

Choosing Regence

Individual and family health benefit plans

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

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Salt Lake City, UT 84130-0270

Thank you for expressing interest in a Regence Individual and family health plan.

Choosing health coverage is an important process, and we're looking forward to helping you find the Regence plan that will give you what you're looking for.

In order to meet the changing needs of our neighbors here in Utah, we've developed a suite of new Individual and family plans. These plans focus on affordability, practical coverage, wellness and protection. You'll find a variety of benefits and costs—including HSA options that give you the ability to save money tax-free for eligible medical expenses. This booklet contains valuable tools designed to help you choose and apply for the coverage that's right for you.

You'll find plan comparisons, brief explanations of how coverage works, a description of our wellness-focused programs and all the forms you'll need to apply.

If you want to explore Regence or our plans in more detail, please visit our website at regence.com. You can also talk to your local agent or an Individual plan specialist at 1-888-REGENCE (1-888-734-3623).

We look forward to hearing back from you soon.

Sincerely,

Jennifer Cannaday
Vice President

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Step 1

Choose a plan that's right for you

Want a variety of choices?

Regence plans provide a number of options when it comes to coverage and cost. With four plans to choose from and multiple cost-sharing options within each plan, you're sure to find the right coverage for you.

Considering an HSA?

Many consider these Consumer-Directed Health Plans to be the future of health care coverage. They combine a specially designed, high-deductible health plan and a tax-advantaged savings account to use for out-of-pocket medical expenses or to save for future medical expenses. We offer a variety of HSA options.

Choosing the network that's right for you?

All Regence plans give you access to the largest national network of Preferred Providers, but Regence has a special arrangement with most physicians, hospitals and other health-care providers in Utah. You choose which network saves you the most money with the providers you use most often.

- Preferred BlueOption Network (not available for Regence RealValue)

- Preferred ValueCare Network
- Preferred FocalPointSM Network

If you already have one or more providers that you see regularly, such as a primary care physician you see every year, or a hospital you want to make sure you have access to, the easiest way to pick the right network for you is to use our Provider Search at www.regence.com and find out which network they are contracted with.

Need dental coverage?

Good overall health includes good dental health, too. And good dental health requires regular dental care. If you're interested in coverage for overall well-being, you'll probably want to add dental coverage to your medical benefits.

There are two optional dental plans that can accompany your medical plan. Each one provides flexibility, choices and control over how you spend your dental coverage dollars, all with an eye on maintaining overall good health.

If you have questions about any of the plans, talk to your local agent or call us at 1-888-REGENCE (1-888-734-3623).

For information about our Individual NetCare-compatible plans, call Customer Service at 1 (888) 231-8424.

Comparing medical plans

What you need to know

When shopping for a health plan, it can be helpful to know a little more about how health coverage works.

Below is information that will help you better understand what you're comparing when you're looking at our options side by side.

If you have any questions or want to learn more, please visit our website at regence.com or call us at 1-888-REGENCE (1-888-734-3623).

What is coinsurance?

Coinsurance is your share of the cost of health care services after you've met your deductible and paid any applicable copay. For example, if your plan pays 80%, the remaining 20% is your coinsurance. Coinsurance amounts can vary from plan to plan.

What is an allowed amount?

An allowed amount is the fee that most providers agree to accept as payment in full for covered services. (Any deductible, coinsurance or copay is part of your share of the allowed amount.)

What is a coinsurance maximum?

Standard (non-HSA) plans have a coinsurance maximum, which is the most you would pay in coinsurance in a calendar year. Only your coinsurance counts toward this limit; money you pay in copays or toward the deductible does not accumulate toward this maximum. You would still be responsible for non-coinsurance out-of-pocket expenses, such as office-visit copays, after this maximum is reached.

How does the HSA annual out-of-pocket maximum work?

Your out-of-pocket maximum is the limit to how much you would pay out of pocket during a calendar year. Coinsurance and deductibles both count toward this maximum. This amount varies by plan. After you have reached your out-of-pocket maximum, Regence pays 100% of remaining covered medical expenses for that calendar year.

How does the deductible work?

Your deductible is the cost of covered medical services you incur and are responsible to pay each calendar year before the benefits are available. On standard plans, the family deductible is met when two or more covered family members reach the equivalent of two individual deductible amounts. On HSA family plans, the entire family deductible needs to be met before any family member receives benefits. (On HSA Individual plans, an individual needs to meet just their one deductible.)

What is a Consumer-Directed Health Plan?

It's a health plan design that involves consumers more directly in their health care through higher cost-sharing. Typically, such products are paired with a tax-advantaged health savings account offered through a bank. Funds in this account can be used to cover a portion of out-of-pocket expenses or saved for future medical needs.

Frequently asked questions about applying for coverage

Going to our website, regence.com, is the quickest and easiest way to apply. We've even built some decision-making tools that can help you choose the plan that's right for you. You can also complete and submit the application form that's at the back of this booklet. To help you through the application process, here are some frequently asked questions:

Q. Who can apply for coverage?

A. Individuals and family members who are under the age of 65, and reside within the plan service area six or more months of the year can apply for coverage under these plans. Eligible family members may include your spouse or domestic partner, and any children or students under age 26, regardless of student status, marital status or financial dependence.

Q. Can I apply online?

A. Yes, you can apply online. Online shopping is quick and easy. Compare plans, get a rate quote, find participating doctors and hospitals, and complete an application online. Our website makes it easy to find or match a doctor and hospital to the plan you're considering. To find out more, visit regence.com, then click on *Shop Now*.

Q. How do I apply on paper?

A. Simply complete the enclosed application (one per family). Then return the forms to us. Once we receive all the needed documents, we'll begin our review process.

Q. By completing the application, will I automatically be approved for coverage?

A. We have to review each applicant's health history before we can offer coverage. If we're unable to offer coverage to you or one of your family members, we'll provide contact information for the state program that provides medical coverage for Utah residents who are unable to obtain private coverage due to health conditions.

Q. Are all of my family members required to be on the policy?

A. We do allow partial family policies. All family members applying for coverage must be on the same family policy.

Q. When will my coverage begin?

A. Your contract will be effective on the first of the month after your application is approved. We'll begin to process your application immediately once we receive it. If we need additional information, processing could be delayed. Once coverage is offered, we'll send you your member card(s) and a contract.

Q. Does it cost more to buy through an agent?

A. No. There is never an extra cost or obligation when you use an appointed agent. Agents appointed to represent Regence products provide a valuable service to their clients. They can help you decide which of our products is best for you and your family.

Q. Will my rate ever change?

A. We evaluate Individual rates each quarter for new members coming onto these plans. But once you are a member, you may not see a rate change for your coverage for one year after your enrollment date. For example, if you became a member on July 1, 2012, the next time you may see a rate change is July 1, 2013. See the policy for when we may change the premium rates other than at the renewal date.

