization" means to provide Medically Necessary treatment 1) to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during, or to result from, the transfer of the Member from a facility; and 2) in the case of a covered female Member, who is pregnant, to perform the delivery (including the placenta). Emergency room services do not need to be pre-authorized. See the Hospital Care benefit for coverage of inpatient Hospital admissions.

FAMILY PLANNING

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

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

HABILITATION SERVICES

We cover inpatient and outpatient habilitation services. Habilitation services are health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical, occupational and speech therapy and other services for an Insured with disabilities. Habilitation days or visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

HOME HEALTH CARE

We cover home health care when provided by a licensed agency or facility for home health care. Home health care includes all services for patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. Home health care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with home health care services is covered under the Durable Medical Equipment benefit.

HOSPICE CARE

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

HOSPITAL CARE – INPATIENT AND OUTPATIENT

We cover inpatient and outpatient services and supplies of a Hospital for Injury and Illness (including services of staff Providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered. However, You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance. See the Emergency Room benefit for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

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

MATERNITY CARE/ADOPTION BENEFIT

We cover prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean) and related conditions for all female Insureds. There is no limit for the mother's length of inpatient stay. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit to see how the care of Your newborn is covered.

Certain services such as screening for gestational diabetes; breastfeeding support, supplies and counseling are covered under Your Preventive Care benefit.

Adoption

An adoption benefit is available, covered at the In-Network benefit, when a Policyholder meets all of the following conditions:

- Coverage is in effect on the date a newborn child is placed for the purpose of adoption.
- The newborn child is placed for the purpose of adoption with the Insured within 90 days after the child's birth and the date of placement is on or after the Insured's Effective Date.
- The Policyholder submits a written request for the adoption benefit along with proof of placement for adoption. Proof of placement will be a copy of the court order or its equivalent (for example, a letter from the adoption agency) showing the date of placement for adoption. The written request must contain the child's name, date of birth and a statement regarding any other health coverage of the adoptive parent(s). The written request will be addressed to:

  Regence BlueCross BlueShield of Utah
  P.O. Box 30272
  Salt Lake City, UT 84130-0272

In the event a Policyholder adopts more than one newborn from a single pregnancy (for example, twins), only a single $4,000 adoption benefit is available (subject to reduction for other coverage below).

In the event the Policyholder and/or the Policyholder's spouse are covered by more than one compliant health benefit plan, the adoption benefit will be prorated between or among the plans. The full amount provided by both or all of the plans will not exceed $4,000 per pregnancy.

In the event the post-placement evaluation disapproves the adoption placement and a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety, the Enrolled Employee will be liable for repayment of the adoption benefit. The Enrolled Employee will refund the full amount of such benefit to Us, upon request, within 30 days after the date the child is removed from placement.

Surrogacy

Maternity and related medical services received by You while Acting as a Surrogate are not Covered Services, up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, You Acting as a Surrogate. By incurring and making claim for such services, You agree to reimburse Us the lesser of the amount described in the preceding sentence and the amount We have paid for those Covered Services (even if payment or compensation to You or any other person or entity occurs after the termination of Your coverage under this Policy).

You must notify Us within 30 days of entering into any agreement to Act as a Surrogate and agree to cooperate with Us as needed to ensure Our ability to recover the costs of Covered Services received by You for which We are entitled to reimbursement. To notify Us, or to request additional information on Your responsibilities related to these notification and cooperation requirements, contact Customer Service. Please also refer to the Right of Reimbursement and Subrogation Recovery Section for more information.

Definitions

In addition to the definitions in the Definitions Section, the following definition applies to this Maternity Care benefit:

Acting (or Act) as a Surrogate means You agree to become pregnant and to surrender, relinquish or otherwise give up any parental rights to the baby (or babies) produced by that pregnancy to another person or persons who intend to raise the baby (or babies), whether or not You receive payment, the agreement is written and/or the parties to the agreement meet their obligations.

MEDICAL FOODS (PKU)

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

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES

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

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

Mental Health or Substance Use Disorder Services mean Medically Necessary outpatient services, residential care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is determined by Us to be Medically Necessary). Additionally, Medically Necessary inpatient services must be provided by a licensed facility holding certificates from the Joint Commission on the Accreditation of Hospitals and, when applicable, the Commission on Accreditation of Rehabilitation Facilities.

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

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

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

NUTRITIONAL COUNSELING
We cover outpatient diabetic nutritional counseling and therapy. See the Preventive Care and Immunizations and Mental Health or Substance Use Disorder Services for additional coverage of nutritional counseling. For diabetic education coverage, refer to the Diabetic Education benefit.

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

PRESCRIPTION MEDICATIONS
We cover Prescription Medications listed under the Essential Formulary, which can be viewed on Our Web site.

NOTE: Nonparticipating Pharmacies are not covered under Your Prescription Medications benefit.

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

If You are taking a Prescription Medication while it is removed from the Essential Formulary and its removal was not due to the Prescription Medication being removed from the market, becoming available over-the-counter, or issuance of a black box warning by the Federal Drug Administration, We will continue to cover Your Prescription Medication for the time period required to use Our substitution process to

request continuation of coverage for the removed Prescription Medication and receive a decision through that process, unless patient safety requires an expedited replacement.

Substitution Process

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

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

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

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

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

Covered Prescription Medications

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

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

You are not responsible for any applicable Deductible, Copayment and/or Coinsurance when You fill prescriptions at a Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications, women's contraceptives, or for immunizations, as specified above. For a list of such medications, please visit Our Web site or contact Customer Service. Also, if Your Provider believes that Our covered preventive medications, including women's

contraceptives, are medically inappropriate for You, You may request a coverage exception for a different preventive medication by contacting Customer Service.

Pharmacy Network Information

A nationwide network of Participating Pharmacies is available to You. Pharmacies that participate in this network submit claims electronically.

Nonparticipating Pharmacies are not covered under Your Prescription Medications benefit.

For any Specialty Medication for which the FDA has not restricted distribution to certain Providers, if a Participating Pharmacy demonstrates the ability to provide the same level of services (for example, special handling, provider coordination, and/or patient education) as a Specialty Pharmacy and accepts all Specialty Pharmacy network terms, then that Specialty Medication from that Participating Pharmacy will be eligible for coverage.

Your member card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as Our Insured, a Participating Pharmacy, Specialty Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find Participating Pharmacies and a Pharmacy locator on Our Web site or by contacting Customer Service.

Special Provisions for a Cancer Drug Treatment Regimen

Prescription Medications used as part of a cancer drug treatment regimen for a cancer patient who is undergoing chemotherapy in an outpatient clinic setting, will be covered subject to the same benefits, limitations and exclusions of this Prescription Medications benefit, when dispensed through a professional Provider who meets the requirements set forth in Utah Code 58-17b-309 & 309.5. For purposes of this provision, a "cancer drug treatment regimen" means a Prescription Medication used to treat cancer, manage its symptoms, or provide continuity of care for a cancer patient.

Prescription Medications eligible for dispensing through a professional Provider's office include a chemotherapy drug administered orally, rectally or by dermal methods and medication used to support cancer treatment (including to treat, alleviate or minimize physical and psychological symptoms of pain, to improve patient tolerance of cancer treatments, or prepare a patient for a subsequent course of therapy). Any Prescription Medication listed under federal law as a Schedule I, II, or III drug is not eligible for this special dispensing provision. Intravenous medications are otherwise covered under the applicable Medical Benefits Section(s). You can find a list of Prescription Medications eligible for dispensing through a professional Provider's office on Our Web site.

Claims Submitted Electronically

You must present Your member card at a Participating Pharmacy for the claim to be submitted electronically. You must pay any required Deductible, Copayment and/or Coinsurance at the time of purchase.

Claims Not Submitted Electronically

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

Mail-Order

You can also use mail-order services to purchase covered Prescription Medications. Mail-order coverage applies only when Prescription Medications are purchased from a Mail-Order Supplier and the claim is submitted electronically. Not all Prescription Medications are available from Mail-Order Suppliers.

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

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

Preauthorization

Preauthorization may be required so that We can determine that a Prescription Medication is Medically Necessary before it is dispensed and as indicated under the Substitution Process above. We publish a list of those medications that currently require preauthorization. If You have any questions regarding the list of medications that require preauthorization, You can contact Customer Service or You can view the list on Our Web site. In addition, We notify participating Providers, including Pharmacies, which Prescription Medications require preauthorization. The prescribing Provider must provide the medical information necessary to determine Medical Necessity of Prescription Medications that require preauthorization.

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

Limitations

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

- **Day Supply Limit**
  Prescription Medications benefits are limited to the days' supply shown in the Schedule of Benefits.

- **Maximum Quantity Limit**
  For certain Prescription Medications, We establish maximum quantities other than those listed in the Schedule of Benefits. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. We use information from the FDA and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your member card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service. We do not cover any amount over the established maximum quantity, except if We determine the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

- **Refills**
  We will cover refills from a Participating Pharmacy when You have taken 75 percent of the previous prescription (however, based upon state law, certain controlled substances may be refilled only after You have taken 80 percent of the previous prescription). Refills obtained from a Mail-Order Supplier are allowed after You have taken all but 20 days of the previous Prescription Order. If You choose to refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward any applicable Deductible or any Out-of-Pocket Maximum. If You feel You need a refill sooner than allowed, a refill exception will be considered at Our discretion on a case-by-case basis. You may request an exception by calling Customer Service.

- **Prescription Medications Dispensed by Excluded Pharmacies**
  A Pharmacy may be excluded if it has been investigated by the Office of the Inspector General (OIG) and appears on the OIG's exclusion list. If You are receiving medications from a Pharmacy that is later determined by the OIG to be an excluded Pharmacy, You will be notified, after Your claim has been processed, that the Pharmacy has been excluded, so that You may obtain future Prescription

Medications from a non-excluded Pharmacy. We do not permit excluded Pharmacies to submit claims after the excluded Pharmacies have been added to the OIG list.

Exclusions

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

Biological Sera, Blood or Blood Plasma

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

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

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

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

Insulin Pumps and Pump Administration Supplies: Coverage for insulin pumps and supplies is provided under the Diabetes Supplies and Equipment benefit.

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

Nonprescription Medications: Except for medications included on Our Essential Formulary, approved by the FDA or a Prescription Order by a Physician or Practitioner, We do not cover medications that by law do not require a Prescription Order, for example, over-the-counter medications, including vitamins, minerals, food supplements, homeopathic medicines and nutritional supplements.

Oral Infant and Medical Formulas

Prescription Medications Dispensed from a Nonparticipating Pharmacy

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

Prescription Medications for Treatment of Infertility

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

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

Prescription Medications Used for Sexual Dysfunction or Enhancement

Prescription Medications with Lower Cost Alternatives: Except for higher cost Prescription Medications that are Medically Necessary, We do not cover Prescription Medications for which there are covered therapeutically equivalent (similar safety and efficacy) alternatives or over-the-counter (nonprescription) alternatives.

Prescription Medications without Examination: Except as provided under the Telehealth and Telemedicine benefits, We do not cover prescriptions made by a Provider without recent and relevant in-person examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. For purposes of this exclusion, an examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed. Additionally, this exclusion does not apply to a Provider or Pharmacist who may prescribe an opioid antagonist to an Insured who is at risk of experiencing an opiate-related overdose.

Professional Charges for Administration of Any Prescription Medication

Definitions

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

Brand-Name Medication means a Prescription Medication that is marketed and sold by limited sources or is listed in widely accepted references (or as specified by Us) as a Brand-Name Medication based on manufacturer and price.

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

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

Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references (or specified by Us) as a Generic Medication. For the purpose of this definition, "equivalent" means the FDA ensures that the Generic Medication has the same active ingredients, meets the same manufacturing and testing standards and is as safe and as effective as the Brand-Name Medication. If listings in widely accepted references are conflicting or indefinite about whether a Prescription Medication is a generic or Brand-Name Medication, We will decide.

Mail-Order Supplier means a mail-order Pharmacy with which We have contracted for mail-order services.

Non-Preferred Brand-Name Medication means other Brand-Name Medications used to treat the same or similar medical conditions either at a higher cost or determined to be of lesser value than Preferred Brand-Name Medications.

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

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

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

Preferred Brand-Name Medication means all preferred brand medications.

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

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

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

Self-Administrable Prescription Medications (also Self-Administrable Medications, Self-Administrable Injectable Medication or Self-Administrable Cancer Chemotherapy Medication) means, a Prescription Medication (including, for Self-Administrable Cancer Chemotherapy Medication, oral Prescription Medication including those used to kill or slow the growth of cancerous cells), determined by Us, which can be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician office or clinic) and that does not require administration by a Provider. In determining what We consider Self-Administrable Medications, We refer to information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that We consider a relevant and reliable indication of safety and acceptability. We do not consider Your status, such as Your ability to administer the medication, when determining whether a medication is self-administrable.

Specialty Medications means medications used for patients with complex disease states, such as but not limited to multiple sclerosis, rheumatoid arthritis, cancer and hepatitis C. Non-Preferred Specialty Medication means all less preferred medications as described herein. Preferred Specialty Medication means all preferred medications as described herein. For a list of some of these medications, please visit Our Web site or contact Customer Service.

Specialty Pharmacy means a Pharmacy that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. To find a Specialty Pharmacy, please visit Our Web site or contact Customer Service.

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

PROSTHETIC DEVICES

We cover an artificial prosthetic eye, when made necessary by loss from an Injury or Illness and breast prosthesis (external or internal) following a mastectomy. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility benefit (Hospital Care or Ambulatory Surgical Center).

REHABILITATION SERVICES – OUTPATIENT

We cover outpatient rehabilitation services (physical, occupational and speech therapy services only). For the purpose of this benefit, "rehabilitation" means services, including devices, provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to Illness, Injury or disabling condition. Outpatient rehabilitation visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

REHABILITATION AND SKILLED NURSING FACILITY (SNF) SERVICES – INPATIENT

We cover inpatient rehabilitation services (physical, occupational and speech therapy services only) and accommodations. For the purpose of this benefit, "rehabilitation" means services, including devices, provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to Illness, Injury or disabling condition.

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

SPINAL MANIPULATIONS

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

TELEHEALTH

We cover telehealth (live audio only communication and audio and video communication) between the patient and a telehealth Provider. NOTE: Telehealth services are prohibited in some states and therefore You will not be covered for these services if You attempt to access them while in one of those states. Please contact Customer Service for further information and guidance. Coverage is not provided under this benefit for all non-real-time delivery methods, including, but not limited to, store-and-forward solutions, e-mail or fax communication.

For the purposes of this benefit:

"Audio-only communication" is a secure telephonic communication. Audio-only communication is covered if there is a previously established patient-Provider relationship. An audio-only communication must take the place of an in-person visit that would be billable by the Provider.

TELEMEDICINE

We cover telemedicine (audio and video communication) services between a distant-site Practitioner and a patient at an originating site. Originating sites include facilities such as Hospitals, rural health clinics, Physician's offices and community mental health centers.

We also cover store and forward technology. For the purpose of this benefit, "store and forward technology" is secure one-way electronic transmission (sending) of a patient’s medical information from an originating site to a Provider at a distant site, which is later used by the Provider for diagnosis and medical management of the patient. Store and forward technology does not include telephone, fax or e-mail communication.

TERMINATION OF PREGNANCY

We cover termination of pregnancy (abortion) for all female Insureds only for the following:

- when necessary to avert the death of the female Insured on whom the abortion is performed; or
- where the female Insured is pregnant as a result of rape or incest.

TRANSPLANTS

We cover transplants, including transplant-related services and supplies for covered transplants (including hematopoietic stem cell support) for a transplant recipient who is covered under this Policy and fulfills Medically Necessary criteria. The list of covered transplants is subject to change. Insureds can contact Us for a current list of covered transplants.

Donor Organ Benefits

We cover donor organ procurement costs if the recipient is covered for the transplant under this Policy. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ and other such procurement costs that We determine.

