2025 BOOKLET FOR:

[GROUP NAME] (Always applies; Group name is system generated as it appears on the Group Master Application)

[Plan Name] (Always applies Plan Name is system generated based on groups benefit selection)

Group Number: [Group Number] (Always applies; Group number is system generated as it appears on the Group Master Application)

Regence BlueCross BlueShield of Utah Medical Benefits

[

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association] **(Always applies; subject to change based on Company logo and Company tagline updates)**

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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 less favorably because of race, color, national origin, age, disability, or sex.

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

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

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

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. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 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' hódíilnih 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

Regence BluePoint Silver 3250

This Schedule of Benefits is part of Your Booklet provided by Regence BlueCross BlueShield of Utah domiciled in Utah.

This Schedule of Benefits provides information regarding Your cost-shares for Covered Services and how Provider choice affects Your out-of-pocket expenses. Read the entire Booklet to understand the benefits, limitations, exclusions, defined terms and provisions of Your coverage.

	Member Responsibility	
	In-Network Provider	**Out-of-Network Provider**
Coinsurance	35%	50%
Deductible per Calendar Year • Except as noted with "Deductible waived," all benefits are subject to the Deductible and the Deductible must be met before benefits begin for any Member. No one Family Member may contribute more than their individual Deductible amount toward the Family Deductible.	$3,250 per Member $6,500 per Family	$5,000 per Member $10,000 per Family
Out-of-Pocket Maximum per Calendar Year	$8,150 per Member $16,300 per Family	$10,000 per Member $20,000 per Family

Your actual costs for Covered Services provided by an Out-of-Network Provider may exceed this Booklet's Out-of-Network Out-of-Pocket Maximum Amount. In addition, Out-of-Network Providers can bill You for the difference between the amount charged and Our Allowed Amount and that amount does not apply toward any Out-of-Pocket Maximum. Refer to the notice "Your Rights and Protections Against Surprise Medical Bills" attached to this Booklet for information regarding reimbursement and balance billing applicable to Out-of-Network Providers for certain services.

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies		
Benefit	**Member Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Preventive Care and Immunizations	0%, Deductible waived	50%
Preventive Care – Expanded Immunizations	35%	50%

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies		
Benefit	**Member Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Office or Urgent Care Visits – Illness or Injury	Primary Physicians or Practitioners – $40 Copayment, Deductible waived	50%
	Specialists (including urgent care) – $75 Copayment, Deductible waived	
Expanded Office Services • General medical services, surgical procedures and therapeutic injections are covered when provided by a professional Provider in the Provider's office.	35%	50%
Other Professional Services • Includes outpatient complex imaging	35%	50%
Acupuncture • 10 visits per Calendar Year	$40 Copayment, Deductible waived	50%
Ambulance Services • Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum.	35%	
Blood Bank • Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum.	35%	
Dental Hospitalization • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $4,000 per day.	35%	50%
Diabetic Education	0%, Deductible waived	50%

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies		
Benefit	**Member Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Dialysis • Outpatient Initial Treatment Period of 120 days	35%	50%
Dialysis – Outpatient Supplemental Treatment Period • If Our agreement with the Provider expressly specifies that its terms supersede Your benefits (or this benefit), You pay 0% of the Allowed Amount. Otherwise, We pay 125% of the Medicare allowed amount at the time of service.	0%, Deductible waived	0%, Deductible waived If You are not enrolled in Medicare Part B, You pay the balance of billed charges, which will not apply toward the Out-of-Pocket Maximum.
Durable Medical Equipment	35%	50%
Emergency Room • Copayment applies to the facility charge, whether or not You have met the Deductible. However, the Copayment is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis. • Out-of-Network services apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum.	After $400 Copayment and In-Network Deductible, 0%	
Gene Therapy and Adoptive Cellular Therapy	Centers of Excellence facility – 35%	Not a benefit, except for Rural Residents at Out-of-Network rural health care Providers
Gene Therapy and Adoptive Cellular Therapy – Travel Expenses • $7,500 per course of treatment, including companion(s), for transportation and lodging expenses • Additional limitations apply, refer to the Medical Benefits Section.	100% of all expenses. Your travel expenses may be reimbursed subject to Your In-Network Deductible and travel expense limit.	
Habilitation Services • 30 inpatient days per Calendar Year • 40 outpatient combined visits per Calendar Year • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $4,000 per day.	Inpatient services – 35% Outpatient services – $40 Copayment, Deductible waived	50%

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies		
Benefit	**Member Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Hearing Aids and Evaluations • $1,000 for hearing aid devices per Calendar Year	35%	50%
Home Health Care • 130 visits per Calendar Year	35%	50%
Hospice Care • 14 inpatient or outpatient respite days per Lifetime	35%	50%
Hospital Care – Inpatient and Outpatient • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $4,000 per day.	35%	50%
Hospital Care – Ambulatory Surgical Center	10%	50%
Infusion Therapy	35%	50%
Maternity Care/Adoption Benefit • $4,000 per pregnancy for adoption expenses • Out-of-Network services for the Adoption Benefit are covered and apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum. • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $4,000 per day.	35%	50%
	Adoption Expenses – 100% of billed charges. Your payment may be reimbursed up to the Adoption Benefit limit.	
Medical Foods	35%	50%
Mental Health or Substance Use Disorder Services • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $4,000 per day.	Inpatient services – 35%	50%
	Outpatient office/psychotherapy visits – $40 Copayment, Deductible waived Other outpatient services – 35%	

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies		
Benefit	**Member Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Neurodevelopmental Therapy • 40 visits per Calendar Year	$40 Copayment, Deductible waived	50%
Newborn Care • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $4,000 per day.	35%	50%
Nutritional Counseling • 3 visits per Calendar Year (Preventive Care and Immunizations, diabetic counseling and Mental Health or Substance Use Disorder Services are not subject to this limit.)	35%	50%
Orthotic Devices	35%	50%
Palliative Care • 30 visits per Calendar Year	35%	50%
Prosthetic Devices • $30,000 every 3 years per limb for microprocessor components	35%	50%
Provider-Administered Specialty Drugs	Specialty Pharmacy for Provider-Administered Specialty Drugs – 35%	Not a benefit, except for Rural Residents at Out-of-Network rural health care Providers
Radiology and Laboratory Services • Outpatient complex imaging is covered in Other Professional Services.	35%	50%
Rehabilitation Services • 30 inpatient days per Calendar Year • 40 outpatient visits per Calendar Year • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $4,000 per day.	Inpatient services – 35% Outpatient services – $40 Copayment, Deductible waived	50%
Skilled Nursing Facility • 60 inpatient days per Calendar Year	35%	50%

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies		
Benefit	**Member Responsibility**	
	In-Network Provider	**Out-of-Network Provider**
Spinal Manipulations • 10 spinal manipulations per Calendar Year	$40 Copayment, Deductible waived	50%
Temporomandibular Joint (TMJ) Disorders • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $4,000 per day.	35%	50%
Termination of Pregnancy	35%	50%
Transplants • For inpatient non-emergency admission to a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $4,000 per day.	35%	50%
Virtual Care – Store and Forward Services	$10 Copayment, Deductible waived	50%
Virtual Care – Telehealth	$10 Copayment, Deductible waived	50%

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies	
Benefit	**Member Responsibility**
Prescription Medications To obtain any of the lists mentioned below, visit Our website or contact Customer Service. Contact Information is available in the Introduction Section. • **No coverage for Prescription Medications not on the Drug List or Prescription Medications from a Nonparticipating Pharmacy, including a Nonparticipating Specialty Pharmacy and a Nonparticipating Home Delivery Supplier.** • Your cost-sharing will be applied to the In-Network Deductible (if Deductible applies) and In-Network Out-of-Pocket Maximum. • Deductible waived when You fill prescriptions for medications designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List. • You are not responsible for any Deductible, Copayment and/or Coinsurance when You fill prescriptions for medications intended to treat opioid overdose that are on the Opioid Rescue Medication Value List. • 30-day supply for Specialty Medications • 90-day supply for Prescription Medications (Copayment is based on each 30-day supply.) • Cost-sharing for Preferred Brand-Name insulin will not exceed $25 per 30-day supply or $75 per 90-day supply.	$25 Copayment, Deductible waived for each Preferred Generic Medication on the Drug List obtained from a Pharmacy; $75 Copayment, Deductible waived for each Preferred Generic Medication on the Drug List obtained from a Home Delivery Supplier
	$35 Copayment, Deductible waived for each Generic Medication on the Drug List obtained from a Pharmacy; $105 Copayment, Deductible waived for each Generic Medication on the Drug List obtained from a Home Delivery Supplier
	$60 Copayment, Deductible waived for each Preferred Brand-Name Medication on the Drug List obtained from a Pharmacy; $180 Copayment, Deductible waived for each Preferred Brand-Name Medication on the Drug List obtained from a Home Delivery Supplier
	50%, Deductible waived for each Brand-Name Medication on the Drug List obtained from a Pharmacy; 50%, Deductible waived for each Brand-Name Medication on the Drug List obtained from a Home Delivery Supplier
	20% for each Preferred Specialty Medication on the Drug List from a Specialty Pharmacy
	50% for each Specialty Medication on the Drug List from a Specialty Pharmacy
	35% for each Self-Administrable Cancer Chemotherapy Medication on the Drug List, Deductible is waived only for Preferred Generic, Generic, Preferred Brand-Name, and Brand-Name Medications. Refer to the Booklet for Special Provisions for a Cancer Drug Treatment Regimen.

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies		
Benefit – Pediatric Vision (under age 19)	**Member 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 examinations (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 – 100% of billed charges; 75% of Your payment may be reimbursed based upon the Allowed Amount, Deductible waived
	Otis and Piper Collection Frames – 0%, Deductible waived	Frames – 100% of billed charges; 75% of Your payment may be reimbursed based upon the Allowed Amount, Deductible waived
	Lenses – 0%, Deductible waived	Lenses – 100% of billed charges; 75% of Your payment may be reimbursed based upon the Allowed Amount, Deductible waived
	Contact Lens Evaluation and Fitting Examination – 0%, Deductible waived	Contact Lens Evaluation and Fitting Examination – 100% of billed charges; 75% of Your payment may be reimbursed based upon the Allowed Amount, Deductible waived
	Low Vision Supplemental Examinations (Testing) – 0%, Deductible waived	Low Vision Supplemental Examinations (Testing) – 100% of billed charges; 100% of Your payment may be reimbursed based upon the VSP Doctor Allowed Amount, Deductible waived
	Low Vision Supplemental Aids – 0%, Deductible waived	Low Vision Supplemental Aids – 100% of billed charges; 100% of Your payment may be reimbursed based upon the VSP Doctor Allowed Amount, Deductible waived

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

Introduction

Regence BlueCross BlueShield of Utah

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

Regence BlueCross BlueShield of Utah, an independent licensee of the Blue Cross and Blue Shield Association domiciled in Utah, agrees to provide the health care benefits as described in this Booklet.

This Booklet provides the evidence and a description of the terms and benefits of coverage. All covered benefits are subject to the terms, conditions, exclusions, and limitations in this Booklet. The agreement between the Group and Regence BlueCross BlueShield of Utah (called the "Contract") contains all the terms of coverage. Your plan administrator has a copy.

Term: This Booklet describes benefits effective **[{Month - spell out} dd, yyyy]**, or the date Your coverage became effective and is renewable at the option of the Group upon payment of the monthly premium.

This Booklet replaces any plan description, Booklet or certificate previously issued by Us and makes it void. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your Provider before receiving care.

In this Booklet, the terms "We," "Us" and "Our" refer to Regence BlueCross BlueShield of Utah and the term "Group" means the organization whose employees may participate in this coverage. References to "You" and "Your" refer to the Enrolled Employee **[**and/or Enrolled Dependents**]** **(Always applies unless is Enrolled Employee (EE) only coverage)**. Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized.

Essential Health Benefits

This coverage complies with the essential health benefits in the following ten categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitation and habilitation services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services including oral and vision care.

There is no annual or Lifetime maximum applicable to these services.

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

CONTACT INFORMATION

Customer Service: 1 (888) 367-2119
(TTY: 711)

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

Contact Customer Service:

- if You have questions;
- if You would like to learn more about Your coverage;

- if You would like to request written or electronic information regarding any other plan that We offer;
- to talk with one of Our Customer Service representatives;
- via Our website, **regence.com**, to submit a claim online or chat live with a Customer Service representative;
- to request a copy of Your identification card (or print a copy via Our website); or
- for assistance in a language other than English.

Mail Your medical or pediatric dental claims to the following address:

P.O. Box 1106
Lewiston, ID 83501-1106

For questions about Your plan or to contact Us, Our Customer Service and correspondence address is:

P.O. Box 1106
Lewiston, ID 83501-1106

Pediatric Vision Services – Vision Service Plan (VSP): 1 (844) 299-3041
(hearing impaired: 1 (800) 428-4833)

VSP phone lines are open Monday – Saturday, 6 a.m. – 5 p.m., Pacific Time.

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

Mail Your VSP Doctor vision claims to the following address:

Vision Service Plan
P.O. Box 495907
Cincinnati, OH 45249

Mail Your Out-of-Network Provider vision claims to the following address:

Vision Service Plan
P.O. Box 495918
Cincinnati, OH 45249

For questions about Your vision coverage, write to VSP at the following address:

Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100

Case Management. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. For additional information, refer to the Medical Benefits Section or call Case Management at 1 (866) 543-5765.

BlueCard® Program. This unique program 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. Call Customer Service to learn how to have access to care through the BlueCard Program.

Using Your Booklet

ACCESSING PROVIDERS

You are not restricted in Your choice of Provider for care or treatment of an Illness or Injury. You control Your out-of-pocket expenses by choosing between "In-Network" and "Out-of-Network" Providers. Rural Residents have an additional choice, which is described below and in the Rural Health Care Providers provision in the Contract and Claims Administration Section.

- **In-Network.** Choosing In-Network Providers saves You the most in Your out-of-pocket expenses. In-Network Providers will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. NOTE: Covered Services for Preventive Care and Immunizations provided by a Provider that has any form of participating contract to provide services and supplies to Our Members in accordance with the provisions of this coverage, will be covered at the In-Network benefit level.
- **Out-of-Network.** Choosing Out-of-Network Providers means Your out-of-pocket expenses will be higher than choosing an In-Network Provider. Also, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. This is referred to as balance billing. Refer to the notice "Your Rights and Protections Against Surprise Medical Bills" attached to this Booklet for information regarding reimbursement and balance billing applicable to Out-of-Network Providers for certain services.
- **Rural Health Care.** Rural Residents are guaranteed access to Covered Services by rural health care Providers at the In-Network benefit level. Rural health care Providers may not bill Rural Residents for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

For each benefit, We indicate in the Schedule of Benefits, the Provider You may choose and Your payment amount for each provider option. See the Definitions Section for a complete description of In-Network and Out-of-Network. You can go to **regence.com** for further Provider network information.

ADDITIONAL ADVANTAGES OF MEMBERSHIP

Advantages of 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 Our website and Our mobile application to help You navigate Your way through health care decisions. For access, You just set up Your free account once and it is always up to You whether to participate. **THESE SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS IN YOUR BOOKLET.** Additional information about some programs and services can be found in the Value-Added Services Appendix at the end of this Booklet.

- **Go to regence.com or Our mobile application.** You can use these secure applications to:
    - view recent claims, benefits and coverage;
    - find a contracting Provider or identify Participating Pharmacies;
    - use tools to estimate upcoming health care costs and otherwise help You manage health care expenses;
    - get suggestions to improve or maintain wellness and participate in self-guided motivational online wellness programs;
    - learn about prescriptions for various Illnesses;
    - compare medications based upon performance and cost and get assistance in switching to less costly, equally effective alternative medications, if You wish; and
    - access information about Regence Advantages. Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services. We have contracted with several program partners, listed on the secure applications, to offer discounts on their products and services, such as hearing care, health and wellness products and vision care.*

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by this plan, that also may create savings or administrative fees for Us. **ANY SUCH**

DISCOUNTS OR COUPONS ARE COMPLEMENTS TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE.

Table of Contents

Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits, Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximum. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the Schedule of Benefits and benefit sections in this Booklet to see what Your benefits are.

MAXIMUM BENEFITS

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

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

DEDUCTIBLES

The Deductible is the amount You must pay each Calendar Year before We will provide payments for Covered Services. Only Allowed Amounts for Covered Services are applied to satisfy the Deductible. There is an individual Deductible amount and a Family Deductible amount for In-Network benefits and also for Out-of-Network benefits.