Q. What is a pre-existing condition?

A. By pre-existing condition,, we mean a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before we received your application for coverage under this policy. The exclusion period will end 12 months following the date we received your application for coverage under this policy. Pre-existing condition waiting periods do not apply to members up to age 19.

Q. What about prior coverage credit?

A. If we receive your application within 63 days after similar coverage with another insurance carrier ends, we'll credit the time you were covered by the other company to the 12-month pre-existing condition waiting period. We need to receive a copy of your Certificate of Creditable Coverage from your previous insurance carrier in order to apply credits.

Frequently asked questions about applying for coverage

Creditable coverage means any of the following types of coverage:

- Group coverage (including FEHBP and Peace Corps)
- Individual coverage (including student health plans)
- Medicaid
- Medicare
- CHAMPUS/Tricare
- Indian Health Service or tribal organization coverage
- Public health plans
- State Children's Health Insurance Program (S-CHIP)
- State high-risk pool coverage
- Self-funded government plans

Q. How do I pay for my plan?

A. Choose from three convenient billing options: monthly automatic bank deduction (Surepay), quarterly billing, or monthly paper billing. Don't send money with your application. We'll bill after we've processed your application.

If you choose monthly automatic bank deduction, it may take a month or two to get your bank deduction set up. So, please be sure to pay the monthly bills that you receive in the mail until the bank deduction is finalized.

Q. What if I want to add a dependent in the future?

You can add newborns or children recently placed with you for adoption to your policy from the date of birth or placement. If adding the child will change your premium, you must apply within 60 days after the birth or placement. If no premium change will occur, you must apply within 60 days of the first denial of a claim for the child. See your contract for details.

To add a spouse, domestic partner or child after your effective date, send us a completed application form. Once we receive the application, we'll begin the review process. You can also apply online at regence.com.

You may enroll your eligible family member who is under 19 years of age at the annual enrollment period defined in applicable state or federal law. In Utah, the current annual enrollment period is May 1 through June 15 each year for the next July 1, or during an annual open enrollment, beginning 45 days before the policy's renewal. For more information or to see if you qualify for an exemption to this rule, please call our Sales department toll-free at 1 (888) 734-3623.

Q. Can I purchase the dental options separately from the medical plans?

A. No. The dental options are available only to individuals and families who purchase Regence medical plans during initial enrollment. If you want a stand-alone dental plan (one that's not combined with medical coverage), please visit Regence Life & Health Insurance Company at regenceLife.com.

Q. Can individual family members decline dental coverage?

A. If more than one family member is applying for a health plan and dental options on the same application, all family members will have the dental coverage. If individual family members complete separate applications for medical coverage they can choose to add or not add a dental option.

Q. What should I do if I have questions?

A. This booklet is a summary of the Regence Evolve plans. You may find it useful if you need a quick answer to a question about your coverage. The policy will provide complete details about your plan.

Please call us at 1 (888) REGENCE (1-888-734-3623) if you have more questions before you've been accepted for coverage. Once your coverage is effective, please call Customer Service at 1 (888) 231-8424. The TTY line for people with a hearing impairment is 711. If you prefer, an agent appointed to represent our products can also answer questions and help you apply.

For the most up-to-date list of medical providers, please visit our website at regence.com, and choose *Find a Provider*.

Q. Can my employer pay for my coverage?

A. No. Individual plans are not intended for sale as an employer-sponsored health plan for employees. You're required to certify on your application for Individual coverage that your employer is not paying for your plan. For information on employer health benefit plans, contact our Group Sales department.

Q. How do I know if my doctor is covered?

A. You may see any of our contracted providers. For a list, visit our website at regence.com. Simply click on *Find a Provider* at the top of the page and follow the prompts. You will see all the networks the providers are part of as well as other useful information (such as location, hours and languages spoken).

Health Savings Accounts explained

A smarter way to manage your health care

The power of HSA: ownership

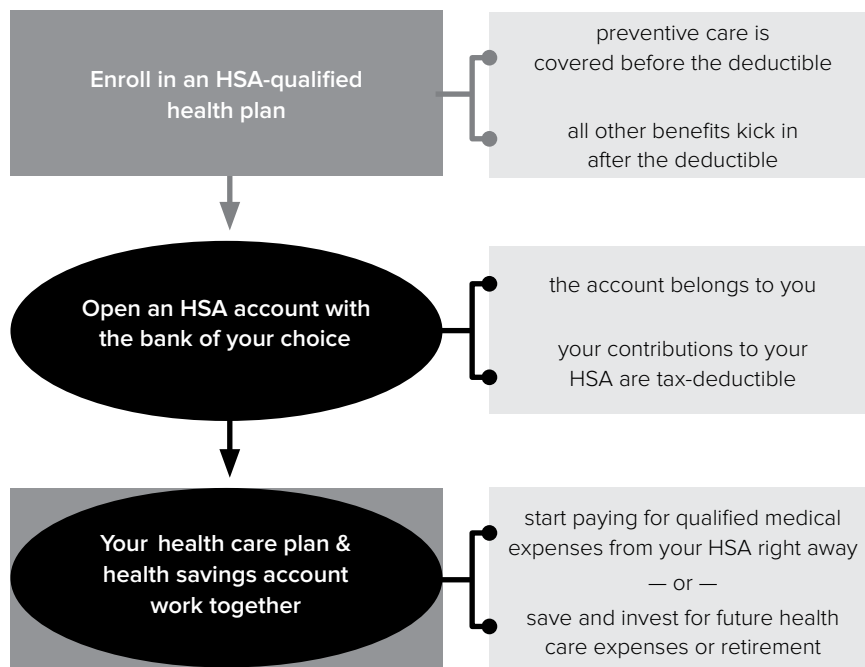
There are many options to choose from when searching for Individual health care coverage for yourself or your family. A new concept in health care—called a Health Savings Account (HSA)—may be the right choice for you if you're looking for coverage that's personalized, tax-advantaged and flexible.

Why should you consider an HSA?

With an HSA, you have more ownership over your health care.

- An HSA offers unique tax savings. Contributions are tax-deductible, interest is earned tax-free, and qualified medical expenses are paid tax-free.
- Your HSA funds belong to you. Your funds roll over each year and follow you wherever you go, allowing you to save and invest for future medical expenses and retirement.
- Your benefits are personalized. The HSA account gives you the flexibility to spend your health care dollars on the services you need most. Even more, you can choose from a list of services that expands beyond what is covered by your health plan.

How an HSA plan works



Health Savings Accounts explained

The power of Regence: unparalleled support

The Regence Evolve HSA options offer full-service solutions that include all the tools and support you need to make the plan your own. From robust benefits to guided tours—we're committed to your success.

