



A Preferred Provider Organization

## **OUTLINE OF COVERAGE**

**VALUECARE PREMIER**  
**Zero Deductible Plan**

**VALUECARE ADVANTAGE PLANS**  
**\$250, \$500 & \$1000 Deductible Plans**  
(With Deductible Waiver for Office/Clinic Visits)

**VALUECARE CLASSIC PLANS**  
**\$250, \$500 & \$1000 Deductible Plans**

## **HEALTH CARE PROTECTION FOR INDIVIDUALS AND FAMILIES**

Insured by Regence BlueCross BlueShield of Utah\*

\* Independent Licensees of the Blue Cross and Blue Shield Association

### VALUECARE DOCTORS AND HOSPITALS

To receive the full value of a ValueCare Plan, you should always use ValueCare doctors and hospitals. Otherwise your out-of-pocket costs will be higher. ValueCare contracts with more doctors and hospitals than any other preferred provider network in the state.

# VALUECARE THE HEALTH BENEFITS

## HIGHLIGHTS OF THE VALUECARE PREMIER AND

BENEFITS/COVERAGE DETAILS	VALUECARE PREMIER ZERO DEDUCTIBLE PLAN
<b>OFFICE VISITS</b> (including clinics and urgent care centers). Office procedures including professional consultation, minor diagnostic tests, office lab work and x-rays, preventive tests and minor surgical procedures.	<b>ZERO DEDUCTIBLE</b> \$15 Copayment
<b>HOSPITAL — INPATIENT AND OUTPATIENT, and SKILLED NURSING CARE</b> For facility and professional care by physicians and practitioners.	<b>ZERO DEDUCTIBLE</b> You pay 20% Coinsurance.
<b>EMERGENCY DEPARTMENT</b> For facility and professional care by physicians and practitioners.	<b>ZERO DEDUCTIBLE</b> You pay \$75 Copayment, plus 20% Coinsurance.
<b>PREVENTIVE CARE — ADULTS AND CHILDREN</b> Designated preventive office/clinic care – Maximum \$300 per Member per year. (\$300 limit does not apply to routine childhood examinations and immunizations through age 5.)	<b>ZERO DEDUCTIBLE</b> \$15 Copayment
<b>BENEFITS FOR ACCIDENTAL INJURY</b> For facility and professional care by physicians and practitioners	<b>\$500 BENEFIT (PER INCIDENT)</b> We pay the first \$500 of Eligible Medical Expenses per incident, subject to the emergency department Copayment, if applicable.
<b>PRESCRIPTION DRUGS</b> <b>All Plans:</b> Copayments for prescriptions under a Prescription Drug Card Rider – not subject to a Deductible.	<b>ZERO DEDUCTIBLE</b> \$5 generic; 25% name brand/formulary and diabetic supplies; 50% psychotropic, non-formulary, and oral contraceptives.

# PROVIDES INSURANCE YOU WANT

## VALUECARE BENEFITS COMPARED

This chart compares the benefits many people want in today's insurance policies. Use this chart as a guide in determining which of the seven plans most closely meets your needs. Read the rest of the brochure for further information and a brief explanation of additional benefits, limitations and exclusions.

## OTHER VALUECARE PLANS (Using ValueCare Providers)

<b>VALUECARE ADVANTAGE PLANS</b> <b>\$250, \$500 &amp; \$1,000 Deductible Plans</b> (with Deductible waiver for Office/Clinic and Urgent Care Center Visits)	<b>VALUECARE CLASSIC PLANS</b> <b>\$250, \$500 &amp; \$1,000 Deductible Plans</b> (with 20% Coinsurance - in most cases after Deductible is met)
<b>ZERO DEDUCTIBLE</b> \$15 Copayment	After Deductible has been met, you pay 20% Coinsurance. No Copayments are required.
After Deductible, you pay 20% Coinsurance. No Copayments are required.	After Deductible, you pay 20% Coinsurance. No Copayments are required.
After Deductible, you pay \$75 Copayment, plus 20% Coinsurance.	After Deductible, you pay \$75 Copayment, plus 20% Coinsurance.
<b>ZERO DEDUCTIBLE</b> \$15 Copayment	After Deductible has been met, you pay 20% Coinsurance. No Copayments are required.
<b>\$500 BENEFIT (PER INCIDENT)</b> We pay the first \$500 of Eligible Medical Expenses per incident, subject to the emergency department Copayment, if applicable.	<b>\$500 BENEFIT (PER INCIDENT)</b> We pay the first \$500 of Eligible Medical Expenses per incident, subject to the emergency department Copayment, if applicable.
<b>ZERO DEDUCTIBLE</b> \$5 generic; 25% name brand/formulary and diabetic supplies; 50% psychotropic, non-formulary, and oral contraceptives.	<b>ZERO DEDUCTIBLE</b> \$5 generic; 25% name brand/formulary and diabetic supplies; 50% psychotropic, non-formulary, and oral contraceptives.

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# GENERAL INFORMATION

## INTRODUCTION

Thank you for your interest in our health care programs for individuals and families. Each ValueCare program is designed to meet the special needs of those who are not eligible for group coverage and are purchasing protection on their own. ValueCare plans offer you these important advantages:

- **A Provider Network** — ValueCare has contracts with more than 70% of the physicians and 80% of the hospitals in Utah. These providers have agreed to accept Eligible Medical Expenses as full payment for Covered Services.
- **Freedom of Choice** — You may choose any physician, hospital, or other provider for your care, but when you choose a ValueCare Provider, your out-of-pocket expenses will be lower. In addition, ValueCare participates with the BlueCard PPO program. When you receive Covered Services outside the ValueCare Area from a BlueCard PPO Provider, Benefit Payments will be provided at the same level as for ValueCare Providers in the ValueCare Area.
- **Reduced Paperwork** — Your ValueCare Provider sends your claims directly to ValueCare.
- **Strength and Dependability** — ValueCare is a subsidiary of Regence BlueCross BlueShield of Utah (Regence BCBSU) - the state's oldest and largest health insurer, currently serving over 600,000, or 1 in 4, Utahns.

After you are accepted, a ValueCare Agreement and identification card will be mailed to you. Please read your ValueCare Agreement carefully. This booklet is a Benefit Summary only, providing a very brief description of the important features of your ValueCare Agreement. This is not the insurance contract and only the actual provisions of the ValueCare Agreement will control. The ValueCare Agreement itself sets forth in detail the rights and obligations of both you and ValueCare. It is, therefore, important that you READ YOUR VALUECARE AGREEMENT CAREFULLY!

ValueCare, as a Preferred Provider Organization, is designed to provide coverage for hospital, medical, and surgical expenses incurred as a result of a covered illness or injury. A higher level of benefits is obtained when services are received from ValueCare Providers. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any Deductibles, Copayments, Coinsurance, or other limitations which may be set forth in the ValueCare Agreement.

[This is Not a Medicare Supplement Contract.](#)

If a Member becomes eligible for Medicare, he or she should review the Medicare Supplement Buyer's Guide available from Regence BlueCross BlueShield of Utah (Regence BCBSU). If the Member chooses to continue coverage under the ValueCare Agreement **and** Medicare, the benefits of the ValueCare Agreement shall be reduced by any amounts paid by Medicare.

