SALT LAKE COMMUNITY COLLEGE
EMPLOYEE HEALTH CARE BENEFITS
Booklet

Group Number: 10003141

July 1, 2024

MEDICAL & DENTAL

Regence BlueCross BlueShield of Utah
2890 East Cottonwood Parkway
Salt Lake City, UT 84121

regence.com

Customer Service	1 (888) 240-9580
Case Management	1 (866) 543-5765

EAP

Employee Assistance Program	1 (866) 750-1327

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Salt Lake Community College Medical Plan: BluePoint℠

	In-Network Provider What You Pay	Out-of-Network Provider What You Pay
Deductible per Plan Year	$600 Individual / $1,200 Family	$2,000 Individual / $4,000 Family
Out-of-Pocket Maximum per Plan Year	$3,500 Individual / $7,000 Family	$5,000 Individual / $10,000 Family
Medical Services		
Ambulance Services	20% after deductible	20% after deductible
Ambulatory Surgical Center	20% after deductible	40% after deductible
Emergency Room (Including Professional Charges)	20% after deductible	20% after deductible
Hearing Aids • Limit: $2,500 per Plan Year	20% after deductible	40% after deductible
Hearing Exam • Limit: 1 exam per Plan Year	$25 copay per visit (deductible waived)	40% after deductible
Home Health Care	$25 copay per visit (deductible waived)	40% after deductible
Home Infusion Therapy • Limit: $50,000 per Plan Year for Parenteral Nutrition	$25 copay per visit (deductible waived)	40% after deductible
Hospice Care	20% (deductible waived)	40% after deductible
Hospital Care	20% after deductible	40% after deductible
Infertility (Diagnosis & Treatment) • Limit: $5,000 per Lifetime	$25 copay per visit (deductible waived)	40% after deductible
Injury to Teeth • Limit: $1,000 per Plan Year	20% after deductible	40% after deductible
Maternity Care	20% after deductible	40% after deductible
Mental Health/Substance Use Disorder Therapy Services - Inpatient/Outpatient Facility	20% after deductible	40% after deductible
Mental Health/Substance Use Disorder Therapy / Non-Therapy Services - Outpatient	$25 copay per visit (deductible waived)	40% after deductible
Neurodevelopmental Therapy • Limit: 30 visits per Plan Year combined with Outpatient Rehabilitation • Children up to age 18	$25 copay per visit (deductible waived)	40% after deductible
Nutritional Counseling • Limit: Diabetic nutritional counseling only	20% after deductible	40% after deductible
Office Visits	Primary - $25 copay per visit / Specialist - $35 copay per visit (deductible waived)	40% after deductible
Orthotics – Foot • Limit: $200 per Plan Year	20% after deductible	40% after deductible

Preventive Care/Immunizations • Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA)	0% coinsurance (deductible waived)	40% after deductible
	In-Network Provider What You Pay	Out-of-Network Provider What You Pay
Radiology and Laboratory – Outpatient Minor	20% after deductible	40% after deductible
Radiology and Laboratory – Outpatient Major	$50 copay per visit	$50 copay per visit + 40% after deductible
Rehabilitation Services • Limit: 60 Inpatient days per Plan Year • Limit: 30 Outpatient visits per Plan Year combined with Outpatient Neurodevelopmental Therapy	$25 copay per visit (deductible waived)	40% after deductible
Skilled Nursing Facility (SNF) Care • Limit: 60 days per Plan Year	20% after deductible	40% after deductible
Spinal Manipulations • Limit: 20 visits per Plan Year	$25 copay per visit (deductible waived)	40% after deductible
Telehealth	$10 copay per visit (deductible waived)	40% after deductible
Temporomandibular Joint (TMJ) Disorders • Limit: $500 per Lifetime	20% after deductible	40% after deductible
Urgent Care	$35 copay per visit (deductible waived)	40% after deductible

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Salt Lake Community College Medical Plan: HSA Healthplan 3.0

	In-Network Provider What You Pay	Out-of-Network Provider What You Pay
Deductible per Plan Year	$1,700 Individual / $3,400 Family	$3,400 Individual / $7,000 Family
Out-of-Pocket Maximum per Plan Year	$3,500 Individual / $7,000 Family	$7,000 Individual / $14,000 Family
Medical Services		
Ambulance Services	10% after deductible	10% after deductible
Ambulatory Surgical Center	10% after deductible	30% after deductible
Emergency Room (Including Professional Charges)	10% after deductible	10% after deductible
Hearing Aids • Limit: $2,500 per plan year	10% after deductible	30% after deductible
Hearing Exams • Limit: 1 exam per Plan Year	10% after deductible	30% after deductible
Home Health Care	10% after deductible	30% after deductible
Home Infusion Therapy • Limit: $50,000 per Plan Year for Parenteral Nutrition	$25 copay per visit after deductible	30% after deductible
Hospice Care	10% after deductible	30% after deductible
Hospital Care	10% after deductible	30% after deductible
Infertility (Diagnosis & Treatment) • Limit: $5,000 per Lifetime	10% after deductible	30% after deductible
Injury to Teeth • Limit: $1,000 per Plan Year	10% after deductible	30% after deductible
Maternity Care	10% after deductible	30% after deductible
Mental Health/Substance Use Disorder Therapy Services - Inpatient	10% after deductible	30% after deductible
Mental Health/Substance Use Disorder Therapy / non-Therapy Services - Outpatient	$25 copay per visit after deductible	30% after deductible
Neurodevelopmental Therapy • Limit: 30 visits per Plan Year combined with Outpatient Rehabilitation • Children up to age 18	10% after deductible	30% after deductible
Nutritional Counseling • Limit: Diabetic nutritional counseling only	10% after deductible	30% after deductible
Office Visits	Primary - $25 copay per visit / Specialist - $35 copay per visit after deductible	30% after deductible
Orthotics – Foot • Limit: $200 per Plan Year	10% after deductible	30% after deductible

Preventive Care/Immunizations • Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA). Childhood Immunizations covered at no cost.	0% (deductible waived)	30% after deductible
Radiology and Laboratory – Outpatient (Minor and Major)	10% after deductible	30% after deductible
	In-Network Provider What You Pay	Out-of-Network Provider What You Pay
Rehabilitation Services • Limit: 60 Inpatient days per Plan Year • Limit: 30 Outpatient visits per Plan Year combined with Outpatient Neurodevelopmental Therapy	10% after deductible	30% after deductible
Skilled Nursing Facility (SNF) Care • Limit: 60 inpatient days per Plan Year	10% after deductible	30% after deductible
Spinal Manipulations • Limit: 20 spinal manipulations per Plan Year	10% after deductible	30% after deductible
Telehealth	$10 copay per visit after deductible	30% after deductible
Temporomandibular Joint (TMJ) Disorders • Limit: $500 per Lifetime	10% after deductible	30% after deductible
Urgent Care	$35 copay per visit after deductible	30% after deductible

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Salt Lake Community College Expressions Dental Plan 1

	In-Network Dentist What You Pay	Out-of-Network Dentist What You Pay
Deductible per Plan Year	$0	
Benefit Maximum per Plan Year	$1,500	
Preventive Dental Services		
Cleaning and Examinations • 2 cleanings per plan year with a 3rd being covered with qualifying diagnosis • 2 preventive oral examinations per plan year	0% coinsurance	0% coinsurance + balance billing
X-rays • 1 complete intra-oral mouth and 1 panoramic mouth x-ray once in a 3-year period	0% coinsurance	0% coinsurance + balance billing
Other Preventive Dental Services • Members under age 15 for sealants (permanent bicuspids and molars only) • Members under age 13 for space maintainers • Members under age 23 and limited to 2 treatments per plan year for topical fluoride application	0% coinsurance	0% coinsurance + balance billing
Basic Dental Services		
Periodontal Services • 4 periodontal maintenance per plan year • 1 per quadrant per plan year for periodontal scaling and root planing	20% coinsurance	20% coinsurance + balance billing
Endodontic Services (Fillings, Extractions)	20% coinsurance	20% coinsurance + balance billing
Emergency and Other Basic Dental Services	20% coinsurance	20% coinsurance + balance billing
Major Dental Services		
Bridges • Replacement bridges once per 5 years after placement	50% coinsurance	50% coinsurance + balance billing
Crowns, Inlays, and Onlays • Replacement crowns, inlays or onlays once per tooth, 5 years after placement	50% coinsurance	50% coinsurance + balance billing
Dentures (Full and Partial) • Replacement dentures 5 years after placement	50% coinsurance	50% coinsurance + balance billing
Implants	50% coinsurance	50% coinsurance + balance billing
Orthodontia		

Orthodontia Services • Deductible waived • $500 per Claimant per plan year • $1,000 per Claimant lifetime • No waiting period for orthodontic services • Orthodontic treatment for members under 26 years of age	50% coinsurance	50% coinsurance + balance billing

Introduction

Salt Lake Community College (hereafter referred to as the "Plan Sponsor") has restated the Salt Lake Community College Employee Health Care Benefits (hereafter referred to as the "Plan") effective **July 1, 2024**. This Booklet provides the written description of the terms and benefits of coverage available under the Plan. This Booklet replaces any plan description, Booklet or certificate previously issued by the Plan Sponsor and makes it void.

The Booklet is not meant to interpret, extend, or change the provisions of the Plan in any way. Benefits under this Plan will be paid only if the Plan Sponsor decides, in their sole discretion, that you are entitled to them. The provisions of the Plan may only be determined fully and completely from the actual Plan document, which is available from the Plan Sponsor. Prior to amendments, the Plan Document is this Booklet. If the Plan Document and this Booklet differ, the Plan Document will prevail. No oral interpretations can change this Plan.

The Booklet includes separate sections for Medical Benefits, Prescription Medications benefits, and Dental Benefits, all of which are separate and independent plans. Each section contains the complete benefits, conditions, limitations, and important information that can only be found within that particular section, such as the percentages paid, Deductibles, Copayments, and Out-of-Pocket Maximum amounts under each Plan.

The Plan Sponsor intends the Plan to be permanent, but since future conditions affecting the Plan Sponsor cannot be anticipated or foreseen, the Plan Sponsor reserves the right to amend, modify or terminate the Plan, or any portion thereof, in any manner, at any time, regardless of Your, Your Spouse's (or Domestic Partner's) and/or Your Child's health or treatment status, which may result in the termination or modification of Your coverage and/or the coverage for Your Spouse (or Domestic Partner) and/or Children. If the Plan is amended, modified, or terminated, the rights of You, Your Spouse (or Domestic Partner) and/or Your Children are limited to services and Allowed Amounts incurred prior to the Plan's amendment, modification or termination, which will be paid as provided under the terms of the Plan as it existed at the time they were incurred.

All benefits under the Plan are self-insured by the Plan Sponsor. Participants and the Plan Sponsor share the cost of providing benefits. The cost of providing benefits are charged first to Participants' contributions and then paid out of the general assets of the Plan Sponsor. The Plan Sponsor shall from time to time determine the amount of contributions payable by Participants.

The Plan Sponsor is the Plan Administrator. The Plan sponsor has entered into an agreement with Regence BlueCross BlueShield of Utah (hereafter referred to as the "Claims Administrator"), as a third-party administrator, to assist the Plan Sponsor in the Plan's claims administration and certain other administrative matters. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except in the case of claims that exceed certain amounts which may be reinsured.

CONTACT INFORMATION

Customer Service: 1 (866) 240-9580
(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 the Claims Administrator offers;
- to talk with one of the Claims Administrator's Customer Service representatives;
- via the Claims Administrator's 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 the Claims Administrator's website); or
- for assistance in a language other than English.

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 MEDICAL 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.

- **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.
- **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.

ACCESSING DENTAL PROVIDERS

You are not restricted in Your choice of Dentist for dental care or treatment. You control Your out-of-pocket expenses by choosing between "In-Network Dentist" and "Out-of-Network Dentist."

- **In-Network Dentist.** Choosing In-Network Dentists saves You the most in Your out-of-pocket expenses. In-Network Dentists will not bill You for balances beyond any Deductible and/or Coinsurance for Covered Services.
- **Out-of-Network Dentist.** Choosing Out-of-Network Dentists means Your out-of-pocket expenses will be higher than choosing an In-Network Dentist. Also, an Out-of-Network Dentist may bill You for balances beyond any Deductible and/or Coinsurance. This is referred to as balance billing.

For each benefit, the Provider or Dentist You may choose and Your payment amount for each provider option is indicated. See the Definitions Section for a complete description of In-Network Providers and Out-of-Network Providers and an In-Network Dentist and Out-of-Network Dentist. You can go to **regence.com** for further Provider network information.

ADDITIONAL ADVANTAGES OF PARTICIPATION

The Claims Administrator provides access to discounts on select items and services, personalized health/dental care planning information, health/dental-related events and innovative health/dental decision tools, as well as a team dedicated to Your personal health/dental care needs. You also have access to the Claims Administrator's website and mobile application to help You navigate Your way through health/dental 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 the Booklet.

- **Go to regence.com** or the Claims Administrator's mobile application. You can use the Claims Administrator's secure applications to:
    - view recent claims, benefits and coverage;
    - find a contracting Provider or dental Provider;
    - 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, as well as discover how to receive discounts on prescriptions; 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. The Claims

Administrator has 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 the Claims Administrator. **ANY SUCH DISCOUNTS OR COUPONS ARE COMPLEMENTS TO THE PLAN, BUT ARE NOT INSURANCE.**

Table of Contents

Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under the Women's Health and Cancer Rights Act, certain breast reconstruction services in connection with a covered mastectomy are protected. If You are receiving benefits in connection with a mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, coverage under the Plan will be provided (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.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending Provider (for example, Your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan may not, under federal law, require that a Physician or other health care provider obtain preauthorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain preauthorization. For information on preauthorization, contact the Claims Administrator.

NOTICE OF PRIVACY PRACTICES UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

This is a general Notice of Privacy Practices under HIPAA. You also will receive a Notice of Privacy Practices from the Claims Administrator who pays claims under this Plan. The specific Privacy Notice(s) You receive from the Claims Administrator will take precedence over this general Notice, if there is any conflict between the two Notices.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights with respect to your Protected Health Information ("PHI"), including the right to know how your PHI may be used by a group health Plan.

This Notice of Privacy Practices ("Notice") covers the following group health Plans (collectively referred to as the "Plan"):

- Medical
- Prescription
- Dental
- EAP

The Plan is required by law to maintain the privacy of your PHI and to provide this Notice to you pursuant to HIPAA. This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, health care operations, or for any other purposes that are permitted or required by law. This Notice also provides you with the following important information:

- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan's Privacy Officer and/or to the Secretary of the Office of Civil Rights of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

PHI is health information (including genetic information) in any form (oral, written, electronic) that:

- Is created or received by or on behalf of the Plan;
- Relates to your past, present or future physical or mental condition, or the provision of health care services to you, or the payment for those health care services; and
- Identifies you or from which there is a reasonable basis to believe the information can be used to identify you.

Health information your employer receives during the course of performing non-Plan functions is not PHI. For example, health information you submit to your employer to document a leave of absence under the Family and Medical Leave Act is not PHI.

SECTION 1. USES AND DISCLOSURES OF YOUR PHI

Under HIPAA, the Plan may use or disclose your PHI under certain circumstances without your consent, authorization or opportunity to agree or object. Such uses and disclosures fall within the categories described below. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

General Uses and Disclosures

Treatment. The Plan may use and/or disclose your PHI to help you obtain treatment and/or services from Providers. Treatment includes the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your Providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist. The Plan may also disclose information about your prior prescriptions to a pharmacist to determine if any medicines contraindicate a pending prescription.

Payment. The Plan may use and/or disclose your PHI in order to determine your eligibility for benefits, to facilitate payment of your health claims and to determine benefit responsibility. Payment includes, but is not limited to billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. The Plan may also disclose your PHI to another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate payment of benefits.

Health Care Operations. The Plan may use and/or disclose your PHI for other Plan operations. These uses and disclosures are necessary to run the Plan and include, but are not limited to, conducting quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, underwriting, premium and other activities relating to Plan coverage. It also includes cost management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general Plan administrative activities. For example, the Plan may use your PHI in connection with submitting claims for stop-loss coverage. The Plan may also use your PHI to refer you to a disease management program, project future costs or audit the accuracy of its claims processing functions. However, the Plan is prohibited from using or disclosing PHI that is an individual's genetic information for underwriting purposes.

Business Associates. The Plan may contract with individuals or entities known as Business Associates to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide such services, the Business Associates will receive, create, maintain, use and/or disclose your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide pharmacy benefit management services. However, Business Associates will

receive, create, maintain, use and/or disclose your PHI on behalf of the Plan only after they have entered into a Business Associate agreement with the Plan and agree in writing to protect your PHI against inappropriate use or disclosure and to require that their subcontractors and agents do the same.

