UTAH STATE UNIVERSITY
EMPLOYEE HEALTH CARE BENEFITS

July 1, 2023

Group Number: 10002583

Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the BlueCross and BlueShield Association

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

<u>When balance billing isn't allowed, you also have these protections:</u>

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact **www.cms.gov/nosurprises/consumers** or call the No Surprises Help Desk at 1-800-985-3059.

Visit **www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

NONDISCRIMINATION NOTICE

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

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

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

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

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

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

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

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Introduction

Utah State University (hereafter referred to as the "Plan Sponsor") has restated the Utah State University Employee Health Care Benefits (hereafter referred to as the "Plan") effective **July 1, 2023**. This Summary Plan Description (SPD) describes the terms and benefits of coverage available through Utah State University. This SPD replaces any plan description or SPD previously issued by the Plan Sponsor and makes it void.

This SPD 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 SPD. If the Plan Document and this SPD differ, the Plan Document will prevail. No oral interpretations can change this Plan.

This SPD includes separate sections for Medical Benefits and Dental Benefits. While the first portion of each section contains only a summary (the complete benefits, conditions, limitations, and exclusions are described later), it includes some important information that can only be found within that particular portion of the section, such as the percentages paid, Deductibles, Copayments, and Out-of-Pocket Maximum amounts under the 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 or Your Dependents' health or treatment status, which may result in the termination of modification of Your coverage and/or the coverage for Your Dependents. If the Plan is amended, modified, or terminated, the rights of You and Your Dependents 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 as the time they were incurred.

The Plan Sponsor also reserves the right to interpret the Plan's coverage and meaning in the exercise of its sole discretion.

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 Blue Cross Blue Shield of Utah (hereinafter 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.

PLAN IDENTIFICATION CARD

When Participants enroll in the Plan, they will receive Plan identification cards. The identification card will include important information such as the Participant's identification number, group number and name.

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

If You lose Your card, or if it gets destroyed, You can get a new one by contacting the Claims Administrator’s Customer Service department. You can also view or print an image of Your Plan identification card by visiting the Claims Administrator's Web site on Your PC or mobile device. If the Agreement terminates, Your Plan identification card will no longer be valid.

CONTACT INFORMATION

Regence Customer Service: 1 (866) 240-9580
(TTY: 711)

Phone lines are open Monday–Friday 6 a.m. – 9 p.m. and Saturday 9 a.m. – 5:30 p.m. Mountain 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 Web site, **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 Web site); 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 Summary Plan Description

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 SPD 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 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 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 In-Network Dentists and Out-of-Network Dentists. 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 Web site 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 SPD.** Additional information about some programs and services can be found in the Value-Added Services Appendix at the end of the SPD.

- **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, dental Provider or identify Participating Pharmacies;
  - use tools to estimate upcoming health care costs and otherwise help You manage health care expenses;
  - get suggestions to improve or maintain wellness and participate in self-guided motivational online wellness programs;
  - learn about prescriptions for various Illnesses; 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.**

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Legal Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT
If You are receiving benefits in connection with a mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, the Plan will provide coverage (subject to the same provisions as any other benefit) for:

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

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT
Under federal law, group health plans and health insurance issuers offering group health insurance coverage 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 or issuer may pay for a shorter stay if the attending Provider, after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, the Plan or issuer 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, the Plan or issuer 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. Contact the Claims Administrator's Customer Service for additional information on preauthorization.

NOTICE OF PRIVACY PRACTICES UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
This is a general Notice of Privacy Practices under HIPAA. You will also receive a Notice of Privacy Practices from the Claims Administrator who pays claims under this Plan. The specific Privacy Notices(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.

Effect Date of Notice: This privacy notice is effective as of the date You receive this document.

The health care components of this Plan (called the "Plan" in this section) are required by law to take reasonable steps to ensure the privacy of Your personally identifiable health information and to inform You about:

- the Plan's uses and disclosures of Protected Health Information (PHI);
- 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 and to the Secretary 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.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

As of February 17, 2009, the Plan and Employer comply, to the basic extent required by law, with the HIPAA Privacy and Security provisions of the American Recovery and Reinvestment Act, including but

not limited to compliance with individuals' requests for certain restrictions on disclosure of their PHI or ePHI, increased obligation to account for disclosures of ePHI if maintained in electronic health records, increased access to PHI maintained in electronic format, and required notification of breaches of "unsecured" PHI where the unauthorized person who received the PHI might reasonably be able to retain the information.

Section A. Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon Your request, the Plan is required to give You access to certain PHI in order to inspect and copy it.

Use and disclosure of Your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and Disclosures to Carry Out Treatment, Payment and Health Care Operations

The Plan and its business associates will use PHI without Your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan also will disclose PHI to the Plan Sponsor for purposes related to treatment, payment and health care operations. The Plan Sponsor has amended its plan documents to protect Your PHI as required by federal law.

Treatment is 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, a dental 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.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorization).

- 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.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance or health maintenance organization contracts. It also includes disease management, case 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 administrative activities.

- For example, the Plan may use information about Your claims to refer You to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

Uses and Disclosures that Require Your Written Authorization

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about You from Your psychotherapist. Psychotherapy notes are separately filed notes about Your conversations with Your mental health professional during a counseling session. They do not include summary information about Your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by You.

Uses and Disclosures that Require that You be Given an Opportunity to Agree or Disagree Prior to the Use or Release

Disclosure of Your PHI to family members, other relatives and Your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with Your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and Disclosures for which Consent, Authorization or Opportunity to Object is Not Required

Use and disclosure of Your PHI is allowed without Your consent, authorization or request under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. 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, if authorized by law.
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that You may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform You that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
- The Plan may disclose Your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensures or disciplinary actions (for example, to investigate complaints against Providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- The Plan may disclose Your PHI when required for judicial or administrative proceedings. For example, Your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those 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.
- When required for law enforcement purposes (for example, to report certain types of wounds).
- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
- 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.
- The Plan may use or disclose PHI for research, subject to conditions.
- When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- Military and Veterans: If You are or become a member of the U.S. armed forces, the Plan may release medical information about You as deemed necessary by military command authorities.
- National Security, Intelligence Activities, and Protective Services: The Plan may release Your PHI to authorized federal officials:

    - for intelligence, counterintelligence, and other national security activities authorized by law; and

  - to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special transplantation.

- Organ and Tissue Donation: If You are an organ donor, the plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- State Privacy Rights: You may have additional privacy rights under state laws, including rights in connection with:

  - mental health and psychotherapy reports;
  - pregnancy;
  - HIV/AIDS-related Illness; and
  - the health treatment of minors.

Except as otherwise indicated in this notice, uses and disclosures will be made only with Your written authorization subject to Your right to revoke such authorization.

Section B. Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of Your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by You who are involved in Your care or payment for Your care. However, the Plan is not required to agree to Your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or Your personal representative will be required to complete a form to request restrictions on uses and disclosures of Your PHI.

Such requests should be made to the Plan's Privacy Officer.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of Your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

Protected Health Information (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

Designated Record Set includes the medical records and billing records about individuals 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 individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or Your personal representative will be required to complete a form to request access to the PHI in Your designated record set. Requests for access to PHI should be made to the Plan's Privacy Officer.

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

You have the right to request the Plan to amend Your PHI or a record about You in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. 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 or Your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of Your PHI.

Requests for amendment of PHI in a designated record set should be made to the Plan's Privacy Officer or to the Employer's Benefits/Human Resources Representative at the address listed below in Section E.

You or Your personal representative will be required to complete a form to request amendment of the PHI in Your designated record set.

The Right to Receive an Accounting of PHI Disclosures

At Your request, the Plan will also provide You with an accounting of disclosures by the Plan of Your PHI during the six years prior to the date of Your request. However, such accounting need not include PHI disclosures made:

- to carry out treatment, payment or health care operations;
- to individuals about their own PHI;
- prior to the compliance date; or
- based on Your written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

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

To obtain a paper copy of this Notice contact the Plan's Privacy Officer or to the Employer's Benefits/Human Resources Representative at the address listed below in Section E.

A Note about Personal Representatives

You may exercise Your rights through a personal representative. 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.

The Plan retains discretion to deny access to Your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section C. The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (Participants and Dependents) with notice of its legal duties and privacy practices.

This Notice is effective as required by law, and 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. If a privacy practice is changed, a revised

version of this Notice will be provided (to all past and present Participants and Dependents) for whom the Plan still maintains PHI.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care Provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures that are required for the Plan's compliance with legal regulations; and
- uses of disclosures made pursuant to an Authorization.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information is information which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan, and from which identifying information has been deleted in accordance with HIPAA.

Additionally, this Notice (and the "minimum necessary" standard) does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Section D. Your Rights to File a Complaint With the Plan or the HHS Secretary

If You believe that Your privacy rights have been violated, You may complain to the Privacy Officer of the applicable carrier who provides the benefits (this information should be in the Notice of Privacy Practices that You receive from that carrier), or You may complain to the Plan itself in care of the Privacy Officer or the Benefits/Human Resources representative at: Utah State University, 8800 Old Main, Logan, Utah 84322-8800.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200, Independence Avenue S.W., Washington, D.C. 20201.

The Plan, Plan Sponsor, and Claims Administrator will not retaliate against You for filing a complaint.

Section E. Whom to Contact at the Plan for More Information

If You have any questions regarding this Notice or the subjects addressed in it, You may contact the Privacy Officer or the Benefits/Human Resources representative at: Utah State University, 8800 Old Main, Logan, Utah 84322-8800.

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

Conclusion

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.

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 Sections to determine if a Covered Service has a specific Maximum Benefit.

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

DEDUCTIBLES – WELLNESS WHITE AND HIGH PREMIUM BLUE PLANS

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. 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. Further, reduction in Your cost-sharing for Prescription Medications resulting from the use of a drug manufacturer coupon may 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. 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. 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.

The High Deductible Health Plan may include "single" or "family" coverage.

Single Coverage means only one person has coverage. Examples include, but are not limited to:

- a Participant who is the only one in their Family who has coverage;
- spouses who both work for the Plan Sponsor and have each filled out an application and are Participants on separate coverages; or
- an eligible Dependent who is continuing insurance coverage on their own.

Family Coverage means two or more members of the same Family have the same coverage.

COPAYMENTS - WELLNESS WHITE AND HIGH PREMIUM BLUE PLANS

Copayments are a specific dollar amount that You pay directly to the Provider at the time You receive a specified service. The Copayment amount will apply after Your Deductible amount has been met. Refer to the benefit sections to see what Covered Services are subject to a Copayment.

COINSURANCE

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.

OUT-OF-POCKET MAXIMUM - WELLNESS WHITE AND HIGH PREMIUM BLUE PLANS

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.

The Family Out-of-Pocket Maximum is satisfied when any combination of Family members' payments of their cost shares for Covered Services total the Family Out-of-Pocket Maximum. No one 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.

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. 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.

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. 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.

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. 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.

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.

Medical Benefits - Wellness (White) 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, Upfront Benefits 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 Web site or contact Customer Service.

NOTE: If You choose to access new medical supplies, equipment and devices through the Claims Administrator's Web site, 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 Web site at: **regence.com/web/regence_provider/pre-authorization** or by calling Regence Customer Service at 1 (866) 240-9580.

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

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 SPD 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

Per Claimant: $750
Per Family: $1,500

PLAN YEAR OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLES)

Per Claimant: $4,000
Per Family: $8,000

PREVENTIVE CARE AND IMMUNIZATIONS

Preventive Care

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** 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:** 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:** 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) 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, 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.

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: Certain preventive care and immunization services that do not meet these criteria may be covered in this Preventive Care and Immunizations benefit when received and billed as preventive. 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 Preventive Care

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

Preventive care services and supplies 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 are covered. Covered services include the first of each of the following services for each Plan Year, regardless of the diagnosis:

- pap smear;
- PSA test;
- mammography;
- occult blood
- bone density;
- sigmoidoscopy; and
- colonoscopy.

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: No charge.	**Payment:** 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. Coverage does not 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 and Specialist	**Payment:** After Deductible, You pay $35 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Urgent Care/After Hours	**Payment:** After Deductible, You pay $40 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
Payment: After Deductible, You pay 0% of the Allowed Amount.	**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, and therapeutic injections (including clotting factor products) 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.

UPFRONT BENEFITS

Outpatient Radiology and Laboratory Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
In-Network Limit: $1,000 per Claimant per Plan Year. Once this limit is reached, radiology and laboratory services, including Medically Necessary genetic testing and diagnostic mammography, are covered elsewhere as specified in this Medical Benefits Section.	

OTHER PROFESSIONAL SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% 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 those to treat a congenital anomaly, 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 Web site 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 after any limit for Upfront Benefits is exhausted. This includes Medically Necessary genetic testing and diagnostic 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.

AMBULANCE SERVICES

Provider: All
Payment: After Deductible, You pay 30% 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 Plan Sponsor's group number and Your identification number.

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 subject to any Deductible and/or Out-of-Pocket Maximums 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 and $250 Copayment per admission, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% 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 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% 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 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% 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). Autism Spectrum Disorder Services may be covered in the Upfront Benefits. Once any applicable Upfront limit is reached, Autism Spectrum Disorder Services will be covered as specified here.

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 Deductible, You pay 30% of the Allowed Amount.

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

DENTAL AND ORTHODONTIC TREATMENT DUE TO AN ACCIDENTAL INJURY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% 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. Payment for services and supplies will first be paid by any dental plan the Claimant has in effect.

Orthodontic services and supplies are covered for treatment required as a result of an Injury when orthodontic benefits are not available under any other plan. To be covered, treatment must be completed within 12 months of the Injury, unless a delay in treatment is Medically Necessary. If a delay in treatment is Medically Necessary, the Claimant must receive prior approval from the Plan.

Once the maximum under this benefit is reached, all additional services will be covered the same as any other Illness or Injury.

