This is a partial summary of benefits only and in the event of any inconsistency between this summary and Your Booklet, the terms of the Booklet will prevail. The Booklet contains a complete detail of benefits, limitations and exclusions, and also describes grievance procedures. Your group may have selected the Traditional, ValueCare or HealthWise provider networks as contracting providers. Regence BlueCross BlueShield of Utah or Regence HealthWise will be the insurer.

BluePreferred $250 Deductible Plan

With EAP

BENEFIT	CONTRACTING PROVIDER	NON-CONTRACTING PROVIDER
Maximum Benefit	$2,000,000 per Enrollee.	
Calendar Year Deductible (Separate for Contracting and Non-Contracting Providers)	$250 per Enrollee; $500 per Family Unit	$250 per Enrollee; $500 per Family Unit
Maximum Coinsurance	$1,500 per Enrollee; $3,000 per Family Unit	$2,000 per Enrollee; $4,000 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**.
Chiropractic Care • Limited to 10 visits per Enrollee per Calendar Year	After Deductible, You pay $15 Copayment per visit.	After Deductible and Copayment, We pay 80% of Eligible Medical Expenses and You pay balance of billed charges**.
Durable Medical Equipment and Supplies, Prosthetic and Orthotic Devices • Durable Medical Equipment limited to $2,500 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**.
Emergency Department (Including Professional Services)	After Deductible, You pay $100 Copayment per visit.	After Deductible and Copayment, We pay 80% of Eligible Medical Expenses and You pay balance of billed charges**.
Home Health Care/Home Infusion Therapy 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**.
Hospital - Inpatient Facility Care (Including Professional Services) • Semi-Private Room Accommodations • Related Services and Supplies • Skilled Nursing Facility (SNF) limited to 60 days per Enrollee per Calendar Year • Inpatient Rehabilitation limited to 30 days 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**.
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**.
Maternity Care • Physician/Practitioner Services • Facility 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**.
Office or Clinic Visits for Injury/Sickness [1] Office Visit with Minor Surgeries, Diagnostic and Laboratory Services [2] Office Visit with Major Surgeries, Diagnostic and Laboratory Services	[1] After Deductible, You pay $15 Copayment per Practitioner or Primary Physician visit. [1] After Deductible, You pay $30 Copayment per Specialist Physician visit. [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 • Annual Vision Examination	After Deductible, You pay $15 Copayment per Practitioner or Primary Physician visit. After Deductible, You pay $30 Copayment per Specialist Physician visit.	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 Rehabilitation Services • Limited to 30 visits per Enrollee per Calendar Year [3] When services are rendered in a Physician/Practitioner's office or clinic [4] When services are rendered in the outpatient department of a Hospital	[3] After Deductible, You pay $15 Copayment per visit. [4] After Deductible, We pay 80% and You pay 20% of Eligible Medical Expenses.	[3] After Deductible and Copayment, We pay 80% of Eligible Medical Expenses and You pay balance of billed charges**. [4] After Deductible, We pay 60% of Eligible Medical Expenses and You pay balance of billed charges**.
Urgent Care Clinic	After Deductible, You pay $35 Copayment per visit.	After Deductible and Copayment, We pay 80% of Eligible Medical Expenses and You pay balance of billed charges**.
Employee Assistance Program and 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 Booklet for details).

LIMITATIONS

- During the 9 months immediately following Your Enrollment Date, (or 18 months immediately following Your Effective Date if a Late Enrollee), NO BENEFITS will be provided for a Preexisting Condition ("PEC"). Your PEC limitation will be reduced by the aggregate periods of Creditable Coverage applicable to You as of Your Enrollment Date.
- A "Preexisting Condition" is a physical or mental condition (except pregnancy) for which medical advice, diagnosis, care or treatment was recommended or received within 6 months prior to the Enrollment Date. See Booklet for details regarding late enrollment and crediting of coverage.
- Limited coverage is available for certain solid organ transplants and bone marrow and stem cell transplants (see the Booklet for details).

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

- Artificial heart, pancreas, or liver implants; bone marrow transplants except in the treatment of certain conditions (see Booklet 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 Booklet 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 Booklet 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
- Mental Health Condition services
- 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 Booklet as covered
- Services rendered by halfway houses, public or private schools
- 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
- Services provided for or in connection with erectile dysfunction
- 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 Maximum Coinsurance.

myRegence.com is designed to advise you on health care and lifestyle options, navigate you through the health care system, and reward you who make healthy choices. Go to **www.myRegence.com** and view claims; get fitness and nutrition tips; learn about medical conditions, medications and formulary information; search for doctors; and research cost and care options.