Plan Sponsor. For purposes of administering the Plan, the Plan may disclose your PHI to certain employees of Salt Lake Community College. However, these employees will only use or disclose such information as necessary to perform administration functions for the Plan or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Required By Law. The Plan may disclose your PHI when required to do so by federal, state or local law. For example, the Plan may disclose your PHI when required by public health disclosure laws.

Health or Safety. The Plan may disclose and/or use your PHI when necessary to prevent a serious threat to your health or safety or the health or safety of another individual or the public. Under these circumstances, any disclosure will be made only to the person or entity able to help prevent the threat.

Special Situations

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your PHI without your consent, authorization or opportunity to agree or object. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

Public Health Activities. The Plan may disclose your PHI when permitted for purposes of public health actions, including when necessary to report child abuse or neglect or domestic violence, to report reactions to drugs or problems with products or devices, and to notify individuals about a product recall. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

Health Oversight. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. Oversight activities can include civil, administrative or criminal actions, audits and inspections, licensure or disciplinary actions (for example, to investigate complaints against Providers); other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud); compliance with civil rights laws and the health care system in general.

Lawsuits, Judicial and Administrative Proceedings. If you are involved in a lawsuit or similar proceeding, the Plan may disclose your PHI in response to a court or administrative order. The Plan may also disclose your PHI in response to a subpoena, discovery request or other lawful process by another individual involved in the dispute, provided certain conditions are met. One of these conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

Law Enforcement. The Plan may disclose your PHI when required for law enforcement purposes, including for the purposes of identifying or locating a suspect, fugitive, material witness or missing person.

Coroners, Medical Examiners and Funeral Directors. The Plan may disclose your PHI when required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

Workers' Compensation. The Plan may release your PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

National Security and Intelligence. The Plan may release PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Military and Veterans. If you are a member of the armed forces, the Plan may disclose your PHI as required by military command authorities**.** The Plan may also release PHI about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donations. If you are an organ donor, the Plan may disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Research. The Plan may disclose your PHI for research when the individual identifiers have been removed or when the institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosure to Secretary

The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

Disclosures to Family Members and Personal Representatives

The Plan may disclose your PHI to family members, other relatives and your close personal friends but only to the extent that it is directly relevant to such individual's involvement with a coverage, eligibility or payment matter relating to your care, unless you have requested and the Plan has agreed not to disclose your PHI to such individual. The Plan will disclose your PHI to an individual authorized by you, or to an individual designated as your personal representative, provided the Plan has received the appropriate authorization and/or supporting documents. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

However, the Plan will not disclose information to an individual, including your personal representative, if it has a reasonable belief that:

- You have been, or may be, subjected to domestic violence, abuse or neglect by such person or treating such person as your personal representative could endanger you; and
- In the exercise of professional judgment, it is not in your best interest to disclose the PHI.
- This also applies to personal representatives of minors.

Authorization

Any uses or disclosures of your PHI not described above will be made only with your written authorization. Most disclosures involving psychotherapy notes will require your written authorization. In addition, the Plan generally cannot use your PHI for marketing purposes or engage in the sale of your PHI without your written authorization. You may revoke your written authorization at any time, so long as the revocation is in writing. Once the Plan receives your authorization, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

SECTION 2. RIGHTS OF INDIVIDUALS

You have the following rights with respect to your PHI:

Right to Request Restrictions on PHI Uses and Disclosures. You may request in writing that the Plan restrict or limit its uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or to limit disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. For example, you could request that the Plan not use or disclose specific information about a specific medical procedure you had. However, the Plan is not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that

we only contact you at work or by mail. The Plan will not ask you the reason for your request, which must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests to receive communications of PHI by alternative means if you clearly provide information that the disclosure of all or part of your PHI could endanger you.

Right to Inspect and Copy PHI. You have a right of access to inspect and obtain a copy of your PHI (including electronic PHI) contained in the Plan's "designated record set," for as long as the PHI is maintained by the Plan in a designated record set. If you request a copy of the information, the Plan may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

"Designated Record Set" includes the medical records and billing records about an individual maintained by or for a covered health care Provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about the individual. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

If your request is granted, the requested information will be provided to you within 30 days after the receipt of your request in the form and format requested, if it is readily producible in such form and format, or if not, in a readable hard copy form (or a readable electronic form and format in the case of PHI maintained in designated records sets electronically) or such other form and format as agreed upon by you and the Plan. If the Plan is unable to comply with request within the 30-day deadline, a one-time 30-day extension is permissible. In such case, you will receive notification of the need for an extension within the initial 30-day period.

Please note that your right does not apply to psychotherapy notes or information compiled in reasonable anticipation of a legal proceeding. The Plan may deny your request to inspect and copy your PHI in very limited circumstances. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI. If you believe that the PHI the Plan has about you is incorrect or incomplete, you have the right to request in writing that the Plan amend your PHI or a record contained in a designated record set for as long as the PHI is maintained by the Plan in the designated record set. The Plan has 60 days after the request is made to act on the request. However, a single 30-day extension is allowed if the Plan is unable to comply with the deadline.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask for the amendment of information that: (1) is not part of the medical information kept by or for the Plan; (2) was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information that you would be permitted to inspect or copy; or (4) is already accurate and complete. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.

The Right to Receive an Accounting of PHI Disclosures. You have the right to receive a list of disclosures of your PHI that have been made by the Plan on or after April 14, 2003 (or January 1, 2011 in the case of disclosures of your PHI from electronic health records maintained by the Plan, if any) over a period of up to six years (three years in the case of disclosures from an electronic health record) prior to the date of your request. Certain disclosures are not required to be included in such accounting of disclosures, including but not limited to disclosures made by the Plan (1) for treatment, payment or health care operations (unless the disclosure is made from an electronic health record), or (2) in accordance with your authorization. If you request more than

one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request. You have the right to receive a paper copy of this Notice even if you have agreed to receive this Notice electronically.

To exercise any of your HIPAA rights described above, you or your personal representative must contact the Plan's HIPAA Privacy Officer in writing at Salt Lake Community College 4600 S Redwood Road, Salt Lake City, UT 84123. You or your personal representative may be required to complete a form required by the Plan in connection with your specific request.

SECTION 3. THE PLAN'S DUTIES

Notice of Privacy Practices. The Plan is required by law to provide individuals covered under the Plan with notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. In the event of any material change to this Notice, a revised version of this Notice will be distributed to all individuals covered under the Plan within 60 days of the effective date of such change by first-class U.S. mail or with other Plan communications.

Breach Notification. The Plan has a legal duty to notify you following the discovery of a breach involving your unsecured PHI.

Minimum Necessary Standard. When using or disclosing PHI, the Plan will use and/or disclose only the minimum amount of PHI necessary to accomplish the intended purposes of the use or disclosure. However, the minimum necessary standard will not apply in the following situations:

- Disclosure to or requests by a health care Provider for treatment;
- Uses or disclosures made to you; and
- Uses or disclosures that are required by law.

SECTION 4. COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with the Plan, contact the Plan's HIPAA Privacy Officer in writing at Salt Lake Community College 4600 S Redwood Road, Salt Lake City, UT 84123.

You will not be penalized or in any other way retaliated against for filing a complaint with the Office for Civil Rights or with the Plan.

SECTION 5. ADDITIONAL INFORMATION

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan's HIPAA Privacy Officer in writing at Salt Lake Community College 4600 S Redwood Road, Salt Lake City, UT 84123.

The Claims Administrator, Regence BlueCross BlueShield of Utah, has a **Notice of Privacy Practices** that is available by calling Customer Service or visiting their website.

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

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 Medical Benefits, Prescription Medications and Dental Benefits Sections to see what Your benefits are.

ALLOWED AMOUNT:

- 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 the Claims Administrator has determined to be eligible charges 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 the Claims Administrator and/or as otherwise required by law.
- 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 the Claims Administrator as the amount on which it would base a payment to that Provider. In exceptional circumstances, such as if the Host Blue does not identify an amount on which it would base payment, the Claims Administrator 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 the Claims Administrator's Customer Service.

COINSURANCE (PERCENTAGE YOU PAY)

Your Coinsurance is the percentage You pay when the Plan's 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. The Plan does not reimburse Providers or Dentists for charges above the Allowed Amount.

COPAYMENTS

Copayments are a specific dollar amount that You pay directly to the Provider at the time You receive a specified service. Refer to the benefit sections to see what Covered Services are subject to a Copayment.

DEDUCTIBLES – BLUEPOINT

The Deductible is the amount You must pay each Plan Year before the Plan 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 Claimant may contribute more than their individual Deductible amount toward the Family Deductible in a Plan Year. A Family member does not have to satisfy their individual Deductible if the Family Deductible has already been satisfied. The Plan does not pay for services applied toward the Deductible. Refer to the benefit sections 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.

DEDUCTIBLES – HIGH DEDUCTIBLE HEALTH PLAN

The Deductible is the amount You must pay each Plan Year before the Plan will provide payments for Covered Services. Only Allowed Amounts for Covered Services are applied to satisfy the Deductible. There is a Single Coverage Deductible amount and a Family Coverage Deductible amount for In-Network

benefits and also for Out-of-Network benefits. The Single Coverage Deductible is satisfied by a Claimant who is enrolled on Single Coverage.

The Family Coverage Deductible is satisfied when any combination of Family members' payments total the Family Coverage Deductible amount.

The Plan does not pay for services applied toward the Deductible. Refer to the benefit sections 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. 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.

HOW PLAN YEAR BENEFITS RENEW

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

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 Medical and Dental Benefits Section to determine if a Covered Service has a specific Maximum Benefit.

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

OUT-OF-POCKET MAXIMUM – BLUEPOINT

The Out-of-Pocket Maximum is the most You could pay in a Plan 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 Coverage Out-of-Pocket Maximum. No one Claimant may contribute more than their individual Out-of-Pocket Maximum amount toward the Family Out-of-Pocket Maximum in a Plan 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.

A Claimant's payment of any Deductible, Copayment and/or Coinsurance for ambulance, blood bank and emergency room services will apply toward 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. 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 Plan 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 benefit sections to determine if a Covered Service does not apply to the Out-of-Pocket Maximum.

Any amounts You pay for Prescription Medications will apply toward the Prescription Medication Out-of-Pocket Maximum and those amounts do not apply toward this Out-of-Pocket Maximum. Any reduction in Your Copayment and/or Coinsurance for Prescription Medications resulting from the use of any discount or a drug manufacturer coupon may not apply toward the Prescription Medication Out-of-Pocket

Maximum. Refer to the Prescription Medications Section to determine what Prescription Medications apply to the Prescription Medication Out-of-Pocket Maximum.

OUT-OF-POCKET MAXIMUM – HIGH DEDUCTIBLE HEALTH PLAN

The Out-of-Pocket Maximum is the most You could pay in a Plan 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 a Single Coverage Out-of-Pocket Maximum amount and a Family Coverage Out-of-Pocket Maximum amount for In-Network benefits and also for Out-of-Network benefits. The Single Coverage Out-of-Pocket Maximum is satisfied by a Claimant who is enrolled on Single Coverage.

The Family Coverage Out-of-Pocket Maximum is satisfied when any combination of Family members' payments of their cost shares for Covered Services total the Family Coverage Out-of-Pocket Maximum.

A Claimant's payment of any Deductible, Copayment and/or Coinsurance for ambulance, blood bank, emergency room services and Prescription Medications will apply toward 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 Plan Year.

Medical Benefits - BluePoint

This section explains Your benefits and cost-sharing responsibilities 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, Office or Urgent Care Visits – Illness or Injury 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, the Plan 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 the Claims Administrator's website or contact Customer Service.

NOTE: If You choose to access new medical supplies, equipment and devices through the Claims Administrator's website, the Claims Administrator 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 Plan, but are not insurance.

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 the Claims Administrator before providing such services to You. You will not be penalized if the contracted Provider does not obtain preauthorization from the Claims Administrator in advance and the service is determined to be not covered.

Non-contracted Providers are not required to obtain preauthorization from the Claims Administrator 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.

A complete list of services and supplies that require preauthorization may be obtained by visiting the Claims Administrator's website at: **regence.com/web/regence_provider/pre-authorization** or by calling Customer Service.

Preauthorization requests should be faxed by Your Provider following the instructions on the Claims Administrator's website.

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.

PLAN YEAR DEDUCTIBLES

In-Network

Single Coverage Deductible: $600
Family Coverage Deductible: $1,200

Out-of-Network

Single Coverage Deductible: $2,000
Family Coverage Deductible: $4,000

PLAN YEAR OUT-OF-POCKET MAXIMUM

Single Coverage: $3,500
Family Coverage: $7,000

Out-of-Network

Single Coverage: $5,000
Family Coverage: $10,000

PREVENTIVE CARE AND IMMUNIZATIONS

Preventive Care

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Immunizations – Adult

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Immunizations – Childhood

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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;
- 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.

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 may be covered in the Expanded Preventive Care benefit. In the event HRSA, USPSTF or the CDC adopt a new or revised recommendation, the Plan has up to one year before coverage of the related services must be available and effective.

Expanded Preventive Care

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Preventive care services and supplies are covered when provided by a professional Provider, facility or Retail Clinic that do not meet age limits and frequency guidelines according to, and as recommended by, the USPSTF, HRSA or by the CDC. Services rendered must be for preventive care and billed as such. Covered Services that do not meet the above criteria will be covered the same as any other Illness or Injury.

Expanded Immunizations

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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.

OFFICE OR URGENT CARE VISITS – ILLNESS OR INJURY

	Provider: In-Network	Provider: Out-of-Network
Primary Physician or Practitioner	**Payment:** You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Specialist	**Payment:** You pay $35 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Urgent Care	**Payment:** You pay $35 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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, except as otherwise covered in the Expanded Office Services benefit.

Expanded Office Services

	Provider: In-Network	Provider: Out-of-Network
Primary Physician or Practitioner	**Payment:** You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Specialist	**Payment:** You pay $35 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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

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 Section.

OTHER PROFESSIONAL SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Unless otherwise covered in the Expanded Office Services benefit, 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;
- 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, 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 the Claims Administrator's website or contact Customer Service.

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, the Plan will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by Out-of-Network Providers at the In-Network benefit level. Contact the Claims Administrator's Customer Service for further information and guidance.

Radiology and Laboratory
Diagnostic services for treatment of Illness or Injury. This includes Medically Necessary genetic testing and mammography services not covered in the Preventive Care and Immunizations benefit. NOTE: Outpatient diagnostic testing services are covered in the Major Diagnostic Testing 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.

Diagnostic Procedures
Services for diagnostic procedures including cardiovascular testing, pulmonary function studies, sleep studies, stress tests 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

Provider: All
Payment: After In-Network Deductible, You pay 20% of the Allowed Amount.

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's 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 Medical Benefits and Prescription Medications Sections. 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 Claimant 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 Claimant; or
- a service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

AUTISM SPECTRUM DISORDER SERVICES

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient Office/Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Other Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Services for Autism Spectrum Disorder are covered. Covered Services include diagnosis (including assessments, evaluations or tests) and treatment (including Applied Behavioral Analysis, Behavioral Health, Pharmacy Care, psychiatric care, psychological care, or Therapeutic Care, and related equipment).

Definitions

The following definitions apply to this Autism Spectrum Disorder Services benefit:

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

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

Behavioral Health means counseling and treatment programs, including Applied Behavior Analysis, that are:

- necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and provided or supervised by a:
    - board-certified behavior analyst; or
    - person licensed under state law, whose scope of practice includes mental health services.

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

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

BLOOD BANK

Provider: All
Payment: After In-Network Deductible, You pay 20% of the Allowed Amount.

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

DENTAL HOSPITALIZATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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.

DETOXIFICATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 20% of the Allowed Amount and the balance of billed charges.

DIABETIC EDUCATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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 THERAPY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

DIALYSIS

Inpatient

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient Initial Treatment Period

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: three months per Claimant (42 treatments of hemodialysis or 30 days peritoneal dialysis) for the initial treatment period. Once this limit is reached, outpatient dialysis may be covered in the Outpatient Supplemental Treatment Period.	

Hemodialysis, peritoneal dialysis and hemofiltration services, supplies, medications, labs and facility fees are covered during the initial treatment period when Your Physician prescribes outpatient dialysis. You should first contact the Claims Administrator to begin case management. A case manager will help You enroll in the Supplemental Kidney Dialysis Program. The "Supplemental Kidney Dialysis Program" is a supplemental program available to Claimants following the initial treatment period.

The "initial treatment period" will be three months of hemodialysis (42 treatments) or peritoneal dialysis (30 days). Once the initial treatment period limit is reached, outpatient dialysis may be covered according to the Outpatient Supplemental Treatment Period benefit below. If more than three months of treatment is necessary in the initial treatment period, the Claims Administrator must be contacted to approve the additional treatment and document Your progress. Outpatient dialysis treatments that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

Services that are rendered outside the country are covered, even if You have enrolled in the Supplemental Kidney Dialysis Program.