DENTAL HOSPITALIZATION

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $250 Copayment per admission, You pay 30% of the Allowed Amount.	**Payment:** After Deductible and $250 Copayment per admission, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $250 Copayment per admission, You pay 0% of the Allowed Amount.	**Payment:** After Deductible and $400 Copayment per admission, 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

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $250 Copayment per admission, You pay 30% of the Allowed Amount.	**Payment:** After Deductible and $250 Copayment per admission, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

DIABETIC EDUCATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% 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 counseling and nutritional therapy services are covered in the Nutritional Counseling benefit.

DIALYSIS

Inpatient

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $250 Copayment per admission, You pay 30% of the Allowed Amount.	**Payment:** After Deductible and $250 Copayment per admission, 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 30% 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.	

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:** 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 30% 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. Covered Services does not include Durable Medical Equipment if it serves solely as a comfort of convenience item.

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 Web site 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 $250 Copayment per visit. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment:** After Deductible, You pay $250 Copayment per visit and the balance of billed charges. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.

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

Inpatient Services

Provider: Centers of Excellence	Provider: Out-of-Network
Payment: After Deductible and $250 Copayment per admission, You pay 30% of the Allowed Amount.	**Payment:** Not covered.

Outpatient Services

Provider: Centers of Excellence	Provider: Out-of-Network
Payment: After Deductible, You pay 30% 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 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.

HOME HEALTH CARE

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

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $250 Copayment per admission, You pay 30% of the Allowed Amount.	**Payment:** After Deductible and $250 Copayment per admission, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient Surgical Services (including Ambulatory Surgical Center)

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay $250 Copayment per visit.	**Payment:** After Deductible and $400 Copayment per visit, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient Non-Surgical Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% 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.

Outpatient Surgical Center services including Ambulatory Surgical Center may be covered in the Upfront Benefits. Once any applicable Upfront Benefit limit is reached, Outpatient Surgical Center services including Ambulatory Surgical Center will be covered as specified here.

Subsequent visits for wound care will not be subject to additional Copayments.

INFERTILITY TREATMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: $2,000 per Claimant Lifetime (this limit does not apply to preimplantation genetic diagnosis services)	

Surgical and nonsurgical treatment is covered for the correction of infertility. Additionally, assisted reproductive procedures are covered, including:

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer; or

- any associated surgery, medications, testing or supplies.

Coverage does **not** include:

- uterine transplants.

INFUSION THERAPY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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

Certain medications for outpatient infusion therapy may require preauthorization. Additionally, for coverage to be provided, preauthorization for some medications requires that infusion therapy be performed at an approved site of care, unless an exception is authorized. Site of care review is part of the Claims Administrator's preauthorization process and may be a factor used to determine Medical Necessity.

"Approved site of care" means a Provider (such as standalone infusion sites, doctor's offices, home infusion or an approved Hospital-based infusion center) with which the Claims Administrator has expressly identified or contracted to provide outpatient infusion therapy services in a more convenient, less costly manner while maintaining safety and efficiency. Contact Customer Service to verify which medications for outpatient infusion therapy require preauthorization and which Providers are an approved site of care.

MATERNITY CARE/ADOPTION BENEFIT

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $250 Copayment per admission, You pay 30% of the Allowed Amount.	**Payment:** After Deductible and $250 Copayment per admission, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% 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: $4,000 per child under age six

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:

- 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, rape of a child or incest.

An adoption benefit is available, covered as an In-Network benefit, when a Participant meets all of the following conditions:

- Coverage is in effect on the date a child under age six is placed in the Plan Participant's home on a permanent basis.
- 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 be submitted within 12 months after the date of adoption is finalized, and must contain the child's name, date of birth, proof of the actual adoption expenses, 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

Coverage does **not** include:

- The adoption of stepchildren, nieces, nephews, brothers, sisters or grandchildren.

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 $4,000 of medical and/or legal adoption expenses per child for a child under age 6. If both the employee and spouse work for Utah State University, only one $4,000 Adoption Benefit per child will be paid between them. Adoption coverage that is applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

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 30% 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 and $250 Copayment per admission, You pay 30% 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 Office/ Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay $35 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 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Residential Treatment

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** Not covered.
Limit: 60 days per Claimant per Plan Year (this limit is combined with the Skilled Nursing Facility limit)	

Mental Health and Substance Use Disorder Services are covered for treatment of Mental Health Conditions or Substance Use Disorders. Mental Health and Substance Use Disorder Services may be covered in the Upfront Benefits. Once any applicable Upfront limit is reached, Mental Health and Substance Use Disorder Services will be covered as specified here. Inpatient and residential treatment services, days or visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

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 Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health Provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is 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 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: $1,500 per eligible child per Plan Year (this limit is combined with the Speech Therapy 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 six 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.

You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE

Provider: In-Network	Provider: Out-of-Network
Payment: You pay 30% of the Allowed Amount.	**Payment:** You pay 40% 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.

NUTRITIONAL COUNSELING

	Provider: In-Network	Provider: Out-of-Network
Nutritional Counseling	**Payment:** No charge.	**Payment:** You pay 40% of the Allowed Amount and the balance of billed charges.
Diabetes Nutritional Counseling	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: three visits per Claimant per Plan Year (diabetic counseling is not subject to this limit)		

Services for nutritional counseling and nutritional therapy, such as diabetic counseling, discussions on eating habits, lifestyle choices and dietary interventions are covered for all conditions, including obesity. Nutritional counseling visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

ORTHOGNATHIC PROCEDURES

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

Orthognathic surgery and related Hospital and anesthesia services are covered, including, but not limited to:

- Sagittal split osteotomies to advance the mandible.
- Maxillary Lefort I osteotomies.
- Intraoral subcondylar osteotomies to set the mandible back.
- Segmental osteotomies.

ORTHOTIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Foot Orthotics Limit: $500 per Claimant per Plan Year	

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 Web site 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.

PAIN CLINICS

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

Professional charges for the treatment of chronic pain are covered.

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% 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

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Inpatient Limit: 45 days per Claimant per Plan Year **Outpatient Limit:** 40 visits per Claimant per Plan Year (this limit is combined with the Spinal Manipulations limit) **Speech Therapy Limit:** $1,500 per eligible child per Plan Year (this limit is combined with the Neurodevelopmental Therapy 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. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

Speech therapy services are covered for children up to age 18 with a speech defect and/or developmental difficulty until maximum improvement has been made or the above limit has been reached.

ROUTINE HEARING EXAMINATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** 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 (SNF) CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% 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 (this limit is combined with the Residential Treatment limit)	

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 $35 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 40 visits per Claimant per Plan Year (this limit is combined with the Outpatient Rehabilitation limit)	

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

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $250 Copayment per admission, You pay 30% of the Allowed Amount.	**Payment:** After Deductible and $250 Copayment per admission, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: $1,000 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

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $250 Copayment per admission, You pay 30% of the Allowed Amount.	**Payment:** After Deductible and $250 Copayment per admission, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% 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 telemedicine, 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 may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share.

To learn more about how to access virtual care services or Providers that may offer lower-cost services, visit the Claims Administrator's Web site or contact Customer Service.

Store and Forward Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay $10 Copayment per visit.	**Payment:** After Deductible, 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: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay $10 Copayment per visit.	**Payment:** After Deductible, 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 when You are not in a Provider's office healthcare facility. For example, telehealth includes a live video call from Your home to discuss a possible eye infection with Your Provider.

Telemedicine

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

"Telemedicine" means You are located at, and using, a Provider's office or healthcare facility's equipment for Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform. For example, telemedicine includes using the equipment at Your local Provider's office to have a live video call with a secondary Provider such as a cardiologist in a different city.

NOTE: You will receive a separate charge from the secondary Provider You contacted, in addition to the charge from the Provider's office or healthcare facility where You are physically located.

VISION EXAMINATIONS

	Provider: In-Network	Provider: Out-of-Network
First Examination	**Payment:** No charge.	**Payment:** You pay 40% of the Allowed Amount and the balance of billed charges.
All Other Examinations	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

The Plan covers the first vison examination per Plan Year regardless of diagnosis. After the first vision examination, all other vision examinations are subject to Medical Necessity.

Prescription Medications - Wellness (White) 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 Web site or contact Customer Service.

COPAYMENTS AND/OR COINSURANCE

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 Naloxone Value List found on the Claims Administrator's Web site or by calling Customer Service.

When You fill a prescription for Tier 3 insulin, Your cost-share will not exceed $27 per 30-day supply from a Pharmacy or $81 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: $1,750
Per Family: $3,500

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.

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 Deductible or 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:**
  - $10 Copayment.
  - 20% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $150.
- **Tier 2:**
  - $10 Copayment.
  - 20% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $150.
- **Tier 3:**
  - 35% Coinsurance.
  - 20% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $150.
- **Tier 4:**
  - 50% Coinsurance.
  - 35% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $300.
- **Compound Medication:** 50% Coinsurance.
- **Diabetic Supplies:** 20% Coinsurance.

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

- **Tier 1:**
  - $15 Copayment.
  - 20% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $150.
- **Tier 2:**
  - $15 Copayment.
  - 20% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $150.
- **Tier 3:**
  - 35% Coinsurance.
  - 20% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $150.
- **Tier 4:**
  - 50% Coinsurance.
  - 35% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $300.
- **Compound Medication:** 50% Coinsurance.
- **Diabetic Supplies:** 20% Coinsurance.

Prescription Specialty Medications (for Each 30-Day Supply)

• **Tier 5:** - 20% Coinsurance. - 20% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $150.
• **Tier 6:** - 35% Coinsurance. - 35% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $300.

COVERED PRESCRIPTION MEDICATIONS

Prescription Medication benefits are available for the following:

- Prescription Medications;
- erectile dysfunction medications;
- 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;
- 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; 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 Web site 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 Web site.

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 Web site 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 Web site 30 days prior to the effective date of that change unless the removal is done on an emergency basis or if an equivalent Generic Medication becomes available without prior notice. In the case of an emergency removal, the change will be posted as soon as 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 Web site. You or Your Provider may request preauthorization by calling Customer Service or by completing and submitting the form on the Claims Administrator's Web site.

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 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 Web site 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 Web site 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 (Mail-Order)

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 Web site 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 Prescription Medication Out-of-Pocket Maximum. Drug manufacturer coupons for some Prescription Medications may be used to obtain Your medication without any cost-share. Contact the Claims Administrator's Customer Service to identify if the drug manufacturer coupon for Your Prescription Medication qualifies for no cost-sharing.

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 three fills 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 Web site 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.
  - **Home Delivery (Mail-Order) 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.

- **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;
- anti-aging;

- repair of sun-damaged skin; or
- reduction of redness associated with rosacea.

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, 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

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

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 Web site 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 (mail-order) Pharmacy with which the Claims Administrator has contracted for home delivery (mail-order) 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 Web site 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 Web site 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 Premium (Blue) 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, Upfront Benefits 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 Web site or contact Customer Service.

NOTE: If You choose to access new medical supplies, equipment and devices through the Claims Administrator's Web site, 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 Web site at: **regence.com/web/regence_provider/pre-authorization** or by calling Regence Customer Service at 1 (866) 240-9580.

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

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 SPD 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

Per Claimant: $500
Per Family: $1,000

PLAN YEAR OUT-OF-POCKET MAXIMUM

Per Claimant: $3,250
Per Family: $6,500

PREVENTIVE CARE AND IMMUNIZATIONS

Preventive Care

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** 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:** 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:** 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) 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, 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.

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: Certain preventive care and immunization services that do not meet these criteria may be covered in this Preventive Care and Immunizations benefit when received and billed as preventive. Covered Services that do not meet these criteria (for example, diagnostic colonoscopies) 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 Preventive Care

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

Preventive care services and supplies 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 are covered. Covered services include the first of each of the following services for each Plan Year, regardless of the diagnosis:

- pap smear;
- PSA test;
- mammography;
- occult blood
- bone density;
- sigmoidoscopy; and
- colonoscopy.

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: No charge.	**Payment:** 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. Coverage does not 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 and Specialist	**Payment:** After Deductible, You pay $30 Copayment per visit.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Urgent Care/After Hours	**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, except as otherwise covered in the Expanded Office Services benefit.

Expanded Office Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 0% of the Allowed Amount.	**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 and therapeutic injections (including clotting factor products) 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.

UPFRONT BENEFITS

Outpatient Radiology and Laboratory Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
In-Network Limit: $1,000 per Claimant per Plan Year. Once this limit is reached, radiology and laboratory services, including Medically Necessary genetic testing and diagnostic mammography, are covered elsewhere as specified in this Medical Benefits 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 30% 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 those to treat a congenital anomaly, 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 Web site 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 after any limit for Upfront Benefits is exhausted. This includes Medically Necessary genetic testing and diagnostic 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.

AMBULANCE SERVICES

Provider: All
Payment: After 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 Plan Sponsor's group number and Your identification number.

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 subject to any Deductible and/or Out-of-Pocket Maximums 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 and $200 Copayment per admission, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% 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 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% 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 50% 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). Autism Spectrum Disorder Services may be covered in the Upfront Benefits. Once any applicable Upfront limit is reached, Autism Spectrum Disorder Services will be covered as specified here.

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 Deductible, You pay 20% of the Allowed Amount.

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

DENTAL AND ORTHODONTIC TREATMENT DUE TO AN ACCIDENTAL INJURY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% 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. Payment for services and supplies will first be paid by any dental plan the Claimant has in effect.

Orthodontic services and supplies are covered for treatment required as a result of an Injury when orthodontic benefits are not available under any other plan. To be covered, treatment must be completed within 12 months of the Injury, unless a delay in treatment is Medically Necessary. If a delay in treatment is Medically Necessary, the Claimant must receive prior approval from the Plan.

Once the maximum under this benefit is reached, all additional services will be covered the same as any other Illness or Injury.