[The Family Deductible is satisfied when any combination of Family Members' payments toward each of their individual Deductibles total the Family Deductible amount. No one Family Member may contribute more than their individual Deductible amount toward the Family Deductible in a Calendar Year. A Family Member does not have to satisfy their individual Deductible if the Family Deductible has already been satisfied.**]** **(Always applies unless is EE only coverage)**

We do not pay for services applied toward the Deductible. Refer to the Schedule of Benefits to see what Covered Services are subject to the Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not apply toward the Deductible. In addition, the difference in cost between a Brand-Name Medication and its generic equivalent (or a Specialty Medication and its Specialty Biosimilar Medication) does not apply toward the Deductible **[**(including any applicable separate Prescription Medication Deductible)**]** **(Plans with Rx deductible)**. Further, reduction in Your cost-sharing for Prescription Medications resulting from the use of any discount or a drug manufacturer coupon may not apply toward the Deductible **[**(including any applicable separate Prescription Medication Deductible).**]** **(Plans with Rx deductible)**

COPAYMENTS

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

COINSURANCE (PERCENTAGE YOU PAY)

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

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the most You could pay in a Calendar Year for Covered Services. Your payments of any Deductible, Copayments and/or Coinsurance apply to the Out-of-Pocket Maximum, unless specified otherwise. There is an individual Out-of-Pocket Maximum amount and a Family Out-of-Pocket Maximum amount for In-Network benefits and also for Out-of-Network benefits.

[The Family Out-of-Pocket Maximum is satisfied when any combination of Family Members' payments of their cost-shares for Covered Services total the Family Out-of-Pocket Maximum. No one Family Member may contribute more than their individual Out-of-Pocket Maximum amount toward the Family Out-of-Pocket Maximum in a Calendar Year. A Family Member does not have to satisfy their individual Out-of-Pocket Maximum if the Family Out-of-Pocket Maximum has already been satisfied.**]** **(Always applies unless is EE only coverage)**

A Member's payment of Deductible, Copayments and/or Coinsurance for ambulance, blood bank, emergency room services, and Prescription Medications will apply toward the In-Network Out-of-Pocket Maximum amount. Additionally, services provided by a Provider that has an effective participating contract with Us or one of Our Affiliates but is not designated as an In-Network Provider (as further defined in the Definitions Section) will apply to the In-Network Out-of-Pocket Maximum amount. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. In addition, the difference in cost between a Brand-Name Medication and its generic equivalent (or a Specialty Medication and its Specialty Biosimilar Medication) does not apply toward the Out-of-Pocket Maximum. Further, any reduction in Your cost-sharing for Prescription Medications resulting from the use of any discount or a drug manufacturer coupon may 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 the Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum, benefits subject to the Out-of-Pocket Maximum will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. The Coinsurance does not change to a higher payment level or apply to the Out-of-Pocket Maximum for some benefits. Refer to the benefits to determine if a Covered Service does not apply to the Out-of-Pocket Maximum.

INPATIENT NON-EMERGENCY ADMISSIONS AT NONPARTICIPATING FACILITIES

The maximum Allowed Amount for facility charges of an inpatient non-emergency admission to a Nonparticipating Facility is $4,000 per day. In addition to Deductible and/or Coinsurance, You may be billed for the balance of billed charges, including any billed amount in excess of this maximum Allowed Amount, and the balance of billed charges will not apply to any Out-of-Pocket Maximum.

An admission will be "non-emergency" unless it is precipitated by emergency services for an Emergency Medical Condition. Emergency services include a medical screening examination within the capability of a Hospital emergency department, ancillary services routinely available to it to evaluate an Emergency Medical Condition, and further medical examination and treatment within the capabilities of the Hospital staff and facilities.

An inpatient admission to a Nonparticipating Facility that begins as an emergency shall be regarded as an emergency admission through discharge and therefore will not be subject to the $4,000 per day maximum Allowed Amount.

HOW CALENDAR YEAR BENEFITS RENEW

The Deductible, Out-of-Pocket Maximum and Maximum Benefits are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again. Some benefits have a separate Maximum Benefit based upon a Member's Lifetime and do not renew every Calendar Year.

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

Medical Benefits

This section explains Your benefits for Covered Services. Referrals are not required before You can use any of the benefits of this coverage, including women's health care services. All benefits are listed alphabetically, with the exception of Preventive Care and Immunizations, **[**Upfront Benefits for Office Visits,**]** **(Plans with Upfront Office Visit Limit)** **[**Office or Urgent Care Visits,**]** **(Plans with no Upfront Office Visit Limit)** Expanded Office Services and Other Professional Services.

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care) and received from a Provider practicing within the scope of their license. All covered benefits are subject to the limitations, exclusions and provisions of this plan. In some cases, We may limit benefits or coverage to a less costly and Medically Necessary alternative item. A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service. See the Definitions Section for descriptions of Medically Necessary and the types of Providers who deliver Covered Services.

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

Reimbursement may be available when You purchase new medical supplies, equipment and devices from a Provider or from an approved Commercial Seller. New medical supplies, equipment and devices, 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 new retail medical supplies, equipment and devices, visit Our website or contact Customer Service.

NOTE: If You choose to access new medical supplies, equipment and devices through Our website, 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 the Group health plan, but are not insurance.

[IMPORTANT NOTE: EMPLOYEE ONLY COVERAGE

Notwithstanding any other provision of the Contract, the benefits in this Booklet apply only to employees; therefore, all references to Your Enrolled Dependents, including Your spouse, Your Eligible Domestic Partner and any newborn children, do not apply. Your dependents are not eligible to apply for coverage or receive benefits, Your newborn children will not be enrolled at birth, and the term Member is changed to mean Enrolled Employee.**]** **(Groups choose employee only coverage)**

CASE MANAGEMENT

Case management is a program designed to provide early detection and intervention in cases of serious Illness or Injury that have the potential for continuing major or complex care. Case managers are experienced, licensed health care professionals. They will provide information, support and guidance and will work with Your Physicians or other health care professionals in supporting Your treatment plan and proposing alternative benefits.

PREAUTHORIZATION

Some Covered Services may require preauthorization. Those services require contracted Providers to obtain preauthorization from Us before providing such services to You. You will not be penalized if the contracted Provider does not obtain preauthorization from Us in advance and the service is determined to be not covered.

Non-contracted Providers are not required to obtain preauthorization from Us prior to providing services. You may be responsible for the cost of services provided by a non-contracted Provider if those services are not Medically Necessary or a Covered Service. You may request that a non-contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to receiving those services.

PREVENTIVE VERSUS DIAGNOSTIC SERVICES

Covered Services may be either preventive or diagnostic. "Preventive" care is intended to prevent an Illness, Injury or to detect problems before symptoms are noticed. "Diagnostic" care treats, investigates or diagnoses a condition by evaluating new symptoms, following up on abnormal test results or monitoring existing problems.

Your Provider's classification of the service as either preventive or diagnostic and any other terms in this Booklet will determine the benefit that applies. For example, colonoscopies and mammograms are covered in the Preventive Care and Immunizations benefit if Your Provider bills them as preventive and they fall within the recommendations identified in that benefit. Otherwise, colonoscopies and mammograms are covered the same as any other Illness or Injury. You may want to ask Your Provider why a Covered Service is ordered or requested.

PREVENTIVE CARE AND IMMUNIZATIONS

Preventive care and immunization services provided by a professional Provider, facility or Retail Clinic that are within 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), or as required by state or federal guidance for a specific time period as a result of a government declared disease outbreak, epidemic, or other public health emergency, are covered for the following:

- routine physical examinations, well-women's care, well-baby care and routine health screenings;
- nutritional counseling;
- Provider counseling and Prescription Medications prescribed for tobacco use cessation;
- immunizations for adults and children;
- breast pump (including its accompanying supplies) per pregnancy as follows:
    - one new non-Hospital grade breast pump at the In-Network benefit level when obtained from a Provider (including a Durable Medical Equipment supplier); or
    - a comparable new breast pump may be obtained from an approved Commercial Seller in lieu of a Provider. Benefits for a comparable new 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.
- **[**United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods according to, and as recommended by HRSA, including, but not limited to:
    - 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 procedures for women.**]** **(Always applies unless the group asserts a religious, moral or other exemption, accommodation or exclusion available under the law)**

Prostate cancer screening is also covered when recommended by a Physician or Practitioner. Covered Services for prostate cancer screening include digital rectal examinations and prostate-specific antigen (PSA) tests.

NOTE: Covered Services that do not meet these criteria (for example, diagnostic colonoscopies or diagnostic mammograms) will be covered the same as any other Illness or Injury. In the event HRSA, USPSTF or the CDC adopt a new or revised recommendation, We have up to one year before coverage of the related services must be available and effective in this Booklet. For a list of Covered Services, including information about an approved Commercial Seller, visit Our website or contact Customer Service.

Expanded Immunizations

Immunizations that do not meet age limits and frequency guidelines according to, and as recommended by, the USPSTF, HRSA or by the CDC are covered. Covered Services include immunizations for travel, occupation or residency in a foreign country. Contact Customer Service to verify what expanded immunizations are covered.

(PLANS WITH UPFRONT OFFICE VISITS) [UPFRONT BENEFITS FOR OFFICE OR URGENT CARE VISITS – ILLNESS OR INJURY

Office (including home, Retail Clinic or Hospital outpatient department) and urgent care visits are covered for treatment of Illness or Injury up to the visit limit specified in the Schedule of Benefits. Coverage does not include other professional services performed in the office or urgent care that are specifically covered elsewhere in the Medical Benefits Section, including, but not limited to, separate facility fees or outpatient radiology and laboratory services billed in conjunction with the visit. Out-of-Network visits do not accrue to this limit, but are payable as outlined previously. NOTE: Virtual care services are covered in the Virtual Care benefit and do not accrue to this limit.**]** **(Plans with Upfront Office Visit Limit)**

(PLANS WITHOUT UPFRONT OFFICE VISITS) [OFFICE OR URGENT CARE VISITS – ILLNESS OR INJURY

Office (including home, Retail Clinic or Hospital outpatient department) and urgent care visits are covered for treatment of Illness or Injury. Coverage does not include other professional services performed in the office or urgent care that are specifically covered elsewhere in the Medical Benefits Section, including, but not limited to, separate facility fees or outpatient radiology and laboratory services billed in conjunction with the visit.**]** **(Plans with no Upfront Office Visit Limit)**

EXPANDED OFFICE SERVICES

Expanded Office Services are general medical services, therapeutic injections (including clotting factor products), surgical procedures, including anesthesia and supplies provided by a professional Provider. Expanded Office Services are covered when received in and billed as a Provider's office or an urgent care visit.

Coverage does not include other professional services performed in the office that are specifically covered elsewhere in the Medical Benefits Section, such as, but not limited to, outpatient radiology and laboratory services, rehabilitation services or immunizations.

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

OTHER PROFESSIONAL SERVICES

Services and supplies provided by a professional Provider are covered, subject to any specified limits as explained in the following paragraphs:

Medical Services and Supplies

Professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider.

Services and supplies also include:

- treatment of a congenital anomaly;
- administration of Provider-Administered Specialty Drugs;
- Virtual Care service facility fees;
- foot care associated with diabetes; and

- Medically Necessary foot care obtained from a professional Provider due to hazards of a systemic condition causing severe circulatory dysfunction or diminished sensation in the legs or feet.

Additionally, coverage includes certain Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) that are new and obtained from an approved Commercial Seller. Benefits for eligible new 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 new medical supplies, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit Our website or contact Customer Service.

[Office or Urgent Care Visits – After Upfront Benefit Limits

After any Upfront office visit limits are exhausted, office or urgent care visits for treatment of Illness or Injury are covered as specified in the Schedule of Benefits.**]** **(Plans with Upfront Office Visit Limit)**

Professional Inpatient

Professional inpatient visits for treatment of 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 at the In-Network benefit level. Contact Customer Service for further information and guidance.

Radiology and Laboratory

[Diagnostic services and outpatient complex imaging for treatment of Illness or Injury. This includes Medically Necessary genetic testing and diagnostic mammography services not covered in the Preventive Care and Immunizations benefit.**]** **(Applies when deductible applies to outpatient radiology and laboratory services)**

[Outpatient complex imaging for treatment of Illness or Injury. Refer to the Radiology and Laboratory – Outpatient benefit for diagnostic services.**]** **(Applies when deductible is waived for outpatient radiology and laboratory services)**

"Outpatient complex imaging" means:

- bone density screening;
- computerized axial tomography (CT or CAT) scan;
- magnetic resonance angiogram (MRA);
- magnetic resonance imaging (MRI);
- positron emission tomography (PET); and
- single photon emission computerized tomography (SPECT).

Generally, claims for independent clinical laboratory services will be submitted to the Blue plan in the location in which the referring Provider is located.

Diagnostic Procedures

Services for diagnostic procedures including cardiovascular testing, pulmonary function studies, stress tests, sleep studies and neurology/neuromuscular procedures.

Surgical Services

Surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist. Covered Services include vasectomies.

Treatment of varicose veins is only covered when there is:

- active associated venous ulceration;
- objective documentation of persistent or recurrent bleeding from ruptured veins; or
- objective documentation of recurrent superficial phlebitis.

AMBULANCE SERVICES

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

Claims for ambulance services must include the locations You were transported to and from. The claim should also show the date of service, the patient's name, the group and Your identification numbers.

APPROVED CLINICAL TRIALS

If an In-Network Provider is participating in an Approved Clinical Trial and will accept You as a trial participant, benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If an 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. Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating are covered as specified in the Schedule of Benefits. Additional specified limits are as further defined.

Definitions

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 a cooperative group or center 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.
- conducted under an investigational new drug application reviewed by the FDA or that is a drug trial exempt from having an investigational new drug application.

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

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

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

BLOOD BANK

Services and supplies of a blood bank are covered, excluding storage costs.

DENTAL HOSPITALIZATION

When necessary to safeguard Your health, hospitalization for Dental Services is covered. Covered Services include inpatient and outpatient services and supplies (including anesthesia) at an Ambulatory Surgical Center or Hospital.

DIABETIC EDUCATION

Services and supplies for diabetic self-management training and education are covered, when requested by the attending physician, if provided by an accredited or certified program. Diabetic nutritional counseling and nutritional therapy services are covered in the Nutritional Counseling benefit.

DIALYSIS

Services and supplies for outpatient and home dialysis are covered as described below. Dialysis received while inpatient is covered elsewhere in the Medical Benefits Sections, such as the Hospital Care – Inpatient, Outpatient and Ambulatory Surgical Center benefit.

Outpatient Initial Treatment Period

Hemodialysis, peritoneal dialysis and hemofiltration services are covered for an initial treatment period when Your Physician prescribes outpatient dialysis, regardless of Your diagnosis. An initial treatment period is 120 days, measured from the first day You receive dialysis treatment. This initial treatment period benefit is available once for each course of continuous or related dialysis care, even if that course of treatment spans two or more Calendar Years.

Outpatient Supplemental Treatment Period

Hemodialysis, peritoneal dialysis and hemofiltration services are covered beginning the first day following completion of the initial treatment period when Your Physician prescribes outpatient dialysis, regardless of Your diagnosis, for a period that is longer than the initial treatment period. 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.

In addition, a Member receiving supplemental dialysis is eligible to have Medicare Part A and Part B premiums reimbursed as an eligible expense for the duration of the Member's dialysis treatment, as long as the Member continues to be enrolled in Medicare Part A and Part B and continues to be eligible for coverage under the Contract. Proof of payment of the Medicare Part A and Part B premium will be required prior to reimbursement.

"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 is covered, including, but not limited to, oxygen equipment, wheelchairs and supplies or equipment associated with diabetes (such as insulin pumps or continuous glucose monitors, and their supplies).

Additionally, new Durable Medical Equipment is covered when obtained from an approved Commercial Seller. Benefits for eligible new 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 new Durable Medical Equipment, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit Our website or contact Customer Service.

Generally, claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the location in which the equipment was received.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Emergency room services and supplies are covered, including outpatient charges for patient observation, medical screening examinations, and Medically Necessary detoxification services that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be preauthorized.

"Stabilization" means to provide Medically Necessary treatment:

- 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

- in the case of a covered Member, who is pregnant, to perform the delivery (including the placenta).

If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. Contact Customer Service for further information and guidance.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

Gene therapies, adoptive cellular therapies as well as associated services and supplies are covered for Members who fulfill the Medical Necessity criteria.