[Your Rights to Obtain Insurance and Waive PEC Waiting Periods.](#)

Federal and state health insurance regulations provide portability (reduction or elimination of the preexisting condition [PEC] waiting period because of prior coverage) for certain individuals and families who meet the established guidelines. The regulations also provide that those who have been considered to be uninsurable for health reasons may now be able to obtain coverage under one or more policies offered by Regence BCBSU, including the Basic Benefit Plan. Contact your insurance agent or Regence BCBSU for more information about these regulations and how they may affect your rights to obtain insurance and/or receive credit toward your PEC waiting period.

**ELIGIBILITY**

In general, if you or your spouse is covered (or will be eligible to be covered) by a Regence BlueCross BlueShield of Utah, ValueCare or HealthWise group insurance plan, you are not eligible for coverage under one of our individual health insurance plans.

If you allow your employer to pay the premiums directly (or reimburse you for the premiums) on this policy, the policy will be considered a group policy, and you will not be eligible for coverage under this plan.

All eligible family members must be enrolled unless otherwise approved by ValueCare.

You are eligible to apply if you are a Utah tax-paying resident and at least 16 years but less than 65 years of age.

You may also apply for . . .

- Your spouse who is less than 65 years of age.
- Your child who is 6 weeks to 26 years of age and unmarried, and who has been dependent on you for more than 50% of his or her total support for the three months preceding the date of application. For a child born or placed for adoption within the three-month period preceding the date of application, the 50% support test shall apply since the child's date of birth or placement for adoption.

After you have been accepted and your family coverage is in effect, newborn children are automatically covered at birth for 30 days. Adopted children are automatically covered for 30 days from the date of placement for adoption. However, ValueCare **must be notified of the birth or adoption in writing within 30 days to add the child to the contract.**

- A child who is under 18 years of age, or who is any age and incapable of earning a living and without sufficient means, and for whom a Subscriber is required by a court order or administrative order to provide health insurance coverage.

A custodial parent (who isn't the Subscriber) or the state Medicaid agency has the right to apply for coverage for certain dependents, and to submit claims and receive reimbursement when non-Value-Care providers are used.

In certain situations, parents, adoptive parents, and those who have obtained court-appointed legal guardianship who are not eligible for coverage themselves may apply for coverage for children ages 5 to 16. Underwriting approval is required.

## TERMINATION

Coverage will terminate in the event of:

- failure to pay premiums
- establishment of residence outside Utah, or
- fraud or material misrepresentation

Your coverage cannot be terminated for health reasons. ValueCare has the right to terminate this Agreement if ValueCare:

- eliminates coverage under the ValueCare Agreement for all Subscribers (in which case ValueCare shall provide ninety [90] days prior written notice to all Members covered under the ValueCare Agreement and shall make available to the Subscriber, without regard to the claims experience or health status of any Member, the option to purchase any other individual policy being offered by Regence BCBSU, or an affiliate of Regence BCBSU for which they qualify), or
- elects not to renew all health benefit plans issued to individuals in Utah.

## VALUECARE PROVIDERS

ValueCare is a Preferred Provider Organization. This means ValueCare has contracted with providers of health care services to provide services in accordance with the provisions of your ValueCare Agreement.

When you need care, identify yourself as a ValueCare Member to your ValueCare Provider. ValueCare Providers will bill ValueCare and receive reimbursement directly for Covered Services. ValueCare Providers have agreed to accept Eligible Medical Expenses as full compensation for Covered Services. The Member's share of Eligible Medical Expenses is the amount the Member must pay due to the Deductibles, Copayments, and Coinsurance stated in the Agreement.

You will receive the greatest benefit of this program when services are provided by ValueCare Providers. Since a Provider's participation in the ValueCare network is voluntary, there may be instances when a ValueCare Provider is not available. Please check with ValueCare Customer Service to determine provider participation.

## **NON-VALUECARE PROVIDERS**

When services are rendered by a Non-ValueCare Provider, you may be required to submit your claims to ValueCare for reimbursement. Reimbursement for services rendered by a Non-ValueCare Provider will be lower than the amounts ValueCare Providers have agreed to accept. The charges of a Non-ValueCare Provider may exceed Eligible Medical Expenses. In such case, it is your responsibility to pay your Non-ValueCare Provider any balance up to the full amount charged.

## **BLUECARD PPO PROVIDERS (SERVICES OUTSIDE THE VALUECARE AREA)**

When you receive Covered Services outside the ValueCare Area, Benefit Payments will be based on the amount payable by the BlueCard PPO affiliate in the area where you receive the services (see below). For the purpose of determining benefits, Providers outside the ValueCare Area whom or which participate in the BlueCard PPO Program are ValueCare Providers. All other Providers outside the ValueCare Area are Non-ValueCare Providers, so Benefit Payments will be based on the amounts indicated for Non-ValueCare Providers.

Outside the ValueCare Area, ValueCare has arrangements through the BlueCard PPO Program to provide Covered Services to Members. When you receive Covered Services outside the ValueCare Area from a BlueCard PPO Provider, Benefit Payments will be provided at the same benefit level as for ValueCare Providers in the ValueCare Area. Benefit payments will be made directly to the BlueCard PPO Provider. To find a BlueCard PPO Provider outside the ValueCare Area, call 1 (800) 810-2583 for more information.

## **IDENTIFICATION CARD**

Your identification card is issued after you have been accepted into this Health Care Program. You will receive it when you receive your Health Care Agreement. When you or your enrolled family members require medical or hospital attention, just present your identification card. Key information is contained on your card that assists in proper handling of your claim.

## IDENTIFICATION CARD (continued)

For all Plans, your identification card is also your Prescription Drug card. Most pharmacies in Utah accept this card when you order your prescriptions.

## CHANGES IN FAMILY STATUS AND ADDRESS

To change your status as a result of divorce or death, or to change your address, use our Change Form E-27. To change your status as a result of marriage or adding dependents, use our Change Form E-27 **and** a Health Statement Questionnaire. All family additions must be medically underwritten, except for a newborn child or adopted child who is reported to us in writing within 30 days of birth or placement for adoption. **Your new dependent's coverage can be affected by the imposition of additional waiting periods if changes are not reported within 30 days.** If necessary dependent information is not on ValueCare's membership files, benefits may be delayed or denied for such individuals.

## OTHER PARTY LIABILITY

If another party is responsible for your Illness or Injury, the benefits paid under this program may be subject to subrogation. Subrogation means that ValueCare will recover the amounts it has paid in benefits out of the proceeds of any settlement or judgment that you receive as a recovery from the other party, whether or not you are made whole by the recovery and whether or not the recovery includes any amount for Covered Services.

## COORDINATION OF BENEFITS

When you or your family members are also enrolled in another health plan, payments for Covered Services will be determined by coordinating the benefits of the two programs. Dual coverage will provide the maximum benefits to which you are entitled while preventing payment duplication. The primary health plan pays the full benefits covered under its program, and then the secondary health plan may reduce its benefits. In no event will payment be made in excess of expenses incurred.