DENTAL HOSPITALIZATION

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $200 Copayment per admission, You pay 20% of the Allowed Amount.	**Payment:** After Deductible and $200 Copayment per admission, You pay 30% of the Allowed Amount and the balance of billed charges.

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $200 Copayment per admission, You pay 0% of the Allowed Amount.	**Payment:** After Deductible and $300 Copayment per admission, 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

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $200 Copayment per admission, You pay 20% of the Allowed Amount.	**Payment:** After Deductible and $200 Copayment per admission, You pay 30% of the Allowed Amount and the balance of billed charges.

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% 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 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 counseling and nutritional therapy services are covered in the Nutritional Counseling benefit.

DIALYSIS

Inpatient

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $200 Copayment per admission, You pay 20% of the Allowed Amount.	**Payment:** After Deductible and $200 Copayment per admission, You pay 30% 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 30% 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.	

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:** 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 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. Covered Services does not include Durable Medical Equipment if it serves solely as a comfort of convenience item.

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 Web site 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 $250 Copayment per visit. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment:** After Deductible, You pay $250 Copayment per visit and the balance of billed charges. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.

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

Inpatient Services

Provider: Centers of Excellence	Provider: Out-of-Network
Payment: After Deductible and $200 Copayment per admission, You pay 20% of the Allowed Amount.	**Payment:** Not covered.

Outpatient Services

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 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.

HOME HEALTH CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% 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 20% 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

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $200 Copayment per admission, You pay 20% of the Allowed Amount.	**Payment:** After Deductible and $200 Copayment per admission, You pay 30% of the Allowed Amount and the balance of billed charges.

Outpatient Surgical Services (including Ambulatory Surgical Center)

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay $200 Copayment per visit.	**Payment:** After Deductible and $300 Copayment per visit, You pay 30% of the Allowed Amount and the balance of billed charges.

Outpatient Non-surgical Services

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

Outpatient Surgical Center services including Ambulatory Surgical Center may be covered in the Upfront Benefits. Once any applicable Upfront Benefit limit is reached, Outpatient Surgical Center services including Ambulatory Surgical Center will be covered as specified here.

Subsequent visits for wound care will not be subject to additional Copayments.

INFERTILITY TREATMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: $2,000 per Claimant Lifetime (this limit does not apply to preimplantation genetic diagnosis services)	

Surgical and nonsurgical treatment is covered for the correction of infertility. Additionally, assisted reproductive procedures are covered, including:

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer; or

- any associated surgery, medications, testing or supplies.

Coverage does **not** include:

- uterine transplants.

INFUSION THERAPY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

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

Certain medications for outpatient infusion therapy may require preauthorization. Additionally, for coverage to be provided, preauthorization for some medications requires that infusion therapy be performed at an approved site of care, unless an exception is authorized. Site of care review is part of the Claims Administrator's preauthorization process and may be a factor used to determine Medical Necessity.

"Approved site of care" means a Provider (such as standalone infusion sites, doctor's offices, home infusion or an approved Hospital-based infusion center) with which the Claims Administrator has expressly identified or contracted to provide outpatient infusion therapy services in a more convenient, less costly manner while maintaining safety and efficiency. Contact Customer Service to verify which medications for outpatient infusion therapy require preauthorization and which Providers are an approved site of care.

MATERNITY CARE/ADOPTION BENEFIT

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $200 Copayment per admission, You pay 20% of the Allowed Amount.	**Payment:** After Deductible and $200 Copayment per admission, You pay 30% of the Allowed Amount and the balance of billed charges.

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% 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.
Adoption Limit: $4,000 per child under age six

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:

- 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, rape of a child or incest.

An adoption benefit is available, covered as an In-Network benefit, when a Participant meets all of the following conditions:

- Coverage is in effect on the date a child under age six is placed in the Plan Participant's home on a permanent basis.
- 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 be submitted within 12 months after the date of adoption is finalized, and must contain the child's name, date of birth, proof of the actual adoption expenses, 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

Coverage does **not** include:

- The adoption of stepchildren, nieces, nephews, brothers, sisters or grandchildren.

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 $4,000 of medical and/or legal adoption expenses per child for a child under age 6. If both the employee and spouse work for Utah State University, only one $4,000 Adoption Benefit per child will be paid between them. Adoption coverage that is applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

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 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 and $200 Copayment per admission, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Limit: 60 days per Claimant per Plan Year	

Outpatient Office/ Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay $30 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 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Residential Treatment

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** Not covered.
Limit: 60 days per Claimant per Plan Year (this limit is combined with the Skilled Nursing Facility limit)	

Mental Health and Substance Use Disorder Services are covered for treatment of Mental Health Conditions or Substance Use Disorders. Mental Health and Substance Use Disorder Services may be covered in the Upfront Benefits. Once any applicable Upfront limit is reached, Mental Health and Substance Use Disorder Services will be covered as specified here. Inpatient and residential treatment services, days or visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

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, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health Provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is 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 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Limit: $1,500 per eligible child per Plan Year (this limit is combined with the Speech Therapy 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 six 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.

You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE

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

NUTRITIONAL COUNSELING

	Provider: In-Network	Provider: Out-of-Network
Nutritional Counseling	**Payment:** No charge.	**Payment:** You pay 30% of the Allowed Amount and the balance of billed charges.
Diabetes Nutritional Counseling	**Payment:** After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Limit: three visits per Claimant per Plan Year (diabetic counseling is not subject to this limit)		

Services for nutritional counseling and nutritional therapy, such as diabetic counseling, discussions on eating habits, lifestyle choices and dietary interventions are covered for all conditions, including obesity. Nutritional counseling visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

ORTHOGNATHIC PROCEDURES

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

Orthognathic surgery and related Hospital and anesthesia services are covered, including, but not limited to:

- Sagittal split osteotomies to advance the mandible.
- Maxillary Lefort I osteotomies.
- Intraoral subcondylar osteotomies to set the mandible back.
- Segmental osteotomies.

ORTHOTIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Foot Orthotics Limit: $500 per Claimant per Plan Year	

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 Web site 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.

PAIN CLINICS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

Professional charges for the treatment of chronic pain are covered.

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% 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 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Inpatient Limit: 45 days per Claimant per Plan Year **Outpatient Limit:** 40 visits per Claimant per Plan Year (this limit is combined with the Spinal Manipulations limit) **Speech Therapy Limit:** $1,500 per eligible child per Plan Year (this limit is combined with the Neurodevelopmental Therapy 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. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

Speech therapy services are covered for children up to age 18 with a speech defect and/or developmental difficulty until maximum improvement has been made or the above limit has been reached.

ROUTINE HEARING EXAMINATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** 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 (SNF) CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% 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 (this limit is combined with the Residential Treatment limit)	

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 $30 Copayment per visit.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.
Limit: 40 visits per Claimant per Plan Year (this limit is combined with the Outpatient Rehabilitation limit)	

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

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $200 Copayment per admission, You pay 20% of the Allowed Amount.	**Payment:** After Deductible and $200 Copayment per admission, You pay 30% of the Allowed Amount and the balance of billed charges.

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: $1,000 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

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $200 Copayment per admission, You pay 20% of the Allowed Amount.	**Payment:** After Deductible and $200 Copayment per admission, You pay 30% of the Allowed Amount and the balance of billed charges.

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% 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 telemedicine, 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 may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share.

To learn more about how to access virtual care services or Providers that may offer lower-cost services, visit the Claims Administrator's Web site or contact Customer Service.

Store and Forward Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay $10 Copayment per visit.	**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: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay $10 Copayment per visit.	**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 when You are not 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.

Telemedicine

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

"Telemedicine" means You are located at, and using, a Provider's office or healthcare facility's equipment for Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform. For example, telemedicine includes using the equipment at Your local Provider's office to have a live video call with a secondary Provider such as a cardiologist in a different city.

NOTE: You will receive a separate charge from the secondary Provider You contacted, in addition to the charge from the Provider's office or healthcare facility where You are physically located.

VISION EXAMINATIONS

	Provider: In-Network	Provider: Out-of-Network
First Examination	**Payment:** No charge.	**Payment:** You pay 30% of the Allowed Amount and the balance of billed charges.
All Other Examinations	**Payment:** After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges.

The Plan covers the first vison examination per Plan Year regardless of diagnosis. After the first vision examination, all other vision examinations are subject to Medical Necessity.

Prescription Medications - High Premium (Blue) 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 Web site or by contacting Customer Service.

COPAYMENTS AND/OR COINSURANCE

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 Naloxone Value List found on the Claims Administrator's Web site or by calling Customer Service.

When You fill a prescription for Tier 3 insulin, Your cost-share will not exceed $27 per 30-day supply from a Pharmacy or $81 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: $1,500
Per Family: $3,000

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.

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 Deductible or 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:**
  - $10 Copayment.
  - 20% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $150.
- **Tier 2:**
  - $10 Copayment.
  - 20% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $150.
- **Tier 3:**
  - 35% Coinsurance.
  - 20% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $150.
- **Tier 4:**
  - 50% Coinsurance.
  - 35% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $300.
- **Compound Medication:** 50% Coinsurance.
- **Diabetic Supplies:** 20% Coinsurance.

Prescription Medications from a Home Delivery (Mail-Order) Supplier (for Each 90-day Supply)

- **Tier 1:**
  - $15 Copayment.
  - 20% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $150.
- **Tier 2:**
  - $15 Copayment.
  - 20% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $150.
- **Tier 3:**
  - 35% Coinsurance.
  - 20% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $150.
- **Tier 4:**
  - 50% Coinsurance.
  - 35% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $300.
- **Compound Medication:** 50% Coinsurance.
- **Diabetic Supplies:** 20% Coinsurance.

Prescription Specialty Medications (for Each 30-Day Supply)

• **Tier 5:** - 20% Coinsurance. - 20% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $150.
• **Tier 6:** - 35% Coinsurance. - 35% Coinsurance for each Self-Administrable Cancer Chemotherapy Medication, not to exceed $300.

COVERED PRESCRIPTION MEDICATIONS

Prescription Medication benefits are available for the following:

- Prescription Medications;
- erectile dysfunction medications;
- 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;
- 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; 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 Web site 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 Web site.

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 Web site 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 Web site 30 days prior to the effective date of that change unless the removal is done on an emergency basis or if an equivalent Generic Medication becomes available without prior notice. In the case of an emergency removal, the change will be posted as soon as 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 Web site. You or Your Provider may request preauthorization by calling Customer Service or by completing and submitting the form on the Claims Administrator's Web site.

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 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 Web site 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 Web site 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 (Mail-Order)

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 Web site 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 Prescription Medication Out-of-Pocket Maximum. Drug manufacturer coupons for some Prescription Medications may be used to obtain Your medication without any cost-share. Contact the Claims Administrator's Customer Service to identify if the drug manufacturer coupon for Your Prescription Medication qualifies for no cost-sharing.

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 three fills 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 Web site 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.
  - **Home Delivery (Mail-Order) 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.

- **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;
- anti-aging;

- repair of sun-damaged skin; or
- reduction of redness associated with rosacea.

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, 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

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

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 Web site 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 (mail-order) Pharmacy with which the Claims Administrator has contracted for home delivery (mail-order) 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 Web site 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 Web site 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 Web site or contact Customer Service.

NOTE: If You choose to access new medical supplies, equipment and devices through the Claims Administrator's Web site, 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 Web site at: **regence.com/web/regence_provider/pre-authorization** or by calling Regence Customer Service at 1 (866) 240-9580.

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

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 SPD 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

Single Coverage Deductible: $1,500
Family Coverage Deductible: $3,000

PLAN YEAR OUT-OF-POCKET MAXIMUM

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

The maximum Out-of-Pocket for any Claimant on Family Coverage is not to exceed $5,000, including any Deductible. If a Claimant reaches this maximum amount prior to satisfying the Family Out-of-Pocket Maximum, including any Deductible, benefits will be paid at 100 percent of the Allowed Amount for that Claimant.

PREVENTIVE CARE AND IMMUNIZATIONS

Preventive Care

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** 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:** 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:** 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) 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, 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.

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: Certain preventive care and immunization services that do not meet these criteria may be covered in this Preventive Care and Immunizations benefit when received and billed as preventive. 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 Preventive Care

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

Preventive care services and supplies 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 are covered. 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: No charge.	**Payment:** 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. Coverage does not 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
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.

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.

UPFRONT BENEFITS

Outpatient Radiology and Laboratory Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
In-Network Limit: $1,000 per Claimant per Plan Year. Once this limit is reached, radiology and laboratory services, including Medically Necessary genetic testing and diagnostic mammography, are covered elsewhere as specified in this Medical Benefits 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.

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 those to treat a congenital anomaly, 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 Web site 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 after any limit for Upfront Benefits is exhausted. This includes Medically Necessary genetic testing and diagnostic 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.

Therapeutic Injections
Therapeutic injections and related supplies, including clotting factor products, when given in a professional Provider's office.

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

AMBULANCE SERVICES

Provider: All
Payment: After 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 Plan Sponsor's group number and Your identification number.

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 subject to any Deductible and/or Out-of-Pocket Maximums 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 50% 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 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% 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 50% 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). Autism Spectrum Disorder Services may be covered in the Upfront Benefits. Once any applicable Upfront limit is reached, Autism Spectrum Disorder Services will be covered as specified here.

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 Deductible, You pay 20% of the Allowed Amount.

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

DENTAL AND ORTHODONTIC TREATMENT DUE TO AN ACCIDENTAL INJURY

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. Payment for services and supplies will first be paid by any dental plan the Claimant has in effect.

Orthodontic services and supplies are covered for treatment required as a result of an Injury only when orthodontic benefits are not available under any other Plan. To be covered, treatment must be completed within 12 months of the Injury, unless a delay in treatment is Medically Necessary. If a delay in treatment is Medically Necessary, the Claimant must receive prior approval from the Plan.

Once the maximum under this benefit is reached, all additional services will be covered the same as any other Illness or Injury.