To be covered, gene therapy and/or adoptive cellular therapy must be received from one of Our Centers of Excellence (COE) facilities that is expressly identified as a COE for that therapy. However, if a COE has not been identified for a covered gene therapy and/or adoptive cellular therapy, that therapy must be received from an In-Network Provider to be covered at the COE benefit level. For a list of covered therapies or to identify a COE facility, contact Our Customer Service, as the lists are subject to change. Refer to the Rural Health Care Providers provision in the Contract and Claims Administration Section for additional details on Out-of-Network rural health care Provider reimbursement.

Travel Expenses

Transportation and lodging expenses are covered, up to the limit specified in the Schedule of Benefits and subject to the following specified limits:

- based on the generally accepted course of treatment in the United States, the therapy would require an overnight stay of seven or more consecutive nights away from home and within reasonable proximity to the treatment area;
- if a COE has been identified for the specified covered therapy, covered treatment must be received from the COE;
- if a COE has not been identified for the specified covered therapy, covered treatment must be received from an In-Network Provider;
- coverage is for the Member and one companion (or two companions if the Member is under the age of 19);
- commercial lodging expenses are limited to the IRS medical expense allowances (currently $50 per night for the Member, not to exceed $100 per night for the Member and companion(s) combined); and
- covered transportation expenses to and from the treatment area include only:
    - commercial coach class airfare;
    - commercial coach class train fare; or
    - documented auto mileage (calculated per IRS medical expense allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of the treatment. We will reimburse You for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact Our Customer Service for further information and guidance.

Coverage does not include meals or expenses outside of transportation and lodging.

HABILITATION SERVICES

Inpatient and outpatient habilitation services are covered. "Habilitation services" mean health care services including physical, occupational, speech therapy and other services for a Member with disabilities that help keep, learn or improve skills and functioning for daily living (for example, therapy for a child who isn't walking or talking at the expected age).

Habilitation days or visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

HEARING AIDS AND EVALUATIONS

Hearing aids and any associated evaluations are covered when necessary for treatment of hearing loss. Covered Services include the following:

- hearing aids (including evaluations);
- bone conduction sound processors (including examinations and fittings). Implantation and associated surgical services are covered in the Other Professional Services benefit;
- ear molds and replacement ear molds; and
- hearing aid checks and testing.

"Hearing aid" means any nondisposable, wearable instrument designed to aid or compensate for impaired human hearing and any necessary part or ear mold for the instrument.

Cochlear implants are covered the same as any other Illness or Injury.

Covered Services do **not** include:

- over-the-counter hearing aids;
- routine hearing examinations;
- hearing assistive technology systems; or
- the cost of batteries or cords.

HOME HEALTH CARE

Home health care is covered 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 in the Durable Medical Equipment benefit.

HOSPICE CARE

Hospice care is covered 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 their family during the final stages of Illness.

Respite care is also covered to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member. Respite days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered in the Durable Medical Equipment benefit.

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER

Services and supplies of a Hospital or an Ambulatory Surgical Center (including services of staff Providers) are covered for treatment of Illness or Injury. Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. Contact Customer Service for further information and guidance.

[NOTE: Ambulatory Surgical Center services may otherwise be covered under the Upfront Benefits for Office Visits. Once any applicable visit limit listed in the Schedule of Benefits is reached, Ambulatory Surgical Center services will be covered as specified in the Schedule of Benefits.**] (Plans with Upfront Office Visit Limit)**

INFUSION THERAPY

Inpatient, outpatient and home therapy services, supplies (including infusion pumps) and medications for infusion therapy are covered. Covered Services also include parenteral and enteral therapy. Certain medications for outpatient infusion therapy that are provided to treat chronic, complex conditions are otherwise covered in the Provider-Administered Specialty Drugs benefit. Contact Customer Service for further information and guidance.

MATERNITY CARE/ADOPTION BENEFIT

Prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy and related conditions are covered. There is no limit for the patient's length of inpatient stay. The attending Provider will determine an appropriate discharge time in consultation with the patient.

Certain services such as screening for gestational diabetes, breastfeeding support, supplies and counseling are covered in the Preventive Care and Immunizations benefit.

Adoption

An adoption benefit is available, covered at the In-Network benefit level, when a Member 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 Member within 90 days after the child's birth and the date of placement is on or after the Member's Effective Date.
- The Member 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 Member 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 Member is 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. Adoption coverage that is applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

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 Member will be liable for repayment of the adoption benefit. The Member 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 the Contract).

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. Refer to the Right of Reimbursement and Subrogation Recovery Section for more information.

Definitions
The following definition applies to this Maternity Care/Adoption 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
Medical foods for inborn errors of metabolism are covered, including, but not limited to, formulas for Phenylketonuria (PKU). "Medical food" means a food which is formulated to be consumed or administered orally or enterally under the supervision of a Physician. Medical foods are intended for specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES
Mental Health and Substance Use Disorder Services are covered for treatment of Mental Health Conditions or Substance Use Disorders, including nutritional counseling.

Definitions
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, detoxification, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of court ordered treatment (unless the treatment is Medically Necessary).

Mental Health Conditions mean 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. Mental disorders that accompany an excluded diagnosis are covered.

Residential Care means care in a facility setting that offers a defined course of therapeutic intervention and special programming in a controlled environment that also offers a degree of security, supervision and structure, and is licensed by the appropriate state and local authority to provide such services. Patients also must be medically monitored with 24-hour medical availability and 24-hour onsite clinician services. Residential Care does not include half-way houses, supervised living, group homes, wilderness courses or camps, Outward Bound, outdoor youth programs, outdoor behavioral programs, boarding houses, or settings that primarily either focus on building self-esteem or leadership skills or provide a supportive environment to address long-term social needs. However, services by Physicians or Practitioners in such settings may be covered if they are billed independently and would otherwise be a Covered Service.

Substance Use Disorders mean 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.

NEURODEVELOPMENTAL THERAPY
Neurodevelopmental therapy services by a Physician or Practitioner are covered. Covered Services must be to restore and improve function for a Member with a neurodevelopmental delay. "Neurodevelopmental delay" means a delay in normal development that is not related to any documented Illness or Injury. Covered Services include only physical therapy, occupational therapy, speech therapy and maintenance services, if significant deterioration of the Member's condition would result without the service.

Neurodevelopmental therapy visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE

Services and supplies in connection with nursery care for the natural newborn or newly adoptive child are covered by the newborn's own coverage. The newborn child must be eligible and enrolled as explained in the Eligibility and Enrollment Section. There is no limit for the newborn's length of inpatient stay. "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

Services for nutritional counseling and nutritional therapy, such as diabetic counseling, discussions on eating habits, lifestyle choices and dietary interventions are covered. Nutritional counseling visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. See the Preventive Care and Immunizations and Mental Health or Substance Use Disorder Services for additional coverage of nutritional counseling.

ORTHOTIC DEVICES

Medically Necessary orthotics are covered, including, but not limited to:

- braces;
- back or special surgical corsets; and
- splints for extremities and trusses.

Additionally, certain orthotic devices that are new are covered when obtained from an approved Commercial Seller. Benefits for eligible new orthotic devices 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 new orthotic devices, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit Our website or contact Customer Service.

We may elect to provide benefits for a less costly alternative item. Covered Services do **not** include:

- off-the-shelf shoe inserts;
- orthopedic shoes; and
- any other orthotics related to the feet.

PALLIATIVE CARE

Palliative care is covered when a Provider has assessed that a Member is in need of palliative services for a serious Illness (including remission support), life-limiting Injury or end-of-life care. "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. All other Covered Services for a Member receiving palliative care remain covered the same as any other Illness or Injury.

PROSTHETIC DEVICES

Prosthetic devices for functional reasons are covered to replace a missing body part, including artificial limbs, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered in the appropriate facility benefit.

Additionally, the repair or replacement of a prosthetic device due to normal use or growth of a child is covered. Microprocessor component expenses that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

PROVIDER-ADMINISTERED SPECIALTY DRUGS

Provider-Administered Specialty Drugs are covered under this plan only when a Provider-Administered Specialty Drug has been preauthorized and obtained by the administering Provider through the designated Specialty Pharmacy for Provider-Administered Specialty Drugs. Even if the administering

Provider is an In-Network Provider (whose services are otherwise covered in the Other Professional Services benefit), it does not guarantee coverage for Provider-Administered Specialty Drugs if they are not obtained through the Specialty Pharmacy for Provider-Administered Specialty Drugs. An exception may be available when the administering Provider obtains a Provider-Administered Specialty Drug from a source other than a Specialty Pharmacy for Provider-Administered Specialty Drugs. Contact Customer Service for further information and guidance.

When Provider-Administered Specialty Drugs are received outside the service area that We or one of Our Affiliates serves, coverage is provided in the Infusion Therapy benefit and not in this Provider-Administered Specialty Drugs benefit.

Definitions
The following definitions apply to this Provider-Administered Specialty Drugs benefit:

Provider-Administered Specialty Drug(s) means medications used to treat chronic, complex conditions that typically require special handling, administration, or monitoring and that are included in the Provider-Administered Specialty Drug List.

Provider-Administered Specialty Drug List means Our list of selected Provider-Administered Specialty Drugs. The Provider-Administered Drug List is routinely reviewed and updated. It is available on Our website or by calling Customer Service.

Specialty Pharmacy for Provider-Administered Specialty Drugs means an approved Provider or Pharmacy that specializes in the distribution and medication management services of certain injectables and Provider-Administered Specialty Drugs. A Specialty Pharmacy for Provider-Administered Specialty Drugs must also agree to submit claims for Provider-Administered Specialty Drugs to Our designated claims administrator. For more information about Specialty Pharmacies for Provider-Administered Specialty Drugs, visit Our website or contact Customer Service.

[RADIOLOGY AND LABORATORY SERVICES – OUTPATIENT
Outpatient radiology and laboratory services are covered for treatment of Illness or Injury. This includes, but is not limited to, Medically Necessary services for genetic testing and diagnostic mammography services not covered in the Preventive Care and Immunizations benefit. NOTE: Outpatient complex imaging services are covered under the Other Professional Services benefit.

Generally, claims for independent clinical laboratory services will be submitted to the Blue plan in the location in which the referring Provider is located.**] (Applies when deductible is waived for Outpatient Radiology and Laboratory Services)**

REHABILITATION SERVICES
Inpatient and outpatient rehabilitation services and accommodations are covered as appropriate and necessary 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. "Rehabilitation services" mean physical, occupational and speech therapy services only, including associated devices and services such as massage when provided as a therapeutic intervention.

Rehabilitation days or visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

SKILLED NURSING FACILITY
Inpatient services and supplies of a Skilled Nursing Facility are covered for treatment of 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.

Skilled Nursing Facility days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

SPINAL MANIPULATIONS

Spinal manipulations are covered. Manipulations of extremities are covered in the Rehabilitation Services benefit. Spinal manipulations that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Inpatient and outpatient services are covered for treatment of TMJ disorders which have one or more of the following characteristics:

- an abnormal range of motion or limitation of motion;
- arthritic problems;
- internal derangement; and/or
- pain in the musculature.

Covered Services include services that are:

- reasonable and appropriate for the treatment of a TMJ disorder;
- effective for the control or elimination of one or more of the following TMJ disorders:
    - pain;
    - infection;
    - disease;
    - difficulty in speaking; or
    - difficulty in chewing or swallowing food.

TERMINATION OF PREGNANCY

Termination of pregnancy (abortion) is covered for all Members only for the following:

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

Such services are only covered to the extent permitted under applicable law.

TRANSPLANTS

Transplants are covered, including transplant-related services and supplies. Covered Services for a transplant recipient include the following:

- heart;
- lung;
- kidney;
- pancreas;
- liver;
- cornea;
- multivisceral;
- small bowel;
- islet cell; and
- hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors:
    - either autologous (self-donor);
    - allogeneic (related or unrelated donor);
    - syngeneic (identical twin donor); or
    - umbilical cord blood (only covered for certain conditions).

For a list of covered transplants, contact Our Customer Service, as the list is subject to change. Gene and/or adoptive cellular therapies are covered in the Gene Therapy and Adoptive Cellular Therapy benefit. Any organ or tissue which is procured outside the United States and any transplant procedure performed outside the United States are not covered.

Donor Organ Benefits

Donor organ procurement costs are covered for a recipient. 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.

VIRTUAL CARE

Virtual care services are covered for the use of telehealth or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment or management of a covered medical condition. **[**Upfront Benefits for office visits are not covered in this Virtual Care benefit.**]** **(Plans with Upfront Office Visit Limit)** Some Providers may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share. To learn more about how to access virtual care services or the Providers that may offer lower-cost services, visit Our website or contact Customer Service.

Store and Forward Services

"Store and forward services" mean secure one-way electronic asynchronous (not live or real-time) electronic transmission (sending) of Your medical information to a Provider which may include some forms of secure HIPAA compliant texting, chatting or data sharing. For example, store and forward services include using a secure patient portal to send a picture of Your swollen ankle to Your Provider for review at a later time. Store and forward services that are not secure and HIPAA compliant are not covered, including, but not limited to:

- telephone;
- facsimile (fax);
- short message service (SMS) texting; or
- e-mail communication.

Your Provider is responsible for meeting applicable requirements and community standards of care.

Telehealth

"Telehealth" means Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform, including when You are in a Provider's office or healthcare facility. For example, telehealth includes a live video call from Your home to discuss a possible eye infection with Your Provider or using the equipment at Your local Provider's office to have a live video call with a cardiologist in a different city. Separate charges for facility fees are covered in the Other Professional Services benefit.

Prescription Medications

This section explains Your benefits for Prescription Medications. Benefits will be paid in this Prescription Medications benefit, not any other provision, if a medication or supply is covered by both. For Provider-Administered Specialty Drug coverage, refer to the Provider-Administered Specialty Drugs benefit in the Medical Benefits Section.

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

Prescription Medications listed on the Drug List are covered. Prescription Medications not on the Drug List may be covered as described in the Drug List Exception Process provision. The Drug List may be viewed on Our website or by contacting Customer Service.

[PRESCRIPTION MEDICATION CALENDAR YEAR DEDUCTIBLES

{You do not need to meet the Prescription Medication Deductible when You fill a prescription for a Preferred Generic Medication.**}** **(Plans without Rx deductible for tier 1)**

This Prescription Medication Deductible is calculated separately from any other Deductible. However, this Prescription Medication Deductible will be applied toward the Out-of-Pocket Maximum as further specified in the Understanding Your Benefits Section. Further, any reduction in Your cost-sharing for Prescription Medications resulting from the use of any discount or a drug manufacturer coupon may not apply toward the Prescription Medication Deductible.**]** **(Plans with Rx deductible)**

Copayments and Coinsurance

[After You meet the Prescription Medication Deductible,**]** **(Plans with Rx deductible)** **[**After You meet any applicable Deductible,**]** **(Plans without Rx deductible)** You are responsible for paying the Copayment and/or Coinsurance amounts detailed in the Schedule of Benefits at the time of purchase, if the Pharmacy submits the claim electronically.

COVERED PRESCRIPTION MEDICATIONS

Prescription Medication benefits are available for the following:

- Prescription Medications;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Injectable Medications) and teaching doses by which a Member is educated to self-inject;
- diabetic supplies, when obtained with a Prescription Order, including:
    - lancets;
    - test strips;
    - glucagon emergency kits; and
    - insulin syringes.
- certain continuous glucose monitors and insulin pumps (including their supplies), that are on the Drug List, may be purchased from a Participating Pharmacy when obtained with a Prescription Order; continuous glucose monitors and insulin pumps (including their supplies) are also covered in the Medical Benefits Section;
- Specialty Medications (including, but not limited to, medications for multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders, hepatitis C and growth hormones);
- Self-Administrable Cancer Chemotherapy Medication. See below for Special Provisions for a Cancer Drug Treatment Regimen;
- immunizations for travel, occupation or residency in a foreign country; and
- certain Prescription Medications that are administered by Your Provider as determined by the Pharmacy and Therapeutics (P&T) Committee.

Additionally, the following preventive medications obtained from a Participating Pharmacy are covered at no charge to You, including, but not limited to:

- immunizations for adults and children according to, and as recommended by the CDC and/or USPSTF;
- certain preventive medications according to, and as recommended by the USPSTF, that are on the Drug List and when obtained with a Prescription Order, such as:

  - aspirin;
  - fluoride;
  - iron; and
  - medications for tobacco use cessation.