Pediatric Dental Services

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

Preventive And Diagnostic Dental Services

We cover the following preventive and diagnostic Dental Services:

- Routine x-rays, limited to twice per Insured per Calendar Year.
- Full bitewing x-ray series (4), limited to twice per Insured per Calendar Year; vertical bitewings, limited to 8 films.
- Complete mouth x-rays (posterior bitewing films and 14 periapical films plus bitewings), limited to once in a three-year period, in lieu of panoramic x-ray.
- Panorex (panoramic) mouth x-rays, limited to once in a three-year period, in lieu of complete mouth x-ray.
- Preventive oral examinations limited to twice per Insured per Calendar Year.
- Cleanings limited to twice per Insured per Calendar Year.
- Topical fluoride application, limited to two treatments per Insured per Calendar Year.
- Sealants for permanent molars, limited to once in a five-year period.

EXCLUSIONS

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

Aesthetic Dental Procedures

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

Antimicrobial Agents

Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.

Basic (Restorative) Dental Services

Services and supplies provided in connection with basic (restorative) Dental Services, including the following:

- anesthesia;
- emergency (palliative) treatment;
- endodontic procedures (for example, apicoectomy, pulpotomy and root canal);
- fillings;
- oral surgery, including extractions; and
- periodontal procedures (for example, gingivectomy, gingivoplasty and osseous surgery).

Behavior Management

Collection of Cultures and Specimens

Connector Bar or Stress Breaker

Core buildup for a crown

Cosmetic/Reconstructive Services and Supplies

Cosmetic and/or reconstructive services and supplies, except for Dentally Appropriate services and supplies to treat a congenital anomaly and to restore a physical bodily function lost as a result of Injury or Illness.

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

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

Dental Hospitalization
Inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia).

Desensitizing
Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.

Diagnostic Casts or Study Models

Duplicate X-Rays

Experimental or Investigational Services: As Determined by Our Dental Policy

Fractures of the Mandible (Jaw)
Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-Foil Restorations

Home Visits, Including Extended Care Facility Calls

Implants
Services and supplies provided in connection with implants, whether or not the implant itself is covered, including, but not limited to:

- interim endosseous implants;
- eposteal and transosteal implants;
- sinus augmentations or lift;
- implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
- radiographic/surgical implant index; and
- unspecified implant procedures.

Indirect Pulp Capping as a separate charge

Major Dental Services
Services and supplies provided in connection with major Dental Services, including the following:

- bridges;
- dentures (whether interim partial or complete;
- inlays, onlays and crowns; and
- additional procedures to construct new crown under existing partial denture framework

Medications and Supplies
Charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies.

Nitrous Oxide

Occlusal Treatment
Services and supplies provided in connection with dental occlusion, including the following:

- occlusal analysis and adjustments; and
- occlusal guards.

Oral Hygiene Instructions

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

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

Photographic Images

Pin Retention in Addition to Restoration

Precision Attachments

Preventive and Diagnostic Dental Services Not Specifically Listed as a Covered Service

Prosthesis
Services and supplies provided in connection with dental prosthesis, including the following:

- maxillofacial prosthetic procedures; and
- modification of removable prosthesis following implant surgery.

Provisional Splinting

Pulp Vitality Tests

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

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

- any supplies;
- local anesthesia; and
- sterilization.

Services Performed in a Laboratory

Surgical Procedures
Services and supplies provided in connection with the following surgical procedures:

- exfoliative cytology sample collection or brush biopsy;
- incision and drainage of abscess extraoral soft tissue, complicated or non-complicated;
- radical resection of maxilla or mandible;
- removal of nonodontogenic cyst, tumor or lesion;
- surgical stent; or
- surgical procedures for isolation of a tooth with rubber dam.

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

Therapeutic drug injections for Dental Services

Tobacco or Nutritional Counseling for the Control and Prevention of Oral Disease

Tooth Transplantation
Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.

Treatment of post-surgical complications due to unusual circumstances

Veneers

DEFINITIONS
In addition to the definitions in the Definitions Section, the following definitions apply to this Pediatric Dental Services Section:

Allowed Amount means:

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

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

Dentally Appropriate means a Dental Service recommended by the treating Dentist or other Provider, who has personally evaluated the patient, and determined by Us (or Our designee) to be all of the following:

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

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

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

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

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

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

In-Network Dentist Reimbursement

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

Out-of-Network Dentist Claims

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

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

Out-of-Network Dentist Reimbursement

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

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

Pediatric Vision Services

We cover benefits for vision care for Insureds under the age of 19. Coverage will be provided for an Insured until the last day of the monthly period in which the Insured turns 19 years of age. Please note that the BlueCard Program detailed in the Policy and Claims Administration Section does not apply to vision benefits provided under this Pediatric Vision Services Section. Covered Services must be rendered by a Physician or optometrist practicing within the scope of his or her license. We will pay benefits under this Pediatric Vision Services Section, not any other provision in this Policy, if a service or supply is covered under both. This pediatric vision coverage is provided by Us, in collaboration with Vision Service Plan Insurance Company (VSP), which coordinates the provision of benefits and claims processing for this Policy.

Accessing Providers

Your Pediatric Vision Services benefit allows You to control Your out-of-pocket expenses, such as Copayments and Coinsurance, for each Covered Service. Here's how it works – You control Your out-of-pocket expenses by choosing Your vision Provider under two choices called: "VSP Doctor" and "Out-of-Network Provider."

- **VSP Doctor.** You choose to see a VSP Doctor and save the most in Your out-of-pocket expenses. Choosing this vision Provider option means You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network Provider.** You choose to see an Out-of-Network Provider that does not have a contract with VSP and Your out-of-pocket expenses will generally be higher than a VSP Doctor. Also, choosing this vision Provider option means You may be billed for balances beyond any Deductible and/or Coinsurance. This is sometimes referred to as balance billing. Coinsurance for Out-of-Network Providers does not accrue to the Out-of-Pocket Maximum.

Vision Examination

We cover professional complete medical eye examination or visual analysis, including:

- prescribing and ordering proper lenses;
- assisting in the selection of frames;
- verifying the accuracy of the finished lenses;
- proper fitting and adjustment of frames;

- subsequent adjustments to frames to maintain comfort and efficiency; and
- progress or follow-up work as necessary.

Vision Hardware
We cover hardware including frames, contacts and lenses. Coverage is limited to frames and lenses or contacts, but not both in a Calendar Year.

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

Lenses
We cover the following standard lenses in either glass or plastic:

- single vision;
- lined bifocal;
- lined trifocal;
- lenticular;
- polycarbonate;
- photochromic lenses; or
- elective contacts*.

Additionally, We cover lens enhancements, including scratch coating, UV (ultraviolet) protection and tinting.

*Contact lenses are in lieu of all other frame and lens benefits. When You receive contact lenses, You will not be eligible for any frames and/or lenses again until the next Calendar Year. One of the following elective contact lens types may be chosen:

- standard (one pair annually);
- monthly (six-month supply);
- bi-weekly (three-month supply); or
- dailies (three-month supply).

Necessary Contact Lenses are covered without frequency limitations if You have a specific condition for which contact lenses provide better visual correction.

Contact Lens Evaluation and Fitting Examination
We cover services and supplies for contact lens evaluation and fitting examinations.

Low Vision Benefit
Supplemental Testing
We cover complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

Supplemental Aids
In addition to the pediatric vision benefits described above, We cover special aids for Insureds if vision loss is sufficient enough to prevent reading and performing daily activities. If You fall within this category (check with Your Provider), You will be entitled to professional services as well as ophthalmic materials, including, but not limited to: supplemental testing (complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated); evaluations; visual training; low vision prescription services; plus optical and non-optical aids, subject to the frequency and benefit limitations of these vision benefits. Consult Your VSP Doctor for more details.

Limitations

These pediatric vision benefits are designed to cover visual needs rather than cosmetic materials. If You select any of the following extras, We will pay the basic cost of the allowed lenses and You will pay any additional costs for these options:

- optional cosmetic processes;
- anti-reflective coating;
- color coating;
- mirror coating;
- blended lenses;
- cosmetic lenses;
- laminated lenses;
- oversize lenses;
- standard, premium and custom progressive multifocal lenses;
- certain limitations on low vision care; and
- contact lenses not previously described as covered.

Additional Discount

You are entitled to receive a 20 percent discount toward the purchase of non-covered materials from any VSP Doctor when a complete pair of glasses is dispensed. You are also entitled to receive a 15 percent discount off of contact lens examination services from any VSP Doctor, beyond the covered exam. Professional judgment will be applied when evaluating prescriptions written by an Out-of-Network Provider. VSP Doctors may request an additional exam at a discount.

Discounts are applied to the VSP Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye examination. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THIS PEDIATRIC VISION BENEFIT, BUT ARE NOT INSURANCE.**

Discount Limitations

- Discounts do not apply to vision care benefits obtained from Out-of-Network Providers.
- 20 percent discount applies only when a complete pair of glasses is dispensed.
- Discounts do not apply to sundry items, for example, contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

EXCLUSIONS

In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Pediatric Vision Services Section:

Certain Contact Lens Expenses

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

Corneal Refractive Therapy (CRT)

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

Corrective Vision Treatment of an Experimental Nature

Costs for Services and/or Supplies Exceeding Benefit Allowances

Medical or Surgical Treatment of the Eyes

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

Orthoptics or Vision Training

Orthoptics or vision training and any associated supplemental testing.

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

Replacement of Lenses and Frames
Except at the normal intervals when services are otherwise available, We do not cover replacement of lenses and frames furnished under this Policy which are lost or broken.

Two Pair of Glasses in Lieu of Bifocals

DEFINITIONS
In addition to the definitions in the Definitions Section, the following definitions apply to this Pediatric Vision Services Section:

Allowed Amount means:

- For VSP Doctors (see definition of "VSP Doctor" below), the amount that these Providers have contractually agreed to accept as payment in full for a service or supply.
- For Out-of-Network Providers (see definition of "Out-of-Network Provider" below), the billed amount for listed services and supplies.

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

Benefit Authorization means VSP has approved benefits for You.

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

Necessary Contact Lenses are contact lenses that are prescribed by Your VSP Doctor or Out-of-Network Provider for other than cosmetic purposes. Benefit Authorization is not required for You to be eligible for Necessary Contact Lenses, however, certain benefit criteria, as defined by VSP, must be satisfied in order for contact lenses to be covered as Necessary Contact Lenses.

Out-of-Network Provider means any optometrist, optician, ophthalmologist or other licensed and qualified vision care Provider who has not contracted with VSP to provide vision care services and/or vision care materials.

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

General Information
Submission of Claims and Reimbursement
When You visit a VSP Doctor, the VSP Doctor will submit the claim directly to VSP for payment. If You visit an Out-of-Network Provider, however, You will need to pay the Provider his or her full fee at the time You receive the service or supply. You will need to submit a claim to VSP for reimbursement according to the benefits in this Policy, less any Copayment and/or Coinsurance. THERE IS NO ASSURANCE THAT PAYMENT WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR HARDWARE. Be sure the claim is complete and includes the following information:

- copy of claim receipt from the Provider, including Provider's name, address, date of service, and services performed. You may access Out-of-Network Reimbursement under My Benefits on VSP's Web site, **www.vsp.com**, to get a claim form to assist in submission of Out-of-Network Provider claims;
- Your name, date of birth, address and member ID number; and
- patient's name, date of birth and relation to You.

Send to:

Vision Service Plan
P.O. Box 385020
Birmingham, AL 35238-5020

Concerns about Claim Denial or Other Action

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

Accidental Death Benefit

Subject to the terms and conditions of this Section, We will pay the benefit shown here when We receive proof of death by Accidental Bodily Injury of the Policyholder, enrolled spouse, enrolled domestic partner, or an enrolled child as described in the following paragraphs.

BENEFIT

The following conditions must be met in order for this benefit to be payable: the death must result from Accidental Bodily Injury; the Accidental Bodily Injury must occur while covered under this Policy; and the death must occur within 365 days after the date of the Accidental Bodily Injury.

With proof of death by Accidental Bodily Injury, We pay the following benefit:

Policyholder (age 18 or older)	$10,000
Enrolled Spouse	$10,000
Enrolled Domestic Partner	$10,000
Enrolled Child	$2,500

EXCLUSIONS

Even though a death results from Accidental Bodily Injury, no payment will be made under this benefit if such Injury is caused by, or occurs as a result of, any of the following:

- Suicide, intentionally self-inflicted Injury or any attempt to injure oneself, while sane or insane;
- **Voluntary participation in** a violent disorder, riot or insurrection. "Voluntary participation" does not include being at the scene of a violent disorder or riot during the performance of official duties;
- Active participation in a war or any act of war, whether declared or undeclared;
- Injury suffered while serving in the armed forces of any country;
- **Voluntary participation in** a felony;
- Any sickness or pregnancy existing at the time of the accident;
- Voluntary use or consumption of any poison, chemical compound or drug, except a Prescription Medication used or consumed in accordance with the directions of the prescribing Physician;
- Heart attack (including but not limited to myocardial infarction) or stroke (including but not limited to cerebral infarction);
- Diagnostic test, medical or surgical treatment; or
- Bodily infirmity or disease from bacterial or viral infections, other than infection caused from an Injury sustained while covered under this benefit.

GENERAL PROVISIONS

Notice of Claim

Written notice of any loss resulting in a claim being filed under this benefit must be given to Us within 20 days after the loss occurs, or as soon as reasonably possible.

Claim Forms

When notice of claim is received, We will send You the forms for filing proof of loss. If the forms are not received within 15 days, You can send Us written proof of loss without waiting for the forms.

Proof of Loss

Written proof of loss must be received within 90 days after the date of loss for which a claim is made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. We will deny a claim that is not filed in a timely manner unless You can reasonably demonstrate that the claim could not have been filed in a timely manner.

Timely Payment of Claims

Losses covered by this benefit will be paid as soon as We receive written proof of such loss.

Payment of Claims
Losses covered by this benefit will be paid to You. Payment due at the time of Your death will be paid to Your estate.

Autopsy
We have the right to require an autopsy at Our expense where it is not forbidden by law.

Legal Actions
No legal action may be brought to recover on this benefit until 60 days after proof of loss has been furnished. No action may be brought after three years from the time written proof of loss is required to be furnished.

DEFINITIONS
In addition to the definitions in the Definitions Section, the following definition applies only to this Accidental Death Benefit Section:

Accidental Bodily Injury means immediate traumatic physical damage to the body which results directly from an unexpected and unintentional event, and which is independent of disease, bodily infirmity or any other cause.

General Exclusions

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

PREEXISTING CONDITIONS

This coverage does not have an exclusion period for Preexisting Conditions. A Preexisting Condition normally means a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within a specified period of time before the enrollment date.

EXCLUSION EXAMPLES

The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered in this Policy, including related secondary medical conditions and are not all inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications relating to services and supplies for, or in connection with, gastric or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for, or in connection with, reversal or revision of such procedures, or any direct complications or consequences thereof;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
    - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
    - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- complications that result from an Injury or Illness resulting from active participation in illegal activities.

SPECIFIC EXCLUSIONS

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise Covered Service for preventive service as specified under the Preventive Care and Immunizations or the Prescription Medications benefits.

Activity Therapy

Creative arts, play, dance, aroma, music, equine or other animal-assisted, recreational or similar therapy; sensory movement groups; and wilderness or adventure programs.

Assisted Reproductive Technologies

Assisted reproductive technologies (including, but not limited to, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception), or associated surgery, drugs, testing or supplies, regardless of underlying condition or circumstance.

Aviation

Services in connection with Injuries sustained in aviation accidents (including accidents occurring in flight or in the course of take-off or landing), unless the injured Insured is a passenger on a scheduled commercial airline flight or air ambulance.

Certain Therapy, Counseling and Training

Educational, vocational, social, image, milieu or marathon group therapy, premarital or marital counseling, Individual Assistance Program (IAP) services; job skills or sensitivity training.

Complementary Care

Complementary care, including, but not limited to, acupuncture.

Conditions Caused By Active Participation In a War or Insurrection
The treatment of any condition caused by or arising out of an Insured's active participation in a war or insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services
The treatment of any Insured's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

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

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

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

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

Counseling in the Absence of Illness
Except as required by law, We do not cover counseling in the absence of Illness.

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

Dental Hospitalization
Inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia).