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 40% 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 counseling and nutritional therapy services are covered in the Nutritional Counseling benefit.

DIALYSIS

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 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 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. Covered Services does not include Durable Medical Equipment if it serves solely as a comfort of convenience item.

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 Web site 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 Deductible, You pay 20% of the Allowed Amount and the balance of billed charges.

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

"Stabilization" means to provide Medically Necessary treatment:

- to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during or to result from, the transfer of the 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 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.

HOME HEALTH 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.

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 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

Hospital 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.

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 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.

Outpatient Surgical Center services including Ambulatory Surgical Center may be covered in the Upfront Benefits. Once any applicable Upfront Benefit limit is reached, Outpatient Surgical Center services including Ambulatory Surgical Center will be covered as specified here.

INFERTILITY TREATMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: $2,000 per Claimant Lifetime (this limit does not apply to preimplantation genetic diagnosis services)	

Surgical and nonsurgical treatment is covered for the correction of infertility. Additionally, assisted reproductive procedures are covered, including:

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

Coverage does **not** include:

- uterine transplants.

INFUSION 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.

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

Certain medications for outpatient infusion therapy may require preauthorization. Additionally, for coverage to be provided, preauthorization for some medications requires that infusion therapy be

performed at an approved site of care, unless an exception is authorized. Site of care review is part of the Claims Administrator's preauthorization process and may be a factor used to determine Medical Necessity.

"Approved site of care" means a Provider (such as standalone infusion sites, doctor's offices, home infusion or an approved Hospital-based infusion center) with which the Claims Administrator has expressly identified or contracted to provide outpatient infusion therapy services in a more convenient, less costly manner while maintaining safety and efficiency. Contact Customer Service to verify which medications for outpatient infusion therapy require preauthorization and which Providers are an approved site of care.

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: $4,000 per child under age six

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:

- 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, rape of a child or incest.

An adoption benefit is available, covered as an In-Network benefit, when a Participant meets all of the following conditions:

- Coverage is in effect on the date a child under age six is placed in the Plan Participant's home on a permanent basis.
- 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 be submitted within 12 months after the date of adoption is finalized, and must contain the child's name, date of birth, proof of the actual adoption expenses, 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

Coverage does **not** include:

- The adoption of stepchildren, nieces, nephews, brothers, sisters or grandchildren.

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 $4,000 of medical and/or legal adoption expenses per

child for a child under age six. If both the employee and spouse work for Utah State University, only one $4,000 Adoption Benefit per child will be paid between them. Adoption coverage that is applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

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.
Limit: 60 days per Claimant per Plan Year	

Outpatient Office/Psychotherapy Visits

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.

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.

Residential Treatment

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** Not covered.
Limit: 60 days per Claimant per Plan Year (this limit is combined with the Skilled Nursing Facility limit)	

Mental Health and Substance Use Disorder Services are covered for treatment of Mental Health Conditions or Substance Use Disorders. Mental Health and Substance Use Disorder Services may be covered in the Upfront Benefits. Once any applicable Upfront limit is reached, Mental Health and Substance Use Disorder Services will be covered as specified here. Inpatient and residential treatment services, days or visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

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 Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health Provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is 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 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: $1,500 per eligible child per Plan Year (this limit is combined with the Speech Therapy 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 six 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.

You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN 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.

Services and supplies in connection with nursery care for the natural newborn or newly adoptive child are covered by the newborn's own coverage. The newborn child must be eligible and enrolled as explained in the Eligibility and Enrollment Section. There is no limit for the newborn's length of inpatient stay. "Newborn care" means the medical services provided to a newborn child following birth including Hospital nursery charges, the initial physical examination and a PKU test.

NUTRITIONAL COUNSELING

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 visits per Claimant per Plan Year (diabetic counseling is not subject to this limit)	

Services for nutritional counseling and nutritional therapy, such as diabetic counseling, discussions on eating habits, lifestyle choices and dietary interventions are covered for all conditions, including obesity. Nutritional counseling visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

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.
Foot Orthotics Limit: $500 per Claimant per Plan Year	

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 Web site 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.

PAIN CLINICS

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

Professional charges for the treatment of chronic pain are covered.

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

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 Limit: 45 days per Claimant per Plan Year **Outpatient Limit:** 40 visits per Claimant per Plan Year (this limit is combined with the Spinal Manipulations limit) **Speech Therapy Limit:** $1,500 per eligible child per Plan Year (this limit is combined with the Neurodevelopmental Therapy 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. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

Speech therapy services are covered for children up to age 18 with a speech defect and/or developmental difficulty until maximum improvement has been made or the above limit has been reached.

ROUTINE HEARING EXAMINATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** 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 (SNF) 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.
Limit: 60 inpatient days per Claimant per Plan Year (this limit is combined with the Residential Treatment limit)	

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 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 40 visits per Claimant per Plan Year (this limit is combined with the Outpatient Rehabilitation limit)	

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 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: $1,000 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 telemedicine, 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 may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share.

To learn more about how to access virtual care services or Providers that may offer lower-cost services, visit the Claims Administrator's Web site or contact Customer Service.

Store and Forward Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, 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: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, 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 when You are not 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.

Telemedicine

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.

"Telemedicine" means You are located at, and using, a Provider's office or healthcare facility's equipment for Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform. For example, telemedicine includes using the equipment at Your local Provider's office to have a live video call with a secondary Provider such as a cardiologist in a different city.

NOTE: You will receive a separate charge from the secondary Provider You contacted, in addition to the charge from the Provider's office or healthcare facility where You are physically located.

VISION EXAMINATIONS

	Provider: In-Network	Provider: Out-of-Network
First Examination	**Payment:** No charge.	**Payment:** You pay 40% of the Allowed Amount and the balance of billed charges.
All Other Examinations	**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.

The Plan covers the first vison examination per Plan Year regardless of diagnosis. After the first vision examination, all other vision examinations are subject to Medical Necessity.

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 Web site or contact Customer Service.

COPAYMENTS AND/OR COINSURANCE

After You meet the 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 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 Naloxone Value List found on the Claims Administrator's Web site or by calling Customer Service.

When You fill a prescription for Tier 2 insulin, Your cost-share will not exceed $27 per 30-day supply from a Pharmacy or $81 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 30-Day Supply)

• **Tier 1:** 20% Coinsurance.
• **Tier 2:** 20% Coinsurance.
• **Tier 3:** 20% Coinsurance.
• **Compound Medication:** 50% Coinsurance.
• **Diabetic Supplies:** 20% Coinsurance.

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

• **Tier 1:** 20% Coinsurance.
• **Tier 2:** 20% Coinsurance.
• **Tier 3:** 20% Coinsurance.
• **Compound Medication:** 50% Coinsurance.
• **Diabetic Supplies:** 20% Coinsurance.

Prescription Specialty Medications (for Each 30-Day Supply)

• **Specialty Medication:** 20% Coinsurance.
• **Diabetic Supplies:** 20% Coinsurance.

COVERED PRESCRIPTION MEDICATIONS

Prescription Medication benefits are available for the following:

- Prescription Medications;
- erectile dysfunction medications;
- 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;
- 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); 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 Web site 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 Web site.

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 Web site 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 Web site 30 days prior to the effective date of that change unless the removal is done on an emergency basis or if an equivalent Generic Medication becomes available without prior notice. In the case of an emergency removal, the change will be posted as soon as 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 Web site. You or Your Provider may request preauthorization by calling Customer Service or by completing and submitting the form on the Claims Administrator's Web site.

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 Web site 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 Web site 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 (Mail-Order)

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 Web site 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 three fills 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 Web site 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.
    - **Home Delivery (Mail-Order) 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.

- **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;
- anti-aging;
- repair of sun-damaged skin; or
- reduction of redness associated with rosacea.

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, 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

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

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 Web site 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 (mail-order) Pharmacy with which the Claims Administrator has contracted for home delivery (mail-order) 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 Web site 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 Web site 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 3 benefit level. Substituted Medication also means a Specialty Medication not on the Drug List that is approved for coverage at the Tier 3 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. Usually includes Brand-Name and Specialty Medications that are categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

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

General Medical Exclusions

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

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.

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.

Alcohol or Drug Use
Care, treatment or services for any Illness or Injury resulting from or caused by intoxication or the use of any narcotic or drug unless such narcotic or drug is administered or prescribed by a Physician.

Alternative Care
The following alternative care therapies are not covered, including, but not limited to:

- biofeedback;
- electrohypnosis;
- electrosleep therapy;
- electronarcosis;
- ecological or environmental medicine;
- scream therapy;
- psychic surgery;
- channeling;
- sensory deprivation;
- rolfing;
- thermography;
- music, art, dance or recreation therapy;
- crystal therapy; and
- hypertherapy (therapeutically induced fever) for treatment of cancer.

Appliances or Restorations Necessary to Increase Vertical Dimension or Restore Occlusion

Benefits Not Stated
Services and supplies provided for which there is no stated benefit under the Plan. When a non-covered service or supply is performed or received at the same time as a Covered Service, then only the portion of charges relating to the Covered Service will be considered eligible for payment under the Plan.

Certain Therapy, Counseling and Training
The following therapies, counseling and training services are not covered:

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

Cognitive Therapy

Complementary Care
The following complementary care therapies are not covered, including, but not limited to:

- acupuncture;
- massage or massage therapy;
- and naturopathic services.

Complications Resulting from a Non-Covered (Excluded) Procedure
Treatment, services or supplies in connection with complications resulting from any non-covered (excluded) procedure will be considered ineligible for payment under this Plan.

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.

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.

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

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

Psychological factors (for example, poor self-image, difficult social or peer relations) are not relevant and are not considered a physical body function.

Counseling in the Absence of Illness
Except as required by law, counseling in the absence of Illness is not covered.

Custodial, Domiciliary and Convalescent Care (other than extended care)
Non-skilled care and helping with activities of daily living and services provided for or in connection with institutional care which is for the primary purpose of controlling or changing the Claimant's environment.

"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
Except as provided in the Dental and Orthodontic Treatment Due to an Accidental Injury benefit or Dental Benefits Section in this SPD, the Plan does not cover Dental Services 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.

Drug Abuse/Over-utilization
Prescription Drugs or drugs given by injection when it has been determined by the Claims Administrator that there is over-utilization of drugs or evidence of drug abuse.

Erectile Dysfunction
Except or when documented medical evidence proves that expenses are the result of an Injury, trauma, diabetes mellitus, or other rare penile disease and not as the result of psychological factors, or the natural consequences of aging with its attendant atherosclerosis, services and supplies for or in connection with

erectile dysfunction (impotence), regardless of its origin and expenses in connection with a penile prosthesis are not covered.

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 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.

Gastric Procedure
The following gastric procedures are not covered, including, but not limited to:

- gastric or intestinal bypass;
- gastric stapling or other similar surgical procedure; or
- for or in connection with reversal or revision of such procedures.

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.

Growth Hormone Therapy

Hearing Aids and Other Devices
Except for cochlear implants, hearing aids (externally worn or surgically implanted), over-the-counter hearing aids, or other hearing devices, including implantation and associated surgical services, are not covered.

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.

Immunizations for the Purposes of Travel, Occupation or Residence in a Foreign Country

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.

Liposuction for the Treatment of Lipedema
Liposuction (a fat-removal procedure used in plastic surgery) is not covered for the treatment of lipedema, a condition that causes excess fat to accumulate in the body.

Mental Health Condition Services As A Physical Illness
Treatment or services related to a diagnosis of manic depression, manic depressive psychosis, or bipolar affective disorder as a physical Illness.

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-Covered Surgical Procedures
The following care, treatment, services or surgical procedures are not covered:

- abdominoiplasties;
- diastasis recti abdominous;
- protruding ears;
- breast enlargement;
- breast reduction not deemed Medically Necessary by the Claim Administrator's Medical Director; or gynecomastia.

Non-Covered Testing Procedures
Care, treatment, services associated with the following are not covered:

- autogenous urine immunization;
- sublingual provocation testing;
- leukocytoxicity testing;
- subcutaneous provocation; and
- neutralizing testing.

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).

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.

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

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

- telephones;
- televisions;
- air conditioners, air filters or humidifiers;
- whirlpools;
- heat lamps;
- light boxes;
- weightlifting equipment; and
- therapy or service animals, including the cost of training and maintenance; and
- guest meals while in a facility if they are charged separately from the cost of the room.

Physical Examinations required by a Third-Party
Physical examinations required by a third-party, including but not limited to, employment examinations, examinations for insurance applications, examinations to permit travel outside the United States.

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.

Prescription Drugs And Other Medications
Except as provided under the Prescription Medications benefits of this SPD, the Plan does not cover Prescription Medications, including:

- outpatient prescription drugs and over-the-counter drugs and medications. EXCEPTION: All over the counter (OTC) medications with an identical prescription drug equivalent are covered as a prescription benefit. This includes Prilosec OTC;
- special formulas, food supplements, or special diets, except as provided by a Hospital or Skilled Nursing Facility during a confinement for which benefits are available and as required for inborn metabolic errors; and
- preventive medications, including equipment for application of such medications, for example, fluoride, vitamins, minerals and homeopathic medication, except as follows:
    - vitamins prescribed by a Physician for prenatal care during pregnancy; and

- prescription vitamins and fluoride for children.

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

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

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

Routine Foot Care
Services and supplies for routine foot care are not covered, including, but not limited to:

- treatment of corns and calluses and trimming of nails, except when indicated for diabetic patients or for patients with peripheral vascular disease such as arteriosclerosis;
- foot impression casting, including x-rays;
- non-surgical treatment of bunions, flat feet, fallen arches, weak feet, chronic foot strain, or other symptomatic complaints of the foot;
- arch supports;
- special shoe accessories; and
- foot orthotics, except as specifically provided herein.