Outpatient Supplemental Treatment Period (Following Initial Treatment Period)

Provider: In-Network	Provider: Out-of-Network
Payment: No charge. If the Claims Administrator's agreement with the Provider expressly specifies that its terms supersede Your benefits (or this benefit), You pay 0% of the Allowed Amount. Otherwise, the Plan pays 150% of the Medicare allowed amount at the time of service.	**Payment:** After Deductible, the Plan pays 150% of the Medicare allowed amount at the time of service. 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.

Outpatient supplemental treatment is covered for any outpatient dialysis that is required beyond the initial treatment period.

In addition, a Claimant receiving supplemental dialysis is eligible to have Medicare Part B premiums reimbursed by the Plan as an eligible Plan expense for the duration of the Claimant's dialysis treatment, as long as the Claimant continues to be enrolled in Medicare Part B and continues to be eligible for coverage under this Plan. Proof of payment of the Medicare 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.

Case Managed Dialysis and Supplemental Kidney Dialysis Program

Receive one-on-one help and support in the event Your Physician prescribes dialysis. An experienced, compassionate case manager will serve as Your personal advocate during a time when You need it most. Your case manager is a licensed health care professional who will help You understand Your treatment options, show You how to get the most out of Your available Plan benefits and work with Your Physician to support Your treatment plan.

To learn more or to enroll in Case Management, call the Claims Administrator's Customer Service.

DURABLE MEDICAL EQUIPMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Durable Medical Equipment is covered, including, but not limited to, oxygen equipment, wheelchairs, and supplies or equipment associated with diabetes.

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 the Claims Administrator's 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)

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After In-Network Deductible, You pay 20% of the Allowed Amount.

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 Claimant from a facility; and
- in the case of a covered Claimant, 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 the Claims Administrator's Customer Service for further information and guidance.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

Provider: Centers of Excellence	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** Not covered.

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

To be covered, gene therapy and/or adoptive cellular therapy must be received from one of the Claims Administrator's 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. Receiving therapy from one of the Claims Administrator's COE facilities will save the most in Your out-of-pocket expenses. For a list of covered therapies or to identify a COE facility, contact the Claims Administrator's Customer Service, as the lists are subject to change.

Travel Expenses

Payment: You pay 100% of all expenses. Your travel expenses may be reimbursed subject to Your In-Network Deductible and travel expense limit.
Limit: $7,500 per Claimant per course of treatment, including companion(s), for transportation and lodging expenses. Additional limitations included below.

Transportation and lodging expenses are covered, 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 Claimant and one companion (or two companions if the Claimant is under the age of 19);

- commercial lodging expenses are limited to the IRS medical expense allowances (currently $50 per night for the Claimant, not to exceed $100 per night for the Claimant 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. The Plan will reimburse You for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact the Claims Administrator's Customer Service for further information and guidance.

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

HEARING AIDS AND EVALUATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: $2,500 per Claimant per Plan Year	

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:

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

HOME HEALTH CARE

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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.

Durable Medical Equipment associated with home health care services is covered in the Durable Medical Equipment benefit.

HOSPICE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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 Claimant and allow temporary relief to family members from the duties of caring for the Claimant. Durable Medical Equipment associated with hospice care is covered in the Durable Medical Equipment benefit.

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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.

INFERTILITY TREATMENT

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: $5,000 per Claimant Lifetime	

Surgical and nonsurgical treatment is covered for the correction of infertility.

Coverage does **not** include:

- assisted reproductive procedures, 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.
- fertility medications;
- uterine transplants; and
- other medications associated with fertility treatment.

INFUSION THERAPY
Inpatient and Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Inpatient and outpatient services, supplies (including infusion pumps) and medications for infusion therapy are covered. Covered Services also include parenteral and enteral therapy.

Home Infusion Therapy

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: $50,000 per Claimant per Plan year for total parenteral nutrition.	

Home infusion therapy is covered when provided in the home by a licensed home infusion therapy agency when the patient is under the care of a Physician and when the home infusion therapy regimen is Medically Necessary for the treatment of an Illness or Injury as follows:

- professional skilled nursing services of a registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN) required for:
  - training the patient and/or alternative care giver;
  - the administration of therapy; or
  - monitoring the intravenous therapy regimen;
- medical surgical supplies which are customarily furnished by the home infusion therapy agency for its patients and which are necessary to administer the home infusion therapy regimen;
- Non-replaced blood, blood plasma, blood derivatives; and their administration; and
- Prescribed drugs furnished by the home infusion therapy agency which are part of the home infusion therapy regimen. The administration of such drugs must require the professional skills of a nurse (RN, LPN, or LVN) and does not include prescribed drugs that can be self-administered or administered by a non-professional caretaker.

Durable Medical Equipment associated with parenteral nutrition is covered under the Durable Medical Equipment benefit in this Booklet.

MAJOR DIAGNOSTIC TESTING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay $50 Copayment per visit and 0% of the Allowed Amount.	**Payment:** After Deductible, You pay $50 Copayment per visit and 40% of the Allowed Amount and the balance of billed charges.

Major Diagnostic Tests are covered.

"Major Diagnostic Tests" include, but are not limited to:

- bone density screening;
- cardiovascular diagnostics;
- computerized axial tomography (CT or CAT) scan;
- magnetic resonance angiogram (MRA);
- magnetic resonance imaging (MRI);
- nuclear medicine;
- neurological diagnostics; 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.

MATERNITY CARE/ADOPTION BENEFIT

Maternity Care

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Adoption Benefit

Payment: You pay 100% of billed charges. Your payment may be reimbursed up to the adoption limit.
Adoption Limit: $3,000 per pregnancy

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.

Coverage for termination of pregnancy (abortion) will be provided for all Claimants only for the following, to the extent permitted under applicable law:

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

An adoption benefit is available when a Participant 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 Participant within 12 months after the child's birth and the date of placement is on or after the Participant's Effective Date.
- The Participant 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 2998
  Tacoma, WA 98401-2998

In the event a Participant adopts more than one newborn from a single pregnancy (for example, twins), only a single $3,000 adoption benefit is available (subject to reduction for other coverage below).

In the event the Participant and/or the Participant's spouse are covered by more than one compliant health benefit plan, the adoption benefit will be prorated between or among the plans. The full amount provided by both or all of the plans will not exceed $3,000 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 Participant will be liable for repayment of the adoption benefit. The Participant will refund the full amount of such benefit to the Plan, 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 the Claims Administrator the lesser of the amount described in the preceding sentence and the amount the Plan has paid for those Covered Services (even if payment or compensation to You or any other person or entity occurs after the termination of Your coverage under this Plan).

You must notify the Claims Administrator within 30 days of entering into any agreement to Act as a Surrogate and agree to cooperate with the Plan as needed to ensure the Claims Administrator's ability to recover the costs of Covered Services received by You for which the Plan is entitled to reimbursement. To notify the Claims Administrator, or to request additional information on Your responsibilities related to these notification and cooperation requirements, contact Customer Service. Refer to the Subrogation and Right of 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

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient Office/Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Other Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Mental Health and Substance Use Disorder Services are covered for treatment of Mental Health Conditions or Substance Use Disorders.

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, 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

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 30 visits per Claimant per Plan Year (combined with outpatient rehabilitation services visit limit)	

Neurodevelopmental therapy services by a Physician or Practitioner are covered. Covered Services must be to restore or improve function for a Claimant up to age 18 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 Claimant'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.

NEWBORN CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible,* You pay 20% of the Allowed Amount. *Deductible does not apply for newborns delivered without complications.	**Payment:** After Deductible,* You pay 40% of the Allowed Amount and the balance of billed charges. *Deductible does not apply for newborns delivered without complications.

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.

ORTHOTIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: $200 per Claimant per Plan Year for foot orthotics	

Braces, splints, orthopedic appliances and orthotic supplies or apparatuses are covered when used to support, align or correct deformities or to improve the function of moving parts of the body.

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 the Claims Administrator's website or contact Customer Service.

The Plan may elect to provide benefits for a less costly alternative item. Off-the-shelf shoe inserts and orthopedic shoes are not covered.

OUTPATIENT RADIOLOGY AND LABORATORY SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient radiology and laboratory services are covered for treatment of Illness or Injury. This includes, but is not limited to, mammography services not covered in the Preventive Care and Immunizations benefit. NOTE: Major diagnostic testing services are covered in the Major Diagnostic Testing 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.

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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.

REHABILITATION SERVICES

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 60 days per Claimant per Plan Year	

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 30 visits per Claimant per Plan Year (combined with neurodevelopmental visit limit)	

Inpatient and outpatient rehabilitation services and accommodations are covered as appropriate and necessary to restore or improve lost function caused by Illness or Injury. "Rehabilitation services" mean physical, occupational and speech therapy services only, including associated 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.

REPAIR OF TEETH

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: $1,000 per Claimant per Plan Year	

Services and supplies for treatment required as a result of damage to or loss of sound natural teeth are covered when such damage or loss is due to an Injury.

ROUTINE HEARING EXAMINATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: one routine hearing examination per Claimant per Plan Year	

Routine hearing examinations that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

SKILLED NURSING FACILITY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 60 inpatient days per Claimant per Plan Year	

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

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 20 visits per Claimant per Plan Year	

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

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: $500 per Claimant Lifetime	

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.

TRANSPLANTS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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 the Claims Administrator's 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.

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. Some providers or virtual care vendors may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share.

"Virtual care vendors" mean a select group of Providers that have entered into an agreement with the Claims Administrator to provide virtual care services at a lower cost. To learn more about how to access virtual care services or Providers and virtual care vendors that may offer lower-cost services, visit the Claims Administrator's website or contact Customer Service.

Store and Forward Services

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $10 Copayment per visit.	**Payment:** You pay 40% of the Allowed Amount and the balance of billed charges.

"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

Provider: Virtual Care Vendor	Provider: In-Network	Provider: Out-of-Network
Payment: You pay $10 Copayment per visit.	**Payment:** You pay $10 Copayment per visit.	**Payment:** You pay 40% of the Allowed Amount and the balance of billed charges.

"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 - BluePoint

This section explains Your benefits and cost-sharing responsibilities 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.

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. To view the Drug List and find medications by tier, visit the Claims Administrator's website or contact Customer Service.

PRESCRIPTION MEDICATION PLAN YEAR DEDUCTIBLES

Per Claimant: $150
Per Family: $450

You do not need to meet the Prescription Medication Deductible when You fill a prescription for Tier 1 and Tier 2 medications or Prescriptions received through a Home Delivery Supplier. You also do not need to meet the Deductible when You fill a prescription for a Self-Administrable Cancer Chemotherapy Medication.

This Prescription Medication Deductible is calculated separately from any other Deductible. However, this Prescription Medication Deductible will be applied toward the Prescription Medication Out-of-Pocket Maximum. Any costs in excess of the Covered Prescription Medication Expense that are charged by a Nonparticipating Pharmacy do not apply toward the Prescription Medication 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 Prescription Medication Deductible. 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.

COPAYMENTS AND/OR COINSURANCE

After You meet the Prescription Medication Deductible, You are responsible for paying the following Copayment and/or Coinsurance amounts at the time of purchase, if the Pharmacy submits the claim electronically. Your Copayment and/or Coinsurance will be applied toward the Prescription Medication Out-of-Pocket Maximum.

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 found on the Claims Administrator's website or by calling Customer Service.

When You fill a prescription for Tier 3 insulin, Your cost-share will not exceed $28 per 30-day supply from a Pharmacy or $84 per 90-day supply from a Home Delivery Supplier, whether or not You have met any applicable Deductible.

PRESCRIPTION MEDICATION PLAN YEAR OUT-OF-POCKET MAXIMUM

Per Claimant: $2,000
Per Family: $6,000

This Prescription Medication Out-of-Pocket Maximum is calculated separately from any other Out-of-Pocket Maximum. Copayments and/or any Coinsurance amounts You pay to Participating and Nonparticipating Pharmacies as well as to Home Delivery Suppliers apply toward the Prescription Medication Out-of-Pocket Maximum. Additionally, the Prescription Medication Deductible will be applied toward the Prescription Medication Out-of-Pocket Maximum.

Once You reach the Prescription Medication Out-of-Pocket Maximum, Prescription Medications that are subject to the Prescription Medication Out-of-Pocket Maximum will be paid at 100 percent of the Allowed Amount for the remainder of the Plan Year.

Any costs in excess of the Covered Prescription Medication Expense that are charged by a Nonparticipating Pharmacy, do not apply toward the Prescription Medication Out-of-Pocket Maximum and

You will continue to be responsible for these amounts, even after You reach any 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 count toward the Prescription Medication 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 Prescription Medication Out-of-Pocket Maximum.

Prescription Medications from a Pharmacy (for Each 30-Day Supply)

- **Tier 1:** $7 Copayment.
- **Tier 2:** $7 Copayment.
- **Tier 3:** 25% Coinsurance, not to exceed $150.
- **Tier 4:** 30% Coinsurance, not to exceed $175.
- **Compound Medication:** 50% Coinsurance.
- **Diabetic Supplies:** 20% Coinsurance.

Prescription Medications from a Home Delivery Supplier (for Each 90-Day Supply)

- **Tier 1:** $7 Copayment.
- **Tier 2:** $7 Copayment.
- **Tier 3:** 25% Coinsurance, not to exceed $300.
- **Tier 4:** 30% Coinsurance, not to exceed $437.50.
- **Compound Medication:** 50% Coinsurance.
- **Diabetic Supplies:** 20% Coinsurance.

Prescription Specialty Medications (for Each 30-Day Supply)

- **Tier 5:** 10% Coinsurance, not to exceed $250.
- **Tier 6:** 15% Coinsurance, not to exceed $300.

COVERED PRESCRIPTION MEDICATIONS

Prescription Medication benefits are available for the following:

- Prescription Medications;
- Growth hormones, when preauthorized, limited to $8,000 per Claimant Lifetime;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Injectable Medications) and teaching doses by which a Claimant 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 that are on the Drug List may be purchased from a Pharmacy, when obtained with a Prescription Order; related supplies and other continuous glucose monitors or other insulin pumps are covered in the Durable Medical Equipment benefit;
- Compound Medications;
- Prescription medications for sexual dysfunction;
- Specialty Medications (including, but not limited to, medications for multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders and hepatitis C);

- 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:

    - 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).

When preventive medications or immunizations are obtained from a Nonparticipating Pharmacy, You will be responsible for any Deductible, Copayment and/or Coinsurance listed above for Prescription Medications. If Your Provider believes that the Plan's covered preventive medications, including contraceptives, are medically inappropriate for You, You may request an equivalent preventive medication by contacting Customer Service. For additional information on covered Prescription Medications, visit the Claims Administrator's 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 the Claims Administrator's website.

PRESCRIPTION MEDICATION COST-SHARE ASSISTANCE

Your Plan Sponsor has coordinated with an alternate funding service to provide a cost-share assistance program for a select list of Prescription Medications. The program is separate from Your benefits under this Plan and is designed to reduce or eliminate any out-of-pocket expenses for qualifying Prescription Medications. If You are eligible to participate, the Claims Administrator will contact You and help You enroll. Upon enrollment in the program, a review will be conducted to locate cost-sharing assistance for You based on Your specific Prescription Medication. If cost-sharing assistance is identified and You are eligible but choose not to enroll, You will be responsible for any Deductible, Copayment, and/or Coinsurance as explained in this Prescription Medications Section. Whether You choose to enroll in the program or not, Your cost-sharing responsibility under this Prescription Medication Benefit will remain the same throughout the Calendar Year.

PRESCRIPTION MEDICATIONS CLAIMS AND ADMINISTRATION

Preauthorization

Some Prescription Medications may require preauthorization before they are dispensed. The Claims Administrator notifies 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 the Claims Administrator's website or contact Customer Service.

Drug List Changes

Any removal of a Prescription Medication from the Drug List will be posted on the Claims Administrator's 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, the Plan will continue to cover Your Prescription Medication for the time period required to use the 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 the Claims Administrator 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 the Claims Administrator's website. You or Your Provider may request preauthorization by calling Customer Service or by completing and submitting the form on the Claims Administrator's 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 Plan 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 the Prescription Medication Deductible or any Out-of-Pocket Maximum. If the prescribing Provider specifies that the Brand-Name Medication or 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. You can find Participating Pharmacies on the Claims Administrator's website or by contacting Customer Service.

You must present Your identification card to identify Yourself as a Claimant of this Plan when obtaining Prescription Medications from a 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. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, the Plan will pay the Nonparticipating Pharmacy directly. Nonparticipating Pharmacies, however, may charge amounts in excess of Covered Prescription Medication Expenses. If that happens, You will be responsible for the excess amounts, as well as any Deductible, Copayment and/or Coinsurance shown electronically to the Nonparticipating Pharmacy at the time of purchase.

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, 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 the Claims Administrator. To find the Prescription Medication claim form visit the Claims Administrator's website or contact Customer Service.