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

Discretionary Surgery
We do not cover eye lid surgery, varicose vein surgery or breast reductions except when following a Medically Necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice in this Policy.

Durable Medical Equipment
We do not cover certain durable medical equipment as detailed in the Appendix attached to the end of this Policy.

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

Facilities Without a Provider Legally Required to be on Duty
Admission and treatment in a setting where neither a Physician nor licensed nurse is legally required to be on duty at all times that a patient is admitted.

Family Counseling
Except when family counseling is part of the treatment for a child or adolescent with a covered diagnosis, We do not cover family counseling.

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

Genetic Testing Services

Government Programs
Benefits that are covered, or would be covered in the absence of this Policy, by any federal, state or government program, except for facilities that contract with Us and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. We do not cover government facilities outside the Service Area (except as required by law for emergency services).

Hearing Aids and Other Devices
Except for cochlear implants, We do not cover hearing aids (externally worn or surgically implanted) or other hearing devices.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses, including, but not limited to, use of such services for the treatment of painful physical conditions, Mental Health Conditions, Substance Use Disorders or for anesthesia purposes.

Illegal Services, Substances and Supplies
Services, substances and supplies that are illegal as defined under state or federal law.

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

Infertility
Except to the extent Covered Services are required to diagnose such condition, We do not cover treatment of infertility, including, but not limited to, surgery, fertility drugs and medications.

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

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

Neurodevelopmental Therapy
Except as provided under the rehabilitation and Skilled Nursing Facility or rehabilitation and habilitation services benefits, We do not cover neurodevelopmental therapy, including physical therapy, occupational

therapy and speech therapy and maintenance service, to restore and improve function for an Insured with neurodevelopmental delay. By "neurodevelopmental delay," We mean a delay in normal development that is not related to any documented Illness or Injury.

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

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

Obesity or Weight Reduction/Control
Except as required by law, We do not cover medical treatment, medications, surgical treatment (including treatment of complications, revisions and reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.

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

Orthotics
Except as provided under the Durable Medical Equipment benefit in the Medical Benefits Section and detailed in the Appendix, We do not cover orthotics.

Out-of-Network Services
Except as specified for Out-of-Network Providers in the Medical Benefits Section or the Schedule of Benefits, We do not cover Out-of-Network services.

Over-the-Counter Contraceptives
Except as provided under the Prescription Medications benefit or as required by law, We do not cover over-the-counter contraceptive supplies.

Personal Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control, education or general physical fitness. For example, We do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps, weight lifting equipment, physical fitness programs and therapy or service animals, including the cost of training and maintenance.

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

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

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

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

Routine Foot Care
Except for foot care associated with diabetes, We do not cover routine foot care.

Routine Hearing Examinations

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

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

This exclusion does not apply to services for training or educating an Insured when provided without separate charge in connection with Covered Services or when specifically indicated as a Covered Service (for example, diabetic education and teaching doses for Self-Administrable Injectable Medications).

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

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

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

Sexual Dysfunction
Except for covered Mental Health Services, We do not cover treatment, services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause.

Sleep Studies

Surrogacy
Maternity and related medical services received by You Acting as a Surrogate are not Covered Services up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, Your Acting as a Surrogate. For purpose of this exclusion, "maternity and related medical services" includes otherwise Covered Services for conception, prenatal, maternity, delivery and postpartum care. Please refer to the Maternity Care and/or Right of Reimbursement and Subrogation Recovery Sections for more information.

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

Termination of Pregnancy (Abortion)
Except as provided under the Termination of Pregnancy benefit, We do not cover services or supplies related to the termination of a pregnancy (abortion).

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

Travel and Transportation Expenses
Travel and transportation expenses other than covered ambulance services provided in this Policy.

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

Vision Care
Except as provided under the Pediatric Vision Services Section, We do not cover routine eye exams and vision hardware.

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

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

Policy and Claims Administration

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

PREAUTHORIZATION

Contracted Providers may be required to obtain preauthorization from Us in advance for certain services provided to You. You will not be penalized if the contracted Provider does not obtain those approvals from Us in advance.

MEMBER CARD

When You, the Policyholder, enroll with Us, You will receive a member card. It will include important information such as Your identification number and Your name.

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

If You lose Your card, or if it gets destroyed, You can get a new one by contacting Customer Service. You can also view or print an image of Your member card by visiting Our Web site on Your PC or mobile device. If coverage under this Policy terminates, Your member card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

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

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

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

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

Timely Filing of Claims

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

Freedom of Choice of Provider

Nothing contained in this Policy is designed to restrict You in selecting the Provider of Your choice for pediatric dental care or treatment, pediatric vision care or treatment or for care or treatment of an Illness or Injury.

In-Network Provider Claims

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

In-Network Provider Reimbursement

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

Out-of-Network Provider Claims

We do not cover services provided by Out-of-Network Providers, except as specifically noted in the Medical Benefits Section. In order for Us to pay for eligible Covered Services received from an Out-of-Network Provider, You or the Out-of-Network Provider must first send Us a claim. Be sure the claim is complete and includes the following information:

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

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

Out-of-Network Provider Reimbursement

In most cases, We will pay You directly for eligible Covered Services received from an Out-of-Network Provider.

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

Rural Health Care Providers

If You are a Rural Resident with regard to the Provider, You are entitled to coverage for Covered Services by an Independent Hospital (or its Credentialed Staff Member at an Independent Hospital or his Local Practice Location) or by a Federally Qualified Health Center (or its Credentialed Staff Member at the Federally Qualified Health Center). For a list of rural health care Providers in rural counties, please visit Our Web site and search for Rural Health Care Providers, then click on the *Notice Regarding Access to Health Care Providers in Rural Counties*. If You have questions concerning Your rights to see a rural health care Provider, contact Customer Service. The non-contracting Independent Hospital or Federally Qualified Health Center may not balance bill You for services covered under this Rural Health Care Providers provision. Additional information can be found in Utah Code Annotated §31A-8-501 and Rule R590-237.

Ambulance Claims

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

Claims Determinations

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

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

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

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

OUT-OF-AREA SERVICES

We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You obtain health care services outside of Our service area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

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

We cover only limited healthcare services received outside of Our service area. As used in this section, “Out-of-Area Covered Healthcare Services” are limited to otherwise covered emergency care (including ambulance) obtained outside the geographic area We serve. Out-of-area urgent care is covered only when received from an In-Network Provider. Any other services will not be covered when processed through any Inter-Plan Arrangements.

BlueCard Program

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

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, or urgent care from an In-Network Provider, where available. The In-Network Provider will automatically file a claim for the Out-of-Area Covered Healthcare Services or urgent care provided to You, so there are no claim forms for You to fill out. You will be responsible for any Deductible, Copayment and/or Coinsurance, if applicable.

Emergency Care Services: If you experience a medical emergency while traveling outside the service area, go to the nearest emergency or urgent care facility.

When You receive Out-of-Area Covered Healthcare Services outside Our service area and the claim is processed through the BlueCard Program, the amount You pay for the Out-of-Area Covered Healthcare Services is calculated based on the lower of:

- The billed charges for Your Out-of-Area Covered Healthcare Services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your health care Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments

will not affect the price We have used for Your claim because they will not be applied after a claim has already been paid.

Federal or the state laws or regulations may require a surcharge, tax or other fee. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

Nonparticipating Providers Outside Our Service Area

- Your Liability Calculation. When Out-of-Area Covered Healthcare Services are provided outside of Our service area by Out-of-Network Providers, the amount You pay for such services will normally be based on either the Host Blue's Out-of-Network Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the Out-of-Network Provider bills and the payment We will make for the Out-of-Area Covered Healthcare Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for Out-of-Network emergency services.
- Exceptions. In certain situations, We may use other payment methods, such as billed charges for Out-of-Area Covered Healthcare Services, the payment We would make if the health care services had been obtained within Our service area, or a special negotiated payment to determine the amount We will pay for services provided by Out-of-Network Providers. In these situations, You may be liable for the difference between the amount that the Out-of-Network Provider bills and the payment We will make for the Out-of-Area Covered Healthcare Services as set forth in this paragraph.

BLUE CROSS BLUE SHIELD GLOBAL CORE

If You are outside the United States, You may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered health services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States in certain ways. For instance, although Blue Cross Blue Shield Global Core assists You with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when You receive care from Providers outside the United States, You will typically have to pay the Providers and submit the claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or Hospital) outside the United States, You should call the service center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

- **Inpatient Services**
  In most cases, if You contact the service center for assistance, Hospitals will not require You to pay for covered inpatient services, except for Your applicable Deductible, Coinsurance, etc. In such cases, the Hospital will submit Your claims to the service center to begin claims processing. However, if You paid in full at the time of services, You must submit a claim to receive reimbursement for covered healthcare services.

- **Outpatient Services**
  Physicians, urgent care centers and other outpatient Providers located outside the United States will typically require You to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**
  When You pay for covered healthcare services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from Us, the service center or online at **www.bcbsglobalcore.com**. If You need assistance with Your claim submission, You should call the service center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week.

NONASSIGNMENT

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

CLAIMS RECOVERY

If We pay a benefit to which You or Your Enrolled Dependent was not entitled, or if We pay a person who is not eligible for benefits at all, We have the right, at Our discretion, to recover the payment from the person We paid or anyone else who benefited from it, including a Provider of services. Our right to recovery includes the right to deduct the mistakenly paid amount from future benefits We would provide the Policyholder or any of his or her Enrolled Dependents, even if the mistaken payment was not made on that person's behalf. We will not seek recovery from You, Your Enrolled Dependent, or a Provider more than 12 months after a mistaken payment, except We may seek recovery:

- Within 36 months if the mistake in payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal program;
- In matters involving coordination of benefits as described in the Coordination of Benefits provision in this Policy and Claims Administration Section;
- In accordance with Utah law concerning fraudulent insurance acts; or
- In accordance with any other provision of state or federal law.

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

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

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

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

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

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

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

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

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

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

LIMITATIONS ON LIABILITY

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

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

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

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

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

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

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

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

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

Advancement of Benefits

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

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

    - the third-party or third-party's insurer admits liability;
    - the health care expenses are itemized or expressly excluded in the recovery; or
    - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered in this Policy.

- We will not reduce Our reimbursement or subrogation due to Your not being made whole. Our right to reimbursement or subrogation, however, will not exceed the amount of recovery.
- By accepting benefits under this Policy, You or Your representative agrees to notify Us promptly (within 30-days) and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to third-party Injuries sustained by You.
- You and Your representative must cooperate with Us and do whatever is necessary to secure Our rights of subrogation and reimbursement under this Policy. We may require You to sign and deliver all legal papers and take any other actions requested to secure Our rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third-party or other source). If We ask You to sign a trust agreement or other document to reimburse Us from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.
- You must agree that nothing will be done to prejudice Our rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by Us. You will also cooperate fully with Us, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify Us of any facts that may impact Our right to reimbursement or subrogation, including, but not necessarily limited to, the following:

    - the filing of a lawsuit;
    - the making of a claim against any third-party;
    - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
    - intent of a third-party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Injury or Illness that gives rise to Our right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).

- You and/or Your agent or attorney must agree to serve as constructive trustee and keep any recovery or payment of any kind related to Your Illness or Injury which gave rise to Our right of subrogation or reimbursement segregated in its own account, until Our right is satisfied or released.
- In the event You and/or Your agent or attorney fails to comply with any of these conditions, We may recover any such benefits advanced for any Illness or Injury through legal action.
- Any benefits We have provided or advanced are provided solely to assist You. By paying such benefits, We are not acting as a volunteer and are not waiving any right to reimbursement or subrogation.

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

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

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

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

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

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

COORDINATION OF BENEFITS
If You are covered under any other individual or group medical contract or policy (referred to as "Other Plan" and defined below), the benefits in this Policy and those of the Other Plan will be coordinated in accordance with the provisions of this section.

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

Definitions

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

Allowable Expense means, with regard to services that are covered in full or part in this Policy or any Other Plan(s) covering You, the amount on which that plan would base its benefit payment for a service, including Coinsurance or Copayments and without reduction for any applicable Deductible, except that the following are examples of expenses that are not an Allowable Expense:

- An expense or portion of an expense not covered by any of Your involved plans.
- Any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You.
- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, unless one of Your involved plans provides coverage for private Hospital rooms.
- Any amount by which a Primary Plan's benefits were reduced because You did not comply with that Plan's provisions regarding second surgical opinion or preauthorization.
- If You are covered by two or more plans that: 1) compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified benefit; or 2) that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
- If You are covered by a plan that calculates its benefits or services on the basis of usual and customary fees, relative value schedule reimbursement, or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, that negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

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

Birthday, for purposes of these Coordination of Benefits provisions, means only the day and month of birth, regardless of the year.

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

Group-Type Coverage is a coverage that is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including blanket coverage. Group-Type Coverage does not include an individually underwritten and issued guaranteed renewable coverage, even if the coverage is purchased through payroll deduction at a premium savings to You (since You would have the right to maintain or renew the coverage independently of continued employment with the employer).

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

- Individual and group accident and health insurance and subscriber contracts.
- Uninsured arrangements of group or Group-Type Coverage.
- Group-Type Coverage.
- Coverage through closed panel plans (a plan that provides coverage primarily in the form of services through a panel of providers that have contracted with or are employed by a plan and that excludes benefits for services provided by other providers, except in the cases of emergency or referral by a panel member).
- Medical care components of long-term care contracts, such as skilled nursing care.
- Medicare and other governmental coverages, as permitted by law.

Other Plan does not include:

- Hospital indemnity coverage benefits or other fixed indemnity coverage.
- Accident only coverage.
- Specified disease or specified accident coverage.
- Limited benefit health coverage.
- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.
- Benefits provided in long-term care insurance policies for non-medical services (for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and Custodial Care) or for coverages that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
- Medicare supplement coverage.
- A state plan under Medicaid, or a governmental plan that, by law, provides benefits that are in excess to those of private insurance or other nongovernmental coverage.

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

- The plan has no order of benefit determination provision or its order of benefit determination provision differs from the order of benefit determination provision included herein; or
- Both plans use the order of benefit determination provision included herein and under that provision the plan determines its benefits first.

Secondary Plan means a plan that is not a Primary Plan.

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

Order of Benefit Determination

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

Non-dependent or dependent coverage: A plan that covers You other than as a dependent, for example as an employee, member, policyholder retiree, or subscriber, will be primary to a plan under which You are covered as a dependent.

Child covered under more than one plan: Plans that cover You as a child shall determine the order of benefits as follows:

- When Your parents are married or living together (whether or not they have ever been married), the plan of the parent whose Birthday falls earlier in the Year is the Primary Plan. If both parents have the same Birthday, the plan that has covered a parent longer is the Primary Plan.
- When Your parents are divorced or separated or are not living together (if they have never been married) and a court decree states that one of Your parents is responsible for Your health care expenses or health care coverage, the plan of that parent is primary to the plan of Your other parent. If the parent with that responsibility has no health care coverage for Your health care expenses, but that parent's spouse does, the plan of the spouse shall be primary to the plan of Your other parent.
- If a court decree states that both parents are responsible for Your health care expenses or health care coverage, or if a court decree states that the parents have joint custody of You, without specifying that one of the parents is responsible for Your health care expenses or health care coverage, the provisions of the first bullet above (based on parental Birthdays) shall determine the order of benefits.
- If there is no court decree allocating responsibility for Your health care expenses or health care coverage, the order of benefits is as follows:
    - The plan of Your custodial parent shall be primary to the plan of Your custodial parent's spouse;

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

If You are covered under more than one plan and one or more of the plans provides You coverage through individuals who are not Your parents (for example, a guardian or step-parent), the order of benefits shall be determined, as applicable using the provisions under the first or second bullets above, as if those individuals were Your parents.

Active, retired, or laid-off employees: A plan that covers You as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee, is primary to a plan under which You are covered as a laid off or retired employee. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

COBRA or state continuation coverage: A plan that covers You as an employee, member, subscriber or retiree or as a dependent of an employee, member, subscriber or retiree, is primary to a plan under which You are covered pursuant to COBRA or a right of continuation pursuant to state or other federal law. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

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

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

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

If an order of benefit determination is not identified by the preceding rules, the plans shall share equally in the Allowable Expenses. Each of the plans under which You are covered, and each of the benefits within the plan, will be considered separately in administering this Coordination of Benefits provision.