Regence Evolve HSA Plan 2.0 offers robust coverage

- Preventive care covered at 100% and before you meet your deductible when you see an in-network provider
- Integrated wellness programs
- Comprehensive coverage after the deductible

Regence Evolve HSA 100 Plan 2.0

- Preventive care covered at 100% and before you meet your deductible when you see an in-network provider
- 100% in-network coverage after yearly deductible
- Integrated wellness programs
- Easy-to-use benefits and features

Our tools make the difference

- myRegence.com takes you from the basics to a deeper understanding of plan personalization, tax savings and investment options, with:
 - Guided online tours
 - Webinars
 - Ask an HSA Expert
 - Online community of Regence members

Personalized support

- A team of member advocates is available to answer questions about your health plan, your health savings account and all our HSA tools.
- CareEnhance® 24-hour nurse hotline is available to answer medical questions quickly and conveniently.

Getting started is easy

Follow these simple steps:

1. Obtain an application from your local agent, apply online at regence.com, or call us toll-free: 1 (888) REGENCE (1-888-734-3623).
2. Once you're approved for coverage, you can open a Health Savings Account. You can work with one of Regence's preferred banking partners or you may choose your own bank.

3. Put your HSA to work for you. Spend your HSA dollars on qualified medical expenses, or save and invest for the future.

Frequently asked questions

What is an HSA-qualified plan?

For a plan to be HSA-qualified, it must meet requirements set by the IRS that include the deductible and out-of-pocket expense amounts.

Who is eligible to enroll in an HSA?

Individuals may open an HSA if:

- They are enrolled in a qualified high-deductible health plan
- They don't have coverage under another health plan, such as a spouse's plan
- They are not enrolled in Medicare
- They are not claimed as a dependent on someone else's tax return

How much can be contributed to an HSA?

Combined HSA contributions cannot exceed the maximum contribution limit as determined by the IRS. For 2012, the annual limits are \$3,100 for individual coverage, or \$6,250 for family coverage.

How do I get the account set up?

Once you're enrolled in an Evolve HSA medical plan, you will need to set up an account with the banking partner of your choice by contacting the bank and filling out the appropriate forms. A list of Regence's preferred banking partners can be found on the following page.

When should I set up the account?

You may set up the account at any time, but you cannot fund the account until you have been approved for the health plan. To take full advantage of the value of the HSA, we encourage you to have the account set up and funded as soon as you have received approval. Only claims that occurred since the account has been open can be paid out of the account.

For investment or tax advice on HSA plans, please talk to an accountant or tax advisor.

Regence Financial Services Partners

The Regence Evolve HSA plans are a combination of a specially designed, high-deductible Regence health plan and a tax-advantaged savings account. For your convenience, we have developed partnerships with a select group of financial institutions that offer HSA accounts along with some added benefits to Regence members. You may choose to open an account with one of our partners or with any financial institution that offers HSAs.

Benefits of using a Regence Financial Services Partner

- They offer high-quality customer service.
- Our members have access to negotiated fee schedule.
- All partners have extensive experience working with HSAs.
- The connection process between banking partners and Regence provides seamless member service over the phone.
- You can link from myRegence.com to the bank's member login page.

Financial Services Partner website and contact information

HealthEquity
regenceut.healthequity.com
1 (866) 960-8055

US Bank
healthsavings.usbank.com
1 (877) 472-6789

HSA Bank
hsabank.com/utregence
1 (800) 357-6246

Additional information

Feature/item	HealthEquity	HSA Bank	US Bank
Member services availability	24/7/365	M-F	M-F
Paper check available	No	Yes	Yes
Debit card provider	Yes	Yes	Yes
PIN available (for ATM usage)	Yes	Yes*	No
Ability to pay provider online	Yes	No	No
Minimum balance required to invest funds	\$2,000	\$1	\$2,500

**Subject to transaction fees*

Key features of Regence Individual and Family Plans:

Coverage, savings, flexibility

Regence Evolve Core 2.0

- Preventive care covered at 100% before you meet your deductible when you see an in-network provider
- Four up-front office visits per member per year covered before you meet your deductible (\$35 copay per visit)
- First \$200 per member per year outpatient X-ray and lab services covered at 100% per year before you meet your deductible
- Coverage for generic and brand-name medications

Regence RealValue

- Basic affordable coverage
- Preventive care covered at 100% before you meet your deductible when you see an in-network provider
- \$10 copay and no deductible for generic medications

Regence Evolve HSA Plan 2.0

- Preventive care covered at 100% before you meet your deductible when you see an in-network provider
- Simple plans with either 80% or 60% coverage options
- Coverage for generic and brand-name medications
- Personal service and help from dedicated Regence HSA Customer Service department

Regence Evolve HSA 100 Plan 2.0

- Preventive care covered at 100% before you meet your deductible when you see an in-network provider
- Unique plan that covers you at 100% in-network once your annual deductible is met
- Simple to understand and use
- Coverage for generic and brand-name medications
- Personal service and help from dedicated Regence HSA Customer Service department

Regence Dental Option 1

- \$750 annual maximum that increases on a rewards basis (*When you incur services less than \$750, you may be rewarded with an additional benefit of \$250 the following year, not to exceed a total benefit of \$1,500.*)
- No deductible for preventive care
- Discounts available through the national **Regence Dental network**

Regence Dental Option 2

- Annual maximum of \$750 (basic, restorative and major services combined)
- Your coinsurance is 0% for the first \$200 and then 50% up to the \$750 calendar year maximum
- No deductibles
- Discounts available through the national **Regence Dental network**