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

- childbirth-related classes including infant care; and
- instructional programs that:

    - teach a person how to use Durable Medical Equipment;
    - teach a person how to care for a family member; or
    - provide a supportive environment focusing on the Claimant's long-term social needs when rendered by individuals who are not Providers.

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

"Immediate family" means:

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

Services and Supplies Provided by Any Public or Private School or Halfway House
Services and supplies provided by any public or private school or halfway house, or by their employees and services provided solely to satisfy institutional requirements.

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

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

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

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

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

Speech Therapy
Except as provided in the Neurodevelopmental Therapy and Rehabilitation Services benefits, speech therapy services are not covered, including, but not limited to:

- speech therapy provided solely to maintain the Claimant's condition at the level to which it has been restored with no expectation of significant improvement;
- speech therapy provided as assistance in learning a new language;
- voice training; or
- therapy to reduce an accent.

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 as provided in the Maternity Care/Adoption Benefit, services or supplies related to the termination of a pregnancy (abortion) are not covered.

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

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

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

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

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

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

Work-Related Conditions
Except when a 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.

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.

MAXIMUM BENEFITS

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

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

The Plan pays a portion of the Allowed Amount (or, for Orthodontic Dental Services, a portion of the billed charges) for Covered Services, up to the Maximum Benefit amount for each Claimant each Plan Year.

PLAN YEAR DEDUCTIBLES

Not applicable

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

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

- The following services are limited to once per Claimant per Plan Year:
  - bitewing x-ray sets.
- The following x-rays are limited to one per Claimant in a three-year period:
  - complete intra-oral mouth x-rays; and
  - panoramic mouth x-rays.
- The following services are limited to two per Claimant per Plan Year:
  - cleanings (however, in no Plan Year will any Claimant be entitled to more than two cleanings whether standard cleaning or periodontal maintenance); and.
  - preventive oral examinations.
- Problem-focused oral examinations.
- Sealants, limited to permanent bicuspids and molars of Claimants age 25 and under, limited to $80 per Plan Year.
- Space maintainers for Claimants age 16 and under.
- Topical fluoride application, limited to two treatments per Claimant per Plan Year

BASIC DENTAL SERVICES

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

- Adjustment and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within one year of insertion.
- Complex oral surgery procedures including:
  - surgical extractions of teeth;
  - impactions;
  - alveoloplasty; and
  - residual root removal.
- Emergency treatment for pain relief.
- Endodontic services:
  - apicoectomy;
  - debridement;
  - direct pulp capping;
  - pulpal therapy;
  - pulpotomy; and
  - root canal treatment.
- Fillings consisting of composite and amalgam restorations:
  - repairs to restorations are limited to once per Claimant in an 18-month period
- 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 age seven and under 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 two per Claimant per Plan Year. (However, in no Plan Year will any Claimant be entitled to more than two cleanings whether periodontal maintenance or standard cleaning); and
  - scaling and root planing limited to once per Claimant per quadrant in a two-year period.
- Uncomplicated oral surgery procedures including removal of teeth, incision and drainage.

MAJOR DENTAL SERVICES

Provider: In-Network	Provider: Out-of-Network
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 SPD; and
  - additional procedures to construct a new crown under an existing partial denture framework.
- Dental implant crown and abutment related procedures.
- 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 SPD.
  - interim partial or complete dentures;
  - office relines; or
  - pediatric dentures.
- Endosteal implants, limited to four per Claimant Lifetime.
- Recement crown, inlay or onlay.
- Repair of crowns is limited to one per tooth per Claimant Lifetime.
- Repair of implants.
- Repair of implant supported prosthesis or abutment.
- Vestibuloplasty.

ORTHODONTIC DENTAL SERVICES

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

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

- 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

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

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.

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.

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.

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.

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

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

Desensitizing

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

Diagnostic Casts or Study Models Unless in Connection with Orthodontics

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

Duplicate X-Rays

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.

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

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 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.

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

General Anesthesia
Unless otherwise noted under Basic Dental Services, General Anesthesia is not covered under the Dental Plan.

Gold-Foil Restorations

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 required by law for emergency services, government facilities or government facilities outside the service area are not covered.

Home Visits

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.

Implants
Except as provided in the Dental Benefits Section, implants and any associated services and supplies are not covered (whether or not the implant itself was covered), including, but not limited to:

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

- unspecified implant procedures.

Investigational Services
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.

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.

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.

Nitrous Oxide

Non-Direct Patient Care
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).

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.

Personal Items
Items that are primarily for comfort, convenience, cosmetics, contentment, hygiene, aesthetics or other nontherapeutic purposes.

Photographic Images Unless in Connection with Orthodontics

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.

Pulp Vitality Tests

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

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.

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

"Immediate family" means:

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

Services 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.

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

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.

Travel and Transportation Expenses

Veneers

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.

Utilization Management and Preauthorization

UTILIZATION MANAGEMENT

The Claims Administrator has a responsibility to the Plan Administrator to ensure services received are medically necessary. This responsibility includes but is not limited to reviews for medical necessity and appropriateness of care (utilization review) and preauthorization.

This means that if You or Your Dependents receive services that are determined not to be medically necessary, or were not preauthorized, claims may be denied and You may be responsible to pay the Provider for these services outside of Your insurance coverage.

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
- 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.

To ensure medical necessity the Claims Administrator has developed medical policy in accordance with generally accepted standards of medical practice in the United States. The medical policy manual is available on the Claims Administrator Web site at **http://blue.regence.com/trgmedpol/**.

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.

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 or In-Network Dentist Claims and Reimbursement

You must present Your identification card to an In-Network Provider 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 or Out-of-Network Dentist 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 may pay You directly for Covered Services provided by an Out-of-Network Provider, however the Plan may 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 and Out-of-Network Dentists have not agreed to accept the Allowed Amount as payment in full for Covered Services. You are responsible for paying any difference between the amount billed by the Out-of-Network Provider or Out-of-Network Dentist 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 and Out-of-Network Dentists, 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 SPD 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: 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 SPD 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 SPD 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 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 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 SPD 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. This Plan is considered to be Primary in relation to any pediatric dental benefits of another Plan. 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 SPD.

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.

DUAL EMPLOYED COORDINATION OF BENEFITS

Policy Holder Determination

When You and Your spouse or Domestic Partner are both employed at Utah State University in benefit eligible positions and elect to cover themselves and eligible family members with medical and/or dental coverage, they have the option of enrolling in an enhanced "dual employed" benefit package as described below. When electing the dual employed benefit package, the individual assigned to the lowest salary tier, at the beginning of the Plan Year or at the effective date of coverage, will be enrolled as the insurance policy holder and the spouse/children or partner/children will be enrolled as Dependents.

Premium Determination

For purposes of determining employee paid premium, the insurance policy holder (couple or family coverage) will be assigned to the individual in the lowest salary tier of the employee paid premium schedule. The other spouse/partner will be assigned to single coverage in their salary tier of the employee paid premium schedule.

If one spouse/partner is working on a part-time basis (eligible for benefits), they will be assigned a single, part-time coverage premium. The other spouse/partner who is working full-time will be assigned to family or couple coverage based on their salary tier of the employee paid premium schedule. If both You and Your spouse or Domestic Partner are working on a part-time basis (eligible for benefits) the individual in the lowest salary tier will be the policy holder and pay the couple or family coverage premium.

If a dual covered employee experiences a salary increase or decrease during the Plan Year, this will not change the policy holder unless the decrease is due to going part-time.

Enhanced Dual Employed Benefits

Under this dual employed arrangement, the following enhanced benefits are extended to all enrolled family members:

DUAL OPTION MEDICAL

	Wellness (White)	High Premium (Blue)
Plan Year Deductible	Per Claimant: $375 Per Family: $750	Per Claimant: $250 Per Family: $500
Office Visit Copayment	You pay $15 per visit	You pay $15 per visit
Emergency Room Copayment	You pay $125 per visit	You pay $125 per visit
Prescription Drugs Copayment/Coinsurance	Generic: You pay $5 Formulary: You pay 15% Non-Formulary: You pay 25% Compounds: You pay 25% Diabetic supplies: You pay 10% Self-Administrable Cancer Chemotherapy Medications: 10% up to $75 for Preferred Generic, Generic, and Preferred Brand-Name medications; 15% up to $150 for Brand-Name medications	Generic: You pay $5 Formulary: You pay 15% Non-Formulary: You pay 25% Compounds: You pay 25% Diabetic supplies: You pay 10% Self-Administrable Cancer Chemotherapy Medications: 10% up to $75 for Preferred Generic, Generic, and Preferred Brand-Name medications; 15% up to $150 for Brand-Name medications

No applicable Deductible, Copayment and/or Coinsurance when prescriptions are filled at a Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications (including, but not limited to, aspirin, fluoride, iron and medications for tobacco use cessation) or for immunizations. Applicable Deductible, Copayment and/or Coinsurance will apply when these preventive medications and immunizations are filled at a Nonparticipating Pharmacy.

DUAL OPTION DENTAL

	Wellness (White)	High Premium (Blue)
Maximum Benefits (Per Plan Year)	$2,000 per Claimant	$2,000 per Claimant
Orthodontic Maximum Benefits (Per Lifetime)	$2,000 per Claimant	$2,000 per Claimant
	You Pay	**You Pay**
Preventive & Diagnostic Dental Services	No charge.	No charge.
	Sealants, limited to $160 per Plan Year.	
Basic Dental Services	No charge.	No charge.
Major Dental Services	You pay 20% of the Allowed Amount.	You pay 20% of the Allowed Amount.
Orthodontic Dental Services	You pay 50% of billed charges and You pay balance of billed charges.	You pay 50% of billed charges and You pay balance of billed charges.

Loss of Dual Employed Benefits

If a spouse or Domestic Partner covered under the "dual employed" benefit package loses their benefit eligibility, the employee and any covered Dependents remaining on the Plan must be moved to one of the standard, non-dual plan options. The spouse or Domestic Partner losing coverage may choose coverage

as a Dependent of the remaining eligible employee, or they may elect COBRA coverage according to the continuation of coverage provisions in this SPD.

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.

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	Use 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 91015 Seattle, WA 98111-9115

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.

Who Is Eligible

Employees
You are eligible to enroll in this Plan if You work at least 50 percent time of Your assigned nine or 12 month base and are employed in a benefit eligible position that is not temporary (less than three months).

Eligible Early Retirees
An eligible Employee of the Employer who meets the eligibility requirements of the Early Retirement Program as defined by the Employer's policy and is approved by their respective administration for early retirement, may have medical insurance continue from the time of their early retirement until the first of the month in which they reach age 65. Additionally, the dental insurance may be continued from the time of their early retirement for the duration of their early retirement agreement.

Dependents
Your Dependents are eligible for coverage when You have enrolled and have listed them on the application form or on subsequent change forms. Copies of marriage license, Domestic Partner documentation, and/or birth certificates or adoption records may be required at the time of enrollment for verification purposes. Dependents are limited to the following:

- the person to whom You are legally married (spouse);
- Your (or Your spouse's or Your Domestic Partner's) children by birth, legal adoption, placed for adoption, or legal (court-appointed) guardianship granting full guardianship rights who are under age 26;
- Your (or Your spouse's or Your Domestic Partner's) children by birth, legal adoption, placed for adoption, or legal (court-appointed) guardianship granting full guardianship rights who are a Disabled Dependent due to a Physical Impairment or Mental Impairment that started before the child's 26th Birthday, are covered as of that date or have been continuously covered since that date without any break in coverage greater than 63 days;
- a child who is under 18 years of age for whom the noncustodial parent is required by a court order or administrative order to provide health insurance coverage. (If You are not a Participant, but eligible for coverage under the Plan at the time of the order, You and the child will be enrolled as Participants);
- a child, as described in the third bullet above, who is any age and a Disabled Dependent for whom the noncustodial parent is required by a court order or administrative order to provide health insurance coverage. (If You are not a Participant, but eligible for coverage under the Plan at the time of the order, You and the child will be enrolled as Participants).

NOTE: the term "Dependents" does not necessarily mean that the spouse and/or child(ren) are financially dependent upon You.

Domestic Partner
Your Domestic Partner of the same or opposite sex who:

- is unmarried;
- is at least 18 years old;
- is mentally competent to consent to the partnership;
- not related by blood in the way that prohibits lawful marriage;
- shares the same primary residence and have been in a mutually exclusive relationship for at least the last twelve (12) 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.

Any of the following must be submitted to the Office of Human Resources:

- At least three of the following: joint mortgage, lease, utility bills, phone listing, bank account, credit account, ownership of a motor vehicle, or other documents that would conclusively establish residency at the same address; or

- Designation of the domestic partner as a primary beneficiary for a life insurance policy or retirement contract; or
- Durable power of attorney for health care or financial management.

NOTE: eligibility of a Domestic Partner may not be established retroactively.

Where a reference is made to spouse, all of the same terms and conditions in this SPD will be applied to a Domestic Partner, except when specified to the contrary.

Dependent Coverage Beyond Limiting Age

- You may continue coverage for an enrolled child who is a Disabled Dependent due to a Physical Impairment or Mental Impairment that started before the child reached age 26. To do so, You must provide written notice of intent to continue coverage along with proof of the Dependent's disability, as follows:

  - within 30 days after the Dependent reaches age 26; and
  - at reasonable times thereafter as the Claims Administrator may consider necessary, but not more often than annually.

- You may enroll a child whose 26th Birthday precedes Your Effective Date and who is a Disabled Dependent due to a Physical Impairment or Mental Impairment that started before the child reached age 26, if the child also, since reaching age 26, continuously has been covered by health insurance, with no break in coverage of more than 63 days, and chiefly dependent upon You or Your spouse or Domestic Partner. To do so, You must provide written notice of the Dependent's disability, as follows:

  - within 30 days after Your Effective Date; and
  - at reasonable times thereafter as the Claims Administrator may consider necessary, but not more often than annually.