- **[**FDA-approved prescription and over-the-counter contraception methods according to, and as recommended by the HRSA and when obtained with a Prescription Order:
  - 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).**]** **(Always applies unless the group asserts a religious, moral or other exemption, accommodation or exclusion available under law)**

If Your Provider believes that Our covered preventive medications**[**, including contraceptives,**]** **(Always applies unless the group asserts a religious, moral or other exemption, accommodation or exclusion available under law)** are medically inappropriate for You, You may request an equivalent preventive medication by contacting Customer Service. For additional information on covered Prescription Medications, visit Our website or contact 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-102(23)(a)(i) and (ii). "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 website.

PRESCRIPTION MEDICATIONS CLAIMS AND ADMINISTRATION

Preauthorization

Some Prescription Medications may require preauthorization before they are dispensed. We notify participating Providers, including Pharmacies, which Prescription Medications require preauthorization. Prescription Medications that require preauthorization must have medical information provided by the prescribing Provider to determine Medical Necessity. Prescribed Medications that require preauthorization will not be covered until they are preauthorized. For a list of medications that require preauthorization or if You have any questions, visit Our website or contact Customer Service.

Drug List Changes

Any removal of a Prescription Medication from Our Drug List will be posted on Our website 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 possible.

If You are taking a Prescription Medication while it is removed from the Drug List 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 Drug List exception 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.

Drug List Exception Process

Non-Drug List medications are not covered by Your Prescription Medications benefit. However, a Prescription Medication not on the Drug List may be covered in certain circumstances.

"Non-Drug List" means those self-administered Prescription Medications not listed on the Drug List.

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

- medication policy criteria are met, if applicable;
- You are not able to tolerate a covered Prescription Medication(s) on the Drug List;
- Your Provider determines that the Prescription Medication(s) on the Drug List is not therapeutically effective for treating Your covered condition; or
- Your Provider determines that a dosage required for effective treatment of Your covered condition differs from the Prescription Medication on the Drug List dosage limitation.

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

Once preauthorization has been approved, the Prescription Medication not on the Drug List will be available for coverage at the Substituted Medication Copayment and/or Coinsurance level determined by Your benefit and will apply toward any Deductible or Out-of-Pocket Maximum.

Your Responsibility for Cost Differences of Chosen Medications

You will be responsible for the applicable Copayment and/or Coinsurance for the Brand-Name Medication or Specialty Medication at the time of purchase. You will also be responsible for paying excess costs above Your applicable cost-share if either of the following occur:

- if You choose to fill a Prescription Order with a Brand-Name Medication and an equivalent Generic Medication is available, You will be responsible for paying the difference in cost; or
- if You choose to fill a Prescription Order with a Specialty Medication and a Specialty Biosimilar Medication is available, You will be responsible for paying the difference in cost.

The excess in cost does not apply toward any Deductible or any Out-of-Pocket Maximum. If the prescribing Provider specifies that the Brand-Name Medication or the Specialty Medication must be dispensed, You will still be responsible for the excess in cost.

Pharmacy Network Information

A nationwide network of Participating Pharmacies is available to You. Pharmacies that participate in this network submit claims electronically. You can find Participating Pharmacies on Our website or by contacting Customer Service.

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.

You must present Your identification card to identify Yourself as Our Member when obtaining Prescription Medications from a Participating Pharmacy, Specialty Pharmacy or Home Delivery Supplier. If You do not present Your identification card You may be charged more than the Covered Prescription Medication Expense.

Claims Submitted Electronically
Participating Pharmacies will submit claims electronically.

Claims Not Submitted Electronically
It is best to use a Participating Pharmacy so Your claims can be submitted electronically, and so You won't have to pay the difference between the Pharmacy's charges and the Covered Prescription Medication Expense in addition to Your Deductible, Copayment and/or Coinsurance.

However, 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, complete a Prescription Medication claim form and mail a copy of the form and the Prescription Medication receipt to Us. To find the Prescription Medication claim form visit Our website or contact Customer Service.

We will reimburse You directly based on the Covered Prescription Medication Expense, minus the applicable Deductible, Copayment and/or Coinsurance that would have been required had the medication been submitted electronically by a Participating Pharmacy.

Home Delivery
You can use home delivery services to purchase covered Prescription Medications. Home delivery coverage applies when Prescription Medications are purchased from a Home Delivery Supplier and the claim is submitted electronically. Not all Prescription Medications are available from Home Delivery Suppliers.

To buy Prescription Medications through the mail, send all of the following items to the Home Delivery Supplier at the address shown on the prescription home delivery form (which also includes refill instructions) available on Our website or from Your Group:

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

Prescription Medications Dispensed by Excluded Pharmacies
We do not permit excluded Pharmacies to submit claims after the excluded Pharmacies have been added to the Office of the Inspector General (OIG) list. A Pharmacy may be excluded if it has been investigated by the OIG and appears on the OIG's exclusion list.

You will be notified if You are receiving medications from a Pharmacy that is later determined to be an excluded Pharmacy so that You may obtain future Prescription Medications from a non-excluded Pharmacy. Up to the time of notification, Your previously submitted claims will still be processed.

Refills
Refills obtained from:

- a Participating Pharmacy are covered when You have taken 75 percent of the previous prescription;
    - except as based upon state law, Schedule II or III controlled substance medications may be refilled only after You have taken 85 percent of the previous prescription.

- a Home Delivery Supplier are covered after You have taken all but 20 days of the previous Prescription Order.

However, if You:

- choose to refill Your Prescription Medications sooner, You will be responsible for the full cost of the Prescription Medication and those costs will not apply toward any Deductible and/or Out-of-Pocket Maximum.
- receive maintenance medications for chronic conditions, You may qualify for prescription "refill synchronization" which allows refilling Prescription Medications on the same day of the month.
- feel You need a refill sooner than allowed, a refill exception will be considered on a case-by-case basis.

Contact Customer Service for further information on prescription refills, refill synchronization, or to request an exception for an early refill.

Discounts or Manufacturer Coupons

Any reduction in Your cost-sharing resulting from the use of any discount or a drug manufacturer coupon may not apply toward the Deductible **[**(including any applicable separate Prescription Medication Deductible)**]** **(Plans with Rx deductible)** or Out-of-Pocket Maximum.

LIMITATIONS

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

Prescription Medication Supply Limits

30-Day Supply Limit:

- **Specialty Medications** – the largest allowable quantity for a Specialty Medication purchased from a Specialty Pharmacy is a 30-day supply. Specialty Medications are not allowed through Home Delivery Suppliers.

  The first fill for Specialty Medications is allowed at a Pharmacy. Additional fills must be provided at a Specialty Pharmacy, however some Specialty Medications must have the first and subsequent fills at a Specialty Pharmacy. For more information on those medications, visit Our website or contact Customer Service.

90-Day Supply Limit:

- **Pharmacy** – the largest allowable quantity of a Prescription Medication purchased from a Pharmacy is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities. The Copayment and/or Coinsurance is based on each 30-day supply.
- **Home Delivery Supplier** – the largest allowable quantity of a Prescription Medication purchased from a Home Delivery Supplier is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
- **Multiple-Month Supply** – the largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Pharmacy is a 90-day supply (even if the packaging includes a larger supply). The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The Copayment and/or Coinsurance is based on the Prescription Order up to a 34-day supply within that multiple-month supply.

Maximum Quantity Limit:

- For certain Prescription Medications, We establish maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. We use information from the FDA and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your identification 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.
- For certain Self-Administrable Cancer Chemotherapy Medications, due to safety factors and the Member's ability to tolerate these medications, the Prescription Medication may be reduced to an initial 14-day or 15-day supply before larger quantities are dispensed.
- Any amount over the established maximum quantity is not covered, 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.

EXCLUSIONS
The following exclusions apply to this Prescription Medications Section and are not covered:

Biological Sera, Blood or Blood Plasma

Bulk Powders
Except as included on Our Drug List and presented with a Prescription Order, bulk powders are not covered.

Cosmetic Purposes
Prescription Medications used for Cosmetic purposes, including, but not limited to:

- removal, inhibition or stimulation of hair growth, except as related to a covered medical condition;
- anti-aging; or
- repair of sun-damaged skin.

Devices or Appliances
Except as provided in the Medical Benefits Section, devices or appliances of any type, even if they require a Prescription Order are not covered.

Diagnostic Agents
Except as provided in the Medical Benefits Section, diagnostic agents used to aid in diagnosis rather than treatment are not covered.

Digital Therapeutics
Except as included on Our Drug List and presented with a Prescription Order, digital therapeutics are not covered.

Foreign Prescription Medications
Except for the following, foreign Prescription Medications are not covered:

- 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.

These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered in this section if obtained in the United States.

General Anesthetics
Except as provided in the Medical Benefits Section, general anesthetics are not covered.

Medical Foods
Except as provided in the Medical Benefits Section, medical foods are not covered.

Medications that are Not Considered Self-Administrable
Except as provided in the Medical Benefits Section or as specifically indicated in this Prescription Medications Section, medications that are not considered self-administrable are not covered.

Nonprescription Medications
Except for the following, nonprescription medications that by law do not require a Prescription Order are not covered:

- medications included on Our Drug List;
- medications approved by the FDA; or
- a Prescription Order by a Physician or Practitioner.

Nonprescription medications include, but are not limited to:

- over-the-counter medications;
- vitamins;
- minerals;
- food supplements;
- homeopathic medicines;
- nutritional supplements; and
- any medications listed as over-the-counter in standard drug references, regardless of state law prescription requirements, such as pseudoephedrine and cough syrup products.

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 by this benefit if obtained from a Pharmacy.

Prescription Medications Found to be Less than Effective under Drug Efficacy Safety Implementation (DESI)

Prescription Medications Not Approved by the FDA

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

Prescription Medications Not on the Drug List
Except as provided through the Drug List Exception Process provision, Prescription Medications that are not on the Drug List are not covered.

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 with Therapeutic Alternatives
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 in the Virtual Care benefit, whether the Prescription Order is provided by mail, telephone, internet or some other means, Prescription Medications without a recent and relevant in-person examination by a Provider, are not covered. Additionally, this exclusion does not apply to a Provider or Pharmacist who may prescribe an opioid antagonist to a Member who is at risk of experiencing an opiate-related overdose.

An examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

DEFINITIONS

The following definitions apply to this Prescription Medications Section:

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

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

Home Delivery Supplier means a home delivery Pharmacy with which We have contracted for home delivery services.

Nonparticipating Pharmacy means a Pharmacy with which We neither have a contract nor have contracted access to any network it belongs to.

Participating 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. To find a Participating Pharmacy, visit Our website or contact Customer Service.

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

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed.

Pharmacy and Therapeutics (P&T) Committee means an officially chartered group of practicing Physicians and Pharmacists who review the medical and scientific literature regarding medication use, provide input and oversight of the development of Our Drug List and medication policies. Additionally, the P&T Committee is free from conflict of interest of drug manufacturers and the majority of whom are also free from conflict of interest of Your coverage.

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

Preferred Generic Medication and Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references as a Generic Medication. "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. Medications available only from one source (also referred to as "single source") are not considered Generic Medications. 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.

Preferred Specialty Medications and Specialty Medications means medications that may be used to treat complex conditions, including, but not limited to:

- multiple sclerosis;
- rheumatoid arthritis;
- cancer;
- clotting factor for hemophilia or similar clotting disorders;
- hepatitis C; and

- growth hormones.

Information from the manufacturer, scientific literature, practice standards, Medicare practices and other information that is considered relevant and reliable is used to determine a Specialty Medication. For a list of such medications, visit Our website or contact Customer Service.

Prescription Medications and Prescribed Medications mean medications and biologicals that:

- relate directly to the treatment of an Illness or Injury;
- legally cannot be dispensed without a Prescription Order;
- by law must bear the legend, "Prescription Only;" or
- are specifically included on Our Drug List.

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

Self-Administrable Prescription Medications, Self-Administrable Medications, Self-Administrable Injectable Medication or Self-Administrable Cancer Chemotherapy Medication means a Prescription Medication labeled by the manufacturer as intended to be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician's office or clinic). Self-Administrable Cancer Chemotherapy Medications include oral Prescription Medications used to kill or slow the growth of cancerous cells. Information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that is considered a relevant and reliable indication of safety and acceptability is used to determine a Self-Administrable Medication. We do not consider Your status, such as Your ability to administer the medication, when determining whether a medication is self-administrable.

Specialty Biosimilar Medication means an FDA-approved Prescription Medication that has a biological similarity to a Specialty Medication. The Specialty Biosimilar Medication is identical in function to the comparable Specialty Medication and may be more cost efficient. Similar to the FDA's requirements for a generic equivalent, a Specialty Biosimilar Medication must meet the same manufacturing and testing standards, and must be as safe and effective as the comparable Specialty Medication.

Specialty Pharmacy means a Pharmacy or designated Hemophilia Treatment Center (HTC) that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. To find a Specialty Pharmacy, visit Our website or contact Customer Service.

Substituted Medication means a Generic Medication or a Brand-Name Medication not on the Drug List that is approved for coverage at the Brand-Name Medication benefit level. Substituted Medication also means a Specialty Medication not on the Drug List that is approved for coverage at the Specialty Medication benefit level.

Pediatric Vision Services

Vision Services are covered for Members under the age of 19. Coverage will be provided for a Member until the last day of the month in which the Member turns 19 years of age. The BlueCard Program does not apply to Vision Services covered in this Pediatric Vision Services benefit. Benefits will be paid in this Pediatric Vision Services benefit, not any other provision, if a service or supply is covered by both.

This pediatric vision coverage is provided by Us, in collaboration with Vision Service Plan Insurance Company (VSP), which coordinates the pediatric vision benefits and associated claims processing. VSP is a separate company that provides vision benefit services.

Accessing Providers

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

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

VISION EXAMINATION

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

- prescribing and ordering proper lenses;
- verifying the accuracy of the finished lenses; and
- progress or follow-up work as necessary.

VISION HARDWARE

Hardware including frames, contacts and lenses is covered, subject to any specified limits as explained in the Schedule of Benefits and the following paragraphs:

Frames

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

Lenses

Standard glass, plastic or polycarbonate lenses for one of the following:

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

Any of the following lens enhancements:

- scratch coating;
- UV (ultraviolet) protection; and
- tinting.

*Contact lenses are limited to one of the following:

- for elective contact lenses:

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

- for Necessary Contact Lenses, a Calendar Year supply if You have a specific condition for which contact lenses provide better visual correction.

Necessary Contact Lenses and elective 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 or other types of lenses again until the next Calendar Year.

CONTACT LENS EVALUATION AND FITTING EXAMINATION

Services and supplies for contact lens evaluation and fitting examinations are covered.

LOW VISION BENEFIT

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

Supplemental Examinations (Testing)

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

Supplemental Aids

Low vision aids, including, but not limited to:

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

DISCOUNTS FROM VSP DOCTORS

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

- when You receive a complete pair of glasses, You are entitled to receive a 20 percent discount on non-covered materials;
- You are entitled to receive a 15 percent discount on contact lens examination services, beyond the covered vision examination; and
- VSP Doctors may request an additional vision examination within 12 months if necessary, at a discount.

You should confirm with the VSP Doctor that they participate in this discount program.

Discounts are applied to the VSP Doctor's usual and customary fees and are unlimited for 12 months on or following the date of the patient's last eye examination.

Discounts do not apply to:

- vision care benefits obtained from Out-of-Network Providers; or
- sundry items, including, but not limited to:

  - contact lens solutions;
  - cases;
  - cleaning products; or
  - repairs of spectacle lenses or frames.

THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THIS PEDIATRIC VISION BENEFIT, BUT ARE NOT INSURANCE.

PEDIATRIC VISION CLAIMS AND REIMBURSEMENT

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

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

Submit the claim to:

Vision Service Plan
P.O. Box 495918
Cincinnati, OH 45249

Concerns about Claim Denial or Other Action

If You have a concern regarding a claim denial or other action in these Pediatric Vision Services benefits and wish to have it reviewed, You may Appeal. See the Appeal Process 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.

EXCLUSIONS

The following exclusions apply to this Pediatric Vision Services Section and are not covered:

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)

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

Corrective Vision Treatment of an Experimental Nature

Costs for Services and/or Supplies Exceeding Benefit Allowances

Lens Enhancements
Except as provided in the Vision Hardware benefit, lens enhancements are not covered, including, but not limited to:

- anti-reflective coating;
- color coating;
- mirror coating;
- blended lenses;
- Cosmetic lenses;
- laminated lenses;
- oversize lenses; or
- standard, premium and custom progressive multifocal lenses.