Regence Evolve Core 2.0SM

<p>Calendar Year Deductible Applies to all covered expenses except where noted</p> <p>Separate deductibles for In-Network and Out-of-Network services</p>	<p>Individual deductible options per calendar year: In-Network: \$2,500/Out-of-Network: \$5,000 In-Network: \$5,000/Out-of-Network: \$10,000 In-Network: \$7,500/Out-of-Network: \$15,000 In-Network: \$10,000/Out-of-Network: \$20,000</p> <p>Family deductible is two times the In-Network/Out-of-Network Individual deductible amount</p>	
<p>Calendar Year Coinsurance Maximum Applies to all covered expenses except where noted. When the coinsurance maximum is reached, this plan provides benefits at 100% of the allowed amount for the remainder of the calendar year. (Applies only to services received in the applicable network for which the coinsurance maximum was reached.)</p> <p>Separate coinsurance maximums for In-Network and Out-of-Network services.</p>	<p>Individual coinsurance maximum per calendar year: In-Network: \$5,000/Out-of-Network: \$10,000</p> <p>Family coinsurance maximum is two times the In-Network/Out-of-Network Individual coinsurance maximum amount</p>	
<p>Annual Maximum</p>	<p>\$2,000,000 Annual Maximum</p>	
<p>Network Options</p>	<p>Choose from one of three networks for In-Network benefits: Preferred BlueOption Network, Preferred ValueCare Network or Preferred FocalPoint Network.</p>	
<p>Covered Services</p>	<p>Member Responsibility Coinsurance applies after In-Network/Out-of-Network deductible is met and until In-Network/Out-of-Network coinsurance maximum is reached.</p>	
<p>Upfront Office Visits (Injury and Illness) Up-front office visits: first four per calendar year</p>	<p>\$35 copay (In-Network deductible waived)</p>	<p>25% (Out-of-Network deductible applies)</p>
<p>Up-front Outpatient Radiology and Laboratory First \$200 per calendar year</p>	<p>0% (In-Network deductible waived)</p>	<p>0% (Out-of-Network deductible waived)</p>
<p>Professional Services/Outpatient Radiology and Laboratory Deductible applies after upfront benefit limits are met. Office and inpatient services and supplies.</p>	<p>30% (In-Network deductible applies)</p>	<p>45% (Out-of-Network deductible applies)</p>
<p>Preventive Care and Immunizations Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA).</p>	<p>0% (In-Network deductible waived)</p>	<p>25% (Out-of-Network deductible applies)</p>
<p>Hospital Services/Ambulatory Surgical Center Inpatient and outpatient services and supplies</p>	<p>30% (In-Network deductible applies)</p>	<p>45% (Out-of-Network deductible applies)</p>
<p>Home Health 130 visits per calendar year</p>	<p>30% (In-Network deductible applies)</p>	<p>45% (Out-of-Network deductible applies)</p>
<p>Hospice Respite care limited to 14 days inpatient/outpatient per lifetime</p>	<p>30% (In-Network deductible applies)</p>	<p>45% (Out-of-Network deductible applies)</p>
<p>Maternity Separate routine maternity deductible of \$7,500 per pregnancy</p>	<p>30% (Separate routine maternity deductible applies)</p>	<p>45% (Separate routine maternity deductible applies)</p>
<p>Rehabilitation Services Inpatient: 5 days per calendar year Outpatient: 30 visits per calendar year</p>	<p>30% (In-Network deductible applies)</p>	<p>45% (Out-of-Network deductible applies)</p>
<p>Skilled Nursing Facility 30 days per calendar year</p>	<p>30% (In-Network deductible applies)</p>	<p>45% (Out-of-Network deductible applies)</p>
<p>Complex Outpatient Imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density)</p>	<p>50% (In-Network deductible applies)</p>	<p>50% (Out-of-Network deductible applies)</p>
<p>Emergency Room Services \$150 copay per ER visit (waived if directly admitted)</p>	<p>30% (In-Network deductible and coinsurance maximum apply)</p>	<p>30% (In-Network deductible and coinsurance maximum apply)</p>
<p>Prescription Medication Coverage</p>	<p>\$10 copay for generics \$3,750 deductible, 50% coinsurance for brand formulary only. Brand formulary tobacco cessation medications not covered.</p> <p>Retail: 30-day supply per copay Mail order: 90-day supply (one copay per 30-day supply) Up to 30-day supply for covered self-administrable injectable medications at retail and mail order.</p> <p>We cover certain preventive medications according to United States Preventive Services Task Force (USPSTF) guidelines at 100%, no deductible, no copay at participating pharmacies only. Member must have a prescription.</p>	

Regence RealValueSM

<p>Calendar Year Deductible Applies to all covered expenses except where noted</p> <p>Separate deductibles for In-Network and Out-of-Network services</p>	<p>Individual deductible options per calendar year:</p> <p>In-Network: \$2,500/Out-of-Network: \$5,000 In-Network: \$5,000/Out-of-Network: \$10,000 In-Network: \$7,500/Out-of-Network: \$15,000 In-Network: \$10,000/Out-of-Network: \$20,000</p> <p>Family deductible is three times the In-Network/Out-of-Network Individual deductible amount</p>																					
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<p>Covered Services</p>	<p>Member Responsibility Coinsurance applies after In-Network/Out-of-Network deductible is met and until In-Network/Out-of-Network coinsurance maximum is reached.</p> <table border="1" data-bbox="573 800 1524 877"> <thead> <tr> <th data-bbox="573 800 1024 877">In-Network</th> <th data-bbox="1024 800 1524 877">Out-of-Network (Member may be responsible for any provider costs above the allowed amount)</th> </tr> </thead> <tbody> <tr> <td data-bbox="573 877 1024 1045"> <p>0% (In-Network deductible waived)</p> </td> <td data-bbox="1024 877 1524 1045"> <p>25% (Out-of-Network deductible applies)</p> </td> </tr> <tr> <td data-bbox="573 1045 1024 1123"> <p>35% (In-Network deductible applies)</p> </td> <td data-bbox="1024 1045 1524 1123"> <p>50% (Out-of-Network deductible applies)</p> </td> </tr> <tr> <td data-bbox="573 1123 1024 1182"> <p>35% (In-Network deductible applies)</p> </td> <td data-bbox="1024 1123 1524 1182"> <p>50% (Out-of-Network deductible applies)</p> </td> </tr> <tr> <td data-bbox="573 1182 1024 1241"> <p>35% (In-Network deductible applies)</p> </td> <td data-bbox="1024 1182 1524 1241"> <p>50% (Out-of-Network deductible applies)</p> </td> </tr> <tr> <td data-bbox="573 1241 1024 1318"> <p>35% (In-Network deductible applies)</p> </td> <td data-bbox="1024 1241 1524 1318"> <p>50% (Out-of-Network deductible applies)</p> </td> </tr> <tr> <td data-bbox="573 1318 1024 1396"> <p>35% (In-Network deductible applies)</p> </td> <td data-bbox="1024 1318 1524 1396"> <p>50% (Out-of-Network deductible applies)</p> </td> </tr> <tr> <td data-bbox="573 1396 1024 1455"> <p>35% (In-Network deductible applies)</p> </td> <td data-bbox="1024 1396 1524 1455"> <p>50% (Out-of-Network deductible applies)</p> </td> </tr> <tr> <td data-bbox="573 1455 1024 1514"> <p>50% (In-Network deductible applies)</p> </td> <td data-bbox="1024 1455 1524 1514"> <p>50% (Out-of-Network deductible applies)</p> </td> </tr> <tr> <td data-bbox="573 1514 1024 1591"> <p>35% (In-Network deductible and coinsurance maximum apply)</p> </td> <td data-bbox="1024 1514 1524 1591"> <p>35% (In-Network deductible and coinsurance maximum apply)</p> </td> </tr> </tbody> </table>		In-Network	Out-of-Network (Member may be responsible for any provider costs above the allowed amount)	<p>0% (In-Network deductible waived)</p>	<p>25% (Out-of-Network deductible applies)</p>	<p>35% (In-Network deductible applies)</p>	<p>50% (Out-of-Network deductible applies)</p>	<p>35% (In-Network deductible applies)</p>	<p>50% (Out-of-Network deductible applies)</p>	<p>35% (In-Network deductible applies)</p>	<p>50% (Out-of-Network deductible applies)</p>	<p>35% (In-Network deductible applies)</p>	<p>50% (Out-of-Network deductible applies)</p>	<p>35% (In-Network deductible applies)</p>	<p>50% (Out-of-Network deductible applies)</p>	<p>35% (In-Network deductible applies)</p>	<p>50% (Out-of-Network deductible applies)</p>	<p>50% (In-Network deductible applies)</p>	<p>50% (Out-of-Network deductible applies)</p>	<p>35% (In-Network deductible and coinsurance maximum apply)</p>	<p>35% (In-Network deductible and coinsurance maximum apply)</p>
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<p>Preventive Care and Immunizations Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA).</p> <p>Professional Services/Outpatient Radiology and Laboratory Office and inpatient services and supplies</p> <p>Hospital Services/Ambulatory Surgical Center Inpatient and outpatient services and supplies</p> <p>Home Health 130 visits per calendar year</p> <p>Hospice Respite care limited to 14 days inpatient/outpatient per lifetime</p> <p>Rehabilitation Services Inpatient: 5 days per calendar year Outpatient: 15 visits per calendar year</p> <p>Skilled Nursing Facility 30 days per calendar year</p> <p>Complex Outpatient Imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density)</p> <p>Emergency Room Services \$200 copay per ER visit (waived if directly admitted)</p> <p>Prescription Medication Coverage</p>	<p>No deductible \$10 copay for generics 35% coinsurance for brand diabetic drugs and supplies only. No other coverage for brand medications.</p> <p>Retail: 30-day supply per copay Mail order: 90-day supply (one copay per 30-day supply) Up to 30-day supply for covered self-administrable injectable medications at retail and mail order.</p> <p>We cover certain preventive medications according to United States Preventive Services Task Force (USPSTF) guidelines at 100%, no deductible, no copay at participating pharmacies only. Member must have a prescription.</p>																					