Primary Health Plan Benefits

When, in accordance with the order of benefit determination, this coverage is the Primary Plan, We will pay the benefits in this Policy as if no Other Plan exists. Despite the provisions of timely filing of claims, where We are the Primary Plan, We will not deny benefits on the ground that a claim was not timely submitted if the claim was timely submitted to one or more Secondary Plans and was submitted to Us within 36 months of the date of service.

Secondary Health Plan Benefits

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

We will calculate the benefits that We would have paid for a service if this coverage were the Primary Plan. We will apply that calculated amount to any Allowable Expense in this Policy for that service that is unpaid by the Primary Plan. We will:

- reduce payment so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total Allowable Expense for that claim; and
- credit to this Policy's Deductible (if applicable), any amounts We would have credited for the service if this coverage were the Primary Plan.

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

Right to Receive and Release Needed Information

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

Right of Recovery

If We provide benefits to or on behalf of You in excess of the amount that would have been payable in this Policy by reason of Your coverage under any Other Plan(s), We will be entitled to the excess as follows:

- From You, if payment was made to You. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentations. We will be entitled to recover the amount of such excess by the reversal of payment from You and You agree to reimburse Us on demand for any and all such amounts. You also agree to pay Us interest at 18 percent per annum until such debt is paid in full, which will begin accruing the date the demand for reimbursement is made. If We use a third-party collection agency or attorney to collect the overpayment, You agree to pay collection fees incurred, including, but not limited to, any court costs and attorney fees. If You do not pay Us, We may withhold future benefits to offset the amount owing to Us. We are responsible for making proper adjustments between insurers and Providers.
- From Providers, if payment was made to them. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentation(s). We are responsible for making proper adjustments between insurers and Providers.
- From the Other Plan or an insurer.
- From other organizations.

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

Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action by Us under this Policy and wishes to have it reviewed, You (or he or she) may Appeal. There is one level of Appeal You (or he or she) may pursue within Regence BlueCross BlueShield of Utah. In some circumstances there is an additional voluntary Appeal level You (or he or she) may pursue. Certain matters requiring quicker consideration may qualify for a level of expedited Appeal and are described separately later in this section.

FILING APPEALS

For pediatric vision benefits, We have delegated certain activities, including Appeals, to VSP, though We retain ultimate responsibility over these activities. If You believe a policy, action or decision of VSP is incorrect, please contact the VSP Customer Service department. If VSP cannot resolve Your concern to Your satisfaction, You or Your Representative (any Representative authorized by You) may Appeal – that is, ask for VSP to review Your case again. A written request can be made by sending it to VSP at: Vision Service Plan, Attention: Complaint and Grievance Unit, P.O. Box 997100, Sacramento, CA 95899-7100. Verbal requests can be made by calling VSP's Customer Service department at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance). For the purpose of Appeals for pediatric vision benefits, references to "We," "Us" and "Our" in this Appeal Process Section refer to VSP.

For all other benefits under this Policy, if You believe a policy, action or decision of Ours is incorrect, please contact Our Customer Service department. If We cannot resolve Your concern to Your satisfaction, You or Your Representative (any Representative authorized by You) may Appeal – that is, ask for Us to review Your case again. A written request can be made by sending it to Us at: Appeals Coordinator, Regence BlueCross BlueShield of Utah, P.O. Box 1408, Lewiston, ID 83501 or facsimile 1 (888) 496-1542. Verbal requests can be made by calling Our Customer Service.

Appeals, including expedited Appeals, must be pursued within 180 days of Your receipt of Our original Adverse Benefit Determination that You are Appealing. A request for Independent Review must be made within 180 days of Your receipt of Our Final Adverse Benefit Determination. If You don't Appeal within these time periods, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum. When We receive an Appeal request, We will send a written acknowledgement.

We will send You free of charge, any new or additional evidence considered, relied upon, or generated by Us in connection with Your Appeal and any new rationale on which a final adverse benefit determination would be made. We will provide You this information as soon as possible and in advance of the date on which We will make Our final decision.

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

An Adverse Benefit Determination may be overturned by Us at any time during the Appeal process if We receive newly submitted documentation and/or information which establishes coverage, or upon the discovery of an error, the correction of which would result in overturning the Adverse Benefit Determination.

Internal Appeals

Appeals are reviewed by an employee or employees who were not involved in, or subordinate to anyone involved in, the initial decision that You are Appealing. In Appeals that involve issues requiring medical judgment, the decision is made by one or more members of Our staff of health care professionals. You or Your Representative may submit written materials supporting Your Appeal, including written testimony on Your behalf. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Post-Service Investigational issue, a written notice of the decision will be sent within 20 working days of receipt of the Appeal. For Appeals involving a Pre-Service

preauthorization of a procedure, We will send a written notice of the decision within 14 days of receipt of the Appeal.

VOLUNTARY INDEPENDENT REVIEW

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

EXPEDITED APPEALS

An expedited Appeal is available for an Urgent Care Claim.

Internal Expedited Appeal

The internal expedited Appeal request is available for a Pre-Service or concurrent Urgent Care Claim and should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. Internal expedited Appeals are reviewed by a health care professional who was not involved in, or subordinate to anyone involved in, the initial denial determination. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the internal expedited Appeals time frame) to provide written materials, including written testimony on Your behalf. Verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. This will be followed by written notification within three calendar days after the verbal notice.

Voluntary Expedited Independent Review

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

YOUR RIGHT TO AN INDEPENDENT REVIEW – NOTICE

Please read this notice carefully. It describes a procedure for review of a Final Adverse Benefit Determination by a qualified professional who has no affiliation with Us. If You request an Independent Review of Your claim, the decision of the Independent Review will be binding and final, except to the extent that federal or state law makes available additional remedies.

You must first exhaust Our internal Appeal process. Exhaustion of that process includes completing all levels of Appeal, or unless You requested or agreed to a delay, Our failure to respond to a standard Appeal within 30 days in writing or to a request for an Urgent Care Claim within 72 hours of the receipt of Your Appeal. However, You may request an Independent Review of a Final Adverse Benefit Determination before You have exhausted Our internal grievance and Appeal process, if:

- We agree to waive the exhaustion requirement for an Independent Review request; or
- We have not complied with Our requirements for the internal Appeal process (except for those failures that are based on de minimis (insignificant) violations that do not cause and are not likely to cause prejudice or harm to You and are not part of a pattern or practice of violations); or
- the Appeal concerns an Urgent Care Claim and You have applied for an expedited Independent Review at the same time as applying for an expedited internal review, as further detailed under the Expedited Independent Review request provision below.

You may submit a written request for an Independent Review to: Utah Insurance Department, ATTN: Independent Review, State Office Building, Suite 3110, Salt Lake City, Utah 84114-6901. For more information and for an Independent Review request form see the Department's Web site at **www.insurance.utah.gov**, call the Department's telephone number at 1 (801) 538-3077 or inquire electronically at: **healthappeals.uid@utah.gov**.

If Your request qualifies for Independent Review, Our Final Adverse Benefit Determination will be reviewed by an Independent Review Organization (IRO) selected by the Department. We will pay the costs of the Independent Review. In order to have the Appeal reviewed by an IRO, You may be required to sign a waiver granting the IRO access to medical records.

Standard Independent Review Request

If We issue a Final Adverse Benefit Determination on Your request to provide or pay for a health care service or supply that is a Covered Service in this Policy, You may have the right to have Our decision reviewed by health care professionals who have no association with Us. You have this right only if Our denial decision involved:

- The Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of Your health care service or supply, or rescission of coverage, as follows:
    - Upon the Department's receipt of Your request for Independent Review, the Department will send a copy to Us for an eligibility review.
    - Within five working days after We receive Your request from the Department, We will review Your request for eligibility. Within one working day after We complete that review, We will notify You and the Department in writing whether Your request is eligible or what additional information is needed. If We deny Your eligibility for review, We will provide You and the Department the reason(s) for the ineligibility in writing. You may Appeal that determination to the Department.
    - If Your request is eligible for Independent Review, the Department will assign an IRO to Your review upon receipt of Our notice. The Department will also notify You in writing.
    - Within five working days, We will provide the IRO the documents and any information considered in making the Adverse Benefit Determination.
    - Within five working days of the date You receive the Department's notice of assignment to an IRO, You may submit any additional information in writing to the IRO that You want the IRO to consider in its review. The IRO will forward to Us within one working day of receipt, any information submitted by You.
    - The IRO must provide written notice of its decision to You, to Us and to the Department within 45 calendar days after receipt of an Independent Review request.
    - Within one working day of receipt of a notice reversing the Adverse Benefit Determination, We will approve the coverage that was the subject of the Adverse Benefit Determination and process any coverage that is due.
- Our determination that Your health care service or treatment was Investigational, as follows:
    - Upon the Department's receipt of Your request, the Department will send a copy to Us for an eligibility review. Such request to the Department must include certification from Your Physician that: 1) standard health care service or treatment has not been effective in improving Your condition; 2) standard health care service or treatment is not medically appropriate for You; or 3) there is no available standard health care service or treatment covered by Us that is more beneficial than the recommended or requested health care service or treatment.
    - Within five working days after We receive Your request from the Department, We will review Your request for eligibility. Within one working day after We complete that review, We will notify You and the Department in writing whether Your request is eligible or what additional information is needed. If We deny Your eligibility for review, We will provide You and the Department the reason(s) for the ineligibility in writing. You may Appeal that determination to the Department.
    - If Your request is eligible for Independent Review, the Department will assign an IRO to Your review upon receipt of Our notice. The Department will also notify You in writing.
    - Within five working days of the date You receive the Department's notice of assignment to an IRO, You may submit any additional information in writing to the IRO that You want the IRO to consider in its review. The IRO will forward to Us within one working day of receipt, any information submitted by You.
    - Within one working day after receiving the request, the IRO will select a clinical reviewer(s) to conduct the review. The clinical reviewer(s) will provide the IRO a written opinion within 20 calendar days after being selected. The IRO will make its decision based upon the clinical reviewer's(s') opinion and must provide written notice of its decision to You, to Us and to the Department within 20 calendar days after receipt of the opinion.
    - Within one working day of receipt of a notice reversing the Adverse Benefit Determination, We will approve the coverage that was the subject of the Adverse Benefit Determination and process any coverage that is due.

Expedited Independent Review Request

You may file a written request with the Department for an expedited Independent Review of a denial concerning an Urgent Care Claim. You may file for an expedited Appeal with Us and for an expedited Independent Review request with the Department at the same time.

- Upon the Department's receipt of Your request, the Department will immediately send a copy to Us for an eligibility review.
- Within one working day after We receive Your request from the Department, We will review Your request for eligibility. Within one working day after We complete that review, We will notify You and the Department in writing whether Your request is eligible or what additional information is needed. If We deny Your eligibility for review, We will provide You and the Department the reason(s) for the ineligibility in writing. You may Appeal that determination to the Department.
- If Your request is eligible for Independent Review, the Department will immediately assign an IRO to Your review upon receipt of Our notice. The Department will also notify You in writing.
- Within one working day of the date You receive the Department's notice of assignment to an IRO, You may submit any additional information in writing to the IRO that You want the IRO to consider in its review. The IRO will forward to Us within one working day of receipt, any information submitted by You.
- For expedited Independent Review of an Investigational health care service or treatment, the IRO will select a clinical reviewer(s) to conduct the review within one working day after receiving the request. The clinical reviewer(s) will provide the IRO a written opinion within five calendar days after being selected. The IRO will make its decision based upon the clinical reviewer's(s') opinion and must provide written notice of its decision to You, to Us and to the Department within 48 hours after receipt of the opinion.
- For all other eligible expedited Independent Review requests, within 72 hours after the date of receipt of the expedited Independent Review request, the IRO must provide notice of its decision to You, to Us and to the Department. If the notice of the IRO is not in writing, the IRO shall provide written confirmation of its decision within 48 hours after the date of the notification of the decision.
- Within one working day of receipt of a notice reversing the Adverse Benefit Determination, We will approve the coverage that was the subject of the Adverse Benefit Determination and process any coverage that is due.

INFORMATION

For pediatric vision benefits, if You have any questions about the Appeal process outlined here, You may contact VSP's Customer Service department at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance), Monday-Friday 5 a.m. - 8 p.m., Saturday 7 a.m. - 8 p.m., and Sunday 7 a.m. - 7 p.m.

For all other benefits under this Policy, if You have any questions about the Appeal Process outlined here, You may call Our Customer Service department or You can write to Our Customer Service department at the following address: Regence BlueCross BlueShield of Utah, P.O. Box 1827, MS CS B32B Medford, OR 97501-9884.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

Adverse Benefit Determination means, based upon Our requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service, the:

- denial, reduction or termination of a benefit;
- failure to provide or make payment, in whole or in part, for a benefit; or
- rescission of coverage.

An Adverse Benefit Determination also includes:

- the denial, reduction, termination, or failure to provide or make payment that is based on a determination of Your ineligibility to participate in the plan;
- failure to provide or make payment, in whole or in part, for a benefit resulting from the application of utilization review;

- the failure to provide coverage for an otherwise Covered Service because it is determined to be:
  - Investigational; or
  - not Medically Necessary.
- other matters as specifically required by state law or regulation.

A "Final" Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by Us at the completion of Our internal review process.

Appeal means a written or verbal request from an Insured or, if authorized by the Insured, the Insured's Representative, to change a previous decision made by Us concerning an Adverse Benefit Determination.

Independent Review means a process that is:

- a voluntary option for the resolution of a Final Adverse Benefit Determination;
- conducted at Your discretion;
- conducted by an IRO designated by the Department;
- renders an independent and impartial decision on a Final Adverse Benefit Determination; and
- may not require You to pay a fee for requesting the Independent Review.

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

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

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

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

Urgent Care Claim means a request for care or treatment which:

- involves a medical condition which could seriously jeopardize Your life or health or ability to regain maximum function (in determining whether such a request is to be treated as an Urgent Care Claim, We shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine);
- in the opinion of Your attending Provider, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment (any request that a Physician with knowledge of Your medical condition determines is an Urgent Care Claim shall be treated as such); or
- concerns an admission, availability of care, continued stay or health care service for which You received emergency services, but have not been discharged from a facility.

Who Is Eligible, How to Apply and When Coverage Begins

This section contains the terms of eligibility under this Policy for a Policyholder and his or her dependents. It also describes when coverage under this Policy begins for You and/or Your eligible dependents. Of course, payment of any corresponding monthly premium is required for coverage to begin on the indicated dates.

WHEN COVERAGE BEGINS

Subject to meeting the eligibility requirements as stated in the following paragraphs, You will be entitled to apply for coverage for Yourself and Your eligible dependents. Coverage for You and Your applying eligible dependents will begin on the first day of the month following acceptance and approval of the application by Us.

Residency Requirement

To be eligible to apply, as a Policyholder, for coverage in this Policy, You must reside in an Eligible County and continue to live in an Eligible County six months or more per Calendar Year. We routinely verify the residence of Our applicants. In order to verify Your current residency status, We may require You to provide Us with copy of:

- the front page of Your most recent income tax return;
- if You are a student, a letter from the college/university registrar noting Your local residence address; or
- alternate documentation as authorized by Us.

For purposes of maintaining this Policy, the Policyholder must maintain a fixed permanent home within an Eligible County. If it is necessary for the Policyholder to leave an Eligible County for an extended period of time, the Policyholder may be required to submit appropriate documentation as proof of maintaining his or her primary residence within an Eligible County during his or her absence. Treatment received in a residential care facility is not considered an eligibility qualification for this Residency Requirement provision.

If You move and are no longer a Resident in an Eligible County, We will terminate this Policy and refund any premium payments made for periods after the end of the billing cycle in which We acquire actual knowledge that You are no longer a Resident. The only exception to the termination policy is if You are a military service member who is stationed outside of an Eligible County, You will not be terminated if Your legal residence continues to be within an Eligible County.