# BENEFIT DESCRIPTION VALUECARE PREMIER ZERO DEDUCTIBLE PLAN

## MAXIMUM BENEFITS

\$1,000,000 total lifetime benefits per Member

## DEDUCTIBLE

There is no Deductible amount applicable to this plan

## COPAYMENTS

\$15	Copayment for each visit to a Physician's or Practitioner's office/clinic or urgent care center
\$75	Copayment for each visit to a Hospital emergency department
\$5,000	Copayment for each pregnancy

## COINSURANCE AND BENEFIT PAYMENTS:

**ValueCare Provider/  
BlueCard PPO Provider**  
(Member pays only  
Copayment and Coinsurance  
for Covered Services)

**Non-ValueCare Provider  
(Out-of-Area Providers)**  
(In addition to Copayment and  
Coinsurance, Member pays  
difference between billed charge  
and Eligible Medical Expenses  
for Covered Services)

## FOR FACILITY SERVICES:

<b>Inpatient Hospital/ SNF; Outpatient Hospital Care;</b> Major Diagnostic Tests; Ambulatory Service Facility; Home Health Care; Home Infusion Therapy	ValueCare pays 80% and Member pays 20% of Eligible Medical Expenses. 20% Coinsurance can be applied toward \$1,500 Maximum Coinsurance.	ValueCare pays 60% of Eligible Medical Expenses. Member pays balance*. 40% of Eligible Medical Expenses can be applied toward \$3,000 Maximum Coinsurance.
<b>Emergency Department</b>	After Copayment, ValueCare pays 80% and Member pays 20% of Eligible Medical Expenses. 20% Coinsurance can be applied toward \$1,500 Maximum Coinsurance.	After Copayment, ValueCare pays 60% of Eligible Medical Expenses. Member pays balance*. 40% of Eligible Medical Expenses can be applied toward \$3,000 Maximum Coinsurance.
<b>Minor Diagnostic Tests</b>	ValueCare pays 100% of Eligible Medical Expenses.	ValueCare pays 80% of Eligible Medical Expenses. Member pays balance*. 20% of Eligible Medical Expenses can be applied toward \$3,000 Maximum Coinsurance.

## FOR PROFESSIONAL SERVICES:

<b>Office/Clinic and Urgent Care Center</b> (including Minor Surgical Procedures and Minor Diagnostic Tests)	After Copayment, ValueCare pays 100% of Eligible Medical Expenses.	After Copayment, ValueCare pays 80% of Eligible Medical Expenses. Member pays balance*. 20% of Eligible Medical Expenses can be applied toward \$3,000 Maximum Coinsurance.
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\* "Balance" includes the amount of charges in excess of Eligible Medical Expenses

**ValueCare Provider/  
BlueCard PPO Provider**  
(Member pays only  
Copayment and Coinsurance  
for Covered Services)

**Non-ValueCare Provider  
(Out-of-Area Providers)**  
(In addition to Copayment and  
Coinsurance, Member pays  
difference between billed charge  
and Eligible Medical Expenses for  
Covered Services)

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**FOR PROFESSIONAL SERVICES (continued):**

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**Inpatient and  
Outpatient Hospital  
Care;** Outpatient  
Rehabilitation  
Services and  
Chiropractic Care;  
Chemotherapy,  
Radiation and Dialysis;  
Major Surgical Proce-  
dures and Major  
Diagnostic Tests;  
professional services  
not otherwise specified  
elsewhere

ValueCare pays 80% and  
Member pays 20% of Eligible  
Medical Expenses. 20%  
Coinsurance can be applied  
toward \$1,500 Maximum  
Coinsurance.

ValueCare pays 60% of  
Eligible Medical Expenses.  
Member pays balance\*.  
40% of Eligible Medical  
Expenses can be applied  
toward \$3,000 Maximum  
Coinsurance.

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**OTHER COVERED SERVICES:**

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**Mental Health  
Condition Services**  
(including use/abuse  
of alcohol/drugs)

After Copayment, ValueCare  
pays 80% and Member pays  
20% of Eligible Medical  
Expenses. Coinsurance  
cannot be applied toward  
Maximum Coinsurance.

After Copayment, ValueCare  
pays 60% of Eligible Medical  
Expenses. Member pays  
balance\*. Coinsurance  
cannot be applied toward  
Maximum Coinsurance.

**Durable Medical  
Equipment and  
Supplies, Prosthetic  
and Orthotic  
Devices**

ValueCare pays 80% and  
Member pays 20% of  
Eligible Medical Expenses.  
20% Coinsurance can be  
applied toward \$1,500  
Maximum Coinsurance.

ValueCare pays 80% of  
Eligible Medical Expenses.  
Member pays balance\*.  
20% of Eligible Medical  
Expenses can be applied toward  
\$3,000 Maximum Coinsurance.

**Maternity Care**  
All Covered Services

After Copayment, ValueCare  
pays 100% of Eligible Medical  
Expenses.

After Copayment, ValueCare  
pays 80% of Eligible Medical  
Expenses. Member pays  
balance\*. 20% of Eligible Medical  
Expenses can be applied toward  
\$3,000 Maximum Coinsurance.

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\* "Balance" includes the amount of charges in excess of Eligible Medical Expenses

## MAXIMUM COINSURANCE

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### *Services provided by ValueCare/BlueCard PPO Providers:*

\$1,500 per Member per Calendar Year;  
Maximum of 2 Maximum Coinsurance amounts  
per Family Unit per Calendar Year.

The \$1,500 Maximum Coinsurance can be met by payments of 20% Coinsurance for ValueCare/BlueCard PPO Providers' services, but not by payments for Mental Health Condition services, non-covered services, Coinsurance for Non-ValueCare Provider services, Copayments, or by any other payments made by the Member. Coinsurance amounts that do not apply toward Maximum Coinsurance continue to be charged even after the Maximum Coinsurance has been reached.

### *Services provided by Non-ValueCare Providers:*

\$3,000 per Member per Calendar Year;  
Maximum of 2 Maximum Coinsurance amounts  
per Family Unit per Calendar Year.

The \$3,000 Maximum Coinsurance can be met by payments of 20% and 40% Coinsurance for Non-ValueCare Providers' services, but not by payments for Mental Health Condition services, non-covered services, Coinsurance for ValueCare/BlueCard PPO Provider services, Copayments, or by any other payments made by the Member. Coinsurance amounts that do not apply toward Maximum Coinsurance continue to be charged even after the Maximum Coinsurance has been reached.

## BENEFITS FOR ACCIDENTAL INJURY

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\$500 per Member per incident for Eligible Medical Expenses incurred in connection with an Accidental Injury. When Covered Services are received from the Hospital emergency department, the Member is responsible for paying the Copayment applicable to the Hospital emergency department.

## MAXIMUM BENEFITS FOR SPECIFIED SERVICES

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**Mental Health Condition Services, including use/abuse of alcohol/drugs:**  
\$1,500 per Member per Calendar Year

**Preventive Care Services:**  
\$300 per Member per Calendar Year  
(\$300 limit does not apply to routine childhood  
examinations and immunizations through age 5)

**Outpatient Rehabilitation Services (includes  
physical, speech and occupational therapy) and Chiropractic Care:**  
\$1,500 per Member per Calendar Year

## SPECIAL REQUIREMENTS FOR MYELOABLATIVE THERAPY (MAT) WITH HEMATOPOIETIC STEM CELL SUPPORT (HSCS) FOR MALIGNANCIES

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Specific criteria must be met for coverage to be provided.  
Prenotification is required.

## PRESCRIPTION DRUG CARD RIDER – NO DEDUCTIBLE

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A Prescription Drug Card applies. The Member Copayment is \$5 for generic prescriptions, 25% of the cost for name brand formulary prescriptions and diabetic supplies, and 50% of the cost of psychotropic prescriptions, non-formulary prescriptions and oral contraceptives. Any amounts paid for Prescription Drugs do not apply toward Maximum Coinsurance amounts.