Regence Evolve HSA Plan 2.0SM

Calendar Year Deductible Applies to all covered expenses except where noted	Deductible per calendar year \$1,200, \$2,000 or \$3,500 for single coverage \$2,400, \$4,000 or \$7,000 for family coverage Family coverage: no one family member is eligible for benefits until the entire family deductible is met.			
Calendar Year Out-of-Pocket Maximum Out-of-pocket maximum amount per calendar year, including deductible, applies to all covered expenses. When the out-of-pocket maximum is reached, this plan provides benefits at 100% of the allowed amount for the remainder of the calendar year.	Out-of-Pocket Maximum per calendar year \$3,600 for single coverage on \$1,200 deductible plan \$5,000 for single coverage on \$2,000 and \$3,500 deductible plans \$7,200 for family coverage on \$2,400 deductible plan \$10,000 for family coverage on \$4,000 and \$7,000 deductible plans Family coverage: no one family member is eligible for 100% coverage until the entire family out-of-pocket maximum is met.			
Annual Maximum	\$2,000,000 Annual Maximum			
Network Options	Choose from one of three networks for In-Network benefits: Preferred BlueOption Network, Preferred ValueCare Network or Preferred FocalPoint Network.			
Covered Services	Member Responsibility Coinsurance applies after deductible is met and until out-of-pocket maximum is reached.			
Coinsurance Options Choose between a 80% or 60% coinsurance option	80% Plan		60% Plan	
Cost Sharing	In-Network	Out-of-Network (Member may be responsible for any provider costs above the allowed amount)	In-Network	Out-of-Network (Member may be responsible for any provider costs above the allowed amount)
Preventive Care and Immunizations Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA).	0% (Deductible waived)	25% (Deductible applies)	0% (Deductible waived)	25% (Deductible applies)
Professional Services Office and inpatient services and supplies	20%	40%	40%	50%
Hospital Services/Ambulatory Surgical Center Inpatient and outpatient services and supplies	20%	40%	40%	50%
Home Health 130 visits per calendar year	20%	40%	40%	50%
Hospice Respite care limited to 14 days inpatient/outpatient per lifetime	20%	40%	40%	50%
Mental Health and Chemical Dependency Treatment (combined) Inpatient: 6 days per calendar year Outpatient: 12 visits per calendar year	20%	40%	40%	50%
Rehabilitation Services Inpatient: 5 days per calendar year Outpatient: 30 visits per calendar year	20%	40%	40%	50%
Skilled Nursing Facility 30 days per calendar year	20%	40%	40%	50%
Complex Outpatient Imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density)	50%	50%	50%	50%
Emergency Room Services	20%	20%	40%	40%
Prescription Medications Subject to medical deductible. Retail or Mail Order: Up to 90-day supply for covered prescription medications.	20% coinsurance for generics. 50% coinsurance for brand formulary only. Brand formulary tobacco cessation medications not covered. We cover certain preventive medications according to United States Preventive Services Task Force (USPSTF) guidelines at 100%, no deductible, no copay at participating pharmacies only. Member must have a prescription			

Regence Evolve HSA 100 Plan 2.0SM

Calendar Year Deductible Applies to all covered expenses except where noted	Deductible per calendar year \$3,000 or \$5,000 for single coverage \$6,000 or \$10,000 for family coverage Family coverage: no one family member is eligible for benefits until the entire family deductible is met.	
Calendar Year Out-of-Pocket Maximum Out-of-pocket maximum amount per calendar year, including deductible, applies to all covered expenses. When the out-of-pocket maximum is reached, this plan provides benefits at 100% of the allowed amount for the remainder of the calendar year.	Out-of-Pocket Maximum per calendar year \$5,000 for single coverage on \$3,000 deductible plan \$5,950 for single coverage on \$5,000 deductible plan \$10,000 for family coverage on \$6,000 deductible plan \$11,900 for family coverage on \$10,000 deductible plan Family coverage: no one family member is eligible for 100% coverage until the entire family out-of-pocket maximum is met.	
Annual Maximum	\$2,000,000 Annual Maximum	
Network Options	Choose from one of three networks for In-Network benefits: Preferred BlueOption Network, Preferred ValueCare Network or Preferred FocalPoint Network.	
Covered Services	Member Responsibility Coinsurance applies after deductible is met and until out-of-pocket maximum is reached.	
	In-Network	Out-of-Network (Member may be responsible for any provider costs above the allowed amount)
Preventive Care and Immunizations Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA).	0% (Deductible waived)	20% (Deductible applies)
Professional Services Office and inpatient services and supplies	0%	20%
Hospital Services/Ambulatory Surgical Center Inpatient and outpatient services and supplies	0%	20%
Home Health 130 visits per calendar year	0%	20%
Hospice Respite care limited to 14 days inpatient/outpatient per lifetime	0%	20%
Mental Health and Chemical Dependency Treatment (combined) Inpatient: 6 days per calendar year Outpatient: 12 visits per calendar year	0%	20%
Rehabilitation Services Inpatient: 5 days per calendar year Outpatient: 30 visits per calendar year	0%	20%
Skilled Nursing Facility 30 days per calendar year	0%	20%
Complex Outpatient Imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density)	0%	20%
Emergency Room Services	0%	0%
Prescription Medications Subject to medical deductible. Retail or Mail Order: Up to 90-day supply for covered prescription medications.	0% coinsurance for generics. 50% coinsurance for brand formulary only. Brand formulary tobacco cessation medications not covered. We cover certain preventive medications according to United States Preventive Services Task Force (USPSTF) guidelines at 100%, no deductible, no copay at participating pharmacies only. Member must have a prescription.	

