Regence

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

This is a partial summary of benefits only and in the event of any inconsistency between this summary and Your Agreement, the terms of the Agreement will prevail. The Agreement contains a complete detail of benefits, limitations and exclusions, and also describes grievance procedures. In any application for the benefits described in this summary, You will choose between using the Regence BlueCross BlueShield of Utah and ValueCare provider networks as contracting providers. Regence BlueCross BlueShield of Utah will be the insurer regardless of the provider network that you choose.

Refer to the Summary of Prescription Drug benefits for Prescription Drug coverage.

Individual BlueChoices - BlueAdvantage $1,000 Deductible Copayment Plan

BENEFIT	CONTRACTING PROVIDER	NON-CONTRACTING PROVIDER
Maximum Benefit	$2,000,000 per Enrollee.	
Calendar Year Deductible	$1,000 per Enrollee; $2,000 per Family Unit	
Out-of-Pocket Maximum	$3,500 per Enrollee; $7,000 per Family Unit	
Ambulance Services	After Deductible, We pay 80% and You pay 20% of Eligible Medical Expenses.	After Deductible, We pay 60% of Eligible Medical Expenses and You pay balance of billed charges.**
Chemotherapy and Radiation Treatment	After Deductible, We pay 80% and You pay 20% of Eligible Medical Expenses.	After Deductible, We pay 60% of Eligible Medical Expenses and You pay balance of billed charges.**
Durable Medical Equipment and Supplies, Prosthetic and Orthotic Devices	After Deductible, We pay 80% and You pay 20% of Eligible Medical Expenses.	After Deductible, We pay 60% of Eligible Medical Expenses and You pay balance of billed charges.**
Emergency Department (Including Professional Services)	After Deductible and $75 Copayment per visit, We pay 80% and You pay 20% of Eligible Medical Expenses.	After Deductible and Copayment, We pay 60% of Eligible Medical Expenses and You pay balance of billed charges.**
Home Health Care/Home Infusion Therapy Services/Hospice Care	After Deductible, We pay 80% and You pay 20% of Eligible Medical Expenses.	After Deductible, We pay 60% of Eligible Medical Expenses and You pay balance of billed charges.**
Hospital - Inpatient Facility Care (Including Professional Services) • Semi-Private Room Accommodations • Related Services and Supplies • Skilled Nursing Facility (SNF) • Inpatient Rehabilitation	After Deductible, We pay 80% and You pay 20%* of Eligible Medical Expenses.	After Deductible, We pay 60% of Eligible Medical Expenses and You pay balance of billed charges.**
Hospital - Outpatient Facility Care (Including Professional Services) • Surgery and Related Services • Diagnostic X-ray and Laboratory Services	After Deductible, We pay 80% and You pay 20%* of Eligible Medical Expenses.	After Deductible, We pay 60% of Eligible Medical Expenses and You pay balance of billed charges.**
Major Diagnostic Tests	After Deductible, We pay 80% and You pay 20% of Eligible Medical Expenses.	After Deductible, We pay 60% of Eligible Medical Expenses and You pay balance of billed charges.**
Maternity Care	You pay $5,000 Copayment per pregnancy*(Deductible waived).	After Copayment, We pay 100% of Eligible Medical Expenses and You pay balance of billed charges** (Deductible waived).
Mental Health Condition Services • Limited to $1,500 per Enrollee per Calendar Year	After Deductible, We pay 50% and You pay 50% of Eligible Medical Expenses. 50% of Eligible Medical Expenses does not apply toward Out-of-Pocket Maximum.	After Deductible, We pay 50% of Eligible Medical Expenses and You pay balance of billed charges.** 50% of Eligible Medical Expenses does not apply toward Out-of-Pocket Maximum.
Minor Diagnostic Tests	You pay $20 Copayment per visit (Deductible waived).	After Deductible and Copayment, We pay 80% of Eligible Medical Expenses and You pay balance of billed charges.**
Office or Clinic Visits for Injury/Sickness [1] Office Visit with Minor Surgeries and Laboratory Services [2] Office Visit with Major Surgeries and Laboratory Services	[1] You pay $20 Copayment per visit (Deductible waived). [2] After Deductible, We pay 80% and You pay 20% of Eligible Medical Expenses.	[1] After Deductible and Copayment, We pay 80% of Eligible Medical Expenses and You pay balance of billed charges.** [2] After Deductible, We pay 60% of Eligible Medical Expenses and You pay balance of billed charges.**
Office or Clinic Visits for Preventive Care • $300 per Enrollee per Calendar Year; unlimited for children age 5 and under • Designated Adult Preventive and Well Baby Care	You pay $20 Copayment per visit (Deductible waived).	After Deductible and Copayment, We pay 80% of Eligible Medical Expenses and You pay balance of billed charges.**

* If Eligible Medical Expenses for facility charges are greater than the billed charges, Your payment will be this percentage of billed charges.