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

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

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

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

Two Pair of Glasses instead of Bifocals

DEFINITIONS
The following definitions apply to this Pediatric Vision Services Section:

Allowed Amount means:

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

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

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

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

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

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

VSP Doctor means a Physician or Practitioner (for example, an ophthalmologist or optometrist) who is duly licensed and who has contracted with VSP to provide vision care services and/or vision care materials to Members in accordance with the provisions of this coverage.

Pediatric Dental Services

Dental Services are covered for Members under the age of 19. Coverage will be provided for a Member until the last day of the month in which the Member turns 19 years of age. The BlueCard Program does not apply to Dental Services covered in this Pediatric Dental Services benefit. Benefits will be paid in this Pediatric Dental Services benefit, not any other provision, if a service or supply is covered by both.

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

Preventive and diagnostic Dental Services are covered, subject to any specified limits as explained in the following:

- The following services are limited to two per Member per Calendar Year:
  - routine x-ray;
  - bitewing x-ray sets (limited to either four full x-ray sets or eight vertical films);
  - preventive oral examinations;
  - Silver diamine fluoride (SDF), per tooth; and
  - cleanings.*
- The following x-rays are limited to one per Member in a three-year period:
  - complete mouth x-rays (posterior bitewing films and 14 periapical films plus bitewings), in lieu of panoramic x-ray; or
  - Panorex (panoramic) mouth x-rays, in lieu of complete mouth x-ray.
- topical fluoride application: limited to two treatments per Member per Calendar Year.
- sealants for permanent molars: limited to one in a five-year period.

*See the Expanded Cleanings Benefit below for the benefits that replace the coverage of cleanings listed here if You have a qualifying medical condition.

EXPANDED CLEANINGS

Cleanings are covered under this benefit, limited to four visits per Member per Calendar Year, for Members with one or more of the following conditions:

- cancers of the head and neck, including oral cancers;
- chronic obstructive pulmonary disease (COPD);
- coronary artery disease (CAD);
- diabetes;
- end-stage renal disease (ESRD);
- metabolic syndrome (MetS);
- pregnancy;
- Sjögren's syndrome; and
- stroke.

For Members with one of the conditions listed above, this expanded benefit replaces the coverage of cleanings listed in Preventive and Diagnostic Dental Services benefit.

PEDIATRIC DENTAL CLAIMS AND REIMBURSEMENT

In-Network Dentist Claims and Reimbursement

You must present Your identification card to an In-Network Dentist and furnish any additional information requested. The In-Network Dentist will submit the necessary forms and information to Us for processing Your claim.

We will pay an In-Network Dentist directly for Covered Services. These In-Network Dentists may require You to pay any Deductible, Copayment and/or Coinsurance at the time You receive care or treatment. In-Network Dentists have agreed not to bill You for balances beyond any Deductible, Copayment and/or Coinsurance and to accept the Allowed Amount as payment in full for Covered Services.

Out-of-Network Dentist Claims and Reimbursement

In order for Us to pay for Covered Services, You or the Out-of-Network Dentist must first send Us a claim. In most cases, We will pay the Dentist directly for Covered Services provided by an Out-of-Network Dentist. 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;
- the patient's name;
- Your identification number; and
- the group number.

Out-of-Network Dentists have not agreed to accept the Allowed Amount as payment in full for Covered Services. 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 Copayment, 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.

EXCLUSIONS

The following exclusions apply to this Pediatric Dental Services Section and are not covered:

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 and 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

Except for the following, Cosmetic and/or reconstructive services and supplies are not covered:

- Dentally Appropriate services and supplies to treat a congenital anomaly; and
- to restore a physical bodily function lost as a result of Illness or Injury.

"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

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
Implants and any associated services and supplies are not covered (whether or not the implant itself was 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
Major Dental Services and supplies are not covered, including, but not limited to:

- 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 medications and supplies, including, but not limited to:

- take home prescription drugs;
- pre-medications; and
- therapeutic drug injections.

Nitrous Oxide

Occlusal Treatment
Dental occlusion services and supplies are not covered, including, but not limited to:

- occlusal analysis and adjustments; and
- occlusal guards.

Oral Hygiene Instructions

Orthodontic Dental Services
Orthodontic services and supplies are not covered, including, but not limited to:

- 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
Dental prosthesis services and supplies are not covered, including, but not limited to:

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

Provisional Splinting

Pulp Vitality Tests

Replacements
Replacement of any lost, stolen or broken dental appliance, including, but not limited to, dentures or retainers.

Separate Charges
Services and supplies that may be billed as separate charges (services that should be included in the billed procedure) are not covered, including, but not limited to:

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

Services Performed in a Laboratory

Surgical Procedures
Surgical procedures and any associated services and supplies are not covered, including, but not limited to:

- 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

The following definitions apply to this Pediatric Dental Services Section:

Allowed Amount means:

- For In-Network Dentists, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Dentists, the amount We have determined to be eligible charges for Covered Services. The Allowed Amount may be based upon billed charges for some services, as determined by Us or as otherwise required by law.

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, contact Customer Service.

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

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

Dentist means an individual who is duly licensed to practice dentistry in all of its branches (including a doctor of medical dentistry, doctor of dental surgery or a denturist) or to practice as a dental hygienist who is permitted by their respective state licensing board, to independently bill third parties.

In-Network Dentist means a Dentist who has an effective participating contract with Us that designates them as a Dentist of the employer Group's network, to provide services and supplies to Members in accordance with the provisions of this coverage.

Out-of-Network Dentist means a Dentist that is not an In-Network Dentist. For reimbursement of Out-of-Network Dentist 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.

Employee Wellness Reward

Employees and their enrolled spouse **[**or domestic partner**]** **(Applies when groups choose domestic partner)** may each qualify for a $100 gift card reward per Contract Year. To qualify, You (the employee or the employee's enrolled spouse **[**or domestic partner**]** **(Applies when groups choose domestic partner)**):

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

Biometric screening by a health care Provider can assist You in assessing Your health risks and identifying changes to improve Your health by providing information about Your blood pressure, cholesterol, and body mass. Approved Providers for the Biometric Screening are identified on Our website or by calling Customer Service.

A General Health Assessment is a tool You complete, describing Your health practices. The General Health Assessment is found online on Our website or by contacting Customer Service.

The Employee Wellness Reward is available to employees and their enrolled spouse **[**or domestic partner**]** **(Applies when groups choose domestic partner)**. **THIS EMPLOYEE WELLNESS REWARD IS A COMPLEMENT TO THE GROUP HEALTH PLAN, BUT IS NOT INSURANCE.**

General Exclusions

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

EXCLUSION PERIOD FOR 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, including related secondary medical conditions, and are not all inclusive:

- a charge in connection with reconstructive or plastic surgery that may have a limited benefit, such as a chemical peel that does not alleviate a functional impairment;
- a complication relating to services and supplies for, or in connection with:
  - gastric or intestinal bypass;
  - gastric stapling;
  - a similar surgical procedure to facilitate weight loss; or
  - a procedure related to the reversal or revision, or any direct complications or consequences of one of these procedures;
- a complication due to infection from a Cosmetic procedure, except in a case of reconstructive surgery:
  - when the service is incidental to or follows a surgery resulting from trauma, infection or other disease of the involved part; or
  - related to a congenital disease or anomaly of a covered dependent child that has resulted in functional defect; or
- a complication that results from an Injury or Illness resulting from voluntary participation in an illegal activity as described in Utah Admin. Code R590-277-4.

SPECIFIC EXCLUSIONS

The following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**, are not covered. However, these exclusions will not apply with regard to a Covered Service for:

- an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law; or
- a preventive service as specified in the Preventive Care and Immunizations benefit and/or in the Prescription Medications Section.

Activity Therapy

The following activity therapy services are not covered:

- creative arts;
- play;
- dance;
- aroma;
- music;
- equine or other animal-assisted;
- recreational or similar therapy; and
- sensory movement groups.

Adventure, Outdoor, or Wilderness Interventions and Camps
Outward Bound, outdoor youth or outdoor behavioral programs, or courses or camps that primarily utilize an outdoor or similar non-traditional setting to provide services that are primarily supportive in nature and rendered by individuals who are not Providers, are not covered, including, but not limited to, interventions or camps focused on:

- building self-esteem or leadership skills;
- losing weight;
- managing diabetes;
- contending with cancer or a terminal diagnosis; or
- living with, controlling or overcoming:
    - blindness;
    - deafness/hardness of hearing;
    - a Mental Health Condition; or
    - a Substance Use Disorder.

Services by Physicians or Practitioners in adventure, outdoor or wilderness settings may be covered if they are billed independently and would otherwise be a Covered Service in this Booklet.

Assisted Reproductive Technologies
Assisted reproductive technologies, regardless of underlying condition or circumstance, are not covered, including, but not limited to:

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer;
- other artificial means of conception; or
- any associated surgery, medications, testing or supplies.

Certain Therapy, Counseling and Training
Except as provided in the Employee Assistance Program (EAP), the following therapies, counseling and training services are not covered:

- educational;
- vocational;
- social;
- image;
- self-esteem;
- milieu or marathon group therapy;
- premarital or marital counseling; and
- job skills or sensitivity training.

Conditions Caused by Active Participation in a War
The treatment of any condition caused by or arising out of a Member's active participation in a war.

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

[Contraceptive Methods
The following contraceptive methods are not covered, including, but not limited to:

- drugs;
- devices;

- supplies;
- sterilization procedures for women; or
- associated patient education and counseling.**]** **(Applies when the group asserts a religious, moral or other exemption, accommodation or exclusion available under law)**

Cosmetic/Reconstructive Services and Supplies
Except for treatment of the following, Cosmetic and/or reconstructive services and supplies are not covered:

- a congenital anomaly;
- to restore a physical bodily function lost as a result of Illness or Injury; 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.

"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, counseling in the absence of Illness is not covered.

Custodial Care
Except as provided in the Palliative Care benefit, non-skilled care and helping with activities of daily living is not covered.

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

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

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

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

- charges for shipping and handling, postage, interest or finance charges that a Provider might bill;
- excise, sales or other taxes;
- surcharges;
- tariffs;
- duties;
- assessments; or
- other similar charges whether made by federal, state or local government or by another entity.

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

Additionally, except as listed below, government facilities or government facilities outside the service area are not covered:

- facilities contracting with the local Blue Cross and/or Blue Shield plan; or
- as required by law for emergency services.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses are not covered, including, but not limited to:

- treatment of painful physical conditions;
- Mental Health Conditions;
- Substance Use Disorders; or
- for anesthesia purposes.

Illegal Activity
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by a Member's **voluntary participation in** an activity where the Member is found:

- guilty of an illegal activity in a criminal proceeding; or
- liable for the activity in a civil proceeding.

A guilty finding includes a plea of guilty, a no contest plea, and a plea in abeyance.

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

Individualized Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids and supports as provided in 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, treatment of infertility is not covered, including, but not limited to:

- surgery;
- uterine transplants;
- fertility medications; and
- other medications associated with fertility treatment.

Investigational Services
Except as provided in the Approved Clinical Trials benefit, Investigational services are not covered, including, but not limited to:

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

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

- automobile medical;
- personal injury protection (PIP);
- automobile no-fault;
- underinsured or uninsured motorist coverage;
- homeowner's coverage;
- commercial premises coverage;
- excess coverage; or
- similar contract or insurance.

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

Non-Direct Patient Care

Except as provided in the Virtual Care benefit, non-direct patient care services are not covered, including, but not limited to:

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

Obesity or Weight Reduction/Control

Except as provided in the Medical Benefits Section or as required by law, services or supplies that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered, including, but not limited to:

- medical treatment;
- medications;
- surgical treatment (including treatment of complications, revisions and reversals); or
- programs.

Orthognathic Surgery

Except for treatment of the following, orthognathic surgery is not covered:

- orthognathic surgery due to an Injury;
- temporomandibular joint disorder;
- sleep apnea (specifically, telegnathic surgery);
- developmental anomalies; or
- congenital anomaly.

"Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development performed to restore the proper anatomic and functional relationship of the facial bones.

"Telegnathic surgery" means skeletal (maxillary, mandibular and hyoid) advancement to anatomically enlarge and physiologically stabilize the pharyngeal airway to treat obstructive sleep apnea.

Over-the-Counter Contraceptives

Except as provided in the Prescription Medications Section or as required by law, over-the-counter contraceptive supplies are not covered.

Personal Items

Items that are primarily for comfort, convenience, Cosmetics, contentment, hygiene, environmental control, education or general physical fitness are not covered, including, but not limited to:

- telephones;
- televisions;
- air conditioners, air filters or humidifiers;
- whirlpools;
- heat lamps;
- light boxes;
- weightlifting equipment; and
- therapy or service animals, including the cost of training and maintenance.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment are not covered (even if recommended or prescribed by Your Provider), including, but not limited to:

- hot tubs; or
- membership fees to spas, health clubs or other such facilities.

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

Provider-Administered Specialty Drugs
Provider-Administered Specialty Drugs that are not obtained through the designated Specialty Pharmacy for Provider-Administered Specialty Drugs are not covered.

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

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

- a riot;
- an armed invasion or aggression;
- an insurrection; or
- a rebellion.

Routine Foot Care

Routine Hearing Examinations

Self-Help, Self-Care, Training or Instructional Programs
Except as provided in the Medical Benefits Section or for services provided without a separate charge in connection with Covered Services that train or educate a Member, self-help, non-medical self-care, and training or instructional programs are not covered, including, but not limited to:

- childbirth-related classes including infant care; and
- instructional programs that:
    - teach a person how to use Durable Medical Equipment;
    - teach a person how to care for a family member; or
    - provide a supportive environment focusing on the Member's long-term social needs when rendered by individuals who are not Providers.

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

"Immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings; and
- Your child's or stepchild's spouse or domestic partner.

Services and Supplies That Are Not Medically Necessary
Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Services Required by an Employer or for Administrative or Qualification Purposes

Physical or mental examinations and associated services (laboratory or similar tests) required by an employer or primarily for administrative or qualification purposes are not covered.

Administrative or qualification purposes, include, but are not limited to:

- admission to or remaining in:
    - school;
    - a camp;
    - a sports team;
    - the military; or
    - any other institution.
- athletic training evaluation;
- legal proceedings (establishing paternity or custody);
- qualification for:
    - employment or return to work;
    - marriage;
    - insurance;
    - occupational injury benefits;
    - licensure; or
    - certification.
- travel, immigration or emigration.

Sexual Dysfunction

Except as provided in the Mental Health Services benefit, treatment, services and supplies are not covered for or in connection with sexual dysfunction regardless of cause.

Subscription, Membership and Access-Related Fees

Fees for accessing care, treatment, or advice are not covered, whether the access is for virtual or in-person care. Excluded fees include, but are not limited to:

- concierge fees;
- subscription fees;
- membership fees;
- retainer fees;
- VIP or priority access fees; and
- any other access-related fees.

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. "Maternity and related medical services" include otherwise Covered Services for conception, prenatal, maternity, delivery and postpartum care. Refer to the Maternity Care/Adoption Benefit and/or Right of Reimbursement and Subrogation Recovery provision for more information.

Termination of Pregnancy (Abortion)

Except as provided in the Termination of Pregnancy benefit, services or supplies related to the termination of a pregnancy (abortion) are not covered.

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
Except as provided in the Ambulance benefit or as otherwise provided in the Medical Benefits Section, travel and transportation expenses are not covered.

Varicose Vein Treatment
Except as provided in the Other Professional Services benefit, treatment of varicose veins is not covered.

Vision Care
Except as provided in the Pediatric Vision Services Section, vision care services are not covered, including, but not limited to:

- routine eye examinations;
- vision hardware;
- visual therapy;
- training and eye exercises;
- vision orthoptics;
- surgical procedures to correct refractive errors/astigmatism; and
- reversals or revisions of surgical procedures which alter the refractive character of the eye.

Wigs
Wigs or other hair replacements regardless of the reason for hair loss or absence.

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

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

Contract and Claims Administration

This section explains administration of benefits and claims, including situations that may arise when Your health care expenses are the responsibility of a source other than Us. Payment of benefits will be made in accordance with the terms and conditions of this Booklet.

ALTERNATIVE BENEFITS

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

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims are submitted and payment is due, We 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.**]** **(Always applies unless is EE only coverage)**

In-Network Provider Claims and Reimbursement

You must present Your identification card to an In-Network Provider and furnish any additional information requested. The Provider will submit the necessary forms and information to Us for processing Your claim.

We will pay an In-Network Provider directly for Covered Services. These Providers may require You to pay any Deductible, Copayment and/or Coinsurance at the time You receive care or treatment. In-Network Providers have agreed not to bill You for balances beyond any Deductible, Copayment and/or Coinsurance and to accept the Allowed Amount as payment in full for Covered Services.