The Plan 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 purchased from 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 the Claims Administrator's website or from Your Plan Sponsor:

- a completed prescription home delivery form;

- any Deductible, Copayment and/or Coinsurance; and
- the original Prescription Order.

Prescription Medications Dispensed by Excluded Pharmacies

The Claims Administrator does 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 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.
- feel You need a refill sooner than allowed, a refill exception will be considered on a case-by-case basis. You may request an exception by calling Customer Service.

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 or Prescription Medication 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 of 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 the Claims Administrator's 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 90-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, the Claims Administrator establishes 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. The Claims Administrator uses 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 Claimant'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 the Claims Administrator determines 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 the Claims Administrator's 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 the Claims Administrator's 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 the Claims Administrator's 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.

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
Except for higher cost Prescription Medications that are Medically Necessary, Prescription Medications for which there are covered therapeutically equivalent (similar safety and efficacy) alternatives or over-the-counter (nonprescription) alternatives are not covered.

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 Claimant 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:

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.

Compound Medication means two or more medications that are mixed together by the Pharmacist. To be covered, Compound Medications must contain a Prescription Medication that has been approved by the FDA and may be subject to review for Medical Necessity.

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 the Claims Administrator's list of selected Prescription Medications. The Claims Administrator established and routinely reviews and updates the Drug List. It is available on the Claims Administrator's website or by calling Customer Service. Medications are reviewed and selected for inclusion on the Claims Administrator's Drug List by an outside committee of Providers, including Physicians and Pharmacists.

Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references 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, the Claims Administrator will decide.

Home Delivery Supplier means a home delivery Pharmacy with which the Claims Administrator has contracted for home delivery services.

Nonparticipating Pharmacy means a Pharmacy with which the Claims Administrator neither has a contract nor has contracted access to any network it belongs to.

Participating Pharmacy means either a Pharmacy with which the Claims Administrator has a contract or a Pharmacy that participates in a network for which the Claims Administrator has contracted to have access.

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. The P&T Committee also provides input and oversight of the development of the Claims Administrator's 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.

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 the Claims Administrator's 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. The Claims Administrator does 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 Medications mean 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; and
- hepatitis C.

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 the Claims Administrator's website or contact Customer Service.

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 the Claims Administrator's 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 Tier 4 benefit level. Substituted Medication also means a Specialty Medication not on the Drug List that is approved for coverage at the Tier 6 benefit level.

Tier 1 means medications that provide the highest overall value. Mostly includes Generic Medications but may include some Brand-Name Medications.

Tier 2 means medications that provide moderate overall value. Mostly includes Generic Medications but may include some Brand-Name Medications.

Tier 3 means medications that provide moderate overall value. Usually includes Brand-Name Medications that are categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

Tier 4 means medications that provide lower overall value. Usually includes Brand-Name Medications that are categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

Tier 5 means Specialty Medications that provide moderate overall value, categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

Tier 6 means Specialty Medications that provide lower overall value, categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

Medical Benefits – High Deductible Health Plan

This section explains Your benefits and cost-sharing responsibilities 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, Office or Urgent Care Visits – Illness or Injury 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, the Plan 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 the Claims Administrator's website or contact Customer Service.

NOTE: If You choose to access new medical supplies, equipment and devices through the Claims Administrator's website, the Claims Administrator 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 Plan, but are not insurance.

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 the Claims Administrator before providing such services to You. You will not be penalized if the contracted Provider does not obtain preauthorization from the Claims Administrator in advance and the service is determined to be not covered.

Non-contracted Providers are not required to obtain preauthorization from the Claims Administrator 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.

A complete list of services and supplies that require preauthorization may be obtained by visiting the Claims Administrator's website at: **regence.com/web/regence_provider/pre-authorization** or by calling Customer Service.

Preauthorization requests should be faxed by Your Provider following the instructions on the Claims Administrator's website.

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.

PLAN YEAR DEDUCTIBLES

In-Network

Single Coverage Deductible: $1,700
Family Coverage Deductible: $3,400 (entire Deductible must be met before benefits begin.)

Out-of-Network

Single Coverage Deductible: $3,500
Family Coverage Deductible: $7,000 (entire Deductible must be met before benefits begin.)

You do not need to meet the Deductible when You fill prescriptions for medications specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List found on the Claims Administrator's website or by contacting Customer Service.

PLAN YEAR OUT-OF-POCKET MAXIMUM

Single Coverage: $3,500
Family Coverage: $7,000

Out-of-Network

Single Coverage: $7,000
Family Coverage: $14,000

PREVENTIVE CARE AND IMMUNIZATIONS

Preventive Care

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Immunizations – Adult

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Immunizations – Childhood

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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;
- 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.

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, the Plan has up to one year before coverage of the related services must be available and effective.

Expanded Immunizations

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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.

OFFICE OR URGENT CARE VISITS – ILLNESS OR INJURY

	Provider: In-Network	Provider: Out-of-Network
Primary Physician or Practitioner	**Payment:** After Deductible, You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Specialist	**Payment:** After Deductible, You pay $35 Copayment per visit.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Urgent Care	**Payment:** After Deductible, You pay $35 Copayment per visit.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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.

Expanded Office Services

	Provider: In-Network	Provider: Out-of-Network
Primary Physician or Practitioner	**Payment:** After Deductible, You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Specialist	**Payment:** After Deductible, You pay $35 Copayment per visit.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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

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 Section.

OTHER PROFESSIONAL SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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;

- 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, 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 the Claims Administrator's website or contact Customer Service.

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, the Plan will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by Out-of-Network Providers at the In-Network benefit level. Contact the Claims Administrator's Customer Service for further information and guidance.

Radiology and Laboratory

Diagnostic services for treatment of Illness or Injury. This includes Medically Necessary genetic testing and mammography services not covered in the Preventive Care and Immunizations 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.

Diagnostic Procedures

Services for diagnostic procedures including cardiovascular testing, pulmonary function studies, sleep studies, stress tests 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

Provider: All
Payment: After In-Network Deductible, You pay 10% of the Allowed Amount.

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's 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 Medical Benefits and Prescription Medications Sections. 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 Claimant 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 Claimant; or
- a service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

AUTISM SPECTRUM DISORDER SERVICES

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Outpatient Office/Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Other Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Services for Autism Spectrum Disorder are covered. Covered Services include diagnosis (including assessments, evaluations or tests) and treatment (including Applied Behavioral Analysis, Behavioral Health, Pharmacy Care, psychiatric care, psychological care, or Therapeutic Care, and related equipment).

Definitions

The following definitions apply to this Autism Spectrum Disorder Services benefit:

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

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

Behavioral Health means counseling and treatment programs, including Applied Behavior Analysis, that are:

- necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and provided or supervised by a:
    - board-certified behavior analyst; or
    - person licensed under state law, whose scope of practice includes mental health services.

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

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

BLOOD BANK

Provider: All
Payment: After In-Network Deductible, You pay 10% of the Allowed Amount.

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

DENTAL HOSPITALIZATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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.

DETOXIFICATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 10% of the Allowed Amount and the balance of billed charges.

DIABETIC EDUCATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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 THERAPY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

DIALYSIS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Services and supplies for inpatient and outpatient dialysis are covered (including outpatient hemodialysis, peritoneal dialysis and hemofiltration).

DURABLE MEDICAL EQUIPMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Durable Medical Equipment is covered, including, but not limited to, oxygen equipment, wheelchairs and supplies or equipment associated with diabetes.

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 the Claims Administrator's 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)

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After In-Network Deductible, You pay 10% of the Allowed Amount.

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 Claimant from a facility; and
- in the case of a covered Claimant, 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 the Claims Administrator's Customer Service for further information and guidance.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

Provider: Centers of Excellence	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.

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

To be covered, gene therapy and/or adoptive cellular therapy must be received from one of the Claims Administrator's 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. Receiving therapy from one of the Claims Administrator's COE facilities will save the most in Your out-of-pocket expenses. For a list of covered therapies or to identify a COE facility, contact the Claims Administrator's Customer Service, as the lists are subject to change.

Travel Expenses

Payment: You pay 100% of all expenses. Your travel expenses may be reimbursed subject to Your In-Network Deductible and travel expense limit.
Limit: $7,500 per Claimant per course of treatment, including companion(s), for transportation and lodging expenses. Additional limitations included below.

Transportation and lodging expenses are covered, 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 Claimant and one companion (or two companions if the Claimant is under the age of 19);
- commercial lodging expenses are limited to the IRS medical expense allowances (currently $50 per night for the Claimant, not to exceed $100 per night for the Claimant 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. The Plan will reimburse You for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact the Claims Administrator's Customer Service for further information and guidance.

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

HEARING AIDS AND EVALUATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Limit: $2,500 per Claimant per Plan Year	

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:

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

HOME HEALTH CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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.

Durable Medical Equipment associated with home health care services is covered in the Durable Medical Equipment benefit.

HOSPICE CARE

Provider: In-Network	Provider: Out-of-Network

Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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 Claimant and allow temporary relief to family members from the duties of caring for the Claimant. Durable Medical Equipment associated with hospice care is covered in the Durable Medical Equipment benefit.

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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.

INFERTILITY TREATMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Limit: $5,000 per Claimant Lifetime	

Surgical and nonsurgical treatment is covered for the correction of infertility.

Coverage does **not** include:

- assisted reproductive procedures, 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.
- fertility medications;
- uterine transplants; and
- other medications associated with fertility treatment.

INFUSION THERAPY
Inpatient and Outpatient Services

Provider: In-Network	Provider: Out-of-Network

Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Inpatient and outpatient services, supplies (including infusion pumps) and medications for infusion therapy are covered. Covered Services also include parenteral and enteral therapy.

Home Infusion Therapy

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Limit: $50,000 per Claimant per Plan year for total parenteral nutrition.	

Home infusion therapy is covered when provided in the home by a licensed home infusion therapy agency when the patient is under the care of a Physician and when the home infusion therapy regimen is Medically Necessary for the treatment of an Illness or Injury as follows:

- professional skilled nursing services of a registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN) required for:
  - training the patient and/or alternative care giver;
  - the administration of therapy; or
  - monitoring the intravenous therapy regimen;
- medical surgical supplies which are customarily furnished by the home infusion therapy agency for its patients and which are necessary to administer the home infusion therapy regimen;
- Non-replaced blood, blood plasma, blood derivatives; and their administration; and
- Prescribed drugs furnished by the home infusion therapy agency which are part of the home infusion therapy regimen. The administration of such drugs must require the professional skills of a nurse (RN, LPN, or LVN) and does not include prescribed drugs that can be self-administered or administered by a non-professional caretaker.

Durable Medical Equipment associated with parenteral nutrition is covered under the Durable Medical Equipment benefit in this Booklet.

MAJOR DIAGNOSTIC TESTING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Major Diagnostic Tests are covered.

"Major Diagnostic Tests" include, but are not limited to:

- bone density screening;
- cardiovascular diagnostics;
- computerized axial tomography (CT or CAT) scan;
- magnetic resonance angiogram (MRA);
- magnetic resonance imaging (MRI);
- nuclear medicine;
- neurological diagnostics; and
- single photon emission computerized tomography (SPECT).

Claims for independent clinical laboratory services will be submitted to this plan or any other Blue Cross and/or Blue Shield Licensee in the locale in which the referring Provider is located, regardless of where

the examination of the specimen occurred. Refer to the plan network where the referring Provider is located for coverage of independent clinical laboratory services.

MATERNITY CARE/ADOPTION BENEFIT

Maternity Care

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Adoption Benefit

Payment: You pay 100% of billed charges. Your payment may be reimbursed up to the adoption limit, after the In-Network Deductible has been met.
Adoption limit: $3,000 per pregnancy

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.

Coverage for termination of pregnancy (abortion) will be provided for all Claimants only for the following, to the extent permitted under applicable law:

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

An adoption benefit is available when a Participant 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 Participant within 12 months after the child's birth and the date of placement is on or after the Participant's Effective Date.
- The Participant 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 2998
  Tacoma, WA 98401-2998

In the event a Participant adopts more than one newborn from a single pregnancy (for example, twins), only a single $3,000 adoption benefit is available (subject to reduction for other coverage below).

In the event the Participant and/or the Participant's spouse are covered by more than one compliant health benefit plan, the adoption benefit will be prorated between or among the plans. The full amount provided by both or all of the plans will not exceed $3,000 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 Participant will be liable for repayment of the adoption benefit. The Participant will refund the full amount of such benefit to the Plan, 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 the Claims Administrator the lesser of the amount described in the preceding sentence and the amount the Plan has paid for those Covered Services (even if payment or compensation to You or any other person or entity occurs after the termination of Your coverage under this Plan).

You must notify the Claims Administrator within 30 days of entering into any agreement to Act as a Surrogate and agree to cooperate with the Plan as needed to ensure the Claims Administrator's ability to recover the costs of Covered Services received by You for which the Plan is entitled to reimbursement. To notify the Claims Administrator, or to request additional information on Your responsibilities related to these notification and cooperation requirements, contact Customer Service. Refer to the Subrogation and Right of 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

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Outpatient Office/Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay $25 Copayment per visit.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Other Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Mental Health and Substance Use Disorder Services are covered for treatment of Mental Health Conditions or Substance Use Disorders.

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, 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

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Limit: 30 visits per Claimant per Plan Year (combined with outpatient rehabilitation services visit limit)	

Neurodevelopmental therapy services by a Physician or Practitioner are covered. Covered Services must be to restore or improve function for a Claimant up to age 18 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 Claimant'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.

NEWBORN CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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.

ORTHOTIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Limit: $200 per Claimant per Plan Year for foot orthotics	

Braces, splints, orthopedic appliances and orthotic supplies or apparatuses are covered when used to support, align or correct deformities or to improve the function of moving parts of the body.

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 the Claims Administrator's website or contact Customer Service.

The Plan may elect to provide benefits for a less costly alternative item. Off-the-shelf shoe inserts and orthopedic shoes are not covered.

PREVENTIVE CARE FOR SPECIFIED CHRONIC CONDITIONS

Services and supplies are covered when used to treat a Claimant diagnosed with the associated chronic condition and prescribed to prevent either exacerbation of the chronic condition or the development of a secondary condition. Covered Services as specified below are covered the same as any other condition, but are not subject to any applicable Deductible for In-Network services:

- blood pressure monitor with a diagnosis of hypertension;
- continuous glucose monitor (device only), hemoglobin A1c testing and retinopathy screening with a diagnosis of diabetes;
- International Normalized Ratio (INR) testing with a diagnosis of liver disease and/or bleeding disorder;
- Low-Density Lipoprotein (LDL) testing with a diagnosis of heart disease; or
- peak flow meter with a diagnosis of asthma.

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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.

REHABILITATION SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Inpatient limit: 60 days per Claimant per Plan Year **Outpatient limit:** 30 visits per Claimant per Plan Year (combined with neurodevelopmental visit limit)	

Inpatient and outpatient rehabilitation services and accommodations are covered as appropriate and necessary to restore or improve lost function caused by Illness or Injury. "Rehabilitation services" mean physical, occupational and speech therapy services only, including associated 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.

REPAIR OF TEETH

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Limit: $1,000 per Claimant per Plan Year	

Services and supplies for treatment required as a result of damage to or loss of sound natural teeth are covered when such damage or loss is due to an Injury.

ROUTINE HEARING EXAMINATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Limit: one routine hearing examination per Claimant per Plan Year	

Routine hearing examinations that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

SKILLED NURSING FACILITY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Limit: 60 inpatient days per Claimant per Plan Year	

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

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Limit: 20 spinal manipulations per Claimant per Plan Year	

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

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Limit: $500 per Claimant Lifetime	

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.

TRANSPLANTS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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 the Claims Administrator's 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.

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. Some Providers or virtual care vendors may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share.

"Virtual care vendors" mean a select group of Providers that have entered into an agreement with the Claims Administrator to provide virtual care services at a lower cost. To learn more about how to access virtual care services or Providers and the virtual care vendors that may offer lower-cost services, visit the Claims Administrator's website or contact Customer Service.

Store and Forward Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay $10 Copayment.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

"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

Provider: Virtual Care Vendor	Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay $10 Copayment.	**Payment:** After Deductible, You pay $10 Copayment.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

"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 – High Deductible Health Plan

This section explains Your benefits and cost-sharing responsibilities 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.

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. To view the Drug List and find medications by tier, visit the Claims Administrator's website or contact Customer Service.

COPAYMENTS AND/OR COINSURANCE

After You meet the In-Network Deductible, You are responsible for paying the following Copayment and/or Coinsurance amounts at the time of purchase, if the Pharmacy submits the claim electronically. However, You are not responsible for any Deductible, Copayment and/or Coinsurance when You fill a prescription for medications specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List found on the Claims Administrator's website or by calling Customer Service. Your Copayment and/or Coinsurance will be applied toward the In-Network Out-of-Pocket Maximum.