Medical plan

Limitations and exclusions

A pre-existing condition is a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before the enrollment date of coverage. Pre-existing waiting periods do not apply to members up to age 19.

Limitations and exclusions	Regence Evolve Core 2.0	Regence RealValue	Regence Evolve HSA Plans 2.0
Acupuncture	Excluded	Excluded	Excluded
Breast Reduction, Eye Lid Surgery, Varicose Vein Surgery	Excluded	Excluded	Excluded
Cosmetic/Reconstructive Services and Supplies	Excluded	Excluded	Excluded
Counseling in the Absence of Illness	Excluded	Excluded	Excluded
Custodial Care	Excluded	Excluded	Excluded
Detoxification	Deductible and coinsurance	Excluded	Deductible and coinsurance
Fees, Taxes, Interest	Excluded	Excluded	Excluded
Genetic Testing	Deductible and coinsurance	Excluded	Deductible and coinsurance
Government Programs	Excluded	Excluded	Excluded
Home Health	130 visits per calendar year	130 visits per calendar year	130 visits per calendar year
Hospitalization for Dentistry	Excluded	Excluded	Excluded
Immunizations if the Insured receives them only for purposes of travel, occupation or residency in a foreign country.	Excluded	Excluded	Excluded
Infertility Treatment	Excluded	Excluded	Excluded
Investigational Services	Excluded	Excluded	Excluded
Maternity Care	Separate \$7,500 routine maternity deductible and coinsurance	Excluded	Excluded
Medications without a Prescription Order	Excluded	Excluded	Excluded
Mental Health and Chemical Dependency (combined)	Excluded	Excluded	Inpatient: 6 days per calendar year Outpatient: 12 visits per calendar year
Military Service Related Conditions	Excluded	Excluded	Excluded
Motor Vehicle Coverage and Other Insurance Liability	Excluded	Excluded	Excluded
Neurodevelopmental Therapy Services	Excluded	Excluded	Excluded
Non-Direct Patient Care	Excluded	Excluded	Excluded
Nutritional Counseling: except as provided for diabetic education	Excluded	Excluded	Excluded
Obesity or Weight Reduction/Control	Excluded	Excluded	Excluded
Orthognathic Surgery (except for congenital conditions, injury, and sleep apnea)	Excluded	Excluded	Excluded
Orthotics (except for diabetic orthotics)	Excluded	Excluded	Excluded
Personal Comfort Items	Excluded	Excluded	Excluded
Physical Exercise Programs and Equipment	Excluded	Excluded	Excluded
Private Duty Nursing	Excluded	Excluded	Excluded

Medical plan

Limitations and exclusions

Limitations and exclusions	Regence Evolve Core 2.0	Regence RealValue	Regence Evolve HSA Plans 2.0
Rehabilitation Services	Inpatient: 5 days per calendar year Outpatient: 30 visits per calendar year	Inpatient: 5 days per calendar year Outpatient: 15 visits per calendar year	Inpatient: 5 days per calendar year Outpatient: 30 visits per calendar year
Respite Care	14 days inpatient/outpatient per lifetime	14 days inpatient/outpatient per lifetime	14 days inpatient/outpatient per lifetime
Riot, Rebellion and Illegal Acts	Excluded	Excluded	Excluded
Routine Foot Care	Excluded	Excluded	Excluded
Routine Hearing Exams	Excluded	Excluded	Excluded
Rural Telemedicine	Deductible and coinsurance	Excluded	Deductible and coinsurance
Self-Help, Self-Care, Training or Instructional Programs	Excluded	Excluded	Excluded
Services and Supplies Provided by a Member of Your Family	Excluded	Excluded	Excluded
Services and Supplies That Are Not Medically Necessary	Excluded	Excluded	Excluded
Services to Alter Refractive Character of the Eye	Excluded	Excluded	Excluded
Sexual Reassignment Treatment and Surgery	Excluded	Excluded	Excluded
Sexual Dysfunction	Excluded	Excluded	Excluded
Skilled Nursing Facility	30 inpatient days per calendar year	30 inpatient days per calendar year	30 inpatient days per calendar year
Spinal Manipulations	Excluded	Excluded	Excluded
Temporomandibular Joint (TMJ) Disorder Treatment	Excluded	Excluded	Excluded
Termination of Pregnancy except under certain circumstances.	Excluded	Excluded	Excluded
Third-Party Liability	Excluded	Excluded	Excluded
Travel and Transportation Expenses (other than covered ambulance services)	Excluded	Excluded	Excluded
Routine Vision Exam and Hardware	Excluded	Excluded	Excluded
Work-Related Conditions	Excluded	Excluded	Excluded

This chart does not contain all limitations and exclusions. Please refer to your policy for a complete list of benefits and the limitations and exclusions that apply.