You must promptly furnish or cause to be furnished any information necessary or appropriate to determine the validity of a Dependent's status. Receipt of such information will be a condition precedent to enrolling a person as a Dependent under the Plan.

Eligible Dependents of Deceased Active Employees

If You die as an active employee prior to completing five continuous years of service with the University, coverage for Your Enrolled Dependents (spouse and/or children) ends the last day of the month following the month in which Your death occurs. Enrolled Dependents will be responsible for the payment of the same premium that You paid for the coverage for this additional month.

- For example, if You pass away on February 15th, coverage for Your Enrolled Dependents will end on March 31st.

Continuation of coverage through COBRA will be offered to any Dependents who were covered under the Plan prior to Your death.

If You die as an active employee after completing five or more continuous years of service, Your Enrolled Dependents (spouse and/or child(ren)) who were covered immediately preceding Your death may continue receiving the medical and/or dental insurance on the same subsidized basis as an active employee as defined by Utah State University policy.

This continuation of coverage will run concurrent with COBRA and will be subsidized by Utah State University, at the level that the University contributes for active employees, for a maximum of 36 months. Coverage may extend beyond 36 months if the spouse or child(ren) pay the full premium. The following termination provisions will apply to this continuation coverage.

- If the enrolled surviving spouse reaches Normal Medicare Eligibility Age before the 36-month maximum time period is exhausted, medical coverage will terminate on the date of Medicare eligibility. Dental coverage may be extended beyond Normal Medicare Eligibility Age until one of the termination events described below occur.

    - Termination for enrolled surviving child(ren) will occur on the later of the child(ren)'s loss of eligibility for coverage as a Dependent due to attainment of maximum age (26) or 36 months from the employee's death.
    - If the enrolled spouse or child(ren) become covered by another group health plan (which does not limit or exclude any preexisting condition the person might have, either because of no applicable preexisting condition or sufficient creditable coverage to eliminate any preexisting condition limitation) during the initial 36-month continuation of coverage or later, the spouse or child(ren) must notify Utah State University within 30 days and coverage under this plan will terminate on the date of eligibility for the other coverage.
    - If, after the initial 36-months of continuation coverage the enrolled spouse has remarried or remarries, the spouse must notify Utah State University within 30 days and coverage under the plan for the spouse and child(ren) will terminate on the date of the marriage.
    - At any time, coverage may be terminated by the enrolled spouse or child(ren) by providing written notice to the Plan Sponsor.

In no event will the employer continue subsidizing the premium once 36-months of continuation coverage is exhausted. At that point, the covered spouse and/or child(ren) will be responsible for paying the full premium until any of the termination events described above occur.

Eligible Dependents of Deceased Active Employees – Dual Employed Benefit Package

If a spouse or Domestic Partner dies while both individuals work at the University in benefit eligible positions, and are covered under the "dual employed" benefit package, the employee remaining on the Plan must elect one of the available standard (non-"dual employed") plan options effective the first of the month following one month after the month in which death occurred.

- For example, if a dual employed employee passes away on February 15th, the surviving spouse must select a standard plan option that will be effective on April 1st.

The amount of premium the employee and/or child(ren) will be required to pay will be based on the salary tier of the surviving employee at the time of his/her spouse's death.

Eligible Dependents of Deceased Early Retiree

If You, as an early retiree of Utah State University die, Your Enrolled Dependents (spouse and/or child(ren)) who were covered immediately preceding Your death may continue receiving the medical and/or dental insurance on the same subsidized basis as prior to Your death. The surviving eligible family member(s) may continue insurance benefits by paying the early retiree rate for the remainder of the eligible early retirement period provided the eligible family member(s) is not Medicare eligible.

- If the enrolled surviving spouse reaches Normal Medicare Eligibility Age before the 36-month maximum time period is exhausted, medical coverage will terminate on the date of Medicare eligibility. Dental coverage may be extended beyond Normal Medicare Eligibility Age until one of the termination events described below occur.

    - Termination for enrolled surviving child(ren) will occur on the later of the child(ren)'s loss of eligibility for coverage as a Dependent due to attainment of maximum age (26) or 36 months from the early retiree's death.
    - If the enrolled spouse or child(ren) become covered by another group health plan (which does not limit or exclude any preexisting condition the person might have, either because of no applicable preexisting condition or sufficient creditable coverage to eliminate any preexisting condition limitation) during the initial 36-month continuation of coverage or later, the spouse or child(ren) must notify Utah State University within 30 days and coverage under this plan will terminate on the date of eligibility for the other coverage.

- If, after the initial 36-months of continuation coverage the enrolled spouse has remarried or remarries, the spouse must notify Utah State University within 30 days and coverage under the plan for the spouse and child(ren) will terminate on the date of the marriage.
- At any time, coverage may be terminated by the enrolled spouse or child(ren) by providing written notice to the Plan Sponsor.

In no event will Utah State University continue subsidizing the premium once 36-months of continuation coverage is exhausted. At that point, the enrolled covered spouse and/or child(ren) will be responsible for paying the full premium until any of the termination events described above occur.

Qualified Medical Child Support Order (QMCSO)

As required by the Federal Omnibus Budget Reconciliation Act of 1993 (OBRA '93) and notwithstanding the above dependency requirement for coverage as a Dependent under this Plan, any child who is under 18 years of age, or who is any age and incapacitated from earning a living and without sufficient means, and who is an alternate recipient under a QMCSO (see Note below) will be considered as having a right to Dependent coverage under this Plan.

If a QMCSO requires that You provide health and dental coverage for Your child(ren) and You do not enroll the child(ren), the Plan must enroll the child(ren) upon application from their custodial parent, the state child support agency or Medicaid agency, as long as You are enrolled in the plan, and withhold from Your pay Your share of the cost of such coverage.

You may not drop coverage for the child(ren) unless You submit written evidence to the Plan that the child support order is no longer in effect. The Plan may make benefit payments for a Nonparticipating Provider's treatment of a child covered by a QMCSO directly to the child's custodial parent or legal guardian.

NOTE: A "Qualified Medical Child Support Order" is a judgment, decree, or order (including an approved settlement agreement) issued by a court of competent jurisdiction which: 1) provides for child support with respect to a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law, and relates to benefits under such plan; or 2) enforces a law relating to medical child support described in section 1908 of the Social Security Act with respect to a group health plan. To be a "Qualified Medical Child Support Order," a medical child support order must clearly specify: 1) Your name and last known mailing address and the name and mailing address of the child for whom health insurance coverage is required; 2) a reasonable description of the type of coverage to be provided by the Plan to the child for whom health insurance coverage is required or the manner in which such type of coverage is to be determined; 3) the period to which such order applies; and 4) each plan to which such order applies.

If a child is eligible for group medical insurance benefits at any place of employment as an employee, that child is not eligible for the Plan.

DEFINITIONS

The following definitions apply to this Who is Eligible 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.

How to Enroll and When Coverage Begins

This section explains how to enroll Yourself and/or Your eligible Dependents when first eligible or during a period of special enrollment. This section also describes when coverage under the Plan begins for You and/or Your Eligible spouse and children (a.k.a. Dependents).

NOTE: When counting days, the day following the event counts as day 1. For example, the day after the first day of work, the day after the date of birth, etc.

HOW TO ENROLL

To enroll, You must complete an application and file it with the Utah State University Human Resources Office within 30 days from Your first day of work as a benefits-eligible position.

To enroll then existing Dependents, You must complete an application including them and file it with the Utah State University Human Resources Office within 30 days from Your first day of work as a benefits-eligible position. If You apply to enroll Dependents who were Your family members on Your orientation or hire date more than 30 days from Your first day of work, they will not be eligible to enroll until the next annual open enrollment period, unless a special enrollment period occurs first.

For individuals originally hired as variable hour employees who subsequently qualify for medical coverage due to the number of hours worked through a specified measurement period, to enroll, You must complete an application and file it with the Utah State University Human Resources Office within 30 days of being eligible for the coverage. You will be notified in writing of Your eligibility by the University. If You don't enroll within the 30 day time period, You will not be eligible to enroll until You again qualify based on hours worked during the specified measurement period, unless a special enrollment period occurs first.

When You And/Or Your Dependents Are Initially Eligible

Upon first becoming eligible for coverage under the eligibility requirements in effect with the Employer, You will be entitled to apply for coverage for Yourself and/or Your eligible Dependents within 30 days of becoming eligible. Coverage for You and Your eligible Dependents will commence on the Effective Date which is the first day of active employment (or as otherwise specified by the Employer) subject to the receipt of a timely application. A timely application is defined as no later than 30 days from Your first day of work as a benefits-eligible position.

NOTE: You will be asked to provide a marriage certificate, Domestic Partner documentation and/or birth certificates or adoption paperwork at the time of enrollment.

NEWLY ELIGIBLE DEPENDENTS

You may enroll a Dependent who becomes eligible for coverage after Your effective date by completing and submitting an enrollment request (and, for a domestic partner, an affidavit of qualifying domestic partnership form) to USU human resources (HR). Request for enrollment must be made within 30 days of the Dependent's attaining eligibility and is done by completing and returning the Claims Administrator's enrollment/change form to USU HR. A document verifying the life event and the relationship (such as birth or marriage certificate) must be provided to the USU HR Office within 60 days, for the birth of a child and 45 days for all other life events. Coverage for such Dependents will begin on their effective dates (which, for a new child by birth, adoption or placement for adoption, is the date of birth, adoption or placement for adoption, if enrolled within the specified 30 days).

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your eligible Dependents, even though You didn't do so when first eligible, and not be considered a Late Enrollee.

Note that loss of eligibility does not include a loss because You failed to timely pay Your portion of the premium or when termination of coverage was because of fraud. It also doesn't include Your decision to terminate coverage, though it may include Your decision to take another action (for example, terminating employment) that results in a loss of eligibility.

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

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

If You declined coverage when first eligible and subsequently have one of the following qualifying events, You, Your spouse and any eligible children are eligible to enroll for coverage under the Contract within 30 days from the date of the qualifying event, except that, where the qualifying event is: becoming eligible for premium assistance under Title 26, Chapter 18 of the Utah Medical Assistance Act, You have 30 days to enroll, measured from the date You receive initial written notification of the eligibility for premium assistance; or You and/or Your Dependent(s) becoming eligible for premium assistance under Medicaid or Children's Health Insurance Program(CHIP), You have 30 days to enroll, measured from the date of the qualifying event:

- You marry or begin a domestic partnership;
- You acquire a new child by birth, adoption, or placement for adoption. NOTE: Your domestic partner is not eligible to enroll for coverage under the Plan in this situation;
- You become eligible for premium assistance according to Title 26, Chapter 18 of the Medical Assistance Act; or
- You and/or Your Dependent(s) become eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP).

For all qualifying events, if You enroll as required, coverage will be effective on the first of the calendar month following the date of the qualifying event, except that where the qualifying event is a child's birth, adoption, or placement for adoption, or You marry, coverage is effect from the date of the qualifying event.

LATE ENROLLMENT/ANNUAL OPEN ENROLLMENT PERIOD

If You wish to enroll and/or add Your eligible Dependents under the Plan but did not enroll when first eligible or during a previous annual open enrollment period (Late Enrollee) and You do not qualify for any of the special enrollment exceptions, You may enroll in coverage and/or add Your eligible Dependents only during a future annual open enrollment period, if any. Coverage for a Late Enrollee will commence on the Effective Date which, for a Late Enrollee, is always the first day of the next Contract Year.

ENROLLMENT BY OTHERS

In the event Your child is the subject of a court or administrative order requiring You to provide health coverage for the child and You are eligible for health coverage including the child, but fail to make application to cover the child, application for enrollment of both You and the child may be made by the child's other parent, any state Medicaid agency or by the state agency administering 42 U.S.C. 651 through 699 (the child enforcement program). See also "Qualified Medical Child Support Order" in the Who Is Eligible Section in this SPD.

NOTICE OF STATUS CHANGE

Any change in Your family status must be reported to the Utah State University Human Resources Office within 30 days after the change. Changes include the following:

- marriage or domestic partnership;
- divorce;
- birth;
- adoption;
- placement of a child in Your home for whom You have court-appointed legal guardianship;
- death of a spouse or Dependent; and
- marriage of a child.

For more information regarding family status changes, please refer to the Utah State University Cafeteria Benefit Plan Document.

NOTICE OF ADDRESS CHANGE

To change Your address, please log in to Self Service Banner and make the change under the Personal Information menu.

When Coverage Ends

This section describes the situations when coverage may end for You and/or Your Dependents.

PLAN TERMINATION

If the Plan is terminated or not renewed by the Employer or the Claims Administrator, coverage ends for You and Your Dependents on the date the Plan is terminated or not renewed.

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

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, You and Your Dependents' coverage will end as indicated. However, it may be possible for You and/or Your Dependents to continue coverage under the Plan according to the continuation of coverage provisions in this SPD.

NOTE: If a spouse or Domestic Partner covered under the "dual employed" benefit package loses their eligibility (as explained in the following paragraphs), the employee remaining on the Plan must be moved to one of the standard plan options. The spouse or Domestic Partner may choose coverage as a Dependent of the remaining employee or they may elect COBRA coverage according to the continuation of coverage provisions in this SPD.

Termination Of Your Employment

If You are no longer eligible due to termination of employment, Your coverage will end for You and all Dependents on the 16th of the month if employment termination occurs between the 1st and the 15th of the month, or the 1st day of the following month if employment termination occurs between the 16th and last day of the month, or the date specified by the Employer, except, nine month base Employees who terminate at the end of the academic year are covered through the last day of the month in which the academic year is completed and retiring Employees are covered through the last day of the month in which they retire.

Termination by You

Because the Plan premiums are run through a Section 125 (pre-tax) plan, You may only terminate coverage for You and/or Your eligible Dependents during the Annual Open Enrollment. Exceptions to this may apply if You or Your Dependents have a qualifying Family Status Change as defined in the Utah State University Cafeteria Benefit Plan Document.