You are not responsible for any Copayment and/or Coinsurance when You fill prescriptions for medications intended to treat opioid overdose that are on the Opioid Rescue Medication Value List found on the Claims Administrator's website or by calling Customer Service.

When You fill a prescription for Tier 3 insulin, Your cost-share will not exceed $28 per 30-day supply from a Pharmacy or $84 per 90-day supply from a Home Delivery Supplier, whether or not You have met any applicable Deductible.

Prescription Medications from a Pharmacy (for Each 90-Day Supply)

- **Tier 1:** $7 Copayment.
- **Tier 2:** $7 Copayment.
- **Tier 3:** 25% Coinsurance, not to exceed $150.
- **Tier 4:** 30% Coinsurance, not to exceed $175.
- **Compound Medication:** 30% Coinsurance, not to exceed $175.
- **Diabetic Supplies:** 10% Coinsurance.

Prescription Medications from a Home Delivery Supplier (for Each 90-Day Supply)

- **Tier 1:** $7 Copayment.
- **Tier 2:** $7 Copayment.
- **Tier 3:** 25% Coinsurance, not to exceed $300.
- **Tier 4:** 30% Coinsurance, not to exceed $437.50.
- **Compound Medication:** 30% Coinsurance, not to exceed $437.50.
- **Diabetic Supplies:** 10% Coinsurance.

Prescription Specialty Medications (for Each 30-Day Supply)

- **Tier 5:** 10% Coinsurance, not to exceed $250.
- **Tier 6:** 15% Coinsurance, not to exceed $300.

COVERED PRESCRIPTION MEDICATIONS

Prescription Medication benefits are available for the following:

- Prescription Medications;
- Growth hormones, when preauthorized, limited to $8,000 per Claimant Lifetime;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Injectable Medications) and teaching doses by which a Claimant 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 that are on the Drug List may be purchased from a Pharmacy, when obtained with a Prescription Order; related supplies and other continuous glucose monitors or other insulin pumps are covered in the Durable Medical Equipment benefit;
- Compound Medications;
- Prescription medications for sexual dysfunction;
- Specialty Medications (including, but not limited to, medications for multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders and hepatitis C);
- 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:
    - 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).

When preventive medications or immunizations are obtained from a Nonparticipating Pharmacy, You will be responsible for any Deductible, Copayment and/or Coinsurance listed above for Prescription Medications. If Your Provider believes that the Plan's covered preventive medications, including contraceptives, are medically inappropriate for You, You may request an equivalent preventive medication by contacting Customer Service. For additional information on covered Prescription Medications, visit the Claims Administrator's 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 the Claims Administrator's website.

PRESCRIPTION MEDICATIONS CLAIMS AND ADMINISTRATION

Preauthorization

Some Prescription Medications may require preauthorization before they are dispensed. The Claims Administrator notifies 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 the Claims Administrator's website or contact Customer Service.

Drug List Changes

Any removal of a Prescription Medication from the Drug List will be posted on the Claims Administrator's 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, the Plan will continue to cover Your Prescription Medication for the time period required to use the 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 the Claims Administrator 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 the Claims Administrator's website. You or Your Provider may request preauthorization by calling Customer Service or by completing and submitting the form on the Claims Administrator's 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 Plan 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 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. You can find Participating Pharmacies on the Claims Administrator's website or by contacting Customer Service.

You must present Your identification card to identify Yourself as a Claimant of this Plan when obtaining Prescription Medications from a 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. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, the Plan will pay the Nonparticipating Pharmacy directly. Nonparticipating Pharmacies, however, may charge amounts in excess of Covered Prescription Medication Expenses. If that happens, You will be responsible for the excess amounts, as well as any Deductible, Copayment and/or Coinsurance shown electronically to the Nonparticipating Pharmacy at the time of purchase.

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, 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 the Claims Administrator. To find the Prescription Medication claim form visit the Claims Administrator's website or contact Customer Service.

The Plan 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 purchased from 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 the Claims Administrator's website or from Your Plan Sponsor:

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

Prescription Medications Dispensed by Excluded Pharmacies

The Claims Administrator does 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 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.
- feel You need a refill sooner than allowed, a refill exception will be considered on a case-by-case basis. You may request an exception by calling Customer Service.

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 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 the Claims Administrator's 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 90-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, the Claims Administrator establishes 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. The Claims Administrator uses 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 Claimant'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 the Claims Administrator determines 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 the Claims Administrator's 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 the Claims Administrator's 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 the Claims Administrator's 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.

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
Except for higher cost Prescription Medications that are Medically Necessary, Prescription Medications for which there are covered therapeutically equivalent (similar safety and efficacy) alternatives or over-the-counter (nonprescription) alternatives are not covered.

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 Claimant 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:

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.

Compound Medication means two or more medications that are mixed together by the Pharmacist. To be covered, Compound Medications must contain a Prescription Medication that has been approved by the FDA and may be subject to review for Medical Necessity.

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 the Claims Administrator's list of selected Prescription Medications. The Claims Administrator established and routinely reviews and updates the Drug List. It is available on the Claims Administrator's website or by calling Customer Service. Medications are reviewed and selected for inclusion on the Claims Administrator's Drug List by an outside committee of Providers, including Physicians and Pharmacists.

Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references 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, the Claims Administrator will decide.

Home Delivery Supplier means a home delivery Pharmacy with which the Claims Administrator has contracted for home delivery services.

Nonparticipating Pharmacy means a Pharmacy with which the Claims Administrator neither has a contract nor has contracted access to any network it belongs to.

Participating Pharmacy means either a Pharmacy with which the Claims Administrator has a contract or a Pharmacy that participates in a network for which the Claims Administrator has contracted to have access.

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. The P&T Committee also provides input and oversight of the development of the Claims Administrator's 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.

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 the Claims Administrator's 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. The Claims Administrator does 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 Medications mean 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; and
- hepatitis C.

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 the Claims Administrator's website or contact Customer Service.

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 the Claims Administrator's 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 Tier 4 benefit level. Substituted Medication also means a Specialty Medication not on the Drug List that is approved for coverage at the Tier 6 benefit level.

Tier 1 means medications that provide the highest overall value. Mostly includes Generic Medications but may include some Brand-Name Medications.

Tier 2 means medications that provide moderate overall value. Mostly includes Generic Medications but may include some Brand-Name Medications.

Tier 3 means medications that provide moderate overall value. Usually includes Brand-Name Medications that are categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

Tier 4 means medications that provide lower overall value. Usually includes Brand-Name Medications that are categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

Tier 5 means Specialty Medications that provide moderate overall value, categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

Tier 6 means Specialty Medications that provide lower overall value, categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

General Plan Exclusions

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

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

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

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

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 Dentist or 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 the Claims Administrator, benefits that are covered (or would be covered in the absence of this Plan) by any federal, state or government program are not covered.

Additionally, except as 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.

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

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 Claimant (whether or not the Claimant makes a claim with such coverage), expenses are not covered for services and supplies that are payable by any:

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

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

Non-Direct Patient Care
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 the Claims Administrator's request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

Personal Items
Items that are primarily for comfort, convenience, Cosmetics, contentment, hygiene, environmental control, education, aesthetics, nontherapeutic purposes 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.

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

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

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.

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.

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

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

General Medical Exclusions

In addition to the exclusions in the General Plan Exclusions Section, the following exclusions apply to the Medical Benefits. 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:

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

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 and/or 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.

Acupuncture

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 by the Plan.

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.

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
Non-skilled care and helping with activities of daily living.

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

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

Growth Hormone Therapy

Hearing Aids and Other Devices
Except for cochlear implants or as provided in the Hearing Aids and Evaluations benefit, hearing aids (externally worn or surgically implanted) or other hearing devices are not covered.

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 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 as provided in the Infertility Treatment benefit or to the extent Covered Services are required to diagnose such condition, treatment of infertility is not covered, including, but not limited to:

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

Liposuction for the Treatment of Lipedema

Nutritional Counseling
Except as provided in the Diabetic Nutritional Therapy benefit, nutritional counseling and nutritional therapy services are not covered, including, but not limited to:

- diabetic counseling;
- discussions on eating habits;
- lifestyle choices; and
- dietary interventions.

Obesity or Weight Reduction/Control
Except 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.

Palliative Care
Palliative care services (including remission support) are not covered. "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.

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.

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

Routine Foot Care

Self-Help, Self-Care, Training or Instructional Programs
Except as provided in the Diabetic Education and Diabetic Nutritional Therapy benefits or for services provided without a separate charge in connection with Covered Services that train or educate a Claimant, self-help, non-medical self-care and training programs are not covered, including, but not limited to:

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

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 and Prescription Medications benefits, treatment, services and supplies are not covered for or in connection with sexual dysfunction regardless of cause.

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 Subrogation and Right of Recovery Sections for more information.

Termination of Pregnancy (Abortion)
Except for the following circumstances, in accordance with the Utah prohibition against public funding for abortions (U.C.A. 76-7-331, as amended), services and supplies in connection with the performance of any induced abortion services are not covered:

- in the professional judgment of the pregnant Claimant's attending physician, the abortion is necessary to save the pregnant Claimant's life.
- the pregnancy is the result of rape or incest reported to law enforcement agencies, unless the Claimant was unable to report the crime for physical reasons or fear of retaliation; or
- in the professional judgment of the pregnant Claimant's attending physician, the abortion is necessary to prevent premature, irreparable, and grave damage to a major bodily function of the pregnant Claimant provided that a cesarean procedure or other medical procedure that could also save the life of the child is not a viable option.

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

Vision Care

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.

Dental Benefits

This section explains Your benefits and cost-sharing responsibilities for Covered Services. All benefits are listed alphabetically, with the exception of Preventive and Diagnostic Dental Services.

PLAN YEAR DEDUCTIBLES
Not applicable

MAXIMUM BENEFITS
Preventive and Diagnostic, Basic and Major Dental Services:
Per Claimant: $1,500 per Plan Year

Orthodontic Dental Services:
Per Claimant: $500 per Plan Year
Per Claimant: $1,000 per Lifetime

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

Provider: In-Network Dentist	Provider: Out-of-Network Dentist
Payment: No charge.	**Payment:** No charge up to the Allowed Amount and You pay the balance of billed charges.

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

- Bitewing x-rays, limited to two sets per Claimant per Plan Year.
- Complete intra-oral mouth x-rays, limited to one in a three-year period.
- Preventive oral examinations, limited to two per Claimant per Plan Year.
- Problem focused oral examinations.
- Panoramic mouth x-rays, limited to one in a three-year period.
- Sealants, limited to permanent bicuspids and molars of Claimants under 16 years of age.
- Space maintainers for Claimants under 14 years of age.
- Topical fluoride application for Claimants under 24 years of age, limited to two treatments per Claimant per Plan Year.
- Cleanings, limited to two* per Claimant per Plan Year.

  *A third cleaning may be covered, in the same Plan Year, for a Claimant with one or more of the following conditions:

  - coronary atherosclerosis;
  - diabetes;
  - hypertensive heart disease; or
  - pregnancy.

  In this instance, a Claimant will be entitled to no more than three cleanings in a Plan Year.

BASIC DENTAL SERVICES

Provider: In-Network Dentist	Provider: Out-of-Network Dentist
Payment: You pay 20% of the Allowed Amount.	**Payment:** You pay 20% of the Allowed Amount and You pay the balance of billed charges.

Basic dental services are covered, subject to any specified limits as explained in the following:

- Complex oral surgery procedures including:

  - surgical extractions of teeth;
  - impactions;
  - alveoloplasty;

  - vestibuloplasty; and
  - residual root removal.

- Treatment for pain relief.
- Endodontic services consisting of:

  - apicoectomy;
  - debridement;
  - direct pulp capping;
  - pulpal therapy;
  - pulpotomy; and
  - root canal treatment.

- Fillings consisting of composite and amalgam restorations.
- General dental anesthesia or intravenous sedation administered for:

  - extractions of partially or completely bony impacted teeth; or
  - to safeguard the Claimant's health (for example, a child under seven years of age or a physically or developmentally disabled individual).

- Periodontal services consisting of:

  - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery) limited to once per Claimant per quadrant in a five-year period;
  - debridement limited to once per Claimant in a three-year period;
  - gingivectomy and gingivoplasty limited to once per Claimant per quadrant in a three-year period;
  - periodontal maintenance limited to four per Claimant per Plan Year; and
  - scaling and root planing limited to once per Claimant per quadrant in a Plan Year.

- Repair of dentures and bridges.
- Uncomplicated oral surgery procedures including removal of teeth, incision and drainage.

MAJOR DENTAL SERVICES

Provider: In-Network Dentist	Provider: Out-of-Network Dentist
Payment: You pay 50% of the Allowed Amount.	**Payment:** You pay 50% of the Allowed Amount and You pay the balance of billed charges.

Major dental services are covered, subject to any specified limits as explained in the following:

- Bridges (fixed partial dentures), except that benefits will not be provided for replacement made fewer than five years after placement.
- Crowns, crown build-ups, inlays and onlays, except that benefits will not be provided for any of the following:

  - any crown, inlay or onlay replacement made fewer than five years after placement (or subsequent replacement) whether or not originally covered in this Booklet; and
  - additional procedures to construct a new crown under an existing partial denture framework.

- Dental implant crown and abutment related procedures, limited to one per Claimant per tooth in a five-year period.
- Dentures, full and partial, including:

  - denture rebase, limited to one per Claimant per arch in a three-year period; and
  - denture relines, limited to one per Claimant per arch in a three-year period.

- Denture benefits will **not** be provided for:

  - any denture replacement made fewer than five years after denture placement (or subsequent replacement) whether or not originally covered in this Booklet.

- interim partial or complete dentures; or
- pediatric dentures.

- Endosteal implants.
- Recement crown, inlay or onlay.
- Repair of crowns is limited to one per tooth per Claimant Lifetime.
- Repair of implant supported prosthesis or abutment, limited to one per tooth per Claimant Lifetime.
- Veneers.

ORTHODONTIC DENTAL SERVICES

Provider: All Dentists
Payment: You pay 50% of the Allowed Amount and You pay the balance of billed charges.
Limit: $500 per Plan Year; $1,000 per Claimant Lifetime

Orthodontic dental services are covered, subject to any specified limits as explained in the following:

- For Claimants under 26 years of age.
- The initial and subsequent installations of orthodontic appliances and all non-surgical orthodontic treatments concerned with the reduction or elimination of an existing malocclusion, subject to the submission of a treatment plan (submitted by the attending Provider). The treatment plan should include all of the following information:

  - a diagnosis indicating an abnormal occlusion that can be corrected by orthodontic treatment;
  - the estimated length of required treatment;
  - the initial banding fee; and
  - the total orthodontic treatment charge.

- If treatment stops before the end of the prescribed treatment period, benefits will end on the last day of the month during which the treatment was discontinued.

General Dental Exclusions

In addition to the exclusions in the General Plan Exclusions Section, the following exclusions apply to the Dental Benefits. Other exclusions may apply as described elsewhere in this Booklet.

SPECIFIC EXCLUSIONS

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

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.

Collection of Cultures and Specimens

Collection of cultures and specimens are not covered, including, but not limited to:

- saliva; or
- tissue of the oral cavity.

Connector Bar or Stress Breaker

A device attached to a prosthesis or coping which serves to stabilize and anchor prosthesis.

Cosmetic/Reconstructive Services and Supplies

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

- a congenital anomaly; or
- 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 performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Desensitizing

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

Diagnostic Casts or Study Models

Services and supplies provided in connection with diagnostic casts or study models including taking the impression and pouring the study models.

Duplicate X-Rays

Facility Charges

Services and supplies provided in connection with facility services, including hospitalization for dentistry and extended-care facility visits.

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

Implants
Except as provided in the Major Dental Services benefit, 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 lifts;
- 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 and Vitality Tests

Medications and Supplies
Charges in connection with medications and supplies are not covered, including, but not limited to:

- take-home 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

Oral Surgery
Oral surgery treating any fractured jaw and orthognathic surgery. "Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

Photographic Images

Pin Retention in Addition to Restoration
Small metal rod used to aid in support of a restoration.

Precision Attachments
Device to stabilize or retain a prosthesis when seated in mouth.

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
Interim or temporary stabilization of loose/mobile teeth.

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

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

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
Services and supplies provided in connection with the following surgical procedures are not covered:

- 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
Except for surgical correction required as the result of an Injury, TMJ disorder treatment and any associated services and supplies are not covered.

Tooth Transplantation
Services and supplies provided in connection with tooth transplantation are not covered, including, but not limited to:

- reimplantation from one site to another;
- splinting; or
- stabilization.

Claims Administration

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

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims are submitted and payment is due, the Claims Administrator decides whether to pay You, the Provider or You and the Provider jointly. The Plan 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.