Policyholder

An applicant must agree to the terms of this Policy by submitting a written application for approval and acceptance by Us. The application will be considered to be a part of this Policy. Applicants are eligible to apply under this Policy if they meet the Residency Requirement provision above at the time of application for enrollment. Applications and statements made on the application will be binding on both the applicant and dependents.

Dependents

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

- The person to whom You are legally married (spouse).
- Your domestic partner, provided that all of the following conditions are met:
    - You have completed, executed and submitted an affidavit of qualifying domestic partnership form with regard to Your domestic partner;
    - both You and Your domestic partner are age 18 or older;
    - You and Your domestic partner share a close, personal relationship and are responsible for each other's common welfare;

- neither You nor Your domestic partner is legally married to anyone else or has had another domestic partner within the 30 days immediately before submitting an application for Your domestic partner;
- You and Your domestic partner share the same regular and permanent residence and intend to continue doing so indefinitely;
- You and Your domestic partner share joint financial responsibility for Your basic living expenses, including food, shelter and medical expenses; and
- You and Your domestic partner are not more closely related by blood than would bar marriage in Your state of residence.

- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:

  - Your (or Your spouse's or Your domestic partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your domestic partner) for adoption;
  - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; and
  - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).

- Your (or Your spouse's or Your domestic partner's) otherwise eligible child who is age 26 or over and who is a Disabled Dependent due to a Physical Impairment or a Mental Impairment that began before his or her 26th birthday, if You complete and submit Our affidavit of dependent eligibility form, with written evidence of the child's impairment, within 31 days of the later of the child's 26th birthday or Your Effective Date, the child meets the requirements of a Disabled Dependent as defined in the Definitions Section below, and either:

  - he or she is an enrolled child immediately before his or her 26th birthday; or
  - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on accident and health insurance with no break in coverage of more than 63 days, since that birthday.

Our affidavit of dependent eligibility form is available by visiting Our Web site or by calling Customer Service.

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an application (and, for a domestic partner, an affidavit of qualifying domestic partnership form) to Us. Applications for enrollment of a newly eligible dependent must be made within 60 days of the dependent's attaining eligibility. Coverage for such dependents will begin on their Effective Dates (which, for a new child by birth, adoption or placement for adoption, is the date of birth, adoption or placement for adoption, if enrolled within the specified 60 days). See also the Special Enrollment provision below.

SPECIAL ENROLLMENT

If You and/or Your eligible dependents have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to enroll (except as specified otherwise below) for coverage under the Policy within 60 days from the date of the qualifying event:

- If You, Your spouse or domestic partner gain a new dependent child or, for a child, become a dependent child by birth, adoption or placement for adoption;
- If You, Your spouse or domestic partner gain a new dependent child or, for a spouse or domestic partner or child, become a dependent through marriage or beginning of a domestic partnership;
- Unintentional, inadvertent, or erroneous enrollment or non-enrollment resulting from an error, misrepresentation, or inaction by an officer, employee, or agent of the Exchange or U.S. Department of Health and Human Services;

- Can adequately demonstrate that a qualified health plan has substantially violated a material provision of Your contract with regard to You and/or Your eligible dependents;
- Become newly eligible or newly ineligible for advance payment of premium tax credits or have a change in eligibility for cost-sharing reductions;
- Lose eligibility for group coverage due to: death of a covered employee, an employee's termination of employment (other than for gross misconduct), an employee's reduction in working hours, an employee's divorce or legal separation, an employee's entitlement to Medicare, a loss of dependent child status, or certain employer bankruptcies;
- Permanently move to an area where one or more new Qualified Health Plans (QHPs) is available; or
- Loss of minimum essential coverage.

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

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

DOCUMENTATION OF ELIGIBILITY

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

DEFINITIONS SPECIFIC TO WHO IS ELIGIBLE, HOW TO APPLY AND WHEN COVERAGE BEGINS SECTION

Resident means a person who is able to provide satisfactory proof of having residence within an Eligible County as his or her primary place of domicile for six months or more in a Calendar Year, for the purpose of being an eligible applicant.

Disabled Dependent means a child who is and continues to be: 1) unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable Physical or Mental Impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and 2) dependent on You for more than 50 percent of his or her support (food, shelter, clothing, medical and dental care, education and the like).

Eligible County means one of the following counties located within the state of Utah: Box Elder, Cache, Carbon, Daggett, Davis, Duchesne, Emery, Juab, Morgan, Rich, Salt Lake, Sanpete, Tooele, Uintah, Utah and Weber.

Mental Impairment means a mental or psychological disorder such as: 1) intellectual disability; 2) organic brain syndrome; 3) emotional or mental illness or 4) specific learning disabilities as determined by Us.

Physical Impairment means a physiological disorder, condition or disfigurement, or anatomical loss affecting one or more of the following body systems: 1) neurological; 2) musculoskeletal; 3) special sense organs; 4) respiratory organs; 5) speech organs; 6) cardiovascular; 7) reproductive; 8) digestive; 9) genito-urinary; 10) hemic and lymphatic; 11) skin or 12) endocrine.

When Coverage Ends

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

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

If this Policy is cancelled for a reason other than an intentional misrepresentation of material fact or fraud, We shall refund the unearned amount of the collected premium. If We cancel this Policy because of an intentional misrepresentation of material fact or fraud, We shall refund all premiums collected minus claims that have been paid.

GUARANTEED RENEWABILITY AND POLICY TERMINATION

This Policy is guaranteed renewable, at the option of the Policyholder, upon payment of the monthly premium when due or within the grace period.

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

In addition, if We choose to discontinue offering coverage in the individual market, We will provide 180-days prior written notice to affected Policyholders and all Enrolled Dependents.

If this Policy is terminated or not renewed by the Policyholder or Us, coverage ends for You and Your Enrolled Dependents on the last day of the calendar month in which this Policy is terminated or not renewed so long as premium has been received for the calendar month.

MILITARY SERVICE

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

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, Your and Your Enrolled Dependents' coverage ends on the last day of the calendar month in which Your eligibility ends so long as premium has been received for the calendar month.

NONPAYMENT OF PREMIUM

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

GRACE PERIOD

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

For a Policyholder receiving advance payments of the premium tax credit, a grace period of three consecutive months will be granted if such Policyholder has previously paid at least one full month's

premium during the benefit year. During this grace period this Policy shall not be terminated; however, claims for services rendered may be pended during the second and third months of the grace period. If the premium has not been received during the grace period, this Policy shall be terminated on the last day of the first month of the three month grace period, not at the end of the grace period.

TERMINATION BY YOU

You have the right to terminate this Policy with respect to Yourself and Your Enrolled Dependents by giving notice to Us within 30 days. Coverage will end on the last day of the calendar month following the date We receive such notice so long as premium has been received for the calendar month. However, it may be possible for an ineligible dependent to continue coverage under this Policy according to the provisions below.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the last day of the calendar month in which his or her eligibility ends so long as premium has been received for the calendar month. However, it may be possible for an ineligible dependent to continue coverage under this Policy according to the provisions below.

Divorce or Annulment

Eligibility ends for Your enrolled spouse and the spouse's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the calendar month following the date a divorce or annulment is final so long as premium has been received for the calendar month.

If You Die

If You die, coverage for Your Enrolled Dependents ends on the last day of the calendar month in which Your death occurs so long as premium has been received for the calendar month.

Policy Continuation

In the event that an Insured shall no longer meet eligibility as set forth above due to divorce, annulment, or death of the Policyholder, such Insured shall have the right to continue the coverage of this Policy without a physical examination, statement of health, or other proof of insurability.

Termination of Domestic Partnership

If Your domestic partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the calendar month following the date of termination of the domestic partnership so long as premium has been received for the calendar month. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. You may not file another affidavit of qualifying domestic partnership within 90 days after a request for termination of a domestic partnership has been received.

Loss of Dependent Status

- For an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the calendar month in which the child exceeds the dependent age limit so long as premium has been received for the calendar month.
- For an enrolled child who is no longer eligible due to disruption of placement before legal adoption and who is removed from placement, eligibility ends on the last day of the calendar month in which the child is removed from placement.
- For an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the calendar month in which the child is no longer a dependent so long as premium has been received for the calendar month.

OTHER CAUSES OF TERMINATION

Insureds may be terminated for any of the following reasons:

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

Fraud or Misrepresentation in Application
We have issued this Policy in reliance upon all information furnished to Us by You or on behalf of You and Your Enrolled Dependents. In the event of any intentional misrepresentation of material fact or fraud, We will have the right to declare all coverage under this Policy null and void in accordance with Utah Code 31A-22-721 (or any successor thereto); or We, at Our option, have the right to retroactively exclude or deny coverage for any claim, condition, or Enrollee related in any way to such untrue, inaccurate, or incomplete information.

MEDICARE SUPPLEMENT
When eligibility under this Policy terminates, You may be eligible for coverage under a Medicare supplement plan through Us as described here.

- If You are eligible for Medicare, You may be eligible for coverage under one of Our Medicare supplement plans. To be eligible for continuous coverage, We must receive Your application within 31 days following Your termination from this Policy. If You apply for a Medicare supplement plan within six months of enrolling in Medicare Part B coverage, We will not require a health statement. After the six-month enrollment period, We may require a health statement. Benefits and premiums under the Medicare supplement plan will be substantially different from this Policy.

General Provisions

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

PREMIUMS

Premiums are to be paid to Us on or before the premium due date. Failure to make timely payment of premiums may result in Our terminating this Policy as further detailed in the Grace Period provision in the When Coverage Ends Section.

Premium Payments

Except as required by law, We will not accept payments of premium or other cost-sharing obligations on behalf of an Insured from a Hospital, Hospital system, health-affiliated aid program, healthcare Provider or other individual or entity that has received or may receive a financial benefit related to the Insured's choice of health care. As required by the Centers for Medicare and Medicaid Services (CMS), We will accept premium and cost-sharing payments made on behalf of Insureds by the Ryan White HIV/AIDS Program, other federal and state government programs that provide premium and cost-sharing support for specific individuals, Indian Tribes, Tribal Organizations and Urban Indian Organizations.

CHOICE OF FORUM

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

GOVERNING LAW AND BENEFIT ADMINISTRATION

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

MODIFICATION OF POLICY

We shall have the right to modify or amend this Policy from time to time. This right includes Our ability to modify or amend premiums, benefits (for example, Deductible, Copayment, Coinsurance, Out-of-Pocket Maximum), exclusions, limitations, Covered Services, eligibility and/or networks. No modification or amendment will be effective until 30 days (or longer, as required by law) after written notice has been given to the Policyholder (except for modification of premium, which shall not be effective until 45 days after written notice has been given to the Policyholder), and modification must be uniform within the product line and at the time of renewal; except, however, when a change in this Policy is beyond Our control (for example, legislative or regulatory changes take place), We may modify or amend this Policy on a date other than the renewal date, including changing the premium rates, as of the date of the change in this Policy. We will give You prior notice of a change in premium rates when feasible. If prior notice is not feasible, We will notify You in writing of a change of premium rates within 30 days after the later of the Effective Date or the date of Our implementation of a statute or regulation. Provided We give notice of a change in premium rates within the above period, the change in premium rates shall be effective from the date for which the change in this Policy is implemented, which may be retroactive. Payment of new premium rates after receiving notice of a premium change constitutes the Policyholder's acceptance of a premium rate change.

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

REINSTATEMENT

If any renewal premium is not paid within the time granted You for payment, a subsequent acceptance of premium by Us, without also requiring an application for reinstatement, shall reinstate this Policy. However, if We require an application for reinstatement and issue a conditional receipt for the premium tendered, the Policy shall be reinstated upon approval of this application from Us or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless We have previously notified You in writing of Our disapproval of the application. The reinstated Policy shall cover only loss resulting

from such accidental Injury as may be sustained after the date of reinstatement and loss due to such Illness as may begin more than 10 days after that date. In all other respects, We and You, have the same rights under the reinstated Policy as was had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to this Policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

NO WAIVER

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

NOTICES

Any notice to Insureds required in this Policy will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Insured will be addressed to the Insured and/or the Policyholder at the last known address appearing in Our records. If We receive a United States Postal Service change of address form (COA) for a Policyholder, We will update Our records accordingly. Additionally, We may forward notice for an Insured if We become aware that We don't have a valid mailing address for the Insured. Any notice to Us required in this Policy may be given by mail addressed to: Regence BlueCross BlueShield of Utah, P.O. Box 30272, Salt Lake City, UT 84130-0272 ; provided, however that any notice to Us will not be considered to have been given to and received by Us until physically received by Us.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

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

REPRESENTATIONS ARE NOT WARRANTIES

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

WHEN BENEFITS ARE AVAILABLE

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

- the person is eligible to be covered according to the eligibility provisions in this Policy;
- the person has applied and has been accepted for coverage by Us; and
- premium for the person for the current month has been paid by the Policyholder on a timely basis.

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

WOMEN'S HEALTH AND CANCER RIGHTS

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

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

Definitions

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

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

Allowed Amount means:

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

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

Ambulatory Surgical Center means a facility or that portion of a facility licensed by the state in which it is located, that operates exclusively for the purposes of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission. An Ambulatory Surgical Center must be a freestanding facility, meaning that it exists independently or is physically separated from another health care facility by fire walls and doors and is administered by separate staff with separate records.

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

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

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

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

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

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

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

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

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

Family means a Policyholder and his or her Enrolled Dependents.

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

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

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

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy. Illness does not include any state of mental health or mental disorder.

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

In-Network means a Provider that has an effective participating contract with Us that designates him, her or it as a network Provider, who is a member of Your chosen Provider network, to provide services and supplies to Insureds in accordance with the provisions of this coverage. In-Network also means a Provider that has an effective participating contract with one of Our Affiliates or a Provider outside the area that We or one of Our Affiliates serves, but who have contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as a Provider in the "In-Network") to provide services and supplies to Insureds in accordance with the provisions of this coverage. For a Rural Resident, In-Network Provider includes an Independent Hospital or Federally Qualified Health Center with regard to which that Insured is a Rural Resident and a Credentialed Staff Member at that Independent Hospital or his Local Practice Location. For In-Network Provider reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

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

Investigational means a Health Intervention that We have classified as Investigational. We will review Scientific Evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health

Intervention to determine if it is Investigational. A Health Intervention not meeting all of the following criteria is, in Our judgment, Investigational:

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

Lifetime means the entire length of time an Insured is covered under this Policy (which may include more than one coverage) with Us.

Medically Necessary or Medical Necessity means health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an Illness or Injury or its symptoms in a manner that is:

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

When a medical question-of-fact exists Medical Necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and that is known to be effective. For Health Interventions not yet in widespread use, the effectiveness shall be based on Scientific Evidence. For established Health Interventions, the effectiveness shall be based on first Scientific Evidence; then professional standards; and then expert opinion.

A HEALTH INTERVENTION MAY BE MEDICALLY INDICATED OR OTHERWISE MEET THIS DEFINITION OF MEDICAL NECESSITY, YET NOT BE A COVERED SERVICE IN THIS POLICY.

Out-of-Network refers to Providers that are not In-Network. We do not cover services provided by Out-of-Network Providers, except as specified in the Schedule of Benefits. For reimbursement of eligible Covered Services received from an Out-of-Network Provider services, You may be billed for balances over Our payment level in addition to any Deductible, Copayment and/or Coinsurance amount for Covered Services provided inside or outside the area that We or one of Our Affiliates serves.

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

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

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include podiatrists, chiropractors, psychologists, certified nurse midwives, certified registered nurse anesthetists, dentists and other professionals practicing within the scope of his or her respective licenses.

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

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

Rural Resident means an Insured who either lives or resides within 30 paved road miles of an Independent Hospital or Federally Qualified Health Center or, if not living or residing within 30 paved road miles, lives or resides in closer proximity to the Independent Hospital than a contracting Hospital or in closer proximity to the Federally Qualified Health Center than a contracting Provider.

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

Service Area means the state of Utah.

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

Upfront Benefit (if applicable) means those Covered Services designated as "Upfront" which are usually accessible to the Member without first having to satisfy any Deductible amount. Generally, there will also be no Coinsurance amount required for an Upfront Benefit, however, a Copayment or Coinsurance may still apply for each visit or access to an Upfront Benefit. Once an Upfront Benefit dollar or visit maximum (if applicable) has been reached, additional coverage is available subject to a Deductible, Copayment and/or Coinsurance. Refer to the Upfront Benefit in the Schedule of Benefits to determine coverage.

Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association (the Association) and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in disability income insurance benefits
  - $500,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's Web site at **www.ulhiga.org** or contact:

Utah Life and Health Insurance Guaranty Assoc. 60 East South Temple, Suite 500 Salt Lake City UT 84111 1 (801) 320-9955	Utah Insurance Department 3110 State Office Building Salt Lake City UT 84114-6901 1 (801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

Appendix - Durable Medical Equipment

This is a general list of covered and non-covered Durable Medical Equipment items. This list is not a complete list of all Durable Medical Equipment and any items not specifically listed will be reviewed to determine if they are eligible for coverage. Some items may be covered under the Preventive Care and Immunizations, Vision or Prescription Medications benefits of the Policy. In addition to the specific item limitations noted in italics below, all Durable Medical Equipment items are subject to Medical Necessity and the provisions and exclusions stated in the Policy.

Durable Medical Equipment	Covered	Non-Covered
Abdominal Binder/ Support	X	
Adaptive Devices or Aids to Daily Living		X
Aerochamber	X	
Air Cleaner, Purifier		X
Air Conditioners		X
Alarm Systems		X
Allergy Free Blanket, Pillow Case or Mattress Cover		X
Ankle Foot Orthotic (AFO)		X
Apnea Monitor	X	
Arch Supports, Insoles, Heel Cushions, etc.		X
Automatic Blood Pressure Monitor	X	
Auto-Tilt Chair		X
Bandages		X
Bar Bell Set, Dumb Bells		X
Barrel Crawl		X
Bathtub Lifts		X
Bathtub Seat/Bench/ Chair		X
Bathtub/Toilet Rails		X
Batteries, Replacement, any type		X
Battery Charger		X
Bed, Air Fluidized		X
Bed Baths (home type)		X
Bed Board		X
Bed Cradle		X
Bed Pans		X
Bed Side Rails		X
Bed Wedges, Foam Slants		X
Bed (hospital - standard, semi-electric)		X
Bed (hospital - total electric)		X
Bed (non-hospital, adjustable)		X
Bed (oscillating)		X
Bed (pressure therapy)		X
Beeper		X
Bilirubin Lights (phototherapy): *limited to 7 days/calendar year*	X	
Biofeedback Device		X

Durable Medical Equipment	Covered	Non-Covered
BiPAP (including attachments and supplies)		X
Blood Pressure Cuff and/or Kit		X
Bone Growth Stimulator (osteogenesis) purchase		X
Bone Growth Stimulator		X
Booster Chair (pediatric)		X
Brace (back - see Corset)	X	
Brace (knee): *limited to 1 per knee in a 3 year period*	X	
Brace	X	
Brace (scoliosis)	X	
Braille Teaching Texts		X
Brassiere/Bra (mastectomy)	X	
Breast Pump*	X	
Cane		X
Car Seat, adult or pediatric		X
Car/Van Lift, Car modifications		X
Carafe		X
Cast Boot (ambulatory surgical boot)	X	
Cervical Collar	X	
Cervical Pillow		X
Chair, adjustable (for dialysis only)		X

Durable Medical Equipment	Covered	Non-Covered
Chest Compression Vest, System Generator and Hoses		X
Circle Balance Discs		X
Cleaning Solutions		X
Coagulation Protime Self-Testing Device (CoaguChek)		X
Commode and accessories		X
Communicative Device, Equipment or Repair		X
Computer Systems or Components		X
Computerized Assistive Devices		X
Contact Lens	X	
Contact Lens, following corneal transplant: *limited to 1 lens/eye*	X	
Contact Lens, for keratoconus	X	
Continuous Hypothermia Machine		X
Continuous Passive Motion (CPM) Machine, including supplies: *limited to 21 days per Calendar Year for total knee or shoulder replacement*	X	

*As provided under the Preventive Care benefit.

Durable Medical Equipment	Covered	Non-Covered
Continuous Passive Motion (CPM) Machine for toe/foot surgeries, including supplies: *limited to 21 days per Calendar Year for toe/ foot surgeries*	X	
Continuous Passive Motion (CPM) Machine - other procedures	X	
Continuous Positive Airway Pressure (CPAP Machine – including attachments and supplies)		X
Contour Chair		X
Corset (lumbar), custom, orthopedic	X	
Cranial Electro Stimulation (CES)		X
Crawler (height adjustable)		X
Crawler(prone)		X
Crawling Coordination Training Unit		X
Crutches—purchase		X
Crutches—rental		X
Crutches, Underarm Pad Replacement		X
Cuff Weights		X
Dehumidifiers (room or central heating system)		X
Deironizer, Water Purification System		X
Dialysis Equipment (home)		X

Durable Medical Equipment	Covered	Non-Covered
Diabetic Supplies (syringes, needles)	X	
Diapers		X
Drionic Machine		X
Dynasplint		X
Ear Plugs, molds: *limited to 1 pair, following ear Surgery*	X	
Electrodes and Accessories for stimulators		X
Electronic Controlled Thermal Therapy Devices		X
Electrostatic Machine		X
Elevators		X
Emesis Basins		X
EMG Machine (Biofeedback)		X
Enuresis Alarm Unit		X
Environmental Control Systems		X
Erectile Aid System (vacuum system)		X
Exercise Equipment		X
Eyeglasses: *limited to 1 pair of lenses/ Calendar Year*	X	
Face Masks		X
Fracture Frame		X
Gel Flotation Pads and Mattresses		X
Glucometer (blood glucose monitor)	X	

Durable Medical Equipment	Covered	Non-Covered
Glucose Monitor (continuous)	X	
Grab Bars		X
Gym Mat		X
Hand Controls for Motor Vehicle		X
Handgrip Replacement (cane, crutch, walker, wheelchair, etc.)		X
Head Float		X
Health Spa		X
Hearing Aids, hearing Devices		X
Heat Lamps		X
Heating Pads, Hot Water Bottle		X
Helmet (cranial molding orthosis)	X	
Home Modifications		X
Home Physical Therapy Kits		X
Hot Tub		X
Humidifier		X
Humidifier (room or central heating)		X
Humidifier (with IPPB or other respiratory equipment)		X
H-Wave Electronic Device, including supplies		X
Hydraulic Patient Lifts		X
Hydrocollater Unit		X
Hydrotherapy Tanks		X

Durable Medical Equipment	Covered	Non-Covered
Ice Packs		X
Immobilizer, shoulder	X	
Incontinence Treatment System		X
Infusion Pumps (ambulatory) Parenteral, Enteral	X	
Insulin Pump (external, ambulatory)	X	
Interferential Nerve Stimulator		X
IPPB Machine		X
IV Pole	X	
Kangaroo Pump/Kit	X	
Lambswool Pads	X	
Lift Platform, wheelchair, van or home		X
Lift, Chair (seat)		X
Light Box(seasonal)		X
Lumbosacral Support	X	
Lymphedema Pump (pneumatic compressor)*		X
Lymphedema Sleeves/ Supplies*		X
Maclaren Buggy, Stroller		X

*Except when required in conjunction with breast reconstruction following a Medically Necessary mastectomy, to the extent required by law.

Durable Medical Equipment	Covered	Non-Covered
Maintenance, Warranty or Service Contracts		X
Maintenance/Repair, Routine		X
Massage Devices		X
Mattress, Hospital bed		X
Mattress, inner spring or foam rubber		X
Mattress, pressure-reducing, including overlay		X
Motor Vehicle		X
Motor Vehicle Alterations, Conversions		X
Motor Vehicle Devices, Hand Controls, Lifts, etc.		X
Mouth Guard		X
Muscle Stimulator, including supplies		X
Myoelectric Prosthetics		X
Nebulizer, with compressor, ultrasonic, heater, etc.: *Limited to one in five years*	X	
Neo-control Chair		X
Neuromuscular Stimulator (NMES)		X
Oral appliance to treat Obstructive Sleep Apnea		X
Orthopedic Brace for sports activities		X
Orthotics, Shoe Inserts (any type)		X
Overbed Tables		X

Durable Medical Equipment	Covered	Non-Covered
Oximeter (pulse oximeter)	X	
Oxygen (contents), Cylinders, Carrier	X	
Oxygen, Portable Systems	X	
Oxygen Humidifier	X	
Oxygen Regulators	X	
Oxygen Systems, Concentrators and Accessories—purchase		X
Oxygen Systems, Concentrators and Accessories—rental	X	
Oxygen Tent	X	
Pager		X
Paraffin Bath Units (therabath)		X
Parallel Bars		X
Patient Lifts, Slings	X	
Peak Flow Meter, (handheld): *limited to 1/calendar year*	X	
Pelvic Floor Stimulator		X
Percussor, Chest (with generator)		X
Polarcare (cold compression Device)		X
Portable Room Heaters		X
Postural Drainage Board		X
Posture Chair		X
Pressure Pads, Cushions and Mattresses (with or without pumps)		X

Durable Medical Equipment	Covered	Non-Covered
Prosthesis, Breast (non-implant)	X	
Prosthesis, Limb		X
Prosthetic Socks (stump socks), and supplies		X
Protonics Knee Orthosis		X
Pulsed Galvanic Stimulator, including supplies		X
Quad-Cane		X
Raised Toilet Seats		X
Reflux Board, infant		X
Repairs, Non-Routine Performed by a skilled technician		X
Rib Belt	X	
Rocking Bed		X
Roho Air Flotation System		X
Rollabout Chair		X
Rowing Machine		X
Safety Grab Bar, Rail, Bathroom, Toilet, Bed		X
Safety Rollers, with walkers		X
Sauna Baths		X
Scales		X
Scoliosis Orthotic Devices	X	
Scooter Board		X
Seat Lift Mechanism		X
Shoes, Orthopedic or Corrective, Modifications, lifts, Heels, Wedges, Inserts, etc.		X

Durable Medical Equipment	Covered	Non-Covered
Shower Bench		X
Sitz Bath		X
Sling, Arm	X	
Spa Membership		X
Speech Augmentation Communication Device		X
Speech Generating Device		X
Speech Teaching Machines, Language Master		X
Sphygmomanometer with Cuff (blood pressure cuff)		X
Spinal Pelvic Stabilizers		X
Stairglide (stairway elevator lift)		X
Stander		X
Standing Table		X
Stethoscope		X
Suction Pump, Aspirator	X	
Sun Glasses		X
Support Hose (elastic stockings, surgical stockings)		X
Support Pillow		X
Swimming Pool		X
Sympathetic Therapy Stimulator (STS), including supplies		X
Telephone		X
Telephone Alert Systems		X
Telephone Arms		X

Durable Medical Equipment	Covered	Non-Covered
Theraband		X
Therapy Ball, Roll, Putty		X
Thermometer		X
Three-Wheeler Wheelchair	X	
Tips, Replacement (wheelchair, walker, crutches, etc.)		X
Toddler Walkabout		X
Toileting Aids		X
Tool Kits		X
Tracheostomy Speaking Valve		X
Traction, Cervical, Extremity, Pelvic		X
Traction, Overdoor		X
Transcutaneous Electrical Nerve Stimulator (TENS) Unit, including supplies		X
Transfer Board		X
Trapeze Bars		X
Tray, Desk, Drafting Table, Easel, Caddy Tray, Cup Holder, etc. (wheelchair)		X
Tricycle, Hip Extensor		X
Truss	X	
Ultraviolet Cabinet		X
Ultraviolet Lamp, handheld		X
Upholstery, Reinforcement or Replacement		X
Urinals		X

Durable Medical Equipment	Covered	Non-Covered
Used Equipment		X
Uterine Activity Monitor (with pregnancy)		X
Vacuum Assisted Closure (VAC) Wound Healing	X	
Van, Van Conversion		X
Vaporizer, room type		X
Ventilator - rental	X	
Ventilator - purchase		X
Vibrating Chair		X
Vibrators		X
Vision Aid or Device		X
Walkers and attachments, Basic—purchase		X
Walkers and attachments, Basic—rental		X
Walkers and attachments, Specialty—purchase		X
Walkers and attachments, Specialty—rental		X
Waterbed		X
Wheelchair	X	
Wheelchair armrest replacements	X	
Wheelchair auto carrier		X
Wheelchair backpacks, caddy, carrier, baskets, etc		X
Wheelchair, caster replacement	X	

Durable Medical Equipment	Covered	Non-Covered
Wheelchair cushions	X	
Wheelchair footrest replacement	X	
Wheelchair heel, toe loops replacement		X
Wheelchair Safety Equipment (belt, harness, vest)	X	
Wheelchair Seatbelts, Crossbar Replacement	X	
Wheelchair Seating System	X	
Wheelchair Spoke Protectors		X
Wheelchair Stand-Up		X
Wheelchair Strap/Belt Harness Replacement	X	
Wheelchair Tires/ Tubes, Replacement	X	
Wheelchair Tune-up		X
Wheelchair Utility Tray		X
Wheelchair Ramp		X
Wheelmobile		X
Whirlpool Bath Equipment		X
Whirlpool Pumps		X
White Cane		X
Wig, Hair Piece		X
Work Table		X
Wrist Alarm		X

SCHEDULE OF BENEFITS

Silver 3000 EPO

This Schedule of Benefits provides You with information regarding Your costs for Covered Services and how Provider choice affects Your out-of-pocket costs. This Schedule of Benefits is part of Your Policy. Please read the entire Policy to understand the benefits, limitations, exclusions, defined terms and provisions of this Policy.

	Insured Responsibility In-Network Provider Only
Coinsurance	30%
Deductible per Calendar Year	$3,000 per Insured $6,000 per Family
Out-of-Pocket Maximum per Calendar Year	$7,350 per Insured $14,700 per Family

EXCLUSIVE PROVIDERS

Be aware that this Plan requires You to receive Covered Services from In-Network Providers. There is no coverage for Out-of-Network Providers except for Covered Services as specified below. When permitted services are received from Out-of-Network Providers, the Insured is responsible for paying the difference between the amount billed by the Out-of-Network Provider and the Allowed Amount. Rural Residents are entitled to Out-of-Network Covered Services by an Independent Hospital, a Credentialed Staff Member at an Independent Hospital or his Local Practice Location, or a Federally Qualified Health Center, as further described in the Policy and Claims Administration Section.