# BENEFIT DESCRIPTION VALUECARE ADVANTAGE

## \$250, \$500 & \$1,000 DEDUCTIBLE PLANS

(With Deductible Waiver for Office/Clinic Visits)

**MAXIMUM BENEFITS**

\$1,000,000 total lifetime benefits per Member

<u>DEDUCTIBLE PER CALENDAR YEAR</u>	<u>250 Plan</u>	<u>500 Plan</u>	<u>1000 Plan</u>
Individual:	\$250	\$500	\$1,000
Maximum per Family Unit	3	2	2

**THERE IS NO DEDUCTIBLE AMOUNT APPLICABLE TO:**

Office, Clinic, or Urgent Care Center Visits

**COPAYMENTS**

- \$15 Copayment for each visit to a Physician's or Practitioner's office/clinic or urgent care center
- \$75 Copayment for each visit to a Hospital emergency department; applies after the Deductible
- \$5,000 Copayment for each pregnancy; not subject to the Deductible

**COINSURANCE AND BENEFIT PAYMENTS:**

**ValueCare Provider/  
BlueCard PPO Provider**  
(Member pays only Deductible,  
Copayment and Coinsurance  
for Covered Services)

**Non-ValueCare Provider  
(Out-of-Area Providers)**  
(In addition to Deductible,  
Copayment and Coinsurance,  
Member pays difference  
between billed charge and  
Eligible Medical Expenses for  
Covered Services)

**FOR FACILITY SERVICES:**

<b>Inpatient Hospital/SNF, Outpatient Hospital Care;</b> Major Diagnostic Tests; Ambulatory Service Facility; Home Health Care; Home Infusion Therapy	After Deductible, ValueCare pays 80% and Member pays 20% of Eligible Medical Expenses. 20% Coinsurance can be applied toward \$1,500 Maximum Coinsurance.	After Deductible, ValueCare pays 60% of Eligible Medical Expenses. Member pays balance*. 40% of Eligible Medical Expenses can be applied toward \$3,000 Maximum Coinsurance.
<b>Emergency Department</b>	After Deductible and Copayment, ValueCare pays 80% and Member pays 20% of Eligible Medical Expenses. 20% Coinsurance can be applied toward \$1,500 Maximum Coinsurance.	After Deductible and Copayment, ValueCare pays 60% of Eligible Medical Expenses. Member pays balance*. 40% of Eligible Medical Expenses can be applied toward \$3,000 Maximum Coinsurance.
<b>Minor Diagnostic Tests</b>	ValueCare pays 100% of Eligible Medical Expenses.	ValueCare pays 80% of Eligible Medical Expenses. Member pays balance*. 20% of Eligible Medical Expenses can be applied toward \$3,000 Maximum Coinsurance.

\* "Balance" includes the amount of charges in excess of Eligible Medical Expenses

**ValueCare Provider/  
BlueCard PPO Provider**  
(Member pays only Deductible,  
Copayment and Coinsurance for  
Covered Services)

**Non-ValueCare Provider  
(Out-of-Area Providers)**  
(In addition to Deductible,  
Copayment and Coinsurance,  
Member pays difference  
between billed charge and  
Eligible Medical Expenses for  
Covered Services)

**FOR PROFESSIONAL SERVICES:**

<b>Office/Clinic and Urgent Care Center</b> (including Minor Surgical Procedures and Minor Diagnostic Tests)	After Copayment, ValueCare pays 100% of Eligible Medical Expenses	After Copayment, ValueCare pays 80% of Eligible Medical Expenses. Member pays balance*. 20% of Eligible Medical Expenses can be applied toward \$3,000 Maximum Coinsurance.
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<b>Inpatient and Outpatient Hospital Care;</b> Outpatient Rehabilitation Services and Chiropractic Care; Chemotherapy, Radiation and Dialysis; Major Surgical Procedures and Major Diagnostic Tests; professional services not otherwise specified elsewhere	After Deductible, ValueCare pays 80% and Member pays 20% of Eligible Medical Expenses. 20% Coinsurance can be applied toward \$1,500 Maximum Coinsurance.	After Deductible, ValueCare pays 60% of Eligible Medical Expenses. Member pays balance*. 40% of Eligible Medical Expenses can be applied toward \$3,000 Maximum Coinsurance.
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**OTHER COVERED SERVICES:**

<b>Mental Health Condition Services</b> (including use/abuse of alcohol/drugs)	After Deductible and Copayment, ValueCare pays 80% and Member pays 20% of Eligible Medical Expenses. Coinsurance cannot be applied toward Maximum Coinsurance.	After Deductible and Copayment, ValueCare pays 60% of Eligible Medical Expenses. Member pays balance*. Coinsurance cannot be applied toward Maximum Coinsurance.
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<b>Durable Medical Equipment and Supplies, Prosthetic and Orthotic Devices</b>	After Deductible, ValueCare pays 80% and Member pays 20% of Eligible Medical Expenses. 20% Coinsurance can be applied toward \$1,500 Maximum Coinsurance.	After Deductible, ValueCare pays 80% of Eligible Medical Expenses. Member pays balance*. 20% Coinsurance can be applied toward \$3,000 Maximum Coinsurance.
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<b>Maternity Care</b> All Covered Services	After Copayment, ValueCare pays 100% of Eligible Medical Expenses.	After Copayment, ValueCare pays 80% of Eligible Medical Expenses. Member pays balance*. 20% of Eligible Medical Expenses can be applied toward \$3,000 Maximum Coinsurance.
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\* "Balance" includes the amount of charges in excess of Eligible Medical Expenses

## MAXIMUM COINSURANCE FOR ALL PLANS

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### *Services provided by ValueCare/BlueCard PPO Providers:*

\$1,500 per Member per Calendar Year;  
Maximum of 2 Maximum Coinsurance amounts  
per Family Unit per Calendar Year.

The \$1,500 Maximum Coinsurance can be met by payments of 20% Coinsurance for ValueCare/BlueCard PPO Providers' services, but not by payments for Mental Health Condition services, non-covered services, Coinsurance for Non-ValueCare Provider services, Deductible, Copayments, or by any other payments made by the Member. Coinsurance amounts that do not apply toward Maximum Coinsurance continue to be charged even after the Maximum Coinsurance has been reached.

### *Services provided by Non-ValueCare Providers:*

\$3,000 per Member per Calendar Year;  
Maximum of 2 Maximum Coinsurance amounts  
per Family Unit per Calendar Year.

The \$3,000 Maximum Coinsurance can be met by payments of 20% and 40% Coinsurance for Non-ValueCare Providers' services, but not by payments for Mental Health Condition services, non-covered services, Coinsurance for ValueCare/BlueCard PPO Provider services, Deductible, Copayments, or by any other payments made by the Member. Coinsurance amounts that do not apply toward Maximum Coinsurance continue to be charged even after the Maximum Coinsurance has been reached.

## BENEFITS FOR ACCIDENTAL INJURY

---

\$500 per Member per incident for Eligible Medical Expenses incurred in connection with an Accidental Injury. When Covered Services are received from the Hospital emergency department, the Member is responsible for paying the Copayment applicable to the Hospital emergency department. This benefit is not subject to and does not apply toward the Deductible.

## MAXIMUM BENEFITS FOR SPECIFIED SERVICES

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**Mental Health Condition Services, including use/abuse of alcohol/drugs:**  
\$1,500 per Member per Calendar Year

**Preventive Care Services:**  
\$300 per Member per Calendar Year  
(\$300 limit does not apply to routine childhood  
examinations and immunizations through age 5)

**Outpatient Rehabilitation Services (includes  
physical, speech and occupational therapy) and Chiropractic Care:**  
\$1,500 per Member per Calendar Year

## SPECIAL REQUIREMENTS FOR MYELOABLATIVE THERAPY (MAT) WITH HEMATOPOIETIC STEM CELL SUPPORT (HSCS) FOR MALIGNANCIES

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Specific criteria must be met for coverage to be provided.  
Prenotification is required.