Out-of-Network Provider Claims and Reimbursement

In order for Us to pay for Covered Services, You or the Out-of-Network Provider must first send Us a claim. In most cases, We will pay You directly for Covered Services provided by an Out-of-Network Provider. 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;
- the patient's name;
- Your identification number; and
- the group 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 Providers have not agreed to accept the Allowed Amount as payment in full for Covered Services. You are responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount in addition to any amount You must pay due to Deductible, Copayment 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.

NOTE: Refer to the notice "Your Rights and Protections Against Surprise Medical Bills" attached to this Booklet for information regarding reimbursement and balance billing applicable to Out-of-Network Providers for certain services.

Rural Health Care Providers

If You are a Rural Resident with regard to the Provider, You are entitled to coverage at the In-Network benefit for Covered Services by an Independent Hospital (or its Credentialed Staff Member at an Independent Hospital or their 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, visit Our website 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 §31A-45-501 and Utah Admin. Code R590-237.

Timely Filing of Claims

Written proof of loss (submission of a claim) must be received within one year after the date of service. Claims that are not filed in a timely manner will be denied, unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. Benefits or coverage will not be invalidated nor reduced if it can be shown that it was not reasonably possible to file the claim and that the claim was submitted as soon as reasonably possible. You may Appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner. If You were covered by more than one health plan on the date of service, see the text of Primary Health Plan Benefits in the Coordination of Benefits provision for an exception to this timely filing rule.

Claim Determinations

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

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

CONTINUITY OF CARE

You may qualify to receive 90 days of continued coverage (or 90 days from the date You are no longer a continuing care patient, whichever is earlier) at the In-Network benefit level, if one of the following situations apply:

- Your Provider was a contracted In-Network Provider, but is no longer contracted (this provision does not apply if the contract with the Provider was terminated due to a failure to meet quality standards or for fraud); or
- Your Group's Contract with Us is terminated for reasons other than fraud, and your Group's new health plan does not include Your In-Network Provider in its network.

To qualify for continued coverage, You must be:

- undergoing a course of treatment for a certain serious and complex condition from the Provider;
- undergoing a course of institutional or inpatient care from the Provider;
- scheduled to undergo non-elective surgery from the Provider (including postoperative care following surgery);
- pregnant and undergoing a course of treatment for pregnancy from the Provider; or
- determined to be terminally ill and receiving treatment for such Illness from the Provider.

We will notify You of Your right to receive continued care from the Provider or You may contact Us with a need for continued care. Coverage under this Continuity of Care provision will be subject to the benefits of this Booklet and provided on the same terms and conditions as any other In-Network Provider. Your

Provider must accept the Allowed Amount and cannot bill You for any amount beyond any Deductible, Copayment and/or Coinsurance. Contact Customer Service for further information and guidance.

OUT-OF-AREA SERVICES

We have a variety of relationships with other Blue Cross and/or Blue Shield 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. Whenever You access health care services outside of the geographic area We serve, the claim for those services may be processed through one of these Inter-Plan Arrangements.

When You receive care outside of the geographic area We serve, You may receive it from Providers as described below. Providers that contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue") as a participating Provider are paid at the In-Network benefit level and will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. Some Providers ("Out-of-Network Providers") don't contract with the Host Blue.

BlueCard Program

In the BlueCard Program, when You obtain Covered Services within the geographic area served by a Host Blue, We will remain responsible for doing what We agreed to in the Contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Providers that participate in the BlueCard Program.

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

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

Often, this "negotiated price" is a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with a Provider or group of Providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of Providers. Host Blues may use several factors to set an estimated or average price, including types of settlements, incentive payments, and/or other credits or charges. Estimated and average pricing may also take into account adjustments to correct Host Blue estimates of past prices. However, such adjustments will not affect the price used for Your claim because those adjustments will not be applied after a claim has already been paid.

Value-Based Programs

You may receive Covered Services under a Value-Based Program ("VBP") inside a Host Blue's service area. Host Blue may pay Providers that participate in a VBP for reaching agreed-upon cost and quality goals, meeting outcome measures, and coordinating care between its Providers. You will not be responsible for paying fees associated with a VBP, except when a Host Blue passes these fees to Us through average pricing or fee schedule adjustments.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state law 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.

Out-of-Network Providers Outside Our Service Area

When Covered Services are provided outside of Our service area by Out-of-Network Providers, the amount You pay will normally be based on either Host Blue's Out-of-Network Provider local payment or pricing arrangements required by applicable state law. We may use other payment methods in certain situations, such as billed charges for Covered 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 any of these situations, You may be responsible for the difference between the Out-of-Network Provider's billed amount and Our payment for Covered Services. Federal or state law, as applicable, will govern payments for Out-of-Network emergency services.

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 ("BCBS Global® Core") when accessing Covered Services. BCBS Global® Core is unlike the BlueCard Program available in the United States in certain ways. For instance, although BCBS Global® Core helps You access a provider network, the network is not served by a Host Blue.

You may have to pay the Provider upfront and submit any claims to Us Yourself in order to obtain reimbursement for those services. When You pay for Covered Services outside the United States, You should complete and submit a BCBS Global® Core claim form with the Provider's itemized bill(s) to the service center (address is on the form) to initiate claims processing. If You contact the BCBS Global® Core service center for assistance, in most cases, Hospitals will not require You to pay for covered inpatient services (except for any applicable Deductible, Copayment and/or Coinsurance). In such cases, the Hospital will also submit Your claims to the service center.

If You need medical assistance services (or help locating a Provider) outside the United States, of if You need assistance with a 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. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary. The claim form is available from Us, the service center, or online at **www.bcbsglobalcore.com**.

Covered Services received from Providers outside the United States may not be subject to state or federal protections from surprise or balance billing, and therefore You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

CLAIMS RECOVERY

If We pay a benefit to which You **[**or Your Enrolled Dependent was**]** **(Always applies unless is EE only coverage)** **[**were**]** **(Applies to EE only Coverage)** 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 for an erroneous payment made on Your **[**or Your Enrolled Dependent's**]** **(Always applies unless is EE only coverage)** behalf includes the right to deduct the mistakenly paid amount from future benefits We would provide You **[**or any of Your Enrolled Dependents**]** **(Always applies unless is EE only coverage)** under this coverage. We will not seek recovery from You**[**, Your Enrolled Dependent,**]** **(Always applies unless is EE only coverage)** 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 matter involving coordination of benefits as described in the Coordination of Benefits provision in this Contract 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 Your Group's experience or the experience of the pool by which You or Your Group is rated. Crediting reduces claims expense and helps reduce future premium rate increases.

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

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 Booklet 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 Booklet, 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 Booklet, 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 Booklet, 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 Illness or Injury 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 Member and/or any third-party or the recovery source. We are entitled to reimbursement from the first dollars received from any recovery. This applies regardless of whether:
    - the third-party or third-party's insurer admits liability;
    - the health care expenses are itemized or expressly excluded in the recovery; or

- the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered in this Booklet.

- We will not reduce Our reimbursement or subrogation due to Your not being made whole. Our right to reimbursement or subrogation, however, will not exceed the amount of recovery.
- By accepting benefits under this Booklet, 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 Booklet. 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 Illness or Injury 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 Booklet 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 with 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 will advance benefits for Covered Services provided that We are notified of such appeal by the Labor Commission.

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 in this provision will not exceed the amount of Your recovery.

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

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

Allowable Expense means, with regard to services that are covered in full or part in this Booklet or any other Plan(s) covering You, the amount on which that Plan would base its benefit payment for a service, including Coinsurance or Copayments and without reduction for any applicable Deductible, 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 means only the day and month of birth, regardless of the year.

Custodial Parent means the parent awarded custody of a child by a court order. In the absence of a court order, 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 Contract 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 Contract does not include an individually underwritten guaranteed renewable coverage, even if the coverage is purchased through payroll deduction at a premium savings to You (and You have the right to maintain or renew the coverage independently of continued employment with the employer).

Plan or Conforming Plan means any of the following plans that allow coordination of benefits:

- individual and group accident and health insurance contracts;
- uninsured arrangements of a group or Group-Type Contract;
- Group-Type Contract;
- 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 an insurer and that excludes benefits for services provided by a non-panel Provider, except in the cases of emergency or referral by a panel Provider);
- a medical care benefit in a long-term care contract that provides reimbursement for an incurred expense, rather than an indemnity benefit; and
- Medicare and other governmental coverages, as permitted by law.

Plan does not mean a non-Conforming Plan, which includes any of the following plans that may not coordinate benefits:

- 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 Medicaid state plan; 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 by that provision the Plan determines its benefits first.

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

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

Order of Benefit Determination

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

Non-dependent 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 for 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 legally 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.
    - Then the Plan of Your noncustodial parent shall be primary to the Plan of Your noncustodial parent's spouse.

If You are covered by 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 by 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.

Continuation of 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 by which You are covered pursuant to a right of continuation 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 longest period of time will be determined before the benefits of the Plan that has covered You for the shortest period of time. To determine the length of time You have been covered by a Plan, two successive Plans will be treated as one if You were eligible by the second Plan within 24 hours after 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 by a Plan is measured from Your first date of coverage with that Plan. If that date is not readily available for a group Plan, the date You first became a member of the group will be used as the date from which to determine the length of time coverage with the present Plan has been in force.

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

Primary Health Plan Benefits

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

We will calculate the benefits that We would have paid for a service if this coverage were the Primary Plan. We will apply that calculated amount to any Allowable Expense in this Booklet 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 Booklet'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 by this coverage. Further, in no event will this Coordination of Benefits provision operate to increase Our payment over what We would have paid in the absence of this Coordination of Benefits provision.

Right to Receive and Release Needed Information

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

Right of Recovery

If We provide benefits to or on behalf of You in excess of the amount that would have been payable in this Booklet by reason of Your coverage with 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 misrepresentation(s). 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. 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 wish to seek review of a claim denial or other dispute that is identified below, You may appeal. There is one appeal to Us, as well as an additional voluntary external review that You may pursue. Certain situations requiring a faster decision may qualify for an expedited appeal as described below.

For pediatric vision benefits, We have delegated the appeal process to VSP, though We retain ultimate responsibility over the appeal process. The terms "We," "Us" and "Our" for the purpose of pediatric vision appeals refer to VSP. If You believe a policy, action, or decision is incorrect, contact the VSP Customer Service department.

NOTE: For all appeals, written materials provided in support of the appeal that include others' medical or health records and other personal health information should not be submitted.

INTERNAL APPEAL
All internal appeals, including expedited appeals, must be pursued within 180 days of Your receipt of Our determination (or, in the case of the initial appeal, within 180 days of Your receipt of Our original Adverse Benefit Determination that You are appealing). 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.

Internal appeals are reviewed by an employee or employees who were not involved in the initial decision that You are appealing. In appeals that involve issues requiring medical judgment, the decision is made by one or more members of Our staff of health care professionals.

What You May Appeal – Internal Appeal

You may appeal an Adverse Benefit Determination.

Voluntary Independent Review

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

INTERNAL EXPEDITED APPEAL
If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision from the internal appeal process, You or Your treating Provider may request an expedited appeal within 180 days of Your receipt of Our Adverse Benefit Determination. See Expedited Appeals later in this section for more information.

Your internal expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. You or Your Representative, on Your behalf, will be given the opportunity (within the expedited appeals time frame) to provide written materials, including written testimony on Your behalf.

The internal expedited appeal request may be submitted orally or in writing. It must include documentation necessary for the appeal decision. Receipt of an oral request for expedited appeal will be acknowledged in writing within 24 hours. 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.

What You May Appeal – Internal Expedited Appeal

An expedited appeal is available for Pre-Service or concurrent Urgent Care Claims.

Voluntary Expedited Independent Review

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

FILING AN INTERNAL APPEAL

For pediatric vision benefits, Appeals can be initiated with VSP using any of the following methods:

Method of Request	Contact Information
Secure Online Account	Create an account or complete the form available at **vsp.com**
Phone	Call 1 (844) 299-3041 for VSP's Customer Service department Call 1 (800) 428-4833 for hearing impaired customer assistance Customer Services hours: Monday – Saturday, 6 a.m. – 5 p.m. Pacific Time
Mail	Attn: Appeals Department Vision Service Plan P.O. Box 2350 Rancho Cordova, CA 95741

For all other benefits in this coverage, both internal and internal expedited appeals can be initiated with Us using any of the following methods:

Method of Request	Contact Information
Secure Online Account	Sign-in to Your account at **regence.com**, navigate to appeals and complete an online appeal request
E-mail	**MemberAppeals@regence.com**
Fax	1 (888) 496-1542
Phone	Call the Customer Service phone number on Your identification card
Mail	Attn: Member Appeals Regence BlueCross BlueShield of Utah P.O. Box 1106 Lewiston, ID 83501-1106

INTERNAL APPEAL DETERMINATION TIMING

We will send Our decision on Your internal appeal as follows:

Type of Appeal	How and When to Expect a Response
Post-Service appeal	In writing, within 60 days of Our receipt of the appeal.
Pre-Service preauthorization of a procedure	In writing, within 30 days of Our receipt of the appeal.
Expedited appeal	Verbal notice of the decision will be provided as soon as possible after the decision, but no later than 72 hours of receipt of the appeal; followed by written notification within 3 days of the verbal notice.

YOUR RIGHT TO AN INDEPENDENT REVIEW – NOTICE

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 Our internal appeal process, 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;
- 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 in the Expedited Independent Review request provision below.

Filing an External Review Request

You may submit a request for an external review as follows:

Method of Request	Contact Information
E-mail	**healthappeals@utah.gov**
Mail	Attn: Independent Review Utah Insurance Department 4315 S 2700 W, Ste 2300 Taylorsville, UT 84129
Phone	1 (801) 957-9280
Website	**www.insurance.utah.gov/health/independent-review**

If Your request qualifies for Independent Review, Our Final Adverse Benefit Determination will be reviewed by an Independent Review Organization (IRO) selected by the Utah Insurance Department (hereafter "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.

What You May Appeal – 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, 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 one of the two appeal reasons in the charts below.

Standard Independent Review Request Timing

A request for Independent Review must be made within 180 days of Your receipt of Our Final Adverse Benefit Determination. A decision will be sent as follows:

Appeal reason: Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of Your health care service or supply, or rescission of coverage.	
Appeal Step	**How and When to Expect a Response**
The Department sends a copy of Your request for external review to Us.	Upon the Department's receipt of Your request.

We review Your request for eligibility.	Within 5 working days after Our receipt of the request from the Department.
We 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 to the Department if We find Your request ineligible.	Within 1 working day of completing Our review.
If Your request is eligible for Independent Review, the Department assigns an IRO to Your review and notifies You in writing.	Upon the Department's receipt of Our notice of eligibility.
We will provide the IRO the documents and any information considered in making the Adverse Benefit Determination.	Within 5 working days.
You may submit any additional information in writing to the IRO that You want the IRO to consider in its review.	Within 5 working days of the date You receive the Department's notice of IRO assignment.
The IRO will forward to Us, any information submitted by You.	Within 1 working day of receipt.
The IRO must provide written notice of its decision to You, to Us and to the Department.	Within 45 calendar days after receipt of Independent Review request.
We approve the coverage that was the subject of the Adverse Benefit Determination and process any coverage that is due.	Within 1 working day of Our receipt of a notice reversing the final Adverse Benefit Determination.

Appeal reason: Our determination that Your health care service or treatment was Investigational.	
Appeal Step	**How and When to Expect a Response**
The Department sends a copy of Your request for external review to Us.*	Upon the Department's receipt of Your request.
* 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.	
We review request for eligibility.	Within 5 working days after Our receipt of the request from the Department.
We notify You and the Department in writing whether 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 to the Department if We find Your request ineligible.	Within 1 working day of completing Our review.

If Your request is eligible for Independent Review, the Department assigns an IRO to Your review and notifies You in writing.	Upon the Department's receipt of Our notice of eligibility.
We will provide the IRO the documents and any information considered in making the Adverse Benefit Determination.	Within 5 working days.
You may submit any additional information in writing to the IRO that You want the IRO to consider in its review.	Within 5 working days of the date You receive the Department's notice of IRO assignment.
The IRO will forward to Us, any information submitted by You.	Within 1 working day of receipt.
The IRO will select a clinical reviewer(s) to conduct the review.	Within 1 working day after receiving the request.
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.
We approve the coverage that was the subject of the Adverse Benefit Determination and process any coverage that is due.	Within 1 working day of Our receipt of a notice reversing the final Adverse Benefit Determination.