Nonpayment Of Required Contribution

If You fail to make the required contribution in a timely manner, Your coverage will end for You and all Dependents on the date You fail to make such a required contribution.

Termination By Employer

If the University terminates Your coverage for any cause not otherwise specified, Your coverage will end for You and all Your Enrolled Dependents on the date of such a termination.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your Dependents are no longer eligible as explained in the following paragraphs, their coverage will end as indicated. However, it may be possible for Your ineligible Dependents to continue coverage under the Plan according to the COBRA Continuation of Coverage Section in this SPD.

Divorce or Annulment

Eligibility ends for Your enrolled spouse and the spouse's children (unless such children remain eligible by virtue of their continuing relationship to You) on the date a divorce or annulment is final.

If You Die – See Eligibility Section for details

Termination of Domestic Partner

If Your Domestic Partner Relationship terminates, eligibility ends for the Domestic Partner and the Domestic Partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the monthly period following the date of termination of the Domestic Partner. Termination of Your Domestic Partner 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 Partner within 30 days of its occurrence. You may not file another affidavit of qualifying Domestic Partner within 90 days after a request for termination of a Domestic Partner has been received.

Loss Of Dependent Status

- For an enrolled child who is no longer an eligible Dependent due to exceeding the Dependent age limit, eligibility ends on the last day of the month following the child's 26th Birthday.
- For an enrolled child who is no longer eligible due to disruption of placement prior to legal adoption and the child is removed from placement, eligibility ends on the date the child is removed from placement.
- For an enrolled child who is no longer an eligible Dependent for any other cause (except by reason of divorce or Your death), eligibility ends on the last day of the monthly period in which the child is no longer a Dependent.

Ramifications For Keeping Ineligible Dependents on Your Plan

If You neglect to notify Human Resources when a Dependent is no longer eligible to remain on the Plan, and subsequently the Plan makes claim payments on the ineligible Dependents behalf, You will be responsible for reimbursing the Plan for 100 percent of all ineligible claim payments.

Military Service

If a Dependent enters active military service of any country, coverage for the Dependent will end on the date of entry into such military service (subject to any rights to continue coverage in the Plan under the Uniformed Services Employment and Reemployment Act of 1994 (USERRA).

- It is the intent of the Plan to comply with all existing regulations of USERRA. If for some reason the information presented here differs from the actual regulations of USERRA, the Plan reserves the right to administer the Plan in accordance with such actual regulations. Coverage under this provision runs concurrently with coverage continued under COBRA.
- Refer to Your Employer for more detailed information regarding Your eligibility for and the terms and conditions of USERRA.

Other Coverage

If an enrolled Claimant obtains group coverage through a non-USU employer group plan, coverage for the Claimant will end on the date such coverage is obtained.

Fraudulent Use of Benefits

If You or Your Dependent engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of material fact in connection with coverage, coverage under the 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 Dependents. In the event of any intentional misrepresentation of material fact or fraud, the Plan will have the following rights in accordance with Utah Code Annotated 31A-31-103 (or any successor thereto):

- 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.

FAMILY AND MEDICAL LEAVE

If You are eligible for and Your Employer 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 Enrolled Dependents 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;
    - the placement of a child with You for adoption or foster care;
    - “to care for Your spouse, child or parent with a serious health condition;”
    - You suffer a serious physical Illness or Mental Health Condition; or
    - a qualifying exigency arises because Your spouse, son, daughter, or parent is on active duty (or has been notified of a call or order to active duty) in the Regular Armed Forces, National Guard or Reserves in support of a "contingency operation."
- Under the Service Member Family Leave, Section 585 of the National Defense Authorization Act, FMLA is amended to permit 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) to take up to 26 work weeks of leave during a 12 month period to care for the service member because of any qualifying exigency, as the Secretary of Labor shall, by regulation determine. Next of kin means the nearest blood relative of the service member. A serious Illness or Injury in the case of a covered service member means an Illness or Injury incurred by the service member in the line of duty while on active duty in the Armed Forces that may render the service member medically unfit to perform the duties of the service member's office, grade, rank, or rating.

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 through Your Employer. The provisions described here will not be available if this Plan terminates.
- If You and/or Your Dependents elect not to remain enrolled during the leave, You (and/or Your Dependents) 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 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 Dependents) 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 Dependents 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. This leave provision is available only to groups that are required by law to comply. The Plan must keep the Claims Administrator advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by the Act.

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 month 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 percent 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"), without a pre-existing condition waiting period.

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.

NOTE: The Uniformed Services Employment and Reemployment Act of 1994 is a federal law addressing the rights of certain employees who return to their previous employers after service in the United States uniformed services under certain conditions. The law also allows such individuals to continue employer plan coverage during their absence for military service for the lesser of 24 months or the period of military service.

Sabbatical Leave

If You are on an approved paid sabbatical leave from Utah State University and currently insured under the Utah State University Plan, You receive full Plan benefits, including medical and dental insurance, during the sabbatical period. You are still considered an Employee of the Employer. Please contact Human Resources for details relating to approved paid sabbatical leaves because some USU employee benefits unrelated to this health plan may have restrictions.

Approved Unpaid Leave Of Absence

If You are on an approved non-FMLA, non-sabbatical leave without pay and drop Your percent time worked below 50 percent for the fiscal year, Your medical and dental coverage will be terminated and You'll be offered COBRA continuation coverage. You may, upon Your return to employment, re-enroll in the medical and dental insurance. Please contact Human Resources for details relating to approved unpaid leaves of absence because some USU employee benefits unrelated to this health plan may have restrictions.

LEAVE OF ABSENCE

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

A leave of absence is a employer-granted period off work made at Your request during which You are still considered to be employed and are carried on the employer's employment records. A leave can be granted for any reason acceptable to Your employer. If You are on leave for an FMLA-qualifying reason,

You remain eligible under the Plan only for a period equivalent to FMLA leave and may not also continue coverage with a non-FMLA leave.

If You and/or Your Dependents elect not to remain enrolled during the leave of absence, You (and/or Your Dependents) may reenroll under the Plan only during the next annual open enrollment period.

COBRA Continuation of Coverage

This COBRA Continuation of Coverage Section applies only when the Employer is subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA. Under certain circumstances called qualifying events, Claimants may have the right to continue coverage beyond the time coverage would ordinarily have ended. 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. This section does not provide a full description of COBRA and more complete information is available from the Employer.

Additionally, there may be other coverage options for You and Your family. When key parts of the health care law take effect, You will be able to buy individual or family coverage through the Health Insurance Marketplace in Your state. In the Marketplace, You could be eligible for a new kind of tax credit that will help You pay for this coverage (based upon income criteria). Being eligible for COBRA does not limit Your eligibility for coverage for a tax credit through the Marketplace.

Who Is Eligible For Cobra Continuation And How Long It Lasts

If Your health coverage terminates due to either of the following qualifying events, You may elect COBRA continuation coverage for a maximum of 18 months following the date that Your coverage normally would have been lost:

- termination of Your employment for reasons other than gross misconduct; or
- reduction in Your hours of employment, which results in a loss of eligibility for coverage.

Your Dependents whose health coverage terminates due to either of these qualifying events may also elect this COBRA Continuation Coverage for a maximum of 18 months. If health coverage for any of Your Dependents terminates due to any of the following qualifying events, that Dependent 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 legally separate;
- You and Your Domestic Partner no longer meet requirements outlined in the definition of a Domestic Partner;
- You become entitled to Medicare benefits; or
- Your Enrolled Dependent loses eligibility as a Dependent under the Plan.

By electing COBRA continuation coverage, unless You specify to the contrary, You will automatically be maintaining benefits on behalf of Yourself, as well as Your Dependents. If COBRA continuation coverage is not desired for You or any of Your Dependents, each Enrollee (including You) may independently elect such coverage on behalf of themself. Any election by Your spouse will automatically continue coverage of Your children, unless specified to the contrary.

Social Security Disability: COBRA coverage following a termination of employment/reduction in hours qualifying event can be extended to a maximum of up to 29 total months if You or Your Dependent is determined to have been disabled for purposes of Title II or Title XVI of the Social Security Act at the time of the initial qualifying event or within the first 60 days of COBRA continuation coverage. To be eligible for the extension, You or Your Dependent must provide the Plan documentation of the Social Security disability determination within 60 days of the date it is made and while still within the 18-month continuation period. The disability extension extends to You and Your Dependents, even if only one of You is disabled.

Second Qualifying Events: Enrolled Dependents who enrolled in COBRA coverage as a result of Your termination of employment or reduction in hours, who experience another qualifying event, may extend

COBRA coverage up to 36 months. You must provide the Employer written notice of the second qualifying event within 60 days from the date of the event. Second qualifying events include:

- Your death;
- You and Your spouse divorce or legally separate;
- You and Your Domestic Partner no longer meet requirements outlined in the definition of a Domestic Partner;
- You become entitled to Medicare benefits; or
- Your Enrolled Dependent loses eligibility as a Dependent under the Plan.

However, in no event will COBRA continuation coverage extend beyond 36 months from the date coverage was first lost due to the termination of employment/reduction in hours qualifying event. You or Your Dependent must provide the Plan notice of the occurrence of one of these qualifying events.

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 Dependents will be allowed to continue their COBRA coverage until the later of:

- up to 18 months from the date coverage otherwise would be lost due to the termination of employment/reduction in hours, or
- up to 36 months from the date You became entitled to Medicare.

When COBRA Continuation Coverage Ends

COBRA continuation under this Plan will end for You and/or Your Dependents as of the last day of the monthly premium payment period in which any of the following occurs:

- failure to make premium payments necessary to bring premiums current within 45 days of electing COBRA;
- failure to make the monthly premium payment within 30 days of the Premium Due Date;
- the date, after election of COBRA, that You and/or Your Dependents become covered under another group health plan (which does not limit or exclude any Preexisting Condition the person might have, either because of no applicable Preexisting Condition or sufficient creditable coverage to eliminate any Preexisting Condition limitation) or become entitled to Medicare benefits;
- the date this Plan terminates; or
- the applicable period of COBRA continuation ends.

COBRA Continuation under this Plan will end for You and/or Your Dependents who are covered under the extended coverage due to disability:

- when there is final determination that You and/or Your Dependents are no longer disabled for the purposes of Title II or Title XVI of the Social Security Act, as of the later of:
    - the last day of 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.
    - This event will terminate the continuation of all Claimants who had qualified to extend by virtue of the Claimant's disability and it is Your or Your Dependent's responsibility to notify the Plan of such a final determination within 30 days of the day it is made.

When You Acquire A New Child While You Are On COBRA

Children born to You or placed with You for adoption while You are on COBRA may be added to COBRA coverage and have all the rights extended to You and/or Your other Dependents who have elected COBRA. Addition of such children must occur in accordance with the terms of the Who Is Eligible Section in this SPD.

Notification Responsibilities

In order to preserve rights under COBRA, Claimants and the Plan must meet certain notification, election and payment deadline requirements.

Employee Notification Obligation: Under COBRA, You or one of Your Dependents must inform the Plan in writing within 60 days that begins on the later of:

- The date of the qualifying event (Your divorce or legal separation, or a loss of Dependent status);
- The date on which there is a Loss of Coverage; or
- The date on which the qualified Dependent is informed of this notice requirement by receiving this SPD or the General COBRA Notice.

Plan Notification Obligation: The Plan is responsible for notifying the COBRA Administrator when coverage terminates due to qualifying events that are the Employee's termination of employment or reduction in hours, death of the Employee, or the Employee becoming entitled to Medicare benefits due to age or disability. The Plan will notify the COBRA Administrator within 30 calendar days when these events occur.

Once the COBRA Administrator is notified of a qualifying event, it will send You and/or Your Dependents information concerning continuation options within 14 days which will include the necessary COBRA continuation election forms. You and/or Your Dependents will have 60 days from the later of the date of the qualifying event or when You and/or Your Dependent receives notice from the Plan in which to make an election.

As mentioned above, to be eligible for disability extension, You or Your Dependent must provide the Plan documentation of a Social Security disability determination within 60 days of the date it is made and while still within the 18 month COBRA Continuation period following a termination or reduction of hours qualifying event. The determination must reflect that You or Your Dependent was disabled for Social Security purposes at the time of the initial qualifying event or within the first 60 days of COBRA continuation. If a final determination is subsequently made that You or Your Dependent is no longer disabled for Social Security purposes, You or Your Dependent must provide the Employer notice of that determination within 30 days of the date it is made.

If Your Dependents experience any of the below second qualifying events, You must provide a written notice to the Employer within 30 days of the second qualifying event and during the original 18 month COBRA coverage period in order to extend COBRA coverage up to 36 months.

- Your death;
- You and Your spouse divorce or legally separate;
- You and Your Domestic Partner no longer meet requirements outlined in the definition of a Domestic Partner;
- You become entitled to Medicare benefits; or
- Your Enrolled Dependent loses eligibility as a Dependent under the Plan.

However, in no event will COBRA continuation coverage extend beyond 36 months from the date coverage was first lost due to the termination of employment/reduction in hours qualifying event. You or Your Dependent must provide the Plan notice of the occurrence of one of these "second" qualifying events.

Paying Continuation Premium

If Claimants wish to continue coverage, they must pay for it. The premium will reflect the total cost (employer and employee portion) of the group health care coverage and up to a 2 percent administration fee. For those Claimants who receive COBRA Continuation Coverage due to a Social Security disability determination, the premium and administration fees will be 150 percent of the total cost for coverage. Coverage will cease if timely premium payments are not made. Claimants have a maximum of 45 days from the date that the election form is mailed to the Plan to submit the first payment. This first payment must retroactively cover any period of time after the date coverage was terminated. All subsequent payments are due on the first day of the month for which coverage is to be provided or within a 30-day

grace period thereafter. If, for whatever reason, any qualified Dependent receives any benefits under the Plan during a month for which the payment was not made on time, then the qualified Dependent will be required to reimburse the Plan for benefits received. If the COBRA Administrator receives a check that is missing information or has discrepancies regarding the information on the check (for example, the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the qualified Dependent and allow him/her 14 days to send in a corrected check. If a corrected check is not received within the 14-day time frame, then the occurrence will be treated as non-payment and the qualified Dependent (s) will be termed from the Plan. Note that payment will not be considered made if a check is returned for non-sufficient funds.