In-Network Provider Claims and Reimbursement

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

The Plan will pay an In-Network Provider or Dentist directly for Covered Services. These Providers or Dentists may require You to pay any Deductible, Copayment and/or Coinsurance at the time You receive care or treatment. In-Network Providers and 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 Provider Claims and Reimbursement

In order for the Claims Administrator to pay for Covered Services, You, the Out-of-Network Provider or Out-of-Network Dentist must first send the Claims Administrator a claim. In most cases, the Plan will pay You directly for Covered Services provided by an Out-of-Network Provider, however the Plan 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.

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

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

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

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 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).

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.

The Claims Administrator will notify You of Your right to receive continued care from the Provider or You may contact the Claims Administrator with a need for continued care. Coverage under this Continuity of Care provision will be subject to the benefits of this Plan 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 the Claims Administrator's Customer Service for further information and guidance.

OUT-OF-AREA SERVICES

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "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 the geographic area the Claims Administrator serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When Your network is ValueCare or FocalPoint: When You receive care outside the Claims Administrator's service area, You may receive it from one of three kinds of Providers. Providers that contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue") as a preferred Provider are paid at the In-Network Provider level and will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. Providers that contract with the Host Blue as a participating Provider are paid at the Out-of-Network Provider level and may not bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Some Providers ("Out-of-Network Providers") don't contract with the Host Blue. The Booklet further explains below how the Plan pays these different kinds of Providers.

When Your network is Participating: When You receive care outside the Claims Administrator's service area, You will receive it from one of two kinds of Providers. Most Providers ("In-Network Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Out-of-Network Providers") don't contract with the Host Blue. The Booklet further explains below how the Plan pays these different kinds of Providers.

BlueCard Program

In the BlueCard Program, when You access Covered Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for doing what the Claims Administrator agreed to in the Agreement. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever You receive Covered Services outside the Claims Administrator's 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 covered charges for Your Covered Services; or
- the negotiated price that the Host Blue makes available to the Claims Administrator.

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price the Claims Administrator has used for Your claim because they will not be applied after a claim has already been paid.

Value-Based Programs

If You receive Covered Services from a Value-Based Program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordination Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

The following definitions apply:

- Value-Based Program: An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.
- Provider Incentive: An additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.
- Care Coordination Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination in a Value-Based Program.

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

Federal law or state law may require a surcharge, tax or other fee that applies to insured accounts. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

Out-of-Network Providers Outside the Claims Administrator's Service Area

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

payment to determine the amount the Claims Administrator will pay for services provided by Out-of-Network Providers. In these situations, You may be liable for the difference between the amount that the Out-of-Network Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

If You are outside the United States (hereinafter "BlueCard service area"), You may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when You receive care from Providers outside the BlueCard service area, You will typically have to pay the Providers and submit the claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, 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.

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

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

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

CLAIMS RECOVERY

If the Plan pays a benefit to which You or Your Beneficiaries were not entitled, or if the Plan pays a person who is not eligible for benefits at all, the Plan has the right to recover the payment from the person the Plan paid or anyone else who benefited from it, including a provider of services. The Plan's right to recovery includes the right to deduct the mistakenly paid amount from future benefits the Plan would provide the Participant or any of their Beneficiaries under this Plan.

The Claims Administrator regularly works to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, fraudulent claims, etc.). The Plan will be credited all amounts recovered.

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

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former Claimants who incur claims and are or have been covered by the Plan. No adult Claimant hereunder, may assign any rights that they may have to recover expenses from any tortfeasor or other person or entity to any minor child or children of said adult Claimant without the prior express written consent of the Plan. These provisions will apply to all claims

arising from Your Illness or Injury, including, but not limited to, wrongful death, survival or survivorship claims brought on Your, Your estate's or Your heirs' behalf, regardless of whether medical expenses were or could be claimed. "You" or "Your" includes anyone on whose behalf the Plan pays benefits.

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

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

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

Subrogation

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

Reimbursement

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

Constructive Trust

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

Lien Rights

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

Assignment

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

First-Priority Claim

By accepting benefits from the Plan, You acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before You receive any recovery for Your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the

Plan will result in a recovery which is insufficient to make You whole or to compensate You in part or in whole for the damages sustained. The Plan is not required to participate in or pay Your court costs or attorney fees to any attorney You hire to pursue Your damage claim.

Applicability to All Settlements and Judgments

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

Cooperation

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

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

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

Workers' Compensation

If the entity providing workers' compensation coverage denies Your claim and You have filed an appeal, benefits will be advanced for Covered Services provided the Plan is notified of such appeal by the Labor Commission.

Future Related Expenses

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

Interpretation

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

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

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

Coordination of Benefits with a High Deductible Health Plan
Laws strictly limit the types of other coverages that a health savings account (HSA) participant may carry in addition to their qualified high deductible health Plan. The benefits of maintaining an HSA are jeopardized if impermissible types of other coverages are maintained. Benefits will be coordinated according to this Coordination of Benefits provision, regardless of whether other coverage is permissible per HSA law or not. It is Your responsibility to ensure that You do not maintain other coverage that might jeopardize any HSA tax benefit that You plan to claim.

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

Allowable Expense means, with regard to services that are covered in full or part by this Plan or any Other Plan(s) covering You, the amount on which that Plan would base its benefit payment for a service, including 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 legal Custodial Parent or the physical Custodial Parent as awarded by a court decree. In the absence of a court decree, Custodial Parent means the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

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

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

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

Other Plan does not include:

- hospital indemnity coverage benefits or other fixed indemnity coverage;
- accident only coverage;
- specified disease or specified accident coverage;
- limited benefit health coverage;
- school accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis;
- benefits provided in long-term care insurance policies for non-medical services (for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and Custodial Care) or for coverages that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- Medicare supplement coverage;
- a 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 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.

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

Longer/shorter length of coverage: When none of the paragraphs above establishes an order of benefit determination, the benefits of the Plan that has covered You for the longer period of time will be determined before the benefits of the Plan that has covered You for the shorter period of time. To determine the length of time You have been covered by a Plan, two 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, the Plan will pay the benefits of this coverage as if no other Plan exists. Despite the provisions of timely filing of claims, where this Plan is the Primary Plan, benefits will not be denied by this Plan 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 the Claims Administrator 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 Plan, the benefits of this Plan will be calculated as follows:

The Claims Administrator will calculate the benefits that the Plan would have paid for a service if this coverage were the Primary Plan. That calculated amount will be applied to any Allowable Expense for that service that is unpaid by the Primary Plan. This Plan 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 Plan's Deductible (if applicable), any amounts that would have been credited for the service if this Plan were the Primary Plan.

Nothing contained in this Coordination of Benefits provision requires this Plan to pay for all or part of any service that is not covered by this Plan. Further, in no event will this Coordination of Benefits provision operate to increase this Plan's payment over what would have been paid in the absence of this Coordination of Benefits provision.

Right to Receive and Release Needed Information

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

Right of Recovery

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

- From You, if payment was made to You. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentations. This Plan will be entitled to recover the amount of such excess by the reversal of payment from You and You agree to reimburse this Plan on demand for any and all such amounts. If a third-party collection agency or attorney is used 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, future benefits may be withheld to offset the amount owing to it. The Claims Administrator is 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). The Claims Administrator is 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.

INTERNAL COORDINATION OF BENEFITS (ICOB)

When Spouses or Domestic Partners are both employed at Salt Lake Community College in benefit eligible positions, and wish to cover themselves and eligible family members with medical and/or dental coverage, only the employee whose birthday comes first in the year must enroll in the Plan for self, Spouse (or Domestic Partner) and all desired Eligible Children. In the case of employees who share the same birth date, the following criteria will be used for enrollment in the Plan:

- the employee who has been on coverage the longest must enroll in the Plan for self, Spouse, (or Domestic Partner) and all desired Eligible Children,
- the employee who was hired by the College first (earliest date of hire) must enroll in the Plan for self, Spouse, (or Domestic Partner) and all desired Eligible Children, or
- the employee who has the highest compensation as of the initial date both employees become benefit eligible must enroll in the Plan for self, Spouse, (or Domestic Partner) and all desired Eligible Children.

Under this arrangement, full coordination of benefits is extended to all enrolled family members according to the definition of the Plan. The following are exceptions specific only to those enrolled in ICOB coverage.

ICOB Medical Benefits

PLAN YEAR DEDUCTIBLES
In-Network
Per Claimant: $300
Per Family: $600

Out-of-Network
Per Claimant: $1,000
Per Family: $2,000

PLAN YEAR OUT-OF-POCKET MAXIMUM
In-Network
Per Claimant: $3,500
Per Family: $7,000

Out-of-Network
Per Claimant: $5,000
Per Family: $10,000

COINSURANCE
In-Network
You pay 0% after applicable deductible and/or copayments.

Out-of-Network
Unless otherwise noted, You pay 40% after applicable deductible and/or copayments. Balance Billing may apply.

COPAYMENTS

In-Network

For the following In-Network services you do not need to meet the In-Network Deductible, but You are responsible for the applicable copayment before receiving benefits:

$5 copayment per visit	$12 copayment per visit	$17 copayment per visit	$25 copayment per test
• Telehealth	• Preventive Care – Expanded Benefits; • Primary Care Office Visits; • Outpatient Services for Autism Spectrum Disorder Services; • Home Health Care; • Home Infusion Therapy; • Infertility; • Outpatient Services for Mental Health or Substance Use Disorders Services; • Outpatient Rehabilitation Services; • Neurodevelopmental Services; • Routine Hearing Examinations; and • Spinal Manipulations	• Specialist Office Visits	• Major Diagnostic Testing (deductible applies)

ICOB Prescription Medication Benefits

PLAN YEAR DEDUCTIBLES
Per Claimant: $75
Per Family: $225

PLAN YEAR OUT-OF-POCKET MAXIMUM
Per Claimant: $2,000
Per Family: $6,000

You do not need to meet the Prescription Medication Deductible when You fill a prescription for Tier 1 and Tier 2 medications or Prescriptions received through a Home Delivery Supplier. You also do not need to meet the Deductible when You fill a prescription for a Self-Administrable Cancer Chemotherapy Medication.

COPAYMENTS AND COINSURANCE
Once the applicable deductible is met, You are responsible for the following Copayment or Coinsurance.

Prescription Medications from a Pharmacy (for Each 30-Day Supply)

• **Tier 1:** $3.50 Copayment
• **Tier 2:** $3.50 Copayment
• **Tier 3:** 12.5% Coinsurance, not to exceed $75
• **Tier 4:** 15% Coinsurance, not to exceed $87.50
• **Diabetic Supplies:** 0% Coinsurance

Prescription Medications from a Mail-Order Supplier (for Each 90-Day Supply)

• **Tier 1:** $3.50 Copayment
• **Tier 2:** $3.50 Copayment
• **Tier 3:** 12.5% Coinsurance, not to exceed $150
• **Tier 4:** 15% Coinsurance, not to exceed $175
• **Diabetic Supplies:** 0% Coinsurance

Prescription Medications from a Specialty Pharmacy (for Each 30-Day Supply)

• **Tier 5:** 5% Coinsurance, not to exceed $125
• **Tier 6:** 7.5% Coinsurance, not to exceed $150

ICOB Dental Benefits

Maximum Benefits
Preventive, Basic and Major Dental Services:
Per Claimant per Plan year: $3,000

Orthodontic Dental Services:
Per Claimant per Plan Year: $1,000
Per Claimant Lifetime: $2,000

You are responsible for the following amounts up to the Maximum Benefit:
In-Network Dentists:
Preventive Services: You pay 0%
Basic and Restorative Services: You pay 0%
Major Services: You pay 0%

Out-of-Network Dentists:
Preventive Services: You pay 0% and balance of billed charges
Basic and Restorative Services: You pay 0% and balance of billed charges
Major Services: You pay 0% and balance of billed charges

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 are two levels of appeal, as well as additional voluntary appeal levels that You may pursue. Certain situations requiring a faster decision may qualify for an expedited appeal as described below.

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.

Each level of appeal, except voluntary external review, must be pursued within 180 days of Your receipt of the Claims Administrator's determination (or, in the case of the first level, within 180 days of Your receipt of the Claims Administrator's original adverse decision that You are appealing). You will be given a reasonable opportunity to provide written materials. If You don't appeal within this time period, You will not be able to continue to pursue the appeal process and may jeopardize Your ability to pursue the matter in any forum. When an appeal request is received, the Claims Administrator will send You a written acknowledgement.

INTERNAL APPEAL – FIRST LEVEL

First-level appeals are reviewed by an employee(s) of the Claims Administrator who was not involved in the initial decision that You are appealing. In appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's staff of health care professionals.

INTERNAL APPEAL – SECOND LEVEL

Second-level appeals are reviewed by an employee(s) of the Claims Administrator who was not involved in, or subordinate to anyone involved in, the initial or the first-level decision.

What You May Appeal – Internal Appeal

You may appeal an Adverse Benefit Determination.

INTERNAL EXPEDITED APPEAL

If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision from the regular appeal process, You or Your treating Provider may specifically request an expedited appeal within 180 days of Your receipt of the Claims Administrator's Adverse Benefit Determination.

The internal expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. Internal expedited appeals are reviewed by an employee(s) of the Claims Administrator who was not involved in, or subordinate to anyone involved in, the initial decision that You are appealing. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the expedited appeal time frame) to provide written materials, including written testimony on Your behalf.

What You May Appeal – Internal Expedited Appeal

An expedited appeal is available if one of the following applies:

- the application of regular appeal time frames on a Pre-Service or concurrent care claim either:
    - could jeopardize Your life, health or ability to regain maximum function; or
    - according to a Provider with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

FILING AN INTERNAL APPEAL

Appeals can be initiated through either written or verbal request 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 appeal request
Phone	Call the Customer Service phone number on Your identification card
Fax	1 (877) 663-7526
Mail	Attn: ASO Appeals and Grievances Regence BlueCross BlueShield of Utah P.O. Box 1106 Lewiston, ID 83501

INTERNAL APPEAL DETERMINATION TIMING

The Claims Administrator will send its decision on Your internal appeal as follows:

Type of Appeal	How and When to Expect a Response
Post-Service appeal	In writing, within 30 days of the Claims Administrator's receipt of the appeal.
Pre-Service appeal for preauthorization	In writing, within 15 days of the Claims Administrator's receipt of the appeal.
Expedited appeal	By phone, fax or e-mail within 72 hours of the Claims Administrator's receipt of the appeal, followed by written notice within 3 working days.

VOLUNTARY EXTERNAL APPEAL – INDEPENDENT REVIEW ORGANIZATION (IRO)

A voluntary appeal to an IRO is available only after You have exhausted all of the applicable non-voluntary levels of appeal, or if the Claims Administrator has failed to adhere to all claims and internal appeal requirements. Voluntary external appeals must be requested within four months of Your receipt of the notice of the prior adverse decision.

The Claims Administrator coordinates voluntary external appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the appeal documentation. Choosing the voluntary external appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision and this section.

The voluntary external appeal by an IRO is optional and You should know that other forums may be used as the final level of appeal to resolve a dispute You have under the Plan.

What You May Appeal – Voluntary External Appeal

A voluntary external appeal is available if the issue on appeal addresses one of the following:

- medical or dental judgement (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, Dental appropriateness, health care setting, level of care or effectiveness of a Covered Service); or
- determination that the treatment is Investigational.

VOLUNTARY EXTERNAL EXPEDITED APPEAL – IRO

If You disagree with the decision made in the internal expedited appeal and You or Your Representative reasonably believes that preauthorization remains clinically urgent (Pre-Service or concurrent), You may request a voluntary external expedited appeal to an IRO. The criteria for a voluntary external expedited appeal to an IRO are the same as described above for a voluntary external appeal.

The Claims Administrator coordinates voluntary external expedited appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the appeal documentation. Choosing the voluntary external expedited appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision and this section.

The voluntary external expedited appeal by an IRO is optional and You should know that other forums may be used as the final level of expedited appeal to resolve a dispute You have under the Plan.

What You May Appeal – Voluntary External Expedited Appeal

A voluntary external expedited appeal is available for the same reasons as described above for an internal expedited appeal.

FILING AN EXTERNAL APPEAL

You may file an external appeal using the same options as described above for filing an internal appeal.

EXTERNAL APPEAL DETERMINATION TIMING

The Claims Administrator will send its decision on Your external appeal as follows:

Type of Appeal	How and When to Expect a Response
External appeal	In writing, within 45 days of the Claims Administrator's receipt of the appeal.
External expedited appeal	By phone, fax or e-mail within 72 hours of the Claims Administrator's receipt of the appeal, followed by a written notice which will be mailed to You within 48 hours of the notice provided by phone, fax or e-mail.

DEFINITIONS

The following definitions apply to this Appeal Process Section:

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including when based on a determination of a Participant's or Beneficiary's eligibility to participate in a Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or Investigational, or not Medically Necessary, appropriate or Dentally Appropriate. A denial or rescission of coverage is subject to review of Adverse Benefit Determination, whether or not the rescission has an adverse effect on any particular benefit at the time.

Independent Review Organization (IRO) is an independent physician review organization that acts as the decision-maker for voluntary external appeals and voluntary external expedited appeals and that is not controlled by the Claims Administrator.