Regence Dental Option 1

Summary of benefits

Dental benefits	
Deductible per calendar year	\$50 per insured \$150 per family (3 times the insured amount)
Maximum benefit per calendar year	When you incur services less than \$750, you may be rewarded with an additional benefit of \$250 the following year, not to exceed a total benefit of \$1,500.
Important note: The dental deductible is calculated separately from any other deductible of the policy.	
Understanding your dental benefits	
<p>We will begin to pay benefits for covered services in any calendar year only after your deductible is satisfied unless otherwise specified.</p> <p>Once you have satisfied any applicable deductible, we pay a percentage of the allowed amount for covered services up to the maximum benefit. When our payment is less than 100%, you pay the remaining percentage. This is your coinsurance (insured responsibility).</p> <p>Under the policy, you have the opportunity to qualify for a reward increase and add certain unused portions of the maximum benefit for the current calendar year to the maximum benefit for the following calendar year. For more information please refer to the policy.</p> <p>We do not reimburse dentists for charges above the allowed amount. A participating dentist will not charge you for any balances for covered services beyond your deductible and/or coinsurance amount. Nonparticipating dentists, however, may bill you for any balances over our payment level in addition to any deductible and/or coinsurance amount. You can find a list of providers at our Web site or by calling Customer Service.</p>	
Covered dental services (per insured)	Insured responsibility
Preventive dental services Bitewing X-rays: 2 per calendar year Complete intra-oral mouth X-rays: Once in a 3-year period Cleanings: 2 per calendar year (including of periodontal maintenance) Oral examinations: 2 per calendar year Panoramic mouth X-rays: Once in a 3-year period Sealants (permanent bicuspid and molars only): Under 18 years of age Space maintainers: Under 12 years of age Topical fluoride application: Under 18 years of age, 2 treatments per calendar year	0% deductible waived
Basic dental services (six-month waiting period) Endodontic services including root canal treatment, pulpotomy and apicoectomy Emergency treatment for pain relief Fillings consisting of composite and amalgam restorations General dental anesthesia) Uncomplicated and complex oral surgery procedures Periodontal maintenance: 2 per calendar year (including prophylaxis) Periodontal debridement: Once in a 3-year period Periodontal scaling and root planing: Once per quadrant in a 2-year period	20%
Major dental services (12-month waiting period) Bridges: Except no benefits are provided for replacement made fewer than seven-years after placement Crowns, inlays and onlays: Except no benefits are provided for replacement made fewer than seven-years after placement Dentures (full and partial): Except no benefits are provided for replacement made fewer than seven-years after placement Implants (endosteal): 4 per insured lifetime	50%

Regence Dental Option 2

Summary of benefits

Dental benefits	
Deductible per calendar year	N/A
Maximum benefit per calendar year	\$750 per insured
Important note: You will not be eligible for any dental benefits until the first day of the seventh month of continuous coverage under the policy.	
Understanding your dental benefits	
<p>We pay a percentage of the allowed amount for covered services up to the maximum benefit. When our payment is less than 100%, you pay the remaining percentage. This is your coinsurance (insured responsibility).</p> <p>We do not reimburse dentists for charges above the allowed amount. A participating dentist will not charge you for any balances for covered services beyond your deductible and/or coinsurance amount. Nonparticipating dentists, however, may bill you for any balances over our payment level in addition to any deductible and/or coinsurance amount. You can find a list of providers at our Web site or by calling Customer Service.</p> <p>There are no age limits or frequency limits for Dental Option 2</p>	
Covered dental services (per insured)	Insured responsibility
Preventive, basic and major dental services The first \$200 of covered services per calendar year	0%
Preventive, basic and major dental services After the first \$200 of covered services each calendar year	50%

Regence Dental

Limitations and exclusions

Exclusions Applicable to both Dental Option 1 and Dental Option 2 except where noted.

Additional procedures to construct new crown under existing partial denture framework

Application of desensitizing medicaments

Application of desensitizing resin for cervical and/or root surface

Behavior management, for Dental Option 1 only

Bleaching of teeth

Broken retainers

Collection of cultures and specimens

Connector bar or stress breaker

Diagnostic casts or study models

Duplicate x-rays, for Dental Option 1 only

Endodontic endosseous implants, for Dental Option 1 only

Exfoliative cytology sample collection or brush biopsy, for Dental Option 1 only

Experimental or investigational services: experimental or investigational services as determined by Regence dental policy, for Dental Option 1 only

Fees, Taxes, Interest

Gold foil restorations, for Dental Option 1 only

Hospitalizations for dentistry

House/extended care facility calls

Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis

Incision and drainage of abscess extraoral soft tissue, complicated or non-complicated

Indirect pulp capping

Interim partial or complete dentures

Labial veneers

Local anesthesia, sterilization, and supplies billed as separate charges (these procedures are considered inclusive of billed procedures)

Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue per tooth, for Dental Option 1 only

Lost or stolen items

Maxillofacial prosthetic procedures

Military service related conditions: Any condition resulting from military service in the armed forces of any country or any act of war (declared or undeclared)

Modification of removable prosthesis following implant surgery

Nitrous oxide, for Dental Option 1 only

Occlusal analysis and adjustments

Occlusal guards, for Dental Option 1 only

Oral hygiene instructions

Oral/facial photographic images

Orthodontic services, including craniomandibular orthopedic treatment: procedures for tooth movement, regardless of purpose, correction of malocclusion, preventive orthodontic procedures, and other orthodontic treatment

Pediatric dentures, for Dental Option 1 only

Pin retention in addition to restoration

Precision attachments

Prescription drugs, including take home prescription drugs, pre-medications, or supplies

Provisional splinting, for Dental Option 1 only

Pulp vitality tests

Radical resection of maxilla or mandible

Radiographic/surgical implant index

Removal of nonodontogenic cyst, tumor, or lesion

Replacement of lost, stolen, or broken dental appliances

Services and supplies provided by a family member:

services and supplies provided to a member by an immediate family member

Services and supplies that are not Medically necessary:

Services and supplies that are not medically necessary for the treatment of an illness, injury or physical disability

Services performed in a laboratory, for Dental Option 1 only

Surgical procedures for isolation of a tooth with rubber dam

Surgical stent, for Dental Option 1 only

Therapeutic drug injections

Third Party Coverage: Services and supplies for treatment of illness or injury for which a third party is responsible [e.g. automobile medical, personal injury protection (PIP), automobile no-fault (Idaho only; unless the automobile contract contains a COB provision in which case the COB provision of the plan shall apply), homeowner, commercial premises coverage or similar coverage

Tobacco or nutritional counseling for the control and prevention of oral disease

Tooth transplantation, for Dental Option 1 only

Travel and transportation expenses

Treatment of complications (post surgical); unusual circumstances

Treatment of simple or compound fractures of the mandible

Treatment of Temporomandibular Joint Dysfunction

Unspecified implant procedures

This page does not contain all limitations and exclusions. Please refer to your policy for a complete list of benefits and the limitations and exclusions that apply

Step 2

See what Regence membership means

As a Regence member, you and enrolled family members have access to a wide range of resources, tools and programs designed to help you improve and maintain your health. Your participation in these programs is free, voluntary and completely confidential.

Want to learn more? Keep reading!

Value-added programs

These programs are not insurance but are offered in addition to your medical plan to help you get information and support when you need it.



Join the conversation at myRegence.com—an online resource designed to advise, navigate and reward you in your health care decisions. On myRegence.com, you can:

- Take a General Health Assessment
- Check your claims
- Enroll in a wellness program
- Find a doctor
- Get an estimate on costs of care
- Learn about health issues
- Earn Rewards points
- Talk to other Regence members

Want to try it out? Visit myRegence.com and click on *Guest Pass Registration*.

Integrated Care Management

When you or your family are dealing with a health challenge, a helping hand can make all the difference. A Personal Care Team of clinical experts is ready to assist you with an ongoing medical condition, or serious illness or injury. The program provides easy access to one-on-one support at no additional cost to you. We'll assign an experienced specialist to serve as your personal contact and advocate during a time when you need it most, to help you understand your treatment options, show you how to get the most out of your benefits, help you to understand what actions you can take to improve your health, and work with your physician to support your treatment plan.