## PRESCRIPTION DRUGS

---

A Prescription Drug Card applies and coverage is not subject to the medical plan Deductible. The Member Copayment is \$5 for generic prescriptions, 25% of the cost of name brand formulary prescriptions and diabetic supplies, and 50% of the cost of psychotropic prescriptions, non-formulary prescriptions and oral contraceptives. Any amounts paid for Prescription Drugs do not apply toward Maximum Coinsurance amounts.

# BENEFIT DESCRIPTION VALUECARE CLASSIC

## \$250, \$500 & \$1,000 DEDUCTIBLE PLANS

### MAXIMUM BENEFITS

\$1,000,000 total lifetime benefits per Member

<u>DEDUCTIBLE PER CALENDAR YEAR</u>	<u>250 Plan</u>	<u>500 Plan</u>	<u>1000 Plan</u>
Individual:	\$250	\$500	\$1,000
Maximum per Family Unit	3	2	2

### COPAYMENTS

\$75	Copayment for each visit to a Hospital emergency department; applies after the Deductible
\$5,000	Copayment for each pregnancy; not subject to the Deductible

### COINSURANCE AND BENEFIT PAYMENTS:

**ValueCare Provider/  
BlueCard PPO Provider**  
(Member pays only Deductible  
Copayment and Coinsurance  
for Covered Services)

**Non-ValueCare Provider  
(Out-of-Area Providers)**  
(In addition to Deductible,  
Copayment and Coinsurance,  
Member pays difference  
between billed charge and  
Eligible Medical Expenses for  
Covered Services)

### FOR FACILITY SERVICES:

<b>Inpatient Hospital/ SNF, Outpatient Hospital Care;</b> Major Diagnostic Tests; Ambulatory Service Facility; Home Health Care; Home Infusion Therapy	After Deductible, ValueCare pays 80% and Member pays 20% of Eligible Medical Expenses. 20% Coinsurance can be applied toward \$1,500 Maximum Coinsurance.	After Deductible, ValueCare pays 60% of Eligible Medical Expenses. Member pays balance*. 40% of Eligible Medical Expenses can be applied toward \$3,000 Maximum Coinsurance.
<b>Emergency Department</b>	After Deductible and Copayment, ValueCare pays 80% and Member pays 20% of Eligible Medical Expenses. 20% Coinsurance can be applied toward \$1,500 Maximum Coinsurance.	After Deductible and Copayment, ValueCare pays 60% of Eligible Medical Expenses. Member pays balance*. 40% of Eligible Medical Expenses can be applied toward \$3,000 Maximum Coinsurance.
<b>Minor Diagnostic Tests</b>	After Deductible, ValueCare pays 100% of Eligible Medical Expenses.	After Deductible, ValueCare pays 80% of Eligible Medical Expenses. Member pays balance*. 20% of Eligible Medical Expenses can be applied toward \$3,000 Maximum Coinsurance.

\* "Balance" includes the amount of charges in excess of Eligible Medical Expenses

See page 15 for continuation of Benefit Description

**ValueCare Provider/  
BlueCard PPO Provider**  
(Member pays only Deductible  
Copayment and Coinsurance  
for Covered Services)

**Non-ValueCare Provider  
(Out-of-Area Providers)**  
(In addition to Deductible,  
Copayment and Coinsurance,  
Member pays difference  
between billed charge and  
Eligible Medical Expenses for  
Covered Services)

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**FOR PROFESSIONAL SERVICES:**

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**Office/Clinic and  
Urgent Care Center**  
(including Minor  
Surgical Procedures  
and Minor  
Diagnostic Tests)

After Deductible, ValueCare  
pays 80% and Member pays  
20% of Eligible Medical  
Expenses. 20% Coinsurance  
can be applied toward \$1,500  
Maximum Coinsurance.

After Deductible, ValueCare  
pays 60% of Eligible Medical  
Expenses. Member pays  
balance\*. 40% of Eligible  
Medical Expenses can be  
applied toward \$3,000  
Maximum Coinsurance.

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**Inpatient and  
Outpatient Hospital  
Care;** Outpatient  
Rehabilitation  
Services and  
Chiropractic Care;  
Chemotherapy,  
Radiation and  
Dialysis; Major  
Surgical Procedures  
and Major Diagnostic  
Tests; professional  
services not  
otherwise specified  
elsewhere

After Deductible, ValueCare  
pays 80% and Member pays  
20% of Eligible Medical Ex-  
penses. 20% Coinsurance can  
be applied toward \$1,500  
Maximum Coinsurance.

After Deductible, ValueCare  
pays 60% of Eligible Medical  
Expenses. Member pays  
balance\*. 40% of Eligible  
Medical Expenses can be  
applied toward \$3,000  
Maximum Coinsurance.

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**OTHER COVERED SERVICES:**

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**Mental Health  
Condition Services**  
(including use/abuse  
of alcohol/drugs)

After Deductible, ValueCare  
pays 80% and Member pays  
20% of Eligible Medical  
Expenses. Coinsurance cannot  
be applied toward Maximum  
Coinsurance.

After Deductible, ValueCare  
pays 60% of Eligible Medical  
Expenses. Member pays  
balance\*. Coinsurance cannot  
be applied toward Maximum  
Coinsurance.

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**Durable Medical  
Equipment and  
Supplies,  
Prosthetic and  
Orthotic Devices**

After Deductible, ValueCare  
pays 80% and Member pays  
20% of Eligible Medical Ex-  
penses. 20% Coinsurance can  
be applied toward \$1,500  
Maximum Coinsurance.

After Deductible, ValueCare  
pays 80% of Eligible Medical  
Expenses. Member pays  
balance\*. 20% Coinsurance  
can be applied toward \$3,000  
Maximum Coinsurance.

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**Maternity Care**  
All Covered Services

After Copayment, ValueCare  
pays 100% of Eligible Medical  
Expenses.

After Copayment, ValueCare  
pays 80% of Eligible Medical  
Expenses. Member pays  
balance\*. 20% of Eligible Medical  
Expenses can be applied toward  
\$3,000 Maximum Coinsurance.

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\* "Balance" includes the amount of charges in excess of Eligible Medical Expenses

## MAXIMUM COINSURANCE

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### *Services provided by ValueCare/BlueCard PPO Providers:*

\$1,500 per Member per Calendar Year;  
Maximum of 2 Maximum Coinsurance amounts  
per Family Unit per Calendar Year.

The \$1,500 Maximum Coinsurance can be met by payments of 20% Coinsurance for ValueCare/BlueCard PPO Providers' services, but not by payments for Mental Health Condition services, non-covered services, Coinsurance for Non-ValueCare Provider services, Deductible, Copayments, or by any other payments made by the Member. Coinsurance amounts that do not apply toward Maximum Coinsurance continue to be charged even after the Maximum Coinsurance has been reached.

### *Services provided by Non-ValueCare Providers:*

\$3,000 per Member per Calendar Year;  
Maximum of 2 Maximum Coinsurance amounts  
per Family Unit per Calendar Year.

