

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.

\$5,000/\$10,000 Regence HSA Healthplan with CMH100		
BENEFIT	CONTRACTING PROVIDER	NON-CONTRACTING PROVIDER
Maximum Benefit	\$2,000,000 per Enrollee.	
Calendar Year Deductible (Separate for Contracting and Non-Contracting Providers)	\$5,000 Single Coverage (one Enrollee); \$10,000 Family Unit Coverage (two or more Enrollees).	\$10,000 Single Coverage (one Enrollee); \$20,000 Family Unit Coverage (two or more Enrollees).
Out-of-Pocket Maximum (Separate for Contracting and Non-Contracting Providers. Includes Deductible amount.)	\$5,000 Single Coverage (one Enrollee); \$10,000 Family Unit Coverage (two or more Enrollees).	\$10,000 Single Coverage (one Enrollee); \$20,000 Family Unit Coverage (two or more Enrollees).
Ambulance Services	After Deductible, We pay 100% of Eligible Medical Expenses.	After Deductible, We pay 100% of Eligible Medical Expenses and You pay balance of billed charges*.
Chiropractic Care <ul style="list-style-type: none">Limited to 10 visits per Enrollee per Calendar Year	After Deductible, We pay 100% of Eligible Medical Expenses.	After Deductible, We pay 100% of Eligible Medical Expenses and You pay balance of billed charges*.
Dental Care <ul style="list-style-type: none">Hospitalization expenses for Dental Services limited to \$1,000 per Enrollee per Calendar YearTreatment of an Accidental Injury limited to \$1,000 per Enrollee per Accidental Injury	After Deductible, We pay 100% of Eligible Medical Expenses.	After Deductible, We pay 100% of Eligible Medical Expenses and You pay balance of billed charges*.
Durable Medical Equipment and Supplies, Prosthetic and Orthotic Devices	After Deductible, We pay 100% of Eligible Medical Expenses.	After Deductible, We pay 100% of Eligible Medical Expenses and You pay balance of billed charges*.
Emergency Department (Including Professional Services)	After Deductible, We pay 100% of Eligible Medical Expenses.	After Deductible, We pay 100% of Eligible Medical Expenses and You pay balance of billed charges*.
Home Health Care/Home Infusion Therapy/Hospice Care <ul style="list-style-type: none">Home health care limited to 130 visits per Enrollee per Calendar Year	After Deductible, We pay 100% of Eligible Medical Expenses.	After Deductible, We pay 100% of Eligible Medical Expenses and You pay balance of billed charges*.
Hospital - Inpatient Facility Care (Including Professional Services) <ul style="list-style-type: none">Skilled Nursing Facility (SNF) limited to 60 days per Enrollee per Calendar YearInpatient Rehabilitation limited to \$30,000 per condition per Enrollee per Calendar Year	After Deductible, We pay 100% of Eligible Medical Expenses.	After Deductible, We pay 100% of Eligible Medical Expenses and You pay balance of billed charges*.
Hospital - Outpatient Facility Care (Including Professional Services) <ul style="list-style-type: none">Surgery and related servicesDiagnostic x-ray and laboratory services	After Deductible, We pay 100% of Eligible Medical Expenses.	After Deductible, We pay 100% of Eligible Medical Expenses and You pay balance of billed charges*.
Maternity Care	Covered the same as any other illness.	
Mental Health Condition Services (Including Drug and Alcohol Use and Abuse)	After Deductible, We pay 100% of Eligible Medical Expenses.	After Deductible, We pay 100% of Eligible Medical Expenses and You pay balance of billed charges*.
Office or Clinic Visits for Injury/Illness Care <ul style="list-style-type: none">Office diagnostic x-ray and laboratory services	After Deductible, We pay 100% of Eligible Medical Expenses.	After Deductible, We pay 100% of Eligible Medical Expenses and You pay balance of billed charges*.

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

BENEFIT	CONTRACTING PROVIDER	NON-CONTRACTING PROVIDER
Preventive Care Services <ul style="list-style-type: none"> Services for children and adults, including professional exams, routine lab and x-rays, screening procedures, and specified routine immunizations 	We pay 100% of Eligible Medical Expenses (Deductible waived).	We pay 100% of Eligible Medical Expenses and You pay balance of billed charges (Deductible waived)*.
Outpatient Rehabilitation Services <ul style="list-style-type: none"> Limited to \$1,500 per Enrollee per Calendar Year 	After Deductible, We pay 100% of Eligible Medical Expenses.	After Deductible, We pay 100% of Eligible Medical Expenses and You pay balance of billed charges*.
Prescription Drugs <ul style="list-style-type: none"> Prescription Drugs and formulas for inborn metabolic errors Growth Hormones limited to \$20,000 per Enrollee per Calendar Year 	After Deductible, We pay 100% of Eligible Medical Expenses.	After Deductible, We pay 100% of Eligible Medical Expenses and You pay balance of billed charges*.
Transplants <ul style="list-style-type: none"> Limited to \$250,000 per Enrollee Lifetime 	After Deductible, We pay 100% of Eligible Medical Expenses.	After Deductible, We pay 100% of Eligible Medical Expenses and You pay balance of billed charges*.

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: 1) the actual billed charges for Your Covered Services; or 2) the negotiated price that the host Blue Cross and/or Blue Shield Plan passes on to Us. See the Booklet for details on the "negotiated price" and other important information regarding the BlueCard Program.

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

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 (e.g., biofeedback, sensitivity training, hypnosis, family or marital problems, behavior disorders, psychosexual dysfunction, learning disabilities, mental retardation)
- 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
- Experimental or investigational treatments or procedures
- Genetic studies; non-prescription contraceptives; reversal of sterilization; reesterilization; 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 TMJ dysfunction; dental care; jaw surgery for augmentation or reduction; services to increase vertical dimension/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 caused by participation in illegal acts of violence; services provided as a result of a court order or other legal proceedings

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