CareEnhance®

Call toll-free, 24 hours a day, for confidential health care advice. A registered nurse can answer any question and even tell you if symptoms call for a trip to the ER, a visit to the doctor or self-care at home.

Value-added programs

Regence Advantages

As a Regence member, you can enjoy savings on the following health-related products and services. This discount program is offered to all Regence members at no additional cost (although some discounted programs offered by vendors may carry separate fees). **Regence Advantages is not insurance but is offered in addition to your medical and/or dental plan(s) to help you stay healthy and live better.**

- **TruVision™:** Significant discounts are offered on laser vision correction procedures such as LASIK and PRK. Also, save 10% to 15% on mail-order contact lenses.
 - **TruHearing™™:** Special contracted health plan pricing on hearing aids and a 45-day money-back guarantee, a one-time three-year replacement for loss or damage, and a one-year supply of batteries with each purchase.
 - **QualSight®:** Save 40% to 50% on traditional or custom LASIK through the QualSight network. IntraLase bladeless LASIK is also available for an additional \$450 per eye.
 - **Epic® Dental:** Purchase smile-protecting supplies at 25% off, including mouthwash, gums, mints and toothpaste. All items contain xylitol, a natural ingredient that fights cavities.
 - **CHP CAMaffinity Program:** As a Regence member, you're eligible for the CHP CAMaffinity Program, which provides a 20% discount on complementary and alternative medicine (CAM) services offered through The CHP Group's growing network of chiropractors, acupuncturists, naturopathic physicians and massage therapists.
 - **CHP Active and Healthy:** CHP Active and Healthy is the discount program that gets you up, moving and saving money! With discounts offered by thousands of participating vendors (e.g. health clubs, ski resorts, sporting events, museums, etc.) for a small annual fee, it's your source for great deals on healthy and fun activities.
- **Take Shape for Life®:** This safe weight management and health program uses clinically proven Medifast® products and a personal health coach to provide one-on-one guidance and encouragement. The program helps you lose weight and manage disease and health through nutritional intervention, free access to health care professionals, educational materials, and healthy habits that last a lifetime. The goal: to help you optimize your health to lead a richer and more fulfilling life. There are no hidden costs or start-up fees. Learn more at myhealthyhuddle.com. Special savings for Regence members:
 - **\$25 special credit on your first order**
 - **Additional \$25 to \$50 off first month's order for the progressive "BeSlim" savings plan: 5% to 10% off monthly order and free shipping (minimum order required)**
 - **Free "The Secret is Out" book**
 - **Redeemable rewards points**
 - **CorCell® Saving Baby's Cord Blood®:** Cord blood stem cells are now being used to treat more than 70 diseases, and research is ongoing to find treatments for even more. Regence has partnered with CorCell to offer a \$350 discount when you bank your baby's umbilical cord blood. Protect your child or give the gift of cord blood preservation to your grandchild, niece, nephew, friend or other loved one. Visit corcell.com for more information.
 - **HearPO®:** Receive a 40% discount on diagnostic services, including hearing exams, and significant savings on hearing aids. You'll enjoy a 60-day no-risk trial period; one-year follow-up care; a three-year warranty, including coverage for loss and damage; and free batteries (160 cells per hearing aid)—all with a lowest-price guarantee.

Value-added programs

- **EyeMed Vision Care®:** Save 35% on a complete pair of glasses (frames and lenses). Save 15% on non-disposable contacts and \$10 on contact lens fittings. These discounts are available at leading retailers and many private practice locations.
- **Jenny Craig®:** Jenny Craig plans are personalized and offer one-on-one support from trained weight-loss consultants. With every Jenny Craig Program you'll receive weekly scheduled consultations, planned or personalized menus, and free e-tools and online support at jennycraig.com. Choose from these options:
 - **A Free 30-day Program***
 - **25% off a Premium Program***
- **Beltone™**:** Receive a free screening, a 25% discount on Beltone hearing aids, a one-year supply of hearing-aid batteries and free follow-up visits and testing.
- **Newport Audiology Centers**:** Receive a free hearing exam if you're a senior, or \$25 off an exam if you're at least age 15. Save 32% on all hearing-aids and receive a free two-year supply of batteries (up to 96 batteries) with a hearing-aid purchase.
- **Safe Beginnings®:** Enjoy a 15% discount on everything you need to baby-proof your home, including safety gates, cabinet locks, outlet covers, window guards, and other items to help keep your baby safe.

Want to learn more?

Go to myRegence.com/advantages or regence.com

* Food and, if applicable, shipping not included. Offer applies to initial membership fee only and is valid at participating centers in the United States, Canada and Puerto Rico and through Jenny Craig At Home. Each offer is a separate offer and can be used only once per person. Restrictions apply.

** Discounts through Beltone, Newport Audiology and TruHearing are available to members and their parents and grandparents.

Regence is independent from the companies that provide these products and services. Regence does not endorse or guarantee the products and services offered or their effectiveness. Regence reserves the right to change the program at any time without prior notice.

Step 3

Apply for coverage

Try our new and improved online shopping tool

Our online application process is quick and easy. It even features tools that can help you decide which plan is right for you. Just go to regence.com and follow the step-by-step directions.

Paper applications

If you prefer to mail in your application, we've provided all the forms you need.

If you're applying for medical coverage, you'll need to **complete and return** the following:

1. *Individual Application Cover Sheet*
2. *Utah Individual Health Insurance Application*
3. *Authorization for Use and Disclosure of Protected Health Information*

Return all materials to us in the enclosed envelope. Please allow seven working days before inquiring about the status of your application.

Your contract will be effective on the first day of the month after your application is approved. We'll begin to process your application immediately once we receive it. If we need additional information, processing could be delayed. Once coverage is offered, we'll send you your member card(s) and a contract.

If you have questions about the application, please call us at 1-888-REGENCE (1-888-734-3623).



Regence

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

Regence BlueCross BlueShield of Utah
2890 E. Cottonwood Parkway
Salt Lake City, Utah 84130-0270
Mail form to: PO Box 1106, MS-LB1
Lewiston, ID 83501

Individual Application Cover Sheet

(to be used with the Utah Individual Health Insurance Application)

SECTION 1 - GENERAL INFORMATION

Applicant's Name (please print) _____ Social Security Number _____

A complete application is needed to begin the underwriting process. Complete application includes: 1) Individual Application Coversheet, 2) Utah Individual Health Insurance Application, and 3) Authorization Form.

Note: If you are requesting a change to your existing plan or deductible, your policy must be paid current in order for the change to be made.

SECTION 2 - ELIGIBLE TO APPLY FOR COVERAGE?

New Policy: If your application includes your