The \$3,000 Maximum Coinsurance can be met by payments of 20% and 40% Coinsurance for Non-ValueCare Providers' services, but not by payments for Mental Health Condition services, non-covered services, Coinsurance for ValueCare/BlueCard PPO Provider services, Deductible, Copayments, or by any other payments made by the Member. Coinsurance amounts that do not apply toward Maximum Coinsurance continue to be charged even after the Maximum Coinsurance has been reached.

## BENEFITS FOR ACCIDENTAL INJURY

---

\$500 per Member per incident for Eligible Medical Expenses incurred in connection with an Accidental Injury. When Covered Services are received from the Hospital emergency department, the Member is responsible for paying the Copayment applicable to the Hospital emergency department. This benefit is not subject to and does not apply toward the Deductible.

## MAXIMUM BENEFITS FOR SPECIFIED SERVICES

---

**Mental Health Condition Services, including use/abuse of alcohol/drugs:**  
\$1,500 per Member per Calendar Year

**Preventive Care Services:**  
\$300 per Member per Calendar Year  
(\$300 limit does not apply to routine childhood  
examinations and immunizations through age 5)

**Outpatient Rehabilitation Services (includes  
physical, speech and occupational therapy) and Chiropractic Care:**  
\$1,500 per Member per Calendar Year

## SPECIAL REQUIREMENTS FOR MYELOABLATIVE THERAPY (MAT) WITH HEMATOPOIETIC STEM CELL SUPPORT (HSCS) FOR MALIGNANCIES

---

Specific criteria must be met for coverage to be provided.  
Prenotification is required.

## PRESCRIPTION DRUGS

---

A Prescription Drug Card applies and coverage is not subject to the medical plan Deductible. The Member Copayment is \$5 for generic prescriptions, 25% of the cost of name brand formulary prescriptions and diabetic supplies, and 50% of the cost of psychotropic prescriptions, non-formulary prescriptions and oral contraceptives. Any amounts paid for Prescription Drugs do not apply toward Maximum Coinsurance amounts.

## **COVERED SERVICES**

Benefits are available for these services and supplies when Medically Necessary.

### **Inpatient and Outpatient Hospital/Skilled Nursing Facility**

- Semi-private room accommodations
- Ancillary services and supplies
- Emergency department services
- X-ray and laboratory services

### **Home Health Care/Home Infusion Therapy Services**

- Home Health Care services provided in the Member's home
- Home Infusion Therapy services provided in the Member's home
- Other services and supplies

### **Physician Services**

- Surgical services
- Assistant surgeon services
- Anesthesia services
- Inpatient medical services
- Outpatient medical services
- Diagnostic services
- Chemotherapy
- Radiation therapy
- Outpatient rehabilitation and chiropractic care (limited)
- Consultations

## **What Is Covered** (continued)

- Preventive services for adults and children (limited)
- Dental services for Accidental Injury
- Skilled nursing services
- Dialysis services
- Mental Health Condition services, including drug/alcohol use/abuse (limited)

## **Maternity Services (limited)**

### **Prescription Drugs**

Outpatient prescription drugs are covered under a Prescription Drug Rider issued in conjunction with the basic policy for all ValueCare Plans (see the Prescription Drug Rider for complete details).

### **Other Services**

- Durable Medical Equipment
- Medical/surgical supplies
- Ambulance services

### **Diabetic Supplies and Educational Benefits**

Diabetic supplies (including needles, syringes, test strips, lancets and other disposable diabetic supplies) are covered under a Prescription Drug Rider issued in conjunction with the basic policy, or under the basic policy benefit for Durable Medical Equipment and supplies. Diabetic education received through an accredited or certified diabetic education program is also covered.

### **Transplants**

Coverage is available for kidney, cornea, heart, heart/lung, lung, liver and pancreas transplants, and bone marrow transplants for certain conditions (see the ValueCare Agreement for details).

## What Is Covered (continued)

### **MAT/HSCS**

Coverage is available for Myeloablative Therapy (MAT) With Hematopoietic Stem Cell Support (HSCS) For Malignancies. Specific criteria must be met for coverage to be provided.

Prenotification is required.

### **Preventive Services (limited)**

Children through age 5:

- Ten professional examinations in the first 24 months of life and four professional examinations per child per year from age 2 through age 5 years, including routine diagnostic tests. Childhood immunizations covered through age 17 years. \$300 Maximum Benefit limit does not apply.

Adults and older children (age 6 and over) - Maximum Benefit \$300 per Member per Calendar Year.

- One routine physical examination each year for Members over age 5 years, including:
  - One Pap smear each year;
  - One prostate specific antigen (PSA) test each year for a Member 40 years or older;
  - Mammography screening in accordance with the following:
    - ... one baseline screening for Member 35 through 39 years;
    - ... one screening each year for Member 35 through 39 years with documentation that Member has inherited predisposition for cancer of the breast;
    - ... one screening each year for a Member 40 years of age or older;
  - An annual test of the stool for occult blood for a Member 40 through 64 years of age;
  - Sigmoidoscopy every 3 years for a Member 40 years of age or older;
  - Specified adult immunizations.

## SPECIAL BEGINNINGS® PROGRAM

Special Beginnings® is a confidential maternity monitoring program administered by registered nurses who are dedicated to making each pregnancy a healthy experience.

To participate in the Special Beginnings® program or for 24-hour nurse access, please call 1(888) JOY-BABY [1(888) 569-2229].

## ACCIDENTAL DEATH BENEFITS

ValueCare provides a death benefit payable to the estate of the insured in the event of death caused by accidental means. This benefit is part of your medical coverage with ValueCare. Adult Subscribers, covered spouses, covered children and Juvenile Subscribers (under age 18) are eligible for this benefit. This coverage will remain in place as long as you maintain your ValueCare policy.

The death benefits are outlined in the following chart:

<b>Status</b>	<b>Death Benefit</b>
Adult Subscriber	\$25,000
Covered Spouse	\$25,000
Each Covered Child	\$5,000
Juvenile Subscriber (under age 18)	\$5,000

Specific exclusions apply to the Accidental Death Benefit. Refer to the ValueCare Agreement for details.

## LIMITATIONS

During the 12-month limitation period following the Member's Effective Date, NO BENEFITS will be provided for:

- Pre-existing conditions, which are physical or mental conditions (including but not limited to pregnancy) for which medical advice, diagnosis, care, or treatment was recommended or received within six months prior to the Effective Date.
- Mental Health Conditions including alcoholism, drug abuse, and other conditions related to use or abuse of alcohol or controlled substances (drugs).

## **Limitations** (continued)

- Pregnancy, unless the expected delivery date is more than 12 months after the Effective Date.
- Organ transplants; bone marrow transplants.
- Sterilization (e.g., vasectomy, tubal ligation).

If you are eligible for waiting period credit due to prior coverage, you may request and complete an application for such credit that shall be applied toward the 12-month limitation for all conditions listed above. You may also eliminate the 12-month limitation period if you have eighteen (18) or more months of Creditable Coverage (the most recent of which is group coverage), you are not eligible for other group coverage, Medicare or Medicaid, and you meet certain other requirements.

## **COVERAGE FOR JOB OR WORK RELATED CLAIMS OR ILLNESSES**

Normally, job or work related claims are excluded from coverage under the Agreement. However, if you are not required by law to be covered under Workers Compensation Insurance, coverage may be available for the cost of care and treatment related to such a claim, in accordance with the terms, conditions, limitations, and exclusions of the Agreement. Coverage under the Agreement will be evaluated at the time a claim for such care and treatment is received by ValueCare and may require additional information from you to determine your entitlement to coverage under the Agreement.