What You May Appeal – 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.

Expedited Independent Review Request Timing

You may file for an internal expedited appeal to Us and for an expedited Independent Review request with the Department at the same time.

Appeal Step	How and When to Expect a Response
The Department sends a copy of request for external review to Us.	Upon the Department's receipt of Your request.
We review request for eligibility.	Within 1 working day after Our receipt of request from the Department.
We notify You and the Department in writing whether 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 to the Department if We find Your request ineligible.	Within 1 working day of completing Our review.
If Your request is eligible for Independent Review, the Department immediately assigns an IRO to Your review and notifies You in writing.	Upon the Department's receipt of Our notice of eligibility.

You may submit any additional information in writing to the IRO that You want the IRO to consider in its review.	Within 1 working day of the date You receive the Department's notice of IRO assignment.
The IRO will forward to Us, any information submitted by You.	Within 1 working day of receipt.
The IRO will select a clinical reviewer(s) to conduct the review.	Within 1 working day after receiving the request.
Clinical reviewer(s) will provide the IRO a written opinion.	Within 5 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 a request due to an Investigational health care service or treatment. Within 72 hours after receipt of the opinion for all other requests. In either scenario, 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.
We approve the coverage that was the subject of the Adverse Benefit Determination and process any coverage that is due.	Within 1 working day of Our receipt of a notice reversing the final Adverse Benefit Determination.

DEFINITIONS
The following are definitions that apply to this Appeal Process Section:

"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;
    - not Medically Necessary; or
- other matters as specifically required by 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.

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 that acts as the decision-maker for a voluntary Independent Review and voluntary expedited Independent Review and that is not controlled by Us.

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

Pre-Service means any claim for benefits 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 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 appeal. No authorization is required from the parent(s) or legal guardian of an enrolled dependent child 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.

Eligibility and Enrollment

(Always applies unless is EE only coverage) [This section explains how to enroll Yourself and/or Your eligible dependents when first eligible, during a period of special enrollment or during an annual open enrollment period. It describes when coverage under the Contract begins for You and/or Your eligible dependents. Payment of any corresponding monthly premiums is required for coverage to begin on the indicated dates.

INITIALLY ELIGIBLE AND WHEN COVERAGE BEGINS

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

If You and/or Your eligible dependents do not enroll for coverage under the Contract when first eligible or You do not enroll in a timely manner, You and/or Your eligible dependents must wait until the next annual open enrollment period to enroll, except as described in the Special Enrollment provision below.

Employees

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

Dependents

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

- The person to whom You are legally married (spouse).
- **{**Your 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 enrollment of 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.

NOTE: Where a reference is made to spouse, all of the same terms and conditions of the Booklet will be applied to a domestic partner, except when specified to the contrary If You and Your domestic partner are in a registered domestic partnership, the domestic partner conditions above do not apply and any requirements for an affidavit of qualifying domestic partnership form stated in the Booklet also do not apply. "Registered domestic partnership" means a civil contract entered into, in-person, between two individuals, which recognizes their intimate relationship and common domestic life and is registered by a U.S. state or municipality or a comparable governmental entity.**}** **(Applies when groups choose domestic partner)**

- Your (or Your spouse's **{**or Your domestic partner's**}** **(Applies when groups choose domestic partner)**) child who is under age 26 and who meets any of the following criteria:

  - Your (or Your spouse's **{**or Your domestic partner's**}** **(Applies when groups choose domestic partner)**) natural child, stepchild, adopted child or child legally placed with You (or Your spouse **{**or Your domestic partner**}** **(Applies when groups choose domestic partner)**) for adoption;
  - a child for whom You (or Your spouse **{**or Your domestic partner**}** **(Applies when groups choose domestic partner)**) have court-appointed legal guardianship; or
  - a child for whom You (or Your spouse **{**or Your domestic partner**}** **(Applies when groups choose 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**}** **(Applies when groups choose domestic partner)**) 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 the child's 26th birthday. You must 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 and either:

  - the child is an enrolled child immediately before their 26th birthday; or
  - the child's 26th birthday preceded Your Effective Date and the child has been continuously covered as a dependent on either a parent's or legal guardian's 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 website 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 enrollment request **{**(and, for a domestic partner, an affidavit of qualifying domestic partnership form)**}** **(Applies when groups choose domestic partner)**.

Enrollment requests must be made according to the following:

- within 60 days of the date of birth, adoption or placement for adoption for a new child. When the addition of a new child by birth, adoption or placement for adoption would not cause a change in the premium amount billed to the Group (as of the date of birth, adoption or placement for adoption), You will have 60 days from the date We first send a denial of a claim for benefits for that new dependent to submit an enrollment request.
- within 30 days of the dependent's attaining eligibility for all other newly eligible dependents.

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; however, for a child placed for adoption within 30 days of birth, the Effective Date will be the child's date of birth).

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your eligible dependents, even though You didn't do so when first eligible, and You do not have to wait for an annual open enrollment period. You must submit an enrollment form **{**(and, in the case of a domestic partner, a completed affidavit of qualifying domestic partnership form)**}** **(Applies when groups choose domestic partner)** on behalf of all individuals who become eligible based on the provisions below.

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

- You and/or Your eligible dependent(s) lose coverage under another group or individual health benefit plan due to one of the following:

  - an employer's contributions to that other plan are terminated;

- exhaustion of federal COBRA or any state continuation; or
- loss of eligibility due to legal separation, divorce, **{**termination of domestic partnership,**}** **(Applies when groups choose domestic partner)** death, termination of employment or reduction in hours.

- You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than Children's Health Insurance Program (CHIP), see below).
- You lose coverage under Medicaid or CHIP.

Timely enrollment for the above qualifying events results in coverage effective on the day after the prior coverage ended. Loss of eligibility does not include a loss because You failed to timely pay Your portion of the premium or when termination of coverage was due to fraud. It also doesn't include Your decision to terminate coverage. However, it may include Your decision to take another action (for example, terminating employment) that results in a loss of eligibility.

If You declined coverage for Yourself or any eligible dependent(s) when first eligible, You (unless already enrolled) and Your eligible dependent(s) are eligible to enroll for coverage under the Contract within 30 days from the date of one of the following qualifying events:

- You marry **{**or begin a domestic partnership**}** **(Applies when groups choose domestic partner)**;
- You acquire a new child by birth, adoption, or placement for adoption**{**. NOTE: Your domestic partner is not eligible to enroll for coverage under the Contract in this situation**}** **(Applies when groups choose domestic partner)**; or
- You become eligible for premium assistance according to Title 26, Chapter 18 of the Medical Assistance Act (receipt of written notification of the eligibility for premium assistance is considered the date of the qualifying event).

If You declined coverage for Yourself or any eligible dependent(s) when first eligible, You (unless already enrolled) and Your eligible dependent(s) are eligible to enroll for coverage under the Contract within 60 days from the date of the following qualifying event:

- You and/or Your eligible dependent(s) become eligible for premium assistance with Medicaid or CHIP.

Timely enrollment for the above qualifying events results in coverage effective on the first of the calendar month following the date of the qualifying event. However, if the qualifying event is a child's birth, adoption, or placement for adoption, coverage is effective from the date of the birth, adoption or placement.

ANNUAL OPEN ENROLLMENT PERIOD

The annual open enrollment period is the period of time before the Group's Renewal Date and is the only time, other than initial eligibility or a special enrollment period, during which You and/or Your eligible dependents may enroll or make allowed changes to Your benefits, like changing Your Provider network. You must submit an enrollment form **{**(and, in the case of a domestic partner, a completed affidavit of qualifying domestic partnership form)**}** **(Applies when groups choose domestic partner)** on behalf of all individuals You want enrolled. Coverage will begin on the Effective Date.

TRANSFER DURING ANNUAL OPEN ENROLLMENT PERIOD

The annual open enrollment period is the period of time before the Group's Renewal Date during which You and/or Your eligible dependents may transfer directly to the Contract from one of the Group's other health benefit plans. You must file an enrollment form **{**(and, in the case of a domestic partner, a completed affidavit of qualifying domestic partnership form)**}** **(Applies when groups choose domestic partner)** on behalf of all individuals You want enrolled. Coverage will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY

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

DEFINITIONS

The following are definitions that apply to this Eligibility and Enrollment Section:

Disabled Dependent means a child who is and continues to be:

- 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
- dependent on You for more than 50 percent of their support (food, shelter, clothing, medical and dental care, education and the like).

Mental Impairment means a mental or psychological disorder such as:

- intellectual disability;
- organic brain syndrome;
- emotional or mental illness; or
- 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:

- neurological;
- musculoskeletal;
- special sense organs;
- respiratory organs;
- speech organs;
- cardiovascular;
- reproductive;
- digestive;
- genito-urinary;
- hemic and lymphatic;
- skin; or
- endocrine.**]** **(Always applies unless is EE only coverage)**

(Applies to EE only coverage) [This section explains how to enroll when first eligible, during a period of special enrollment or during an annual open enrollment period. It describes when coverage under the Contract begins for You. Payment of any corresponding monthly premiums is required for coverage to begin on the indicated dates.

INITIALLY ELIGIBLE AND WHEN COVERAGE BEGINS

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

If You do not enroll for coverage under the Contract when first eligible or You do not enroll in a timely manner, You must wait until the next annual open enrollment period to enroll, except as described in the Special Enrollment provision below.

Employees

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

SPECIAL ENROLLMENT

There are certain situations when You may enroll, even though You didn't do so when first eligible, and You do not have to wait for an annual open enrollment period. You must submit an enrollment form when You become eligible based on the provisions below.

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

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

Timely enrollment for the above qualifying events results in coverage effective on the day after the prior coverage ended. Loss of eligibility does not include a loss because You failed to timely pay Your portion of the premium or when termination of coverage was due to fraud. It also doesn't include Your decision to terminate coverage. However, it may include Your decision to take another action (for example, terminating employment) that results in a loss of eligibility.

If You declined coverage when first eligible, You (unless already enrolled) are eligible to enroll for coverage under the Contract within 30 days from the date of one of the following qualifying events:

- You marry;
- You acquire a new child by birth, adoption, or placement for adoption; or
- You become eligible for premium assistance according to Title 26, Chapter 18 of the Medical Assistance Act (receipt of written notification of the eligibility for premium assistance is considered the date of the qualifying event).

If You declined coverage when first eligible, You (unless already enrolled) are eligible to enroll for coverage under the Contract within 60 days from the date of the following qualifying event:

- You become eligible for premium assistance with Medicaid or CHIP.

Timely enrollment for the above qualifying events results in coverage effective on the first of the calendar month following the date of the qualifying event. However, if the qualifying event is a child's birth, adoption, or placement for adoption, coverage is effective from the date of the birth, adoption or placement.

ANNUAL OPEN ENROLLMENT PERIOD

The annual open enrollment period is the period of time before the Group's Renewal Date and is the only time, other than initial eligibility or a special enrollment period, during which You may enroll or make allowed changes to Your benefits, like changing Your Provider network. You must submit an enrollment form. Coverage for will begin on the Effective Date.

TRANSFER DURING ANNUAL OPEN ENROLLMENT PERIOD

The annual open enrollment period is the period of time before the Group's Renewal Date during which You may transfer directly to the Contract from one of the Group's other health benefit plans. You must submit an enrollment form. Coverage will begin on the Effective Date.**]** **(Applies to EE only coverage)**

When Coverage Ends

(Always applies unless is EE only coverage) [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 after the date coverage is terminated. Termination of Your or Your Enrolled Dependent's coverage under the Contract for any reason will completely end all Our obligations to provide You or Your Enrolled Dependent benefits for Covered Services received after the date of termination. This applies whether or not You or Your Enrolled Dependent is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while the Contract was in effect.

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

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE
If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your Enrolled Dependents on the last day of the month in which Your eligibility ends. However, it may be possible for You and/or Your Enrolled Dependents to continue coverage under the Contract according to the COBRA and Non-COBRA Continuation of Coverage Sections.

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

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

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE
If Your dependent is no longer eligible as explained in the following paragraphs, coverage ends for Your Enrolled Dependents on the last day of the month in which their eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Contract according to the COBRA and Non-COBRA Continuation of Coverage Sections.

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 month following the date a divorce or annulment is final.

NOTE: A spouse whose coverage under the Contract ends due to divorce, annulment or legal separation is entitled to have an individual policy issued without evidence of insurability. When We receive actual notice that the coverage of a spouse is to be terminated due to divorce or annulment, We shall provide the spouse written notification detailing this right to obtain individual coverage.

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

{Termination of Domestic Partnership
If Your domestic partnership terminates, 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 month following the date of termination of the domestic partnership. Termination of Your domestic partnership includes 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. 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.**} (Applies when groups choose domestic partner)**

Loss of Dependent Status

- Eligibility ends on the last day of the month in which an enrolled child exceeds the dependent age limit.
- Eligibility ends on the last day of the month in which an enrolled child is removed from placement due to disruption of placement before legal adoption.
- Eligibility ends on the last day of the month in which the enrolled child is no longer an eligible dependent for any other cause.

OTHER CAUSES OF TERMINATION

Members terminated for any of the following reasons may be able to continue coverage under the Contract according to the COBRA and Non-COBRA Continuation of Coverage Sections.

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 the Contract will terminate for that Member. The Member may reenroll 12 months after the date of discontinuance if the Group's coverage is in effect at the time the Member applies to reenroll.

Fraud or Misrepresentation in Application

We have issued this Booklet 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, including any fraudulent insurance act as described in Utah Code §31A-31-103 (or any successor thereto), We will have the following rights:

- With regard to a Member's health status, We may make a retrospective adjustment to the premium amount as would have been appropriate if true, accurate or complete information had been provided at the time of enrollment.
- With regard to a Member (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Group), We will retroactively adjust coverage to the terms that would have existed if true, accurate or complete information had been received. A Member may reenroll 12 months after the date of a discontinuance of coverage, if the Group's coverage is in effect at the time the Member applies to reenroll.

FAMILY AND MEDICAL LEAVE

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

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

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

If You and/or Your Enrolled Dependents elect not to remain enrolled during the FMLA leave, You (and/or Your Enrolled Dependents) will be eligible to be reenrolled under the Contract on the date You return from the FMLA leave. In order to reenroll after You return from a FMLA leave, You must sign a new enrollment form as if You were a newly eligible employee. In this situation, if You reenroll within the

required time, all of the terms and conditions of the Contract will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Enrolled Dependents) will receive credit for any waiting period served before the FMLA leave and You will not have to re-serve any probationary period under the Contract, although You and/or Your Enrolled Dependents will receive no waiting period credits for the period of noncoverage.

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

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

LEAVE OF ABSENCE

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

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

If You and/or Your Enrolled Dependents elect not to remain enrolled during the leave of absence, You (and/or Your Enrolled Dependents) may reenroll under the Contract only during the next annual open enrollment period.**]** **(Always applies unless is EE only coverage)**

(Applies to EE only coverage) **[**This section describes the situations when coverage will end for You.

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

CONTRACT TERMINATION

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

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, coverage ends for You on the last day of the month in which Your eligibility ends. However, it may be possible for You to continue coverage under the Contract according to the COBRA and Non-COBRA Continuation of Coverage Sections.

Termination of Your Employment or You are No Longer Eligible

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Contract, coverage will end for You on the last day of the month in which eligibility ends.

Nonpayment of Premium

If You fail to make required timely contributions to premium, coverage will end for You.

OTHER CAUSES OF TERMINATION

Members terminated for any of the following reasons may be able to continue coverage under the Contract according to the COBRA and Non-COBRA Continuation of Coverage Sections.

Fraudulent Use of Benefits

If You engage 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 the Contract will terminate for that Member. The Member may reenroll 12 months after the date of discontinuance if the Group's coverage is in effect at the time the Member applies to reenroll.

Fraud or Misrepresentation in Application

We have issued this Booklet in reliance upon all information furnished to Us by You or on behalf of You. In the event of any intentional misrepresentation of material fact or fraud, including any fraudulent insurance act as described in Utah Code §31A-31-103 (or any successor thereto), We will have the following rights:

- With regard to a Member's health status, We may make a retrospective adjustment to the premium amount as would have been appropriate if true, accurate or complete information had been provided at the time of enrollment.
- With regard to a Member, We will retroactively adjust coverage to the terms that would have existed if true, accurate or complete information had been received. A Member may reenroll 12 months after the date of a discontinuance of coverage, if the Group's coverage is in effect at the time the Member applies to reenroll.