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies	
Benefit	**Insured Responsibility In-Network Provider Only**
Office or Urgent Care Facility Visits – Illness or Injury • The Copayment applies until the Out-of-Pocket Maximum is met.	Primary Physician or Practitioner – $20 Copayment, Deductible waived Specialist (including urgent care facility) – $60 Copayment, Deductible waived
Preventive Care and Immunizations	0%, Deductible waived
Other Professional Services	30%
Ambulance Services • Out-of-Network services are covered and apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum.	30%
Ambulatory Surgical Center	20%
Autism Spectrum Disorder Services	30%
Blood Bank • Out-of-Network services are covered and apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum.	30%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies	
Benefit	**Insured Responsibility In-Network Provider Only**
Cardiac and Pulmonary Rehabilitation – Outpatient • 5 visits combined per Calendar Year	30%
Clotting Factor Products – Outpatient	30%
Detoxification	30%
Diabetic Education	0%, Deductible waived
Dialysis – Inpatient	30%
Dialysis – Outpatient Initial Outpatient Treatment Period • Services for the initial outpatient treatment period of 120 days for hemodialysis, peritoneal dialysis and hemofiltration services. • Out-of-Network services are covered and apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum.	30%
Dialysis – Outpatient Supplemental Outpatient Treatment Period for Dialysis (Following Initial Outpatient Treatment Period) • If Our agreement with the Provider expressly specifies that its terms supersede the benefits (or this benefit) of this Policy, We pay 100% of the Allowed Amount. Otherwise, We pay 125% of the Medicare allowed amount at the time of service. • Out-of-Network services are covered and apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum.	0%
Durable Medical Equipment • Additional limitations apply, refer to the Durable Medical Equipment Appendix.	30%
Emergency Room • Out-of-Network Provider services are covered the same as In-Network Provider services.	30%
Family Planning	30%
Habilitation Services • 30 inpatient days per Calendar Year • 20 outpatient combined visits per Calendar Year	30%
Home Health Care • 30 visits per Calendar Year	30%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies	
Benefit	**Insured Responsibility In-Network Provider Only**
Hospice Care • 14 inpatient or outpatient respite days per Lifetime	30%
Hospital Care – Inpatient and Outpatient	30%
Maternity Care/Adoption Benefit • $4,000 per pregnancy for adoption expenses	30%
Medical Foods (PKU)	30%
Mental Health or Substance Use Disorder Services	30%
Newborn Care	30%
Nutritional Counseling • Limited to nutritional counseling and therapy for diabetic counselling only.	30%
Palliative Care • 30 visits per Calendar Year	30%
Prescription Medications – Pharmacy • **Nonparticipating Pharmacies are not covered** • Copayment is based on each 30-day supply • *$5 or 5% discount on Prescription Medications filled at a Preferred Pharmacy. • 30-day supply for Specialty Medications • 90-day supply for Prescription Medications (even if the packaging includes a larger supply) • Multiple-month dispensing: the largest allowed quantity is the smallest multiple-month supply as packaged by the manufacturer. • **Nonparticipating Specialty Pharmacies are not covered** • For Specialty Medications (including those on the Specialty Select Drug List) to be covered after the initial fill, they must be filled at a Specialty Pharmacy. However, some Specialty Medications must have the first and subsequent fills at a Specialty Pharmacy.	*$10 Copayment, Deductible waived for each Preferred Generic Medication on the Essential Formulary
	*25%, Deductible waived for each Non-Preferred Generic Medication on the Essential Formulary
	*30% for each Preferred Brand-Name Medication on the Essential Formulary
	*50% for each Non-Preferred Brand-Name Medication on the Essential Formulary
	40% for each Preferred Specialty Medication on the Essential Formulary from a Specialty Pharmacy
	50% for each Non-Preferred Specialty Medication on the Essential Formulary from a Specialty Pharmacy
	30% for each Self-Administrable Cancer Chemotherapy Medication on the Essential Formulary; refer to Policy for Special Provisions for a Cancer Drug Treatment Regimen
Prescription Medications – Mail-Order Supplier • **Nonparticipating Mail-Order Suppliers are not covered**	$20 Copayment, Deductible waived for each Preferred Generic Medication on the Essential Formulary
	20%, Deductible waived for each Non-Preferred Generic Medication on the Essential Formulary

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies	
Benefit	**Insured Responsibility In-Network Provider Only**
• 90-day supply for Prescription Medications (even if the packaging includes a larger supply) • Multiple-month dispensing: the largest allowed quantity is the smallest multiple-month supply as packaged by the manufacturer.	25% for each Preferred Brand-Name Medication on the Essential Formulary
	45% for each Non-Preferred Brand-Name Medication on the Essential Formulary
	30% for each Self-Administrable Cancer Chemotherapy Medication on the Essential Formulary; refer to Policy for Special Provisions for a Cancer Drug Treatment Regimen
Prosthetic Devices • Artificial prosthetic eye prosthetics limited to once every 5 years per site	30%
Rehabilitation Services • 30 inpatient days per Calendar Year combined with Skilled Nursing Facility services • 20 outpatient combined visits per Calendar Year	30%
Skilled Nursing Facility (SNF) Services • 30 inpatient days per Calendar Year combined with inpatient Rehabilitation Services	30%
Spinal Manipulations • 10 spinal manipulations per Calendar Year	30%
Telehealth	$10 Copayment, Deductible waived
Telemedicine	30%
Termination of Pregnancy	30%
Transplants	30%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit – Pediatric Dental (under age 19)	**Insured Responsibility**	
	Participating Dentist	**Nonparticipating Dentist**
Preventive and Diagnostic Services • Additional limitations apply, refer to the Medical Benefits Section.	0%, Deductible waived	0%, Deductible waived

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies		
Benefit – Pediatric Vision (under age 19)	**Insured Responsibility**	
	VSP Doctor	**Out-of-Network Provider**
• 1 routine eye examination per Calendar Year • 1 frame per Calendar Year • 1 pair of lenses (2 lenses) per Calendar Year • Contacts may be selected (once per Calendar Year) instead of frames and lenses • Low vision supplemental testing and supplemental aids every 2 Calendar Years • Coinsurance amounts for Out-of-Network Providers do not accrue to the Out-of-Pocket Maximum. • Additional limitations apply, refer to the Medical Benefits Section.	Examination – 0%, Deductible waived	Examination – 25%, Deductible waived
	Otis and Piper Collection Frames – 0%, Deductible waived	Frames – 25%, Deductible waived
	Lenses – 0%, Deductible waived	Lenses – 25%, Deductible waived
	Contact Lens Evaluation and Fitting Examination – 0%, Deductible waived	Contact Lens Evaluation and Fitting Examination – 25%, Deductible waived
	Low Vision Supplemental Testing – 0%, Deductible waived	Low Vision Supplemental Testing – 25%, Deductible waived
	Low Vision Supplemental Aids – 0%, Deductible waived	Low Vision Supplemental Aids – 25%, Deductible waived

Additional Benefit - Refer to this Policy for details on this program
Accidental Death Benefit

Regence

Regence BlueCross BlueShield of Utah

OUTLINE OF COVERAGE

OUTLINE OF COVERAGE

General Information

This outline of coverage is a brief description of the important features of your policy. After you are accepted, a policy and member card will be mailed to you. Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Regence. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

This plan is designed to provide coverage for major hospital, medical, and surgical expenses incurred as a result of a covered illness or injury. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in hospital medical services, and out of hospital care, subject to any deductibles, copayments, coinsurance, or other limitations which may be set forth in the policy.

This is NOT a Medicare Supplement Contract.

If you or a family member becomes eligible for Medicare, you should review the Medicare Supplement Buyer's Guide available from Regence. If you choose to continue coverage under the policy and Medicare, the benefits of the policy shall be reduced by any amounts paid by Medicare.

Guaranteed Renewability of Policy

The policy is renewable at the option of the policyholder upon payment of the monthly premium when due or within the grace period, except in cases of intentional misrepresentation of material fact or fraud in connection with the coverage, our decision to cease offering the policy to individual policyholders, or our decision to cease offering coverage in the individual market. No modification or amendment will be effective until 30 days (or longer, as required by law) after written notice has been given to the policyholder (except for modification of premium, which shall not be effective until 45 days after written notice has been given to the policyholder), and modification must be uniform within the product line and at the time of renewal.

Ten-Day Review Period

You will have 10 days after you receive the Regence policy to review the provisions of the policy and to review the benefits, limitations, and exclusions of the plan before acceptance. You may cancel within the 10-day review period and receive a full refund of your premium. There is no provision for premium refund after the 10-day review period. If your premium is refunded, the Regence policy shall be void from the effective date.

Essential Health Benefits

This coverage complies with the essential health benefits in the following ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services including chronic disease management; and pediatric services, including oral and vision care. There is no annual or lifetime maximum applicable to these services.

What is Covered

Benefits are available for these services and supplies when medically necessary. Benefits are subject to all of the applicable exclusions, limitations and requirements of the policy.

Inpatient and Outpatient Hospital/Skilled Nursing Facility

- Semi-private room accommodations
- Ancillary services and supplies
- Emergency room services
- Dialysis treatment chemotherapy and radiation therapy
- X-ray and laboratory services
- Inpatient rehabilitation and skilled nursing facility services limited to 30 days combined per calendar year

Home Health Care/Home Infusion Therapy Services

- Home health care services provided in your home limited to 30 visits per calendar year
- Home infusion therapy services provided in your home
- Other services and supplies

Physician Services

- Office visits
- Surgical services
- Assistant surgeon services
- Anesthesia services
- Inpatient medical services
- Outpatient medical services
- Diagnostic services
- Chemotherapy and radiation therapy
- Consultations
- Preventive services
- Skilled nursing services
- Dialysis treatment
- Mental health or substance use disorder services

Prescription Medications

Pharmacy Network Information

For any specialty medication for which the FDA has not restricted distribution to certain providers, if a participating pharmacy demonstrates the ability to provide the same level of services (for example, special handling, provider coordination, and/or patient education) as a specialty pharmacy and accepts all specialty pharmacy network terms, then that specialty medication from that participating pharmacy will be eligible for coverage.

Other Services

- Ambulatory surgical center
- Approved Clinical Trails
- Autism Spectrum Disorder
- Diabetic education received through an accredited or certified diabetic education program
- Durable medical equipment
- Medical/surgical supplies
- Ambulance services
- Inpatient/outpatient maternity care
- Hospice (inpatient/outpatient and respite) Respite limited to 14 inpatient or outpatient respite care days per lifetime
- Outpatient habilitation services limited to 20 visits combined per calendar year
- Outpatient rehabilitation services limited to 20 visits combined per calendar year
- Spinal manipulations limited to 10 spinal manipulations per calendar year
- Palliative Care limited to 30 visits per calendar year
- Telehealth
- Telemedicine

Diabetic Supplies
Diabetic supplies (including needles, syringes, test strips, lancets, and other disposable diabetic supplies) are covered under the basic policy benefit for prescriptions.

Transplants
Coverage is available. Examples for transplants are (but not limited to): kidney, cornea, heart, heart/lung, lung, liver, and pancreas transplants, and bone marrow transplants for certain conditions. List of covered transplants is subject to change over time. Contact Regence for an up to date list.

Preventive Services
We cover preventive services and immunizations according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC), and Health Services and Resources Administration (HRSA). In the event any of these bodies adopts a new or revised recommendation, we have up to one year before coverage of the related services must be available and effective.

We cover preventive care services provided by a professional provider or facility such as:

- routine well-baby care, routine physical examinations, routine well-women's care and routine health screenings;
- nutritional counseling and provider counseling and prescription medications prescribed for tobacco use cessation;
- immunizations for adults and children according to, and as recommended by, the Advisory Committee on Immunization Practices of the CDC;
- one non-hospital grade breast pump and accompanying supplies per pregnancy at the in-network benefit level when obtained from a provider or approved commercial seller; and
- United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods for women in accordance with HRSA recommendations.

Covered expenses do not include immunizations if the Insured receives them only for the purpose of travel, occupation or residency in a foreign country.

Pediatric Dental Coverage
The following pediatric dental benefits are covered for insureds under the age of 19. Coverage will be provided for an insured until the last day of the monthly period in which the insured turns 19 years of age.

- Routine x-rays, limited to twice per covered individual per calendar year.
- Full bitewing x-ray series (4), limited to twice per covered individual per calendar year; vertical bitewings, limited to 8 films.
- Complete mouth x-rays (posterior bitewing films and 14 periapical films plus bitewings), limited to once in a three-year period, in lieu of panoramic x-ray.
- Panorex (panoramic) mouth x-rays, limited to once in a three-year period, in lieu of complete mouth x-ray.
- Preventive oral examinations limited to twice per covered individual per calendar year.
- Cleanings limited to two per covered individual per calendar year.
- Topical fluoride application, limited to twice treatments per covered individual per calendar year.
- Sealants for permanent molars, limited to once in a five-year period.

Pediatric Vision Coverage
The following pediatric vision benefits are covered for insureds under the age of 19. Coverage will be provided for an insured until the last day of the monthly period in which the insured turns 19 years of age. Pediatric vision coverage is provided by us, in collaboration with Vision Service Plan Insurance Company (VSP), which coordinates the provision of benefits and claims processing.

- Routine Exam: one per calendar year
- Frames: one frame per calendar year
- Lenses: one pair (two lenses) per calendar year
- Contacts may be selected instead of frames and lenses once per calendar year
- Low vision supplemental testing and supplemental aids every two calendar years
- Limitations may apply, refer to the policy
- Discounts for non-covered services may apply, refer to the policy.

Accidental Death Benefit

This plan includes a death benefit payable when we receive proof of death caused by accidental means. Adult subscribers, covered spouses, covered domestic partners and covered children are eligible for this benefit. Benefits are subject to the terms set forth in the policy.

The accidental death benefits are outlined below:

Insured	Death Benefit
Adult Policyholder	$10,000
Covered Spouse or Domestic Partner	$10,000
Covered Dependent Child (per child)	$2,500

Exclusions

EXCLUSION EXAMPLES

The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under the policy, including related secondary medical conditions and are not all inclusive:

- Charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- Complications relating to services and supplies for, or in connection with gastric or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for, or in connection with, reversal or revision of such procedures, or any direct complications or consequences thereof;
- Complications by infection from a cosmetic procedure, except in cases of reconstructive surgery;
    - When the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
    - Related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- Complications that result from an injury or illness resulting from active participation in illegal activities.

GENERAL EXCLUSIONS

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise covered service for preventive service as specified under the preventive care and immunizations or the prescription medications benefits in the policy.

Activity Therapy

Creative arts, play, dance, aroma, music, equine or other animal-assisted, recreational or similar therapy; sensory movement groups; and wilderness or adventure programs.

Assisted Reproductive Technologies

Assisted reproductive technologies (including, but not limited to, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception), or associated surgery, drugs, testing or supplies, regardless of underlying condition or circumstance.

Aviation

Services in connection with Injuries sustained in aviation accidents (including accidents occurring in flight or in the course of take-off or landing), unless the injured insured is a passenger on a scheduled commercial airline flight or air ambulance.

Certain Therapy, Counseling and Training

Educational, vocational, social, image, milieu or marathon group therapy, premarital or marital counseling, Individual Assistance Program (IAP) services; job skills or sensitivity training.

Complementary Care

Complementary care, including, but not limited to, acupuncture.

Conditions Caused By Active Participation In a War or Insurrection

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

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

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

Corneal Refractive Therapy (CRT)

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

Cosmetic/Reconstructive Services and Supplies

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

- to treat a congenital anomaly;

- to restore a physical bodily function lost as a result of injury or illness; or
- related to breast reconstruction following a medically necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice in this outline of coverage or in the policy.

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

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

Counseling in the Absence of Illness
Except as provided under the palliative care benefit, we do not cover counseling in the absence of illness.

Custodial Care
Except as provided under the palliative care benefit, we do not cover non-skilled care and helping with activities of daily living.

Dental Hospitalization
Inpatient and outpatient services and supplies for hospitalization for dental services (including anesthesia).

Dental Services
Except as provided under the pediatric dental services benefit, we do not cover dental services provided to prevent, diagnose or treat diseases, injuries or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Discretionary Surgery
We do not cover eye lid surgery, varicose vein surgery or breast reductions except when following a medically necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice in this outline of coverage or in the policy.

Durable Medical Equipment
We do not cover certain durable medical equipment as detailed in the appendix attached to the end of the policy.

Expenses Before Coverage Begins or After Coverage Ends
Services and supplies incurred before your effective date or after your termination.

Facilities Without a Provider Legally Required to be on Duty
Admission and treatment in a setting where neither a physician nor licensed nurse is legally required to be on duty at all times that a patient is admitted.

Family Counseling
Except when family counseling is part of the treatment for a child or adolescent with a covered diagnosis, we do not cover family counseling.

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

Genetic Testing Services

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

Hearing Aids and Other Devices
Except for cochlear implants, we do not cover hearing aids (externally worn or surgically implanted) or other hearing devices.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses, including, but not limited to, use of such services for the treatment of painful physical conditions, mental health conditions, substance use disorders or for anesthesia purposes.

Illegal Services, Substances and Supplies
Services, substances and supplies that are illegal as defined under state or federal law.

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

Infertility
Except to the extent covered services are required to diagnose such condition, we do not cover treatment of infertility, including, but not limited to, surgery, fertility drugs and medications.

Investigational Services
Except as provided under the approved clinical trials benefit, we do not cover investigational treatments or procedures (health interventions), services, supplies and accommodations provided in connection with investigational treatments or procedures (health interventions). We also exclude any services or supplies provided under an investigational protocol.

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

Neurodevelopmental Therapy
Except as provided under the rehabilitation and skilled nursing facility or rehabilitation and habilitation services benefits, we do not cover neurodevelopmental therapy, including physical therapy, occupational therapy and speech therapy and maintenance service, to restore and improve function for a covered individual with neurodevelopmental delay. By "neurodevelopmental delay," we mean a delay in normal development that is not related to any documented illness or injury.