## **WHAT IS NOT COVERED**

There are NO BENEFITS for any of the following:

- Services provided before the Effective Date or after the termination date
- Services covered by any Workers Compensation law, employer's liability law, or Medicare, or furnished by Veterans Administration hospitals

## What Is Not Covered (continued)

- Any condition, disability, or expense sustained as a result of being engaged in duty as a member of the armed forces of any state or country
- Any condition, disability, or expense sustained as a result of intentional or accidental atomic explosion or other release of nuclear energy
- Services covered under an Automobile No-Fault Insurance Act
- Treatment of an Illness or Injury caused by or arising out of riots, war, insurrection, rebellion, armed invasion or aggression; or sustained in the commission of an illegal act
- Services received outside Utah which would not have been licensed in the State of Utah
- Examinations, reports or appearances in connection with legal proceedings; and services provided solely to satisfy a court order
- Experimental or investigational treatments or procedures
- Any service provided for or in connection with a transplant which is not listed in the ValueCare Agreement; any service in connection with the implantation of any artificial or non-human organ
- Cosmetic surgery; weight-loss treatment, reversal of previous weight-loss surgical procedures
- Services provided in connection with a non-covered service, including any complications resulting from the non-covered service
- Reversal of sterilization or subsequent re-sterilization
- Genetic studies; non-prescription contraceptives; treatment for infertility; fertility drugs and medications; services provided for or in connection with erectile dysfunction
- Artificial insemination or in vitro fertilization
- Growth hormone therapy once bone growth is complete

## What Is Not Covered (continued)

- Custodial care; non-skilled nursing services
- Milieu therapy, biofeedback, behavior modification, sensitivity training or hypnosis; care or treatment of marital or family problems; care or treatment of social, occupational, religious or other social maladjustment; care or treatment of conduct disorders, chronic situational reactions, chronic adjustment disorder, transsexualism, psychosexual identity disorder, psychosexual dysfunction, gender dysphoria, chronic organic brain syndrome, personality disorder, learning disability, or mental retardation
- Treatment or prevention of illness or injury outside generally accepted health care practice as determined by ValueCare
- Holistic or homeopathic treatment, including drugs and other remedies
- Allergy tests and desensitization
- Ecological or environmental medicine
- Counseling services; educational services
- Services by a family member; services by a public or private school or halfway house; chronic pain control programs
- Routine physical examinations required by a third party (e.g., employer, insurance company, etc.); vaccinations, unless specifically provided for in the Agreement
- Acupuncture; acupressure
- Dental services or dental surgery
- Services in connection with temporomandibular joint (TMJ) dysfunction; upper or lower jaw augmentation or reduction procedures (orthognathic surgery); or restorations necessary to increase vertical dimensions or to restore occlusion
- Routine foot care; corrective shoes; special shoe accessories and foot orthotics

## **What Is Not Covered (continued)**

- Routine vision or hearing examinations; eyeglasses or contact lenses; surgical correction of refractive errors of vision (including radial keratotomy); internal or external hearing aids, devices or simulators; cochlear implants; other sound processors
- Personal comfort or convenience items; special formulas, food supplements, or special diets
- “Missed” appointments; telephone consultations
- Shipping, handling, postage, interest or finance charges; travel, whether or not prescribed
- Services determined by ValueCare to be not Medically Necessary
- Services which the Member has no legal obligation to pay
- Aviation accidents; injury due to parachuting or hang-gliding
- Any excise, sales, or other taxes; surcharges; tariffs; duties; assessments; or other similar charges
- Charges for preparing medical reports, itemized bills or claim forms
- Charges which would not be made absent the availability of benefits under the ValueCare Agreement
- Claims not submitted within one year after the date the service is provided to the Member

## **APPEALING A DENIED CLAIM**

### **Member Appeal Process**

A three-level process (and optional arbitration) is available to you to resolve any complaints or grievances regarding a claim denial or other action by ValueCare. In addition, if you or your physician believe that a utilization management decision made denying preauthorization of a pre-service claim will jeopardize your life, health, or ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the disputed care, you

## **APPEALING A DENIED CLAIM (continued)**

may request an expedited appeal. Please refer to the Health Care Agreement for complete details of the Member Appeal Process as well as the Expedited Appeal Process.

### **FIRST LEVEL - Complaint/Grievance/Reconsideration**

The Member may initiate an appeal through either a written or oral request. Written appeal requests should be mailed to Benefits Administration, ValueCare, P.O. Box 25956, Salt Lake City, Utah 84125-0956. Oral requests can be made by calling ValueCare at (801) 333-2310 within the Salt Lake area, or (800) 245-0026 outside the Salt Lake area. Within five (5) working days or seven (7) calendar days, whichever is sooner, of the receipt of request for an appeal, Benefits Administration will send to the Member an acknowledgment of the request for appeal and information describing the entire Member Appeal Process and Member rights. "First Level - Complaint/Grievance/Reconsideration" is a review by a Benefits Administration Representative who was not involved in the initial decision.

### **SECOND LEVEL - Internal Appeal**

If the Member disagrees with the decision made in the "First Level - Complaint/Grievance/Reconsideration," the Member may request further appeal to the "Second Level - Internal Appeal." The appeal request, including any additional information or comments, must be made to the Appeal Coordinator, ValueCare, P.O. Box 25956, Salt Lake City, Utah 84125-0956. Within five (5) working days or seven (7) calendar days, whichever is sooner, of the receipt of the request for "Second Level - Internal Appeal," the Appeal Coordinator will send to the Member information describing the entire Member Appeal Process and Member rights. "Second Level - Internal Appeal" is a review by a Panel comprised of the Appeal Coordinator, a ValueCare Medical Services physician and another officer of ValueCare none of whom were involved in the First Level decision. On three (3) days advance notice, the Member or the Member's Representative, on the Member's behalf, will be given a reasonable opportunity to personally appear for fifteen (15) minutes or participate via telephone, video conference, or other technology, and/or to provide written materials.

## **APPEALING A DENIED CLAIM (continued)**

### **THIRD LEVEL - External Appeal**

If the Member disagrees with the decision made in the “Second Level - Internal Appeal,” but preauthorization could no longer be reasonably believed to be clinically urgent (e.g., the service has been provided), the Member may request further appeal to the “Third Level - External Appeal.” The appeal request, including any additional information or comments, must be made to the Appeal Coordinator, ValueCare, P.O. Box 25956, Salt Lake City, Utah 84125-0956. “Third Level - External Appeal” will be coordinated by the Appeal Coordinator while the decision is made by an Independent Review Organization (IRO). The IRO is a physician review organization which is unbiased, independent, and not controlled by ValueCare. Within the IRO, there will be clinical expertise, use of evidence-based decision making, maintenance of confidentiality, and adequate administration and training capacity. Within five (5) working days or seven (7) calendar days of receipt of the request for a “Third Level - External Appeal,” the Appeal Coordinator will send to the Member information describing the entire Member Appeal process and Member rights.

### **OPTIONAL FOURTH LEVEL - Arbitration**

Arbitration is available as the final level of appeal for a Member’s dispute with ValueCare. All other levels of this Member Appeal Process must be exhausted before arbitration is available. Choosing arbitration as the final level for the settlement of such disputes will be binding in accordance with the Arbitration provision of this section. The Appeal Coordinator can assist Members with procedures for initiating and participating in an arbitration.

Other forums may be utilized in lieu of arbitration as the final level of appeal to resolve a Member’s dispute with ValueCare, including but not limited to mediation or civil action.