Post-Service means a request to change an Adverse Benefit Determination for care or services that have been received, or any claim for benefits that is not considered Pre-Service.

Pre-Service means any claim for benefits which the Claims Administrator 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 an attorney, Your authorized Representative, or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the appeal. No authorization is required from the parent(s) or legal guardian of an enrolled dependent child who is less than 13 years old. For expedited appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative. 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 only be disclosed to You, Your Representative, or treating Provider.

Eligibility and Enrollment

This section contains the terms of eligibility described in this Booklet for an employee, their Spouse (or Domestic Partner) and all children. It explains how to complete enrollment when first eligible, during a period of special enrollment, following a change in status even or during an annual open enrollment period. It also describes when coverage under the Plan begins once enrollment is complete. Payment of any corresponding monthly costs is required for coverage to begin on the indicated dates.

Applications for coverage should be filed in the manner required by the College's Human Resource Office.

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

Upon first becoming eligible for coverage under the eligibility requirements in effect with the Plan Sponsor, You will be entitled to apply for coverage for Yourself and/or Your eligible Spouse (or Domestic Partner) and all Children within 30 days of becoming eligible. Coverage for You, Your Spouse (or Domestic Partner) and Your Eligible Children will commence on either the 1st or the 16th of the month, whichever corresponds with or immediately follows Your date of hire or date You first become eligible.

Employees

Full-time regular employees (75% FTE or more) hired in a designated benefits eligible position are eligible to participate in this Plan. Employees who meet eligibility requirement during a measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as require by the ACA regulations. The President Emeritus, as on file with the Plan Sponsor.

Employee's Spouse (or Domestic Partner) and Eligible Children

Your Spouse (or Domestic Partner) and Children are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when the Claims Administrator has enrolled them in coverage under the Plan. Eligibility is limited to the following:

- Your Spouse - The person to whom You are legally married.
- Your Domestic Partner, provided that all of the following conditions are met:
    - are unmarried in the State of Utah;
    - both are at least 18 years of age or older;
    - mentally competent to consent to this partnership;
    - not related by blood in the way that prohibits lawful marriage;
    - share the same primary residence and have been in a mutually exclusive relationship for at least the last six (6) months, and have plans to continue this arrangement on an indefinite basis; and
    - are jointly responsible for the common welfare of each other and share financial obligations.
- Eligible Child - Your (or Your Spouse's or Your Domestic Partner's) child who is under age 26 and who meets any of the following criteria:
    - Your (or Your Spouse's or Your Domestic Partner's) natural child, stepchild, adopted child or child legally placed with You (or Your Spouse or Domestic Partner) for adoption;
    - a child for whom You (or Your Spouse or Domestic Partner) have court-appointed legal guardianship; and
    - a child for whom You (or Your Spouse or Your Domestic Partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your Spouse's or Your Domestic Partner's) 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, if You complete and submit the Claims Administrator's 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 a covered claimant immediately before their 26th birthday; or

- the child's 26th birthday preceded Your Effective Date and the child has been continuously covered as an Eligible Child on either a parent's or legal guardian's accident and health insurance since that birthday.

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

NEWLY ELIGIBLE CHILDREN

If you participate in the Plan, You may enroll a child who becomes eligible for coverage under the eligibility requirements in effect with the Plan by completing and submitting online to the Plan Sponsor a signed group change request (and, for a Domestic Partner, an affidavit of qualifying Domestic Partnership form) within 30 days of the child attaining eligibility.

- Coverage for a new child by birth, adoption, or placement for adoption will become effective the day of the triggering event and will not be considered a Late Enrollee.

NOTE: When the addition of a new child by birth, adoption or placement for adoption does not cause a change in Your payment under the Plan (as of the date of birth, date of adoption or date of placement for adoption), You will have 30 days as of the date the Claims Administrator first sends a denial of a claim for benefits for such new child to submit a signed group change request.

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your eligible Spouse (or Your Domestic Partner) and/or a child if You failed to do so when first eligible. For example:

- Loss of coverage under another group or individual health benefit plan due to:

  - the exhaustion of federal COBRA or any state continuation;
  - the loss of eligibility due to legal separation, divorce, termination of Domestic Partnership, death, termination of employment, reduction in hours;
  - exhaustion of any lifetime maximum on total benefits;
  - or the employer contributions were terminated;
  - involuntary loss of coverage under Medicare, CHAMPUS/Tricare, Indian Health Service, or a publicly sponsored or subsidized health plan; or
  - involuntary loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP); (enrollment must be requested within 60 days of the loss of coverage).

In all of the above situations, You and/or Your eligible Spouse (or Your Domestic Partner, except as noted) and/or child become eligible for coverage under this Plan on the date the other coverage ends. Note that loss of eligibility does not include a voluntary termination of coverage, a loss because premiums were not paid in a timely manner, or termination of coverage because of fraud. Unless otherwise noted, enrollment must be requested within 30 days of the loss of coverage.

Coverage for You, Your Spouse (or Domestic Partner) and Your Eligible Children will commence on either the 1st or the 16th of the month, whichever corresponds with or immediately follows Your date of hire or date You first become eligible.

- If you declined coverage when You were first eligible and You subsequently marry or begin a Domestic Partnership, You become eligible for coverage under the Plan on behalf of Yourself, Your Spouse (or Your Domestic Partner) and any Eligible Children on the date of marriage. Enrollment must be requested within 30 days of the date of marriage.
- If you declined coverage when You were first eligible (or You declined coverage for Your Spouse (or Your Domestic Partner) when they were first eligible) and You subsequently acquire a new Child by birth, adoption, or placement for adoption, You become eligible for coverage under this Plan along with Your Eligible Spouse (or Your Domestic Partner) and eligible children including the newly acquired child on the date of the birth, adoption, or placement for adoption. Enrollment must be requested within 30 days of acquiring the new dependent. NOTE: When the addition of a new Child by birth, adoption, or placement for adoption does not cause a change in the premium amount (as of the

date of birth, date of adoption, or date of placement for adoption), You will have 30 days from the date the Claims Administrator first sends a denial of a claim for benefits for such new Child, to submit to the Claims Administrator a signed group change request.

- If you declined coverage when You were first eligible and You subsequently become eligible for premium assistance through a state subsidy program, You become eligible for coverage under the Plan on behalf of Yourself, Your Spouse (or Your Domestic Partner) and any Eligible Children on the date of eligibility for premium assistance. Enrollment must be requested within 60 days of the determination of becoming eligible for the state subsidy.

As described above, Special Enrollment opportunities last for either 30 or 60 days beginning with the day of the triggering event, except the Special Enrollment Period following exhaustion of a lifetime maximum on total benefits does not end until 30 days after the first claim is denied on the basis of lifetime maximum exhaustion.

CHANGE IN STATUS

- You may make a prospective mid-year election change (adding or dropping of coverage) for You and/or Your Spouse (or Domestic Partner) and/or any Eligible Child if You and/or Your Spouse (or Domestic Partner) and/or any Eligible Child becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If you and/or Your Spouse (or Your Domestic Partner and/or any Eligible Child who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan as outlined under Special Enrollment.
- You may make prospective mid-year election change (adding or dropping coverage) for You and/or Your Spouse (or Your Domestic Partner) and/or any Eligible Child if the election change is on account of and corresponds with a change made under the plan of an employer of Your Spouse (or Domestic Partner) or an Eligible Child for the following:

    - The period of coverage and open enrollment period of the other plan is different from this Plan's period of coverage. For example, if You gain coverage under Your Spouse's (or Domestic Partner's) employer plan during their open enrollment period, with an effective date of January 1, then You would have the ability to make a corresponding mid-year election change to drop your coverage from this Plan effective January 1.
    - You and/or Your Spouse (or Domestic Partner) and/or Eligible Child become covered under another employer's plan triggered by new hire status or initial eligibility status.

The plan of the other employer must be a qualified cafeteria plan under IRS guidelines. The Plan Sponsor in its sole discretion shall determine, based on prevailing IRS guidance, whether a requested election change satisfies the consistency requirement. Election changes must be requested within 30 days of the effective date of change under the other employer's plan.

Coverage for You, Your Spouse (or Domestic Partner) and Your Eligible Children will commence on either the 1st or the 16th of the month, whichever corresponds with or immediately follows Your date of hire or date You first become eligible.

ANNUAL OPEN ENROLLMENT PERIOD

The annual open enrollment period is the only time, other than initial eligibility, change in status, or a special enrollment period, during which You and/or Your Spouse (or Domestic Partner, except as noted) and/or Eligible Children may enroll or waive coverage. You must submit an enrollment form online (and, in the case of a Domestic Partner, a completed affidavit of qualifying Domestic Partnership form) on behalf of all individuals You want enrolled or wish to waive coverage for. Coverage for You and Your Spouse and/or Eligible Children will begin on the Plan Effective Date.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, Your coverage will be

reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and you do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 26-week period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact the Plan Sponsor.

DEFINITIONS

The following definitions 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 the Claims Administrator.

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.

When Coverage Ends

This section describes the situations when coverage will end for You and/or Your Spouse (or Domestic Partner) and/or children. You must notify the Claims Administrator within 60 days of the date on which Your Spouse (or Domestic Partner) and/or children are no longer eligible for coverage.

No person shall have or acquire a vested right to receive any benefits after the date this Plan is terminated. Termination of You or Your Spouse's (or Domestic Partner's) and/or Children's' coverage under this Plan for any reason shall completely end the Plan's obligations to provide You or Your Spouse (or Domestic Partner) and/or Children benefits for Covered Services received after the date of termination whether or not You or Your Spouse (or Domestic Partner) and/or Child is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while this Plan was in effect.

AGREEMENT TERMINATION

If the Plan is terminated by the Employer, coverage ends for You and Your Spouse (or Domestic Partner) and/or children on the date the Plan is terminated.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, coverage ends for You, Your Spouse (or Domestic Partner) and/or children as indicated. However, it may be possible for You and/or Your Beneficiaries to continue coverage under the Plan according to the COBRA Continuation of Coverage Section.

Termination of Your Employment or You are No Longer Eligible

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Plan, unless otherwise indicated, coverage will end for You, Your Spouse (or Domestic Partner) and all children on the last day of the pay period in which eligibility ends. For example, if You terminate employment on or before the 15th of the month, Your coverage will end at 12:00 a.m. on the 16th day of that month. If You terminate employment on or after the 16th of the month through the end of the month, Your coverage will end at 12:00 a.m. on the 1st day of the following month.

Nonpayment

If You fail to make the required contributions in a timely manner, coverage will end for You, Your Spouse (or Domestic Partner) and all children on the date You fail to make such required contribution.

TERMINATION BY YOU

- If you terminate coverage for You, Your Spouse (or Domestic Partner) and/or Eligible Children because of a Change in Status event, coverage will end when the corresponding coverage begins under the other employer's plan.
- You may terminate/waive coverage for You, Your Spouse and/or Eligible Children at Annual Enrollment. Coverage will end the last day of the Plan Year.
- You may not reenroll in the Plan until the next Annual Enrollment.

WHAT HAPPENS WHEN YOUR SPOUSE (OR DOMESTIC PARTNER) OR CHILD IS NO LONGER ELIGIBLE

If Your Spouse (or Domestic Partner) or children are no longer eligible as explained in the following paragraphs, their coverage will end as indicated. However, it may be possible for Your ineligible spouse or child to continue coverage under the Plan according to the COBRA Continuation of Coverage Section.

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) at 12:00 a.m. on the day following the date the divorce or annulment is final.

Death of the Participant
If You die, coverage for Your Spouse (or Domestic Partner) and/or children ends at 12:00 a.m. on the 1st day of the month following the month in which Your death occurs. If you are a retiree, coverage for Your Beneficiaries will end 30 days after the date of Your death.

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) at 12:00 a.m. on the day following the 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.

Loss of Eligible Child Status
- Eligibility ends at 12:00 a.m. on the 1st day of the month following the month in which the child exceeds age limit.
- Eligibility ends on the date the child is removed from placement due to disruption of placement before legal adoption.
- Eligibility ends on the last day of the pay period in which the child is no longer considered an Eligible Child for any other cause, except by reason of divorce or the death of the Participant. If an enrolled child is no longer eligible on or before the 15th of the month, coverage for that enrolled child will end at 12:00 A.M. on the 16th day of the month. If an enrolled child is no longer eligible on or after the 16th of the month, coverage for that enrolled child will end at 12:00 A.M. on the 1st day of the following month.

OTHER CAUSES OF TERMINATION
Claimants terminated for the following reasons may be able to continue coverage under the Plan according to the COBRA Continuation of Coverage Section.

Fraudulent Use of Benefits
If You or Your Beneficiary 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 Plan will terminate for that Claimant. The Claimant may reenroll 12 months after the date of discontinuance if the Plan Sponsor's coverage is in effect at the time the Claimant applies to reenroll.

Fraud or Misrepresentation in Application
Coverage under the Plan is based upon all information furnished to the Claims Administrator, for the benefit of the Plan by You or on behalf of You and Your Beneficiaries. 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), the Plan will have the following rights:

- With regard to a Claimant's health status, a retrospective adjustment to the cost of coverage under the Plan may be made as would have been appropriate if true, accurate or complete information had been provided at the time of enrollment.
- With regard to a Claimant (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Plan), coverage will be retroactively adjusted to the terms that would have existed if true, accurate or complete information had been received.

Any discovery of intentional material misrepresentation of fact or fraud regarding a Claimant will be subject to the Plan's Right of Recovery.

FAMILY AND MEDICAL LEAVE
If the Plan Sponsor grants You a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3) the following rules will apply. You will be entitled to continued coverage under this provision only to the extent You are eligible for leave under the terms of the FMLA:

- You and Your covered Spouse (or Domestic Partner) and/or Children will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period as provided under the FMLA for one of the following:
  - in order to care for Your newly born child;
  - in order to care for Your Spouse, Domestic Partner, child or parent, if such spouse, child or parent has a serious health condition;
  - the placement of a child with You for adoption or foster care;
  - You suffer a serious physical Illness or Mental Health Condition.
  - A qualifying exigency arises because Your spouse, son, daughter, or parent is on active duty (or have been notified of a call or order to active duty) in the Armed Forces in support of a "contingency operation."

- Under the Service Member Family Leave under FMLA, Section 585 of the National Defense Authorization Act, You, as an eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member (a member of the Armed Forces, including the National Guard or Reserves) are entitled to up to 26 weeks of leave during a 12-month period to care for a service member with a serious injury or illness incurred in the line of duty on active duty in the Armed Forces.

Persons entitled to coverage under this paragraph will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this paragraph. Entitlement to FMLA leave does not constitute a qualifying event for the purpose of COBRA continuation. However, a person entitled to COBRA continuation as a result of not returning to active employment following FMLA leave may be entitled to COBRA continuation coverage, the duration of which will be calculated from the date the person fails to return from the FMLA leave.

- Timely payment of the monthly premium must continue to be made to The Plan Sponsor. The provisions described here will not be available if this Plan terminates.
- If You and/or Your Spouse and or Children elect not to remain enrolled during the leave, You (and/or Your Spouse and/or Children) will be eligible to be reenrolled under the Plan on the date You return from the FMLA leave. In order to reenroll after You return from a FMLA leave, You must sign a new application online just as if You were a newly eligible employee.

In this situation, if You reenroll within the required time, all of the terms and conditions of the Plan will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Spouse and/or Children) will receive credit for any waiting period served prior to the FMLA leave and You will not have to re-serve any probationary period under this Plan, although You and/or Your Spouse and/or Children will receive no waiting period credits for the period of noncoverage.

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.

MILITARY LEAVE OF ABSENCE

If you take a leave of absence for active military duty, you may continue coverage under the Plan as follows:

- if the leave of absence is 30 calendar days or less, you may continue coverage through timely payment of your contribution of the monthly premium to The Plan Sponsor; or
- if the leave of absence is more than 30 calendar days, you may continue coverage by paying the full monthly premium plus 2%, for up to 24 months to the Plan Sponsor.

If you are called to active military duty and you do not elect to continue coverage under the Plan during your leave, your coverage will be terminated. You may reenroll in coverage upon your return to work (if such return is within the time limits set by the Uniformed Services Employment and Reemployment Rights Act "USERRA").

It is the intent of the Plan to comply with all existing regulations of USERRA. If the Plan differs from the actual regulations of USERRA, the Plan reserves the right to administer the Plan in accordance with the USERRA regulations. Coverage under this provision runs concurrently with coverage continued under COBRA.

LEAVE OF ABSENCE

If You are granted a non-FMLA temporary leave of absence by the Plan Sponsor, You can continue coverage for up to twelve months from either the last working day, or the last day of FMLA. Premiums must be paid to the Plan Sponsor in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by the Plan Sponsor at Your request during which You are still considered to be employed and are carried on the employment records of the employer. A leave can be granted for any reason acceptable to the Plan Sponsor, including disability and pregnancy.