BENEFIT	CONTRACTING PROVIDER	NON-CONTRACTING PROVIDER
Outpatient and Office or Clinic Rehabilitation Services • Limited to $1,500 per Enrollee per Calendar Year	After Deductible, We pay 80% and You pay 20% of Eligible Medical Expenses.	After Deductible, We pay 60% of Eligible Medical Expenses and You pay balance of billed charges.**
Urgent Care Clinic	You pay $20 Copayment per visit (Deductible waived).	After Deductible and Copayment, We pay 80% of Eligible Medical Expenses and You pay balance of billed charges.**
Accidental Death Benefits	Death benefits are payable to the estate of the subscriber in the event of death caused by accidental means. The death benefits are as follows: $25,000 per subscriber or spouse; $5,000 per child subscriber (under age 18) or dependent (see the Agreement for details).	
Benefit Payments for Accidental Injury/Life-Threatening Illness	$1,000 per Enrollee per Calendar Year for Eligible Medical Expenses received within 7 days after Accidental Injury or within 72 hours after onset of Life-Threatening Illness. When services are received from Non-Contracting Providers, You pay the balance of billed charges.**	
Special Beginnings®	You pay nothing.	

BLUECARD PROGRAM

When You receive Covered Services outside of Utah be sure to use Participating/BlueCard PPO Providers of the Blue Cross and/or Blue Shield Plan in the area where You receive the services. When You do, the amount You pay for Covered Services is usually calculated from the lower of:

- the actual billed charges for Your Covered Services, or
- the negotiated price that the host Blue Cross and/or Blue Shield Plan passes on to Us.

Often, this "negotiated price" will consist of a simple discount, but sometimes it is an estimated final price that factors in expected settlements with Your health care provider or with a specified group of providers. The negotiated price may also be a discount from billed charges that reflects average expected savings. The estimated or average price may be adjusted to correct for over- or underestimation of past prices. In addition, laws in a small number of states require Blue Cross and/or Blue Shield Plans to use a basis for calculating Your payment for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim. When You receive covered health care services in one of those states, Your required payment for those services will be calculated using that state's statutory methods (see the Agreement for details).

LIMITATIONS

- During the 12 months immediately following the date We received Your application, NO BENEFITS will be provided for Sterilization and a Preexisting Condition ("PEC"). Your limitation will be reduced by the aggregate periods of Creditable Coverage applicable to You as of the date We received Your application.
- A "Preexisting Condition" is a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within 6 months prior to the date We received Your application. See the Agreement for details regarding crediting of coverage.
- Limited coverage is available for certain solid organ transplants and bone marrow and stem cell transplants (see the Agreement for details).

WHAT IS NOT COVERED – This is only a partial summary of exclusions. The Agreement contains a complete list of exclusions.