### **Expedited Appeal**

An expedited appeal process is also available. Refer to the Health Care Agreement for details.

## **APPLICATION FOR MEMBERSHIP**

After carefully reading this brochure and deciding to apply for coverage, you should complete the enrollment Application and Health Statement and return it to ValueCare with your check, depending on the payment option selected (see the enclosed rates). Premiums are determined by the plan selected, the gender and age of the adult insured(s), and the number of children, if any, covered under the policy.

We rely on the information you provide for yourself and your dependents, so the information must be complete and accurate for each person to be enrolled. Acceptance of your application is based upon the health and prior insurance status of you and your family members, if any, and thus:

- Coverage may be accepted at the current rates, or
- Certain health conditions may necessitate coverage acceptance at a higher rate level, or under another type of plan, including the Basic Benefit Plan, or
- Coverage may be denied for failure to meet our underwriting requirements or federal/state health care reform regulations.

## **POLICY EFFECTIVE DATE**

Review of your completed Application and Health Statement generally takes about ten working days. Your coverage effective date will be assigned on the first of the month after your application has been reviewed and accepted. If there is a delay in accepting your application and the effective date is postponed, you will be notified.

## PAYMENT OF PREMIUMS

Premiums are payable in advance to ValueCare. If premiums are not fully paid within 30 days after the due date, coverage under the ValueCare Agreement is automatically terminated. You will be notified of any increase or decrease in premiums 30 days in advance of the change. ValueCare can change your premium or modify your benefits only if it does so for all Subscribers in your class. The amount of your premium is in accordance with the rate schedules in effect at the time of coverage and is based on the plan you have selected, the gender and age of the adult insured(s), and the number of children, if any, covered under the policy. You will not receive separate advance notice of premium changes due to your age change.

## PAYMENT PLAN OPTIONS

When completing your Application and Health Statement, select one of the following payment options and indicate your choice on page 3 of the application form.

### Monthly SurePay

SurePay allows you to have your premium withdrawn automatically each month from your personal checking account. Payments are made monthly rather than quarterly, making your budgeting process easier. SurePay eliminates postage costs, as well as the time and expense of writing checks. Please send in your first month's premium with your application. Future payments will be automatically deducted from your checking account.

### Monthly Coupon Book

This option provides the convenience of monthly payments. You will receive a booklet with a supply of billing coupons (new booklets will be issued to you annually). Each coupon provides monthly billing information and a stub to retain for your own records. Simply tear out the billing portion and mail it along with your check. For your convenience, mailing labels are enclosed in the booklet. It is necessary to send in your first month's premium plus a \$5.00 monthly service charge with your application.

## PAYMENT PLAN OPTIONS (continued)

### Direct Quarterly Bill

If you choose, you can receive a direct quarterly billing, mailed to your home address as indicated on your application. With the direct billing plan, it is necessary for you to send in your first quarter's premium with your application. You will be billed on a quarterly basis thereafter. The enclosed rate table shows monthly premiums. If you choose the quarterly bill, multiply the monthly premium by three.

## TEN-DAY REVIEW PERIOD

You will have ten (10) days after you receive the ValueCare Agreement to review the provisions of the Agreement and to review the benefits, limitations, and exclusions of the plan before acceptance. You may cancel within the 10-day review period and receive a full refund of your premium. **There is no provision for premium refund after the 10-day review period.** If your premium is refunded, the ValueCare Agreement shall be void from the Effective Date.

## CONSUMER PRIVACY NOTICE

We are committed to protecting the privacy of your personal information. The purpose of this notice is to inform you of the types of personal information we obtain and how we protect that information.

### What is personal information?

We treat any information that is identifiable to you as your personal information, whether or not it may be otherwise available to the public. We collect personal information related to your:

- Health condition, including health care treatment and payment;
- Identity, such as your name, age, or address; and
- Income, when necessary for coverage.

## **CONSUMER PRIVACY NOTICE** (continued)

### **Why do we collect your personal information?**

We collect personal information from you to help us:

- Determine the appropriate products to offer you;
- Pay claims;
- Provide case management services; and
- Provide quality improvement services.

### **How do we collect your personal information?**

We collect your personal information through you and your health care providers. For example, we receive personal information from you on your insurance application and from your health care providers through insurance transactions, such as the submission of a claim for reimbursement for covered benefits.

### **To whom do we disclose your personal information?**

We will not disclose your personal information unless we are allowed or required by law to make the disclosure, or if you give us permission. Following are some examples of disclosures we may make as allowed or required by law:

- To health care providers (doctors and others who provide you with care) in connection with an insurance transaction, such as verifying that you have coverage;
- To service companies that perform insurance functions on our behalf, such as third party administrators, insurance agents, auditors, benefit consultants, or care management specialists for utilization management and quality improvement;
- To an insurance regulatory authority; or
- To respond to legal requests such as a subpoena.

## **CONSUMER PRIVACY NOTICE (continued)**

We will not disclose your personal information to any non-affiliated company for that company's marketing purposes.

We may share your financial information with our affiliated companies for marketing purposes to better serve your needs as one of our customers. Financial information means information about your income or your identity, such as your name, age, or address. An affiliated company means a company owned or controlled by us. For example, if you choose to purchase insurance from us, we may share your financial information with an affiliated life insurance company to make our full range of insurance products and services available to you. Also, when you reach a certain age, we may share your financial information with an affiliate to alert you of additional products or programs for which you may become eligible, such as Medicare or Medicaid.

### **How do we protect your personal information?**

We protect your personal information by:

- Treating all of your personal information that we collect as confidential;
- Stating confidentiality policies and practices, as well as disciplinary measures for privacy violations, in our employee handbooks;
- Restricting access to your personal information to only those employees who need to know your personal information in order to provide our services to you, such as paying a claim for a covered benefit;
- Disclosing only your personal information that is necessary for a service company to perform its function on our behalf, and only when the company agrees to protect and maintain the confidentiality of your personal information; and
- Maintaining physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your personal information.

## **CONSUMER PRIVACY NOTICE** (continued)

### **Can I “opt out” of certain disclosures?**

You may have received notices from other organizations that allow you to “opt out” of certain disclosures. The most common type of disclosure that applies to “opt outs” is the disclosure of personal information to a non-affiliated company so that company can market its products or services to you. As a health plan, we must follow many federal and state laws that prohibit us from making these types of disclosures. Because we do not make disclosures that apply to “opt outs,” it is not necessary for you to complete an “opt out” form or take any action to restrict such disclosures.

### **How can you reach us?**

- Visit our Web site at [www.ut.regence.com](http://www.ut.regence.com); or
- Contact your Customer Service Department at 1 (800) 245-0026.

### **Revisions**

We may amend this notice at any time and will inform you of changes as required by law.

You will have ten (10) days after you receive the ValueCare Agreement to review the provisions of the Agreement and to review the benefits, limitations, and exclusions of the plan before acceptance. You may cancel within the 10-day review period and receive a full refund of your premium. There is no provision for premium refund after the 10-day review period. If your premium is refunded, the ValueCare Agreement shall be void from the Effective Date.



**Regence**  
*ValueCare*

2890 East Cottonwood Parkway  
P. O. Box 25956  
Salt Lake City, Utah 84125-0956  
(801) 333-2310 (Benefits, Customer Service)  
(801) 333-2510 (Eligibility)

ValueCare is not an insurance company.  
This program is insured by  
Regence BlueCross BlueShield of Utah.