LONG-TERM DISABILITY

If You are approved for Long-Term Disability (LTD) through the Plan Sponsor's LTD carrier, You can continue Your medical and pharmacy insurance coverage until the later of 24 months or the maximum benefit period allowed under the LTD policy. This continuation of coverage will run concurrently with COBRA continuation coverage and begins upon the date of Your LTD claim approval. Coverage can be continued for You, Your Spouse and Your Children at the same rate You would pay if You were still considered an active employee of the Plan Sponsor.

COBRA Continuation of Coverage

Under certain circumstances called Qualifying Events, Claimants may have the right to continue coverage beyond the time coverage would have ordinarily have ended. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less then COBRA continuation. The following rights and obligations regarding continuation of coverage are governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. In the event of any conflict between this continuation of coverage provision and COBRA, the minimum requirements of COBRA will govern. This provision will automatically cease to be effective when federal law requiring continuation of eligibility for coverage no longer applies to the Employer. A full and more complete description of COBRA is available from the Plan Sponsor.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally does not accept Late Enrollees.

QUALIFYING EVENTS

- Qualifying Events are certain events defined by COBRA regulations that cause an individual to lose health care coverage. If You experience one of these Qualifying Events You and/or Your Enrolled Spouse and/or Child may elect COBRA Continuation Coverage for a maximum of 18 months following the date that Your coverage would have normally ended:
- Your employment is terminated (unless the termination is for gross misconduct); or
- Your hours of work are reduced, resulting in a loss of eligibility for coverage.
- If coverage for Your Enrolled Spouse and/or Children terminates due to any of the following Qualifying Events, that Enrolled Spouse or Child may elect COBRA Continuation Coverage for a maximum of 36 months following the date their coverage would have normally been lost:
- Your death;
- You and Your Spouse divorce or the marriage is annulled;
- You become entitled to Medicare benefits; or
- Your Enrolled Child is no longer considered an Eligible Child under the Plan.

NOTIFICATION RESPONSIBILITIES

You or Your Enrolled Spouse or Child must inform the Plan Sponsor in writing within 60 days of divorce, legal separation, annulment, or a loss of Eligible Child status. The Plan is responsible for notifying You and/or Your Enrolled Spouse and/or Child of the right to elect COBRA Continuation Coverage due to any of the other Qualifying Events. If written notice is not provided to the Plan Sponsor within 60 days of the Qualifying Event, all rights of that individual to elect COBRA Continuation Coverage will be lost.

Once the Plan Sponsor is notified or aware of a Qualifying Event, it will send You and/or Your Enrolled Spouse and/or Child information concerning continuation options, including the necessary COBRA Continuation election forms. You and/or Your Enrolled Spouse and/or Child will have 60 days from the later of the date of the Qualifying Event or when You and/or Your Enrolled Spouse and/or Child receives notice from the Plan Sponsor in which to make an election.

If You or Your Enrolled Spouse or Child qualifies for a Social Security Disability extension, You must provide written notice to the Plan Sponsor within 60 days of the date Social Security Administration determination is made and while still within the 18 month COBRA Continuation Coverage period following a termination or a reduction in hours Qualifying Events. You must also provide a written notice to the Plan Sponsor within 30 days if a final determination is made that You or Your Enrolled Spouse or Child are no longer disabled.

If You experience a Second Qualifying Event, You must provide a written notice to the Plan Sponsor within 30 days of the Second Qualifying Event and during the original 18 month COBRA Continuation Coverage period in order to extend COBRA Continuation Coverage up to 36 months.

Social Security Disability
COBRA Continuation Coverage following a Qualifying Event of termination of employment or a reduction in hours can be extended up to 29 months if You or Your Enrolled Spouse or Child is determined to have been to be disabled on the day of the Qualifying Event or during the first 60 days of the COBRA Continuation Coverage. You must obtain the Social Security Administration determination and provide documentation to the Plan Sponsor within 60 days of the determination and while still within the 18 month continuation period. If coverage is extended, Your premiums will be adjusted to 150% of the full cost during the extended 11 month coverage period.

Second Qualifying Event
Any Enrolled Spouse or Child who enrolled in COBRA Continuation Coverage as a result of termination of employment or a reduction in hours, who experience another Qualifying Event, may extend COBRA Continuation Coverage up to 36 months. The Plan Sponsor must receive written notice of the Second Qualifying Event within 60 days from the date of the event. Second Qualifying Event includes:

- Your death;
- You and Your Spouse divorce or the marriage is annulled; or
- Your Enrolled Child is no longer considered an Eligible Child under the Plan.

When You Acquire a New Child While on COBRA
Children born to You or placed with You for adoption while You are on COBRA may be added to COBRA Continuation Coverage and have all the rights extended to You and/or Your other Enrolled Children or Spouse who have elected COBRA Continuation Coverage. Written notification must be provided to the Plan Sponsor within 30 days of the birth or placement.

If You Become Entitled to Medicare Before Electing COBRA
If You become entitled to Medicare before electing COBRA in connection with a termination of employment or reduction in hours Qualifying Event, You may maintain both Medicare and up to 18 months of COBRA Coverage and Your Enrolled Spouse and Children will be allowed to continue their COBRA Continuation Coverage until the later of:

- up to 18 months from the Qualifying Event; or
- up to 36 months from the date you became entitled to Medicare.

ELECTING COBRA CONTINUATION COVERAGE
You and Your Enrolled Spouse and Children will have 60 days from the later of the date of the Qualifying Event or when You and Your Enrolled Spouse and Children receives notice from the Plan Sponsor in which to make a COBRA Continuation Coverage election. You and Your Enrolled Spouse and/or Children can each elect COBRA Continuation Coverage independently, even if You choose not to elect COBRA Continuation Coverage. COBRA Continuation Coverage is available to each person who had coverage on the day before the Qualifying Event.

If You or Your Enrolled Spouse or Child do not elect COBRA Continuation Coverage, coverage under the Plan will end according to the terms described in the Booklet and claims under the Plan for services provided on and after the date coverage ends will not be paid. Further, this may jeopardize Your, Your Spouse's or Your Child's future eligibility for an individual plan.

COBRA CONTINUATION PREMIUM PAYMENT
If You elect COBRA coverage, You will be responsible for the Total Cost of the coverage plus an administrative fee of 2% for any period of continuation; 50% for Social Security Disability determinations. Coverage will cease if timely payments are not made.

- Initial payment must be received by the Plan Sponsor within 45 days of the date You elect COBRA Continuation Coverage. Your first payment must include premiums due retroactive to the date You lost coverage as a result of Your Qualifying Event. If Your first payment is not received timely, COBRA Continuation Coverage will not be effective and You will lose all rights to COBRA Continuation Coverage.

- Subsequent payments for each subsequent period are due on the first day of the month for which coverage is to be provided. You will have a 45 day grace period from the premium due date to make subsequent payments. If the COBRA Continuation premiums are not paid within the grace period, Your COBRA Continuation Coverage will terminate as of the end of the last period for which payment was received and You will lose all further rights to COBRA Continuation Coverage.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA Continuation Coverage under this Plan will end for You and/or Your Enrolled Spouse and/or Children if any of the following occur:

- The required premium payments are not paid within the timeframe allowed;
- You notify the Plan Sponsor that You wish to cancel Your coverage;
- The applicable period of COBRA coverage ends;
- You become entitled to Medicare benefits;
- The date You reach the Life Maximum Benefit under the Plan;
- The Plan Sponsor terminates its group health plan(s);
- You have extended COBRA coverage through Social Security disability and a final determination is made that You are no longer disabled, coverage for You and Your Enrolled Spouse (or Domestic Partner, except as noted) and/or Children for the disability extension will end the later of:

    - The last day of the 18 months of continuation coverage; or
    - The first day of the month that is more than 30 days following the date of the final determination of the nondisability;

- After the date of Your COBRA election, you become covered under another group health plan that does not contain any exclusion or limitation for any of Your pre-existing conditions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the extent to which health plans may impose pre-existing condition limitations. If You become covered by another group health plan with a pre-existing condition limitation that affects You, Your COBRA coverage may continue. If the plan's pre-existing condition rule does not apply to You by reason of HIPAA's restrictions on pre-existing condition clauses, You are no longer eligible to continue COBRA coverage; or
- An event occurs that permits termination of coverage under the Plan for an individual covered other than pursuant to COBRA (e.g. submitting fraudulent claims).

Notice

The complete details on the COBRA Continuation provisions outlined here are available from the Plan Sponsor.

General Provisions and Legal Notices

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

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

GOVERNING LAW
The Plan will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the state of Utah without regard to its conflict of law rules. The Claims Administrator is not the Plan Administrator, but does provide claims administration under the Plan.

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

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

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

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

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

PLAN SPONSOR IS THE FIDUCIARY
The Plan Sponsor is Your fiduciary for all purposes under the Plan and not the Claims Administrator's agent. You may be entitled to health care benefits pursuant to the Agreement between the Claims Administrator and the Plan Sponsor. In the Agreement, the Plan Sponsor agrees to act as fiduciary for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in

this Booklet. You, through the enrollment form signed by the Participant, and as beneficiaries of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Booklet.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Plan Sponsor on behalf of itself and its Claimants expressly acknowledges its understanding that the Agreement constitutes an agreement solely between the Plan Sponsor 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 the Claims Administrator to use the Blue Cross and Blue Shield Service Marks in the state of Utah and that the Claims Administrator is not contracting as the agent of the Association. The Plan Sponsor on behalf of itself and its Claimants further acknowledges and agrees that it has not entered into the Agreement based upon representations by any person or entity other than Regence 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 Plan Sponsor or the Claimants for any of the Claims Administrator's obligations to the Plan Sponsor or the Claimants created under the Agreement. 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 Agreement.

REPRESENTATIONS ARE NOT WARRANTIES

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND HEALTH RECORDS

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

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

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

Health information requested or disclosed by the Claims Administrator may include, but is not limited to:

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

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

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

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

TAX TREATMENT

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

CLAIMS ADMINISTRATOR IS NOT RESPONSIBLE FOR HSA FINANCIAL OR TAX ARRANGEMENTS

You are solely responsible to ensure that this plan qualifies, and continues to qualify, for use with any HSA that You choose to establish and maintain. The Claims Administrator does not assume any liability associated with Your contribution to an HSA during any period that this high deductible health Plan does not qualify for use with an HSA. An HSA is a tax-exempt account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible but in order to qualify for and make contributions to an HSA, You must be enrolled in a qualified high deductible health Plan (and not be enrolled in other coverage). Note that the tax references contained in this Booklet relate to federal income tax only. The tax treatment of HSA contributions and distributions per Your state's income tax laws may differ from the federal tax treatment, and differs from state to state.

The Claims Administrator does not provide tax advice and assumes no responsibility for reimbursement from the custodial financial institution for any HSA with which this high deductible health Plan is used. Consult with Your financial or tax advisor for tax advice or for more information about Your eligibility for an HSA.

WHEN BENEFITS ARE AVAILABLE

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

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

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

Definitions

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

Affiliate means a company with which the Claims Administrator has a relationship that allows access to Providers in the state in which the Affiliate serves and includes only the following companies: Regence BlueShield 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 the purpose of the Dental Benefits Section only:

- 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 the Claims Administrator has determined to be reasonable charges for Covered Services. The Allowed Amount may be based upon billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

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 the Claims Administrator's Customer Service.

Allowed Amount means, for purpose of the Medical Benefits Section only:

- 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 the Claims Administrator has 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 the Claims Administrator and/or as otherwise required by law.
- 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 the Claims Administrator as the amount on which it would base a payment to that Provider. In exceptional circumstances, such as if the Host Blue does not identify an amount on which it would base payment, the Claims Administrator 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 the Claims Administrator's 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.

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

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

Calendar Year means the period from January 1 through December 31 of the same year.

Claimant means a Participant or a Beneficiary.

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 benefit 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 mean 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.

Dentally Appropriate means a dental service recommended by the treating Dentist or other Provider, who has personally evaluated the patient, and is 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 Claimant's condition; and
- not primarily for the convenience of the Claimant, Claimant's family or Provider.

A dental service may be Dentally Appropriate yet not be a Covered Service.

Dentist means an individual who is licensed to practice dentistry (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.

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 Claimant's home.

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

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 Claimant's health, or with respect to a pregnant Claimant, the Claimant'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.

Family means a Participant and any Spouse (or Domestic Partner) and/or children.

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:

- When Your network is ValueCare or FocalPoint:
    - that has an effective participating contract with the Claims Administrator that designates the Provider as in Your network, to provide services and supplies to Claimants in accordance with the provisions of this coverage. Your network is preferred; or
    - that has an effective participating contract with one of the Claims Administrator's Affiliates (designated as a preferred Provider in the "In-Network"), to provide services and supplies to Claimants in accordance with the provisions of this coverage.
- When Your network is Participating:
    - that has an effective participating contract with the Claims Administrator that designates the Provider as in Your network, to provide services and supplies to Claimants in accordance with the provisions of this coverage. Your network is participating; or
    - that has an effective participating contract with one of the Claims Administrator's Affiliates (designated as a participating Provider in the "In-Network"), to provide services and supplies to Claimants in accordance with the provisions of this coverage.

If the Claims Administrator or one of its Affiliates has more than one Provider network from which the Plan Sponsor may choose for benefits under the Plan, then the Providers contracted with the network selected by the Plan Sponsor will be considered the only In-Network Providers for purpose of payment of benefits.

For In-Network Provider reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

In-Network Dentist means a Dentist who has an effective participating contract with the Claims Administrator that designates them as a Dentist of the Plan Sponsor's network, to provide services and supplies to Claimants in accordance with the provisions of this coverage.

Investigational means a Health Intervention that the Claims Administrator has classified as Investigational. The Claims Administrator will review Scientific Evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is Investigational. A Health Intervention not meeting all of the following criteria is, in the Claims Administrator's judgment, Investigational:

- 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 under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

Lifetime means the entire length of time a Claimant is covered under the Plan (which may include more than one coverage) through the Plan Sponsor with the Claims Administrator.

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 under the Plan.

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 UNDER THE PLAN.

Out-of-Network means a Provider that is not In-Network. For Out-of-Network Provider services, You may be billed for balances over the Plan's payment level in addition to any Deductible, Copayment and/or Coinsurance amount for Covered Services provided inside or outside the area that the Claims Administrator or one of its Affiliates serves.

Out-of-Network Dentist means a Dentist that is not an In-Network Dentist. For Out-of-Network Dentist services, You may be billed for balances over the Plan's payment level in addition to any Deductible and/or Coinsurance amount for Covered Services provided inside or outside the area that the Claims Administrator or one of its Affiliates serves.

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

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

Plan Year means the 12-month period from July 1 through June 30 of the following Year; however, the first Plan Year begins with the Claimant's Effective Date. The Deductible and Out-of-Pocket Maximum provisions are calculated on a Plan Year basis. If the Deductible and/or Out-of-Pocket Maximum amount increases during the Plan Year, You will need to meet the new requirement.

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 Physician assistant, nurse Practitioner or advanced registered nurse Practitioner licensed in one of the above specialties and working under 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.

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.

Appendix: Value-Added Services

This Plan 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.**

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

CARE MANAGEMENT

Receive one-on-one help and support in the event You have a chronic, serious or sudden Illness or Injury. An experienced care management nurse will serve as Your single point of contact and personal advocate to help You understand Your Providers' instructions, help prepare You for an elective surgical procedure, assist in coordinating overall care, connecting to special medical expertise and accessing other Plan Sponsor services and programs. Your nurse is supported by a multidisciplinary team made up of doctors, social workers, Pharmacists and behavioral health experts that can be accessed for additional consultation. The goal is to offer assistance in navigating through Your health care needs, including working with Your community resources to provide a personalized touch and to enhance the quality of Your wellbeing. Care management nurses proactively outreach by telephone and educational mailings or You may request support by directly contacting a nurse. To learn more, call 1 (866) 543-5765.

DIABETES MANAGEMENT

If You are identified to participate, the Diabetes Management program is an online program that has extensive support tools such as glucose tracking, live coaching and mental and emotional care to help You improve health and manage diabetes. To better track blood sugar levels and provide more focused support, You will be provided a cellular-enabled glucose monitor.

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

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. Eight counseling sessions will be covered per incident. Each client affected by an incident will be eligible for a total of eight 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.

INFUSION SITE OF CARE

If You receive certain infused or injectable drugs, You may be notified about an opportunity to receive Your care at an alternative location. Alternative locations such as standalone infusion sites, doctor's offices and home infusion can offer more comfort, convenience, and reduced costs compared to most Hospital settings. You may contact the Claims Administrator for a list of drugs included in the Infusion Site of Care program or for help finding an alternative location.

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 the Claims Administrator's 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. It may include the following:

- earning up to $25 in gift cards for completion of well-being activities such as an online health risk assessment;
- 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.

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

regence.com