If COBRA coverage terminates due to non-payment of premium, it cannot be reinstated under any circumstances.

If Claimants Do Not Elect COBRA Continuation

If Claimants do not elect COBRA continuation coverage, coverage under the Plan will end according to the terms of the Plan and the Plan will not pay claims for services provided on and after the date coverage ends.

Importance Of Keeping Information Current

It is very important that You keep the Employer informed of the current address of all Claimants who are or may become qualified Dependents.

Post-Retirement Continuation Coverage

In addition to those benefits described under the BENEFITS FOR RETIREES section, certain Claimants may qualify for the post-retirement continuation coverages described below. These coverages are conditioned upon election of COBRA and timely payment of any required premiums. These continuation coverages run concurrently with and satisfy all mandated continuation of coverage requirements under federal and state laws, including, but not limited to COBRA; that is, the first 36 months of these post-retirement continuation coverages will exhaust all rights of a continuing member to COBRA coverage and will comply with and be subject to all the terms, conditions, and requirements of COBRA. Maximum periods of post-retirement continuation are described below, but these continuation coverages will end before those maximum periods:

- for any Claimant who becomes entitled to Medicare (medical only),
- for any Claimant for whom required premium is not paid in a timely manner; or
- for all Claimants, if the Employer ceases to offer a group health plan to any of its employees.

These are the "early termination events" and post-retirement continuation will end upon the date of the occurrence of any of them. The occurrence of any event after more than 36 months on post-retirement continuation coverage will not serve to add to the period of available coverage, even if such event would have been a further qualifying event were COBRA coverage in effect. Premiums for post-retirement continuation coverage are calculated as a percentage of an estimate of the premium for active Employees and Dependents and the percentage used for this purpose beyond 36 months of post-retirement continuation may be greater than that used for the first 36 months of continuation coverage. For purposes of the following, "Normal Medicare Eligibility Age" means the age at which an otherwise qualified individual may enroll in Medicare by virtue of attaining a specific number of years of age. At this time, normal Medicare eligibility age is 65 years of age, but references to this term will be amended automatically to reflect any subsequent statutory change in this age.

Eligible Retiree

An eligible Employee of the Employer who retires from service has the option to continue medical coverage at their own expense for themself until the end of the month in which the retiree reaches Normal Medicare Eligibility Age, but in any event for at least 18 months (unless one of the early termination events described above occurs first). An eligible Employee of the Employer who retires from service also has the option to continue dental coverage at their own expense for at least 18 months (unless one of the applicable early termination events described above occurs first). If an Employee has already reached Normal Medicare Eligibility Age before retiring, or retires simultaneously with reaching Normal Medicare Eligibility Age, they have the option to continue medical and dental coverage at their own expense for themself for up to 18 months from retirement (unless one of the early termination events described above occurs first).

NOTE: Please contact Human Resources for more information regarding Your options. In some situations, electing Medicare Parts A and B rather than remaining on the Utah State University medical coverage may be to Your benefit. Dental coverage may be continued on a standalone basis.

Retiree's Spouse

An eligible Employee of the Employer who retires from service has the option to continue medical coverage at their own expense for their spouse who is a Dependent immediately before the retirement until the end of the month in which the spouse reaches Normal Medicare Eligibility Age, but in any event for at least 36 months from the Employee's retirement (unless one of the early termination events described above occurs first). An eligible Employee of the Employer who retires from service also has the option to continue dental coverage at their own expense for their spouse who is a Dependent for at least 36 months (unless one of the applicable early termination events described above occurs first). If an Employee's spouse has already reached Normal Medicare Eligibility Age before the Employee's retirement, or reaches that age simultaneously with the Employee's retirement, the Employee has the option to continue medical and dental coverage at their expense for their spouse for up to 36 months from the Employee's retirement (unless one of the early termination events described above occurs first). See above Note.

Retiree's Children

An eligible Employee of the Employer who retires from service has the option to continue medical coverage at their own expense for their child who is a Dependent immediately before the retirement until the end of the month in which the Employee or Employee's covered spouse reaches Normal Medicare Eligibility Age (whichever reaches that age later), or, if earlier, the child's loss of eligibility for coverage as the Employee's Dependent under the provisions of the Plan, but in any event for at least 36 months from the Employee's retirement (unless one of the early termination events described above occurs first). An eligible Employee of the Employer who retires from service also has the option to continue dental coverage at their own expense for their child who is a Dependent for at least 36 months (unless one of the applicable early termination events described above occurs first.

Eligible Early Retiree

An eligible Employee of the Employer who meets the eligibility requirements of the Early Retirement Incentive Program and is approved by their respective administration may have medical insurance continued for himself or herself under the provisions of the Early Retirement Program from the date of their early retirement until the end of the month in which the early retiree reaches Normal Medicare Eligibility Age, but in any event for at least 18 months (unless one of the early termination events described above occurs first). An eligible Employee of the Employer who meets the eligibility requirements of the Early Retirement Incentive Program and is approved by their respective administration may have dental insurance continued for himself or herself under the provisions of the Early Retirement Program for the duration of the Early Retirement Incentive Agreement. Continuation of medical and dental insurance for an early retiree remains at the shared expense of the Employee and the Employer and will be adjusted commensurate with other annual rate changes. The Employer will not be responsible to pay the expense of continuation for a period in excess of six years and the early retiree may continue coverage at their own expense for any period between the end of those six years and the end of the continuation period described above.

Eligible Early Retiree's Spouse

An eligible Employee of the Employer who meets the eligibility requirements of the Early Retirement Incentive Program and is approved by their respective administration may have medical insurance continued for their spouse who is an Dependent immediately before their retirement under the provisions of the Early Retirement Program from the date of their early retirement until the end of the month in which the spouse reaches Normal Medicare Eligibility Age, but in any event for at least 36 months from the Employee's early retirement (unless one of the early termination events described above occurs first). An eligible Employee of the Employer who meets the eligibility requirements of the Early Retirement Incentive Program and is approved by their respective administration may have dental insurance continued for their spouse who is a Dependent immediately before their retirement for the duration of the Early Retirement Incentive Agreement. Continuation of medical and dental insurance for an early retiree's spouse remains at the shared expense of the Employee and the Employer and will be adjusted commensurate with other annual rate changes. The Employer will not be responsible to pay the expense of continuation for a period in excess of six years and the early retiree or spouse may continue coverage at their own expense for any period between the end of those six years and the end of the continuation period described above. If an Employee's spouse has already reached Normal Medicare Eligibility Age before the Employee's early retirement, or reaches that age simultaneously with the Employee's early retirement, the Employee will have medical and dental insurance continued for their spouse who is covered as their Dependent immediately before their retirement under the provisions of the Early Retirement Program for up to 36 months from the Employee's early retirement (unless one of the early termination events described above occurs first) and such continuation will be at the expense of the Employer.

Early Retiree's Children

An eligible Employee of the Employer who meets the eligibility requirements of the Early Retirement Incentive Program and is approved by their respective administration may have medical insurance continued for their child who is an Dependent immediately before their retirement under the provisions of the Early Retirement Program from the date of their early retirement until the end of the month in which the Employee or Employee's covered spouse reaches Normal Medicare Eligibility Age, or, if earlier, the

child's loss of eligibility for coverage as the Employee's Dependent under the provisions of the Plan, but in any event for at least 36 months from the Employee's retirement (unless one of the early termination events described above occurs first). An eligible Employee of the Employer who meets the eligibility requirements of the Early Retirement Incentive Program and is approved by their respective administration may have dental insurance continued for their child who is a Dependent immediately before their retirement for the duration of the Early Retirement Incentive Agreement. Continuation of medical and dental insurance for an early retiree's child remains at the shared expense of the Employee and the Employer and will be adjusted commensurate with other annual rate changes. The Employer will not be responsible to pay the expense of continuation for a period in excess of six years and the early retiree or child may continue coverage at their own expense for any period between the end of those six years and the end of the continuation period described above.

Incapacitated Dependent Of Early Retiree Or Under-Age-65 Employee In Phased Retirement:

In cases of a covered incapacitated Dependent, eligibility for continuation of coverage will be extended to the end of the month that the early retirement or phased retirement ends. In no case will that exceed the date the employee reaches Full Social Security Age.

Spouse Or Child Of Deceased Retiree Or Early Retiree – refer to Eligibility Section

Benefits For Employees Working Beyond Age 65

Please contact CMS or visit Your local Medicare office for complete information regarding Your Medicare options. Medicare is beyond the purview of this document.

Benefits For Retirees

If You are covered under a Regence BCBSU plan when You retire, You may elect to continue coverage as follows:

- Medicare Advantage Plan or Medicare Supplement Plan (please contact Extend Health at www.extendhealth.com/retireebenefits or call 1 (888) 724-3001 for more information);
- COBRA; or
- Post-Retirement Continuation Coverage.

Refer to the applicable Section in this SPD for details regarding Conversion, COBRA or Post-Retirement Continuation Coverage options.

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 AGENT
The Plan Sponsor is Your agent for all purposes under the Plan and not the Claims Administrator's agent. You are 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 agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in this SPD. 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 SPD.

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 Web site 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 SPD 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 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.
- 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.

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

Claimant means a Participant or a Dependent.

Coinsurance means the percentage of the Allowed Amount for incurred covered services, supplies, or Prescription Medications that You are responsible for.

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.

Copayments mean the fixed dollar amount that You must pay directly to the Provider for specified services or supplies.

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

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.

Deductible means the dollar amount a Claimant is responsible to pay before the Plan will pay for services, supplies or Prescription Medications.

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 under the plan.

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

Dependent means a Participant's eligible spouse or child(ren) who are listed on the Participant's completed enrollment form and who is enrolled under the Plan. (See the Who is Eligible Section in this SPD for more information).

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.

Employer means Utah State University.

Enrolled Dependent means each individual who was covered under the Plan on the day before a COBRA qualifying event and has an independent right to purchase COBRA Continuation Coverage. Enrolled Dependent includes the employee's spouse and child(ren).

Enrollment Date/Enrolled Date means:

- If You enrolled during Your initial period of eligibility, Enrollment Date means Your Effective Date of coverage or, if earlier, the first day of any waiting period for coverage applied to You.
- If You enrolled during a special enrollment, the enrollment date is the Effective Date of coverage.
- If You are a Late Enrollee, the Enrollment Date is the Effective Date of coverage.

Family means a Participant and any Dependents.

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:
    - 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.

Late Enrollee means You or You on behalf of Your Dependent(s) declined coverage when first eligible and subsequently enrolled in the Plan during the annual open enrollment period.

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.

Maximum Benefits means the maximum Allowed Amount the Plan will pay per Participant for services, supplies, and/or Prescription Medications. Maximum amounts may be Lifetime and/or Plan Year limits.

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 Sponsor means Utah State University.

Plan Year means the 12-month period from July 1 through June 30 of the following year; however, the first Plan Year begins on 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.

Upfront Benefit means those Covered Services designated as "Upfront" which may not be subject to any Coinsurance amount. Once the Upfront Benefit dollar maximum has been reached, additional coverage is available subject to any Deductible, Copayment and/or Coinsurance. Refer to the Upfront Benefit provisions in the Medical Benefits Section to determine coverage.

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 SPD.**

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

CONDITION MANAGER

If You are identified to participate, Condition Manager is a support and education program for people with chronic conditions. A care team will provide tailored educational materials, tools and other services to help You get on track with Your care and stay there. They can help You understand the care plan You've developed with Your Physician and/or Practitioner and make smarter choices for health. To learn more, call 1 (833) 521-1411.

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 Web site 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.

General Plan Information

EMPLOYER
The University's legal name and federal Employer Identification Number (EIN) are:

Utah State University

EIN # 87-6000528

PLAN NAME
The name of the Plan is The Utah State University Employee Health Care Benefits Plan.

PLAN YEAR
The Plan Year is the twelve-month period beginning July 1 and ending on June 30.

TYPE OF PLAN
The Plan is commonly known as an employee welfare benefit plan. The Plan has been adopted to provide You certain benefits as described in this document.

PLAN FUNDING
Funding is derived first from the contributions made by the covered employees and then from general assets of The University. The level of Your contributions will be set by The University. Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received.

PLAN SPONSOR
Utah State University
8800 Old Main Hill
Logan, UT 84322

(435) 797-1146

LEGAL PROCESS
Address where a processor may serve legal process:

Utah State University
8800 Old Main Hill
Logan, UT 84322

CLAIMS ADMINISTRATOR
Utah State University has contracted with a Claims Administrator to assist The University with claims adjudication. The Claims Administrator's name, address and telephone number are:

Regence BlueCross BlueShield
P.O. Box 2998
Tacoma, WA, 98401-2998
Customer Service: (866) 240-9580
Case Management: (800) 624-6519

PLAN SPONSOR'S RIGHT TO TERMINATE
The University reserves the right to amend or terminate this Plan in whole or in part, at any time, regardless of You or Your Enrolled Dependent's health or treatment status. Amendment or termination may result in modification or termination of Your coverage and/or the coverage of Your Enrolled Dependents. Covered Services and Allowed Amount incurred prior to the Plan's amendment or termination will be paid as provided under the terms of the Plan as it existed at the time they were incurred.

PLAN SPONSOR'S RIGHT TO INTERPRET THE PLAN

The University reserves the right to interpret the Plan's coverage and meaning in the exercise of its sole discretion.

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

Regence