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

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

Obesity or Weight Reduction/Control
Except as required by law, we do not cover medical treatment, medication, surgical treatment (including treatment of complications, revisions and reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.

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

Orthotics
Except as provided under the durable medical equipment benefit in the medical benefits section and detailed in the appendix attached to the end the policy, we do not cover orthotics.

Out-of-Network Services
Except as specified for out-of-network providers in the policy, we do not cover out-of-network services.

Over-the-Counter Contraceptives
Except as provided under the prescription medications benefit or as required by law, we do not cover over-the-counter contraceptive supplies.

Personal Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control, education or general physical fitness. For example, we do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps, weight lifting equipment, physical fitness programs and therapy or service animals, including the cost of training and maintenance.

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

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

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

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

Routine Foot Care
Except for foot care associated with diabetes, we do not cover routine foot care.

Routine Hearing Examinations

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

- childbirth-related classes including infant care; and
- instruction programs including those that teach a person how to use durable medical equipment or how to care for a family member.

This exclusion does not apply to services for training or educating you when provided without separate charge in connection with covered services or when specifically indicated as a covered service in the medical benefits section (for example, diabetic education and teaching doses for self-administrable injectable medications).

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

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

Services and Supplies That Are Not Medically Necessary
Except for preventive care benefits provided, we do not cover services and supplies that are not medically necessary for the treatment of an illness or injury.

Sexual Dysfunction
Except for covered mental health services, we do not cover treatment, services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause.

Sleep Studies

Surrogacy
Maternity and related medical services received by you acting as a surrogate are not covered services up to the amount you or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, your acting as a surrogate. For purpose of this exclusion, "maternity and related medical services" includes otherwise covered services for conception, prenatal, maternity, delivery and postpartum care.

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

Termination of Pregnancy (Abortion)
Except as provided under the termination of pregnancy benefit the policy, we do not cover services or supplies related to the termination of a pregnancy (abortion).

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

Travel and Transportation Expenses
Travel and transportation expenses other than covered ambulance services.

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

Vision Care
Except as provided under the pediatric vision services benefit, we do not cover routine eye exams and vision hardware.

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

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

PRESCRIPTION MEDICATION EXCLUSIONS

Biological Sera, Blood or Blood Plasma

Brand-Name Medications not on the Essential Formulary
Except as provided through the substitution process in the prescription medications benefit, we do not cover brand-name medications that are not on the essential formulary list.

Cosmetic Purposes
Prescription medications used for cosmetic purposes, including, but not limited to: removal, inhibition or stimulation of hair growth; anti-aging; repair of sun-damaged skin; or reduction of redness associated with rosacea.

Devices or Appliances
Devices or appliances of any type, even if they require a prescription order (coverage for devices and appliances may otherwise be provided under the durable medical equipment benefit).

Foreign Prescription Medications
Except for prescription medications associated with an emergency medical condition while you are traveling outside the United States, or prescription medications you purchase while residing outside the United States, we do not cover foreign prescription medications. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this section if obtained in the United States.

Insulin Pumps and Pump Administration Supplies
Coverage for insulin pumps and supplies is provided under the diabetes supplies and equipment benefit.

Medications We Don’t Consider Self Administrable
Coverage for these medications may otherwise be provided under the policy.

Nonprescription Medications
Except for medications included on our essential formulary, approved by the FDA or a prescription order by a physician or practitioner, we do not cover medications that by law do not require a prescription order, for example, over-the-counter medications, including vitamins, minerals, food supplements, homeopathic medicines and nutritional supplements.

Oral Infant and Medical Formulas

Prescription Medications Dispensed from a Nonparticipating Pharmacy

Prescription Medications Dispensed in a Facility
Prescription medications dispensed to you while you are a patient in a hospital, skilled nursing facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed under the prescription medication benefit if obtained from a pharmacy.

Prescription Medications for Treatment of Infertility

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

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

Prescription Medications Used for Sexual Dysfunction or Enhancement

Prescription Medications with Lower Cost Alternative
Prescription medications for which there are covered therapeutically equivalent (similar safety and efficacy) alternatives or over-the-counter (nonprescription) alternatives, unless the higher cost prescription medications are medically necessary.

Prescription Medications without Examination
Except as provided under the telehealth and telemedicine benefits, we do not cover prescriptions made by a provider without recent and relevant in-person examination of the patient, whether the prescription order is provided by mail, telephone, internet or some other means. For purposes of this exclusion, an examination is "recent" if it occurred within 12 months of the date of the prescription order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the prescription medication is being prescribed. Additionally, this exclusion does not apply to a provider or pharmacist who may prescribe an opioid antagonist to an insured who is at risk of experiencing an opiate-related overdose.

Professional Charges for Administration of Any Medication

PEDIATRIC DENTAL EXCLUSIONS

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

Antimicrobial Agents
Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.

Basic (Restorative) Dental Services
Services and supplies provided in connection with basic (restorative) dental services, including the following:

- anesthesia;
- emergency (palliative) treatment;
- endodontic procedures (for example, apicoectomy, pulpotomy and root canal);
- fillings;
- oral surgery, including extractions; and
- periodontal procedures (for example, gingivectomy, gingivoplasty and osseous surgery).

Behavior Management

Collection of Cultures and Specimens

Connector Bar or Stress Breaker

Core Buildup for a Crown

Cosmetic/Reconstructive Services and Supplies
Cosmetic and/or reconstructive services and supplies, except for dentally appropriate services and supplies to treat a congenital anomaly and to restore a physical bodily function lost as a result of injury or illness.

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

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

Dental Hospitalization
Inpatient and outpatient services and supplies for hospitalization for dental services (including anesthesia).

Desensitizing
Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.

Diagnostic Casts or Study Models

Duplicate X-Rays

Experimental or Investigational Services: As Determined by Our Dental Policy

Fractures of the Mandible (Jaw)
Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-Foil Restorations
Home Visits, Including Extended Care Facility Calls

Implants
Services and supplies provided in connection with implants, whether or not the implant itself is covered, including, but not limited to:

- interim endosseous implants;
- eposteal and transosteal implants;
- sinus augmentations or lift;
- implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
- radiographic/surgical implant index; and
- unspecified implant procedures.

Indirect Pulp Capping as a Separate Charge

Major Dental Services
Services and supplies provided in connection with major dental services, including the following:

- bridges;
- dentures (whether interim partial or complete;
- inlays, onlays and crowns; and
- additional procedures to construct new crown under existing partial denture framework

Medications and Supplies
Charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies.

Nitrous Oxide

Occlusal Treatment
Services and supplies provided in connection with dental occlusion, including the following:

- occlusal analysis and adjustments; and
- occlusal guards.

Oral Hygiene Instructions

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

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

Photographic Images

Pin Retention in Addition to Restoration

Precision Attachments

Preventive and Diagnostic Dental Services Not Specifically Listed as a Covered Service

Prosthesis
Services and supplies provided in connection with dental prosthesis, including the following:

- maxillofacial prosthetic procedures; and
- modification of removable prosthesis following implant surgery.

Provisional Splinting

Pulp Vitality Tests

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

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

- any supplies;
- local anesthesia; and
- sterilization.

Services Performed in a Laboratory

Surgical Procedures
Services and supplies provided in connection with the following surgical procedures:

- exfoliative cytology sample collection or brush biopsy;
- incision and drainage of abscess extraoral soft tissue, complicated or non-complicated;
- radical resection of maxilla or mandible;
- removal of nonodontogenic cyst, tumor or lesion;
- surgical stent; or
- surgical procedures for isolation of a tooth with rubber dam.

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

Therapeutic Drug Injections for Dental Services

Tobacco or Nutritional Counseling for the Control and Prevention of Oral Disease

Tooth Transplantation
Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.

Treatment of Post-Surgical Complications Due to Unusual Circumstances

Veneers

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

Corrective Vision Treatment of an Experimental Nature

Costs for Services and/or Supplies Exceeding Benefit Allowances

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

Orthoptics or Vision Training
Orthoptics or vision training and any associated supplemental testing.

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

Replacement of Lenses and Frames
Except at the normal intervals when services are otherwise available, we do not cover replacement of lenses and frames furnished under the policy which are lost or broken.

Two Pair of Glasses in Lieu of Bifocals

Eligibility

To be eligible to apply, as a policyholder, you must reside in an eligible county and continue to live in an eligible county six months or more per calendar year. An eligible county means one of the following counties located within the state of Utah: Box Elder, Cache, Carbon, Daggett, Davis, Duchesne, Emery, Juab, Morgan, Rich, Salt Lake, Sanpete, Summit, Tooele, Uintah and Utah. The application used in establishing coverage will be considered to be a part of the policy. Any application (including statements made on such application) used in establishing this coverage will be considered to be a part of the policy and will be binding on both the applicant and dependents.

Open Enrollment Period

The open enrollment period is the period of time, as designated by law, during which you and/or your eligible dependents may enroll.

Termination

Coverage will terminate in the event of:

- Failure to pay premiums;
- Establishment of residence outside Utah;
- Intentional misrepresentation of material fact or fraud; or
- Loss of dependent eligibility.

If the policy is cancelled for a reason other an intentional misrepresentation of material fact or fraud, Regence shall refund the unearned amount of the collected premium. If Regence cancels the policy because of an intentional misrepresentation of material fact or fraud, Regence shall refund all premiums collected minus claims that have been paid.

Your coverage cannot be terminated for health reasons.

Regence has the right to terminate the policy if Regence:

- Eliminates coverage under the policy for all policyholders (in which case Regence shall provide 90 days prior written notice to all individuals covered under the policy and shall make available to the policyholder, without regard to the claims experience or health status of any covered person, the option to purchase any other individual policy being offered by Regence or an affiliate of Regence for which they qualify); or
- Elects not to renew all health benefit plans issued to individuals in Utah, in which case, Regence shall provide 180 days prior written notice to all individuals covered under the policy.

Exclusive Providers

Except for those covered services specified for out-of-network providers in the policy, you are required to receive covered services from in-network providers (an exception for rural residents is described below).

Rural residents are guaranteed access for covered services by rural health care providers at in-network benefits. Rural health care providers may not bill rural residents for balances beyond any deductible, copayment and/or coinsurance for covered services.

You can go to **regence.com** for further provider network information.

You will be responsible for the total billed charges for benefits in excess of lifetime or calendar year benefit maximums, if any, and for charges for any other service or supply not covered under the policy, regardless of the provider rendering such service or supply.

PREAUTHORIZATION

Contracted Providers

Contracted providers may be required to obtain preauthorization from us in advance for certain services provided to you. You will not be penalized if the contracted provider does not obtain those approvals from us in advance.

MEMBER CARD

Your member card is issued after you have been accepted for coverage.

IMPORTANT NOTE: YOUR COVERAGE IS NOT ACTIVE, AND YOU ARE NOT ELIGIBLE TO RECEIVE ANY BENEFITS, PRIOR TO:

- **YOUR PLAN'S EFFECTIVE DATE and**
- **PAYMENT OF YOUR FIRST PREMIUM**.

Once your coverage is active, if you or your enrolled family members require medical or hospital attention, simply present your member card. Key information is contained on your card that assists in proper handling of your claim.

OTHER PARTY LIABILITY

If another party is responsible for your illness or injury, the benefits paid under this program may be subject to subrogation. Subrogation means that Regence will recover the amounts it has paid in benefits out of the proceeds of any settlement or judgment that you receive as a recovery from the other party, whether or not you are made whole by the recovery and whether or not the recovery includes any amount for covered services.

COORDINATION OF BENEFITS

When you or your family members are also enrolled in another health plan, payments for covered services will be determined by coordinating the benefits of the two programs. Dual coverage will provide the maximum benefits to which you are entitled while preventing payment duplication. The primary health plan pays the full benefits covered under its program, and then the secondary health plan may reduce its benefits. In no event will payment be made in excess of expenses incurred.

APPEALS PROCESSES

Fair and well established multi-level process is available to you to resolve any complaints or grievances regarding a claim denial or other action by Regence or VSP with internal and external reviews. Refer to the policy for further information.

ENROLLMENT

After carefully reading this brochure and deciding to apply for coverage, you should complete the Utah Individual Health Insurance Application and the Individual Application Cover Sheet and return it to Regence BCBSU. Premiums are determined by the gender and age of the adult individual(s), and the number of children, if any, covered under the policy. We rely on the information you provide for yourself and your dependents, so the information must be complete and accurate for each person to be enrolled.

POLICY EFFECTIVE DATE

Your coverage effective date will be assigned on the first of the month after your application has been reviewed and accepted. If there is a delay in accepting your application and the effective date is postponed, you will be notified. Your premium payment must be received in order for your coverage to become effective.

PAYMENT OF PREMIUMS

Premiums are payable to Regence. If premiums are not fully paid within 30 days after the due date, coverage under the policy is automatically terminated effective with the due date of the unpaid premiums. You will be notified of any increase or decrease in premiums 45 days in advance of the change. Rate adjustments typically occur once each year on the first day of the month of your effective date, unless state or federal governments mandate benefit changes.

MODIFICATION OF POLICY

We have the right to modify or amend the policy from time to time. This right includes our ability to modify or amend premiums, benefits (for example, deductible, copayment, coinsurance, out-of-pocket-maximum), exclusions, limitations, covered services, eligibility and/or networks. No modification or amendment will be effective until 30 days after written notice has been given to the policyholder (except for modification of premium, which shall not be effective until 45 days after written notice has been given to the policy holder), and modification must be uniform within the product line and at the time of renewal.

REINSTATEMENT

If any renewal premium is not paid within the time granted for payment, a subsequent acceptance of premium by Regence, without also requiring an application for reinstatement, shall reinstate the policy. However, if Regence requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon approval of this application, or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless you have been previously notified in writing of a disapproval of the application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such illness as may begin more than 10 days after that date. In all other respects, both you and Regence, have the same rights under the reinstated policy as was had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Special Notices

YOUR SPECIAL ENROLLMENT PERIOD RIGHTS

If you and/or your eligible dependents have one of the following qualifying events, you (unless already enrolled), your spouse (or your domestic partner) and any eligible children are eligible to enroll (except as specified otherwise below) for coverage under the policy within 60 days from the date of the qualifying event:

- If you, your spouse or domestic partner gain a new dependent child or, for a child, become a dependent child by birth, adoption, or placement for adoption;
- If you, your spouse or domestic partner gain a new dependent child or, for a spouse or domestic partner or child, become a dependent through marriage or beginning a domestic partnership;
- Unintentional, inadvertent, or erroneous enrollment or non-enrollment resulting from an error, misrepresentation, or inaction by an officer, employee, or agent of the Exchange or U.S. Department of Health and Human Services;
- Can adequately demonstrate that a qualified health plan has substantially violated a material provision of your contract with regard to you and/or your eligible dependents;
- Become newly eligible or newly ineligible for advance payment of premium tax credits or have a change in eligibility for cost-sharing reductions;
- Lose eligibility for group coverage due to: death of a covered employee, an employee's termination of employment (other than for gross misconduct), an employee's reduction in working hours, an employee's divorce or legal separation, an employee's entitlement to Medicare, a loss of dependent child status, or certain employer bankruptcies;
- Permanently move to an area where one or more new Qualified Health Plans (QHPs) is available; or
- Loss of minimum essential coverage.

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE (WHCRA)

Regence is required by law to provide you with the following notice. This does not represent a change in your coverage. The Women's Health and Cancer Rights Act of 1998 (WHCRA) includes important protections for patients who elect breast reconstruction in connection with mastectomy.

For a covered person who receives benefits in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy including lymphedemas.

Benefits for the above services will be subject to the same subscriber cost-sharing provisions (for example, deductible, copayment and coinsurance) as may be deemed appropriate and as are consistent with those established for other covered services. Your plan is already in compliance with this mandate and provides coverage for this.

James Swayze
President
Regence BlueCross BlueShield of Utah
2890 East Cottonwood Parkway
Salt Lake City, UT 84121

For more information call Us at 1 (888) 231-8424 or You can write to Us at 2890 East Cottonwood Parkway, Salt Lake City, UT 84121

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