FAMILY AND MEDICAL LEAVE

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

- You will remain eligible to be enrolled under the Contract during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
    - to care for Your new born child;
    - to care for Your spouse, child or parent, with a serious health condition;
    - the placement of a child with You for adoption or foster care; or
    - You suffer a serious physical or Mental Health Condition.

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

If You elect not to remain enrolled during the FMLA leave, You will be eligible to be reenrolled with the Contract on the date You return from the FMLA leave. In order to reenroll after You return from a FMLA leave, You must sign a new enrollment form as if You were a newly eligible employee. In this situation, if You reenroll within the required time, all of the terms and conditions of the Contract will resume at the time of reenrollment as if there had been no lapse in coverage. You will receive credit for any waiting period served before the FMLA leave and You will not have to re-serve any probationary period under the Contract, although You will receive no waiting period credits for the period of noncoverage.

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

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the

minimum requirements of FMLA will govern. This leave provision is available only to groups that are required by law to comply. The Group must keep Us advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

LEAVE OF ABSENCE

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

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

If You elect not to remain enrolled during the leave of absence, You may reenroll under the Contract only during the next annual open enrollment period.**]** **(Applies to EE only coverage)**

COBRA Continuation of Coverage

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

[NOTE: The provisions of COBRA Continuation pertaining to Enrolled Dependents do not apply as dependents are not eligible to apply for coverage or receive benefits under this coverage.**]** **(EE only coverage)**

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

- Your employment is terminated (unless the termination is for gross misconduct);
- Your hours of work are reduced;
- You die;
- You and Your spouse divorce or the marriage is annulled;
- **{**You and Your domestic partner terminate the domestic partnership;**}** **(Applies when groups choose to extend COBRA to domestic partner)**
- You become entitled to Medicare benefits; or
- Your enrolled child loses eligibility as a child under this coverage.

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

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

General Rules

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

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

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

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

If You or Your Enrolled Dependents do not elect COBRA continuation coverage, coverage under the Contract will end according to the terms of the Contract and We will not pay claims for services provided on and after the date coverage ends.

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

Non-COBRA Continuation of Coverage

A Group that is not required to offer COBRA Continuation of Coverage must offer a continuation of Group coverage benefits to You and Your Enrolled Dependents upon loss of eligibility for coverage.

[NOTE: The provisions of Non-COBRA Continuation pertaining to Enrolled Dependents do not apply as dependents are not eligible to apply for coverage or receive benefits under this coverage.**]** **(EE only coverage)**

If You are classified by the Group as an independent contractor or a person whose earnings are reported on IRS Form 1099 (or the dependent of either), You are not eligible for this continuation right.

The Group must notify You and Your Enrolled Dependents of this continuation right. If You and/or Your Enrolled Dependents do not receive notice, You may contact Us directly within 60 days following termination of coverage and elect continuation of coverage.

If You and/or Your Enrolled Dependents choose to continue coverage according to this right, You must enroll in writing and pay the premium for such coverage within 60 days of coverage termination. You will be required to make timely premium payments to the Group. The Group may charge You and Your Enrolled Dependents a premium no higher than the current rate paid for coverage of a comparable Member (or Members) who lost coverage and the Group is not required to make any contribution toward premiums for continuation coverage. Where an enrollment form and premium are received within the 60-day period, the accepting Member's coverage continues, without interruption, from the date the Member's coverage was terminated.

This continuation of coverage will terminate when the first of the following occurs:

- You and/or Your Enrolled Dependents fail to make payment of premiums for the coverage to the Group within its established time frame;
- 12 months elapse; or
- the Group's coverage is terminated.

If the Group replaces coverage with a similar plan, those who have continued coverage may obtain coverage with the replacement policy for the balance of the period that they would have been allowed to extend benefits with the replaced coverage.

General Provisions and Legal Notices

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

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

ERISA
This provision applies to the Contract as part of an employee welfare benefit plan regulated by the Employee Retirement Income Security Act of 1974 as amended (ERISA).

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

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

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

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

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

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

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

If You Need More ERISA Information

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

GOVERNING LAW

The Contract will be governed by and construed in accordance with the laws of the United States of America and by the laws of the state of Utah without regard to its conflict of law rules. We are not the plan administrator, but are an insurance company that provides insurance to this benefit plan.

GROUP IS AGENT

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

LIMITATIONS ON LIABILITY

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

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

MODIFICATION OF CONTRACT

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

NO WAIVER

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

NONASSIGNMENT

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

NOTICES

Any notice to Members or to the Group required in the Contract will be considered properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Enrolled Employee or to the Group will be addressed to the last known address appearing in Our records. If We receive a United States Postal Service change of address (COA) form for an Enrolled Employee, We will update Our records accordingly. Additionally, We may forward notice for an Enrolled Employee to the Group administrator if We become aware that We don't have a valid mailing address for the Enrolled Employee. Any notice to Us required in the Contract may be mailed to Our Customer Service address. However, notice to Us will be considered to have been given to and received by Us if written notice is deposited in the United States mail or with a private carrier.

PREMIUMS

Premiums are to be paid in advance to Us by the Group on or before the premium due date. Failure by the Group to make timely payment of premiums may result in Our terminating the Group's or Member's coverage at the end of the grace period as provided by Utah Code §31A-22-607 (or any successor thereto).

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Group on behalf of itself and its Members expressly acknowledges its understanding that the Contract constitutes an agreement solely between the Group and Regence 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. The Group on behalf of itself and its Members further acknowledges and agrees that it has not entered into the Contract based upon representations by any person or entity other than Regence BlueCross BlueShield of Utah and that no person or entity other than Regence BlueCross BlueShield of Utah will be held accountable or liable to the Group or the Members for any of Our obligations to the Group or the Members created under the Contract. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueCross BlueShield of Utah other than those obligations created under other provisions of the Contract.

REPRESENTATIONS ARE NOT WARRANTIES

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by 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 website or contacting Customer Service.

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

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

TAX TREATMENT

We do not provide tax advice. Consult Your financial or tax advisor for information about the appropriate tax treatment of benefit payments and reimbursements.

WHEN BENEFITS ARE AVAILABLE

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS

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

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

Definitions

The following are definitions of important terms, 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 only 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, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Providers who are not accessed through the BlueCard Program, the amount We have determined to be eligible charges or have negotiated for Covered Services. The Allowed Amount may consider factors such as amounts allowed for similar services by In-Network Providers, amounts allowed by other plans or programs or billed charges, as determined by Us and/or as required by law. The maximum Allowed Amount for facility charges for an inpatient non-emergency admission at a Nonparticipating Facility will be $4,000 per day.
- For Out-of-Network Providers 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, except that, for an inpatient non-emergency admission at a Nonparticipating Facility, the maximum Allowed Amount for facility charges is $4,000 per day. 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, contact Customer Service.

Ambulatory Surgical Center means a facility or that portion of a facility licensed by the state in which it is located, that operates exclusively to provide 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.

Booklet is the description of the benefits for this coverage. The Booklet is part of the Contract between the employer Group and Us.

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

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

Cosmetic means services or supplies (including medications) that are provided primarily to improve or change appearance to normal structures of the body.

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

Custodial Care means care for 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 to separate the patient from others or prevent 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.

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Member's home.

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

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

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

[Enrolled Dependent means an Enrolled Employee's eligible dependent who is listed on the Enrolled Employee's completed enrollment form and who is enrolled under the Contract.**] (Always applies unless is EE only coverage)**

Enrolled Employee means an employee of the Group who is eligible under the terms of the Contract, has completed an enrollment form and is enrolled under this coverage. Enrolled Employee may include an independent contractor or a person whose earnings are reported on IRS Form 1099, if this classification of employee is selected by the Group pursuant to the independent contractor attestation form. Employees in this classification should consult the Group to determine coverage and eligibility for provisions such as FMLA, COBRA, etc.

[Family means an Enrolled Employee and any Enrolled Dependents.**] (Always applies unless is EE only coverage)**

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

- disease;
- Illness or Injury;
- genetic or congenital anomaly;
- pregnancy;
- biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or
- to maintain or restore functional ability.

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

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

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 per 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;
- condition, disease, ailment or bodily disorder, other than an Injury; or
- pregnancy.

Illness does not include any state of mental health or mental disorder (which is otherwise defined).

Injury means physical damage to the body caused by:

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

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

In-Network means a Provider:

- that has an effective participating contract with Us, that designates the Provider as in Your network, to provide services and supplies to Members in accordance with the provisions of this coverage. Your network is **[**preferred**]** **(Applies to Preferred ValueCare, FocalPoint, and Preferred BlueOption Networks)** **[**participating**]** **(Applies to Participating Network)**; or
- that has an effective participating contract with one of Our Affiliates (designated as a **[**preferred**]** **(Applies to Preferred ValueCare, FocalPoint, and Preferred BlueOption Networks)** **[**participating**]** **(Applies to Participating Network)** Provider in the "In-Network"), to provide services and supplies to Members in accordance with the provisions of this coverage.

If We or one of Our Affiliates have more than one Provider network from which the employer Group may choose for benefits under the Contract, then the Providers contracted with the network selected by the employer Group will be considered the only In-Network Providers for purpose of payment of benefits. For a Rural Resident, In-Network Provider includes an Independent Hospital or Federally Qualified Health Center with regard to which that Member is a Rural Resident and a Credentialed Staff Member at that Independent Hospital or their 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.

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 FDA as being safe and effective 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, Illness or Injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved by 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 a Member is covered under the Contract (which may include more than one coverage) through the Group with Us.

Medically Necessary or Medical Necessity means health care services or 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 Booklet.

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 BE MEDICALLY NECESSARY, YET NOT BE A COVERED SERVICE IN THIS BOOKLET.

Member means an Enrolled Employee **[**or an Enrolled Dependent**]** **(Always applies unless is EE only coverage)**.

Nonparticipating Facility means an Out-of-Network facility that does not have any effective participating contract with Us, with one of Our Affiliates, or, if located outside the area that We and Our Affiliates serve, with another Blue Cross and/or Blue Shield organization in the BlueCard Program.

Out-of-Network means a Provider that is not In-Network. For reimbursement of 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/or surgery in all of its branches or to practice as an osteopathic Physician and/or surgeon.

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include, but are not limited to:

- podiatrists;
- chiropractors;
- psychologists;
- certified nurse midwives;
- certified registered nurse anesthetists;
- dentists; and
- other professionals practicing within the scope of their respective licenses.

Primary Physician or Practitioner means a Physician, osteopathic Physician or Practitioner who, when acting within the scope of their state license, provides Your primary care or coordinates referral services when needed and is licensed in:

- general or family practice;
- internal medicine;
- pediatrics;
- geriatrics;

- obstetrics/gynecology (Ob/Gyn);
- preventive medicine;
- adult medicine; or
- women's health care.

Primary Physician or Practitioner also means any, nurse Practitioner or advanced registered nurse Practitioner licensed in one of the above specialties and working under the license of a Physician, osteopathic Physician or Practitioner who is licensed in the same specialty.

Provider means:

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

Retail Clinic means a walk-in health clinic located within a retail operation and providing, on an ambulatory basis, preventive and primary care services. A Retail Clinic does not include:

- an office or independent clinic outside a retail operation;
- an Ambulatory Surgical Center;
- an urgent care center or facility;
- a Hospital;
- a Pharmacy;
- a rehabilitation facility; or
- a Skilled Nursing Facility.

Rural Resident means a Member 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.

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.

Specialist means a Physician, Practitioner or urgent care center or facility that does not otherwise meet the definition of a Primary Physician or Practitioner.

[Upfront Benefit means those Covered Services designated as "Upfront" which are usually accessible to the Member without first having to satisfy any Deductible amount. There may not be any Coinsurance amount required for an Upfront Benefit. However, a Copayment may apply for each visit or access to an Upfront Benefit. Once an Upfront Benefit dollar or visit maximum has been reached, additional coverage is available subject to any Deductible, Copayment and/or Coinsurance. Refer to the Upfront Benefit in the Schedule of Benefits to determine coverage.**]** **(Plans with Upfront Office Visit Limit)**

Appendix: Value-Added Services

Your Regence coverage includes access to the value-added services detailed in this Appendix. Services may be provided through third-party program partners who are solely responsible for their services. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS OF THIS BOOKLET.** These value-added services may work alongside Your coverage. Such services are otherwise covered in the benefits provisions of the Booklet.

For additional information regarding any of these value-added services, visit Our website or contact Customer Service. Contact information for value-added services for specific program partners is also included below, if applicable.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

An EAP is short-term, confidential counseling with no out-of-pocket expense. This EAP is available to the following "clients":

- the Enrolled Employee;
- the Enrolled Employee's legal dependents (whether or not they are enrolled in this coverage or living in the Enrolled Employee's home); and
- anyone living in the Enrolled Employee's home (whether or not they are enrolled in this coverage or related to the Enrolled Employee).

You will receive a welcome packet that includes contact information and details of the following services which are provided as part of this EAP:

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

- **Short-Term Counseling**
  An "incident" means a separate event or events occurring in the client's life. Four counseling sessions will be covered per incident. Each client affected by an incident will be eligible for a total of four counseling sessions. If two or more clients are seen together in a joint session, the session is counted as one visit for each attending client.

- **Referral**
  If the counselor and client determine the problem cannot be handled in short-term counseling, the counselor may refer the client to extended care, community resources or another Provider as best suited to address the issue and referred services will not be part of this EAP. Services not included in this EAP will be subject to the benefits in this Booklet.

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

JOINT, SPINE, AND MUSCLE PROGRAM

The Joint, Spine and Muscle program is a digitally delivered program that is provided at no cost to You, to help manage mobility and pain with Your joints, spine, and muscles. In addition, based upon Your specific health condition, You may have access to a customized care plan including guided exercise therapy, one-on-one video coaching with a care team, curated health education, and behavior change support. For those who do not have a way to participate in the digital program please visit Our website or contact Customer Service. You may be eligible for the following at no cost to You:

- exercise bands;
- wearable motion sensors and chargers;
- wearable pain relief device; and/or
- yoga mat.

KIDNEY HEALTH MANAGEMENT

If You are identified to participate, the Kidney Health Management program addresses the medical management needs of chronic kidney disease (CKD) stages 3, 4, 5 and unknown as well as end stage renal disease (ESRD). The program defers progression of CKD, reduces the cost of care by avoiding adverse events such as emergency room visits, hospitalizations and post-acute care.

NURSE ADVICE

You have access to registered nurses to answer Your health-related questions or concerns and to help You make informed decisions on seeking the appropriate level of care (whether to seek care in an emergency room, urgent care, office visit or self-care at home). This service is available to You on an unlimited basis at no additional cost. However, if You are experiencing a medical emergency, immediately call 911 instead.

PREGNANCY PROGRAM

Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions. The Pregnancy Program can provide answers and assistance so that You can relax and enjoy those nine life-changing months.

If You are expecting a child, this program offers access to a nurse 24 hours a day, 7 days a week and educational materials tailored to Your needs. Since the Pregnancy Program is most beneficial when You enroll early in a pregnancy, call 1 (888) JOY-BABY (569-2229) or visit Our website right away to get started.

REGENCE EMPOWER

Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. **This program is separate from the Employee Wellness Reward.** It may include the following:

- earning up to a total of $25 in gift cards for completion of well-being activities such as an online health risk assessment (for Members who are not eligible for the Employee Wellness Reward);
- earning up to a total of $50 in gift cards for completion of well-being activities such as health screening(s) and/or wellness examination(s) (for Members who are also eligible for the Employee Wellness Reward);
- incentives to reward participation in healthy activities; and
- online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals.

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

This disclaimer provides **a brief summary** of the Utah Life and Health Insurance Guaranty Association (the Association) and the protection it provides for policyholders. The 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, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with the funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values
- Accident and Health Insurance
  - $500,000 for health benefit plans
  - $500,000 in disability income insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in other types of health insurance benefits
- Annuities
  - $250,000 in the present value of annuity benefits in aggregated, including any net cash surrender and net cash withdrawal 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 health benefit plans.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) 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. There are various residency requirements and other limitations under Utah law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, please visit the Association's website at **www.ulhiga.org** or contact:

Utah Life and Health Insurance Guaranty Assoc. 450 S. Simmons Way, Suite 650 Kaysville, UT 84037 1 (801) 320-9955	Utah Insurance Department 4315 S 2700 W, Suite 2300 Taylorsville, UT 84129 1 (801) 957-9200

For more information call Us at 1 (888) 367-2119

regence.com

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Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association] **(Always applies; subject to change based on Company logo and Company tagline updates)**

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