- Artificial heart, pancreas, or liver implants; bone marrow transplants except in the treatment of certain conditions (see Agreement for details)
- Certain treatments of mental disorders; for example biofeedback, sensitivity training, hypnosis, family or marital problems, behavior disorders, psychosexual dysfunction, learning disabilities, mental retardation (see the Agreement for complete details)
- Cosmetic surgery; weight-loss treatment, including but not limited to surgical procedures and their reversals or revisions
- Counseling services, training or educational services, or services received to apply toward earning a degree
- Custodial care; Over-the-counter drugs and medicines (see the Agreement for exceptions)
- Experimental or investigational treatments or procedures
- Genetic studies; non-prescription contraceptives; reversal of sterilization; resterilization; artificial insemination; and in vitro fertilization
- Massage therapy; music, art, dance, or recreation therapy
- Physical fitness exercise equipment and spa or club memberships
- Services covered by Workers Compensation, government-sponsored programs and other insurance (such as no-fault automobile insurance)
- Services determined by Us to be not Medically Necessary
- Services for temporomandibular joint (TMJ) dysfunction; dental care; jaw surgery for augmentation or reduction; appliances or restorations to increase vertical dimensions or to restore occlusion
- Services for which the Claimant has no legal obligation to pay
- Services provided before the coverage begins or after coverage ends
- Services provided for or in connection with a non-Covered Service, including complications resulting directly from non-Covered Services
- Services rendered by a member of the patient's immediate family
- Services not licensed in Utah; Treatments or procedures outside generally accepted health care practice including holistic, homeopathic, ecological or environmental medicine; acupuncture
- Services not specifically listed in the Agreement as covered
- Services rendered by halfway houses, public or private schools
- Services provided for or in connection with erectile dysfunction
- Surgical correction of refractive errors of vision; eyeglasses, hearing aids or similar devices; routine foot care; corrective shoes and shoe accessories; personal convenience or hygiene items; special formulas, food supplements, or special diets
- Taxes, surcharges, tariffs, duties, assessments, or similar charges
- Telephone consultations, "missed" appointments, travel expenses, shipping, handling, postage, interest or finance charges
- Treatment of Illness or Injury caused by participation in illegal acts of violence; and services provided as a result of a court order or for other legal proceedings
- Vision and hearing examinations and/or preventive medical care, except as specifically provided

**Of the balance of billed charges, which You pay, amounts in excess of Eligible Medical Expenses do not apply toward Your Out-of-Pocket Maximum.

Regence

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

This is a partial summary of benefits only and in the event of any inconsistency between this summary and Your Agreement, the terms of the Agreement will prevail. The Agreement contains a complete detail of benefits, limitations and exclusions and also describes grievance procedures.

Individual BlueChoices - Prescription Drug Benefit

You pay $5 Copayment For Generic Prescription Drugs
You Pay 25% Copayment For Formulary Name Brand Prescription Drugs*
You Pay 50% Copayment For Non-formulary Name Brand Prescription Drugs*
You Pay 25% Copayment For Diabetic Supplies

*If You request a brand name drug in place of the generic equivalent, You will be responsible for the Copayment, plus the difference in price between the name brand drug and its generic equivalent, unless Your Physician directs the pharmacist to dispense only the brand name drug on the Prescription Order.

YOUR COVERAGE INCLUDES

- Any drug which, by state or federal law, may be dispensed only by written prescription from a licensed Physician (note exclusions)
- Legend oral contraceptives
- Insulin
- Diabetic supplies which include, but are not limited to needles, syringes, test strips, lancets, and other disposable diabetic supplies

Your benefit plan provides payment for the amount normally prescribed by Your Physician, but not more than a 34-day supply.

WHAT IS NOT COVERED

- A prescription drug during the first 6 months following its approval by the United States Food and Drug Administration, unless Our Pharmacy and Therapeutics Committee (or its successor) sooner approves coverage
- Any claim that is received by the Administrator more than one year from the date the prescription drugs were dispensed to the Enrollee
- Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order
- Charges for the administration or injection of any drug
- Contraceptives, except for oral or transdermal, whether medication or device, regardless of intended use
- Drugs for investigational or experimental use, even though a charge is made
- Immunization agents, biological sera, blood or blood plasma
- Items purchased at a pharmacy other than prescription drugs, whether or not there is a prescription for them
- Medication which is to be taken by or administered to You while You are a patient in an institution which operates a dispensing pharmacy
- Non-prescription drugs other than insulin
- Prescription drugs for impotence; enhancement of sexual performance, satisfaction or gratification; enhancement of athletic or intellectual performance; infertility and impedance of the aging process; weight management or weight reduction
- Prescription drugs in excess of a prescription drug unit
- Prescription drugs used to assist in smoking cessation, to restore hair growth; progesterone suppositories, growth stimulating hormones, and over-the-counter medications (see Agreement for exceptions)
- Retin-A for Enrollees over 30 years of age, regardless of intended use
- Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances except as indicated for coverage above. (Please refer to Your contract as these items may be benefits of Your health coverage.)

WHO TO CONTACT

Regence BlueCross BlueShield of Utah

(801) 333-2100
Toll-free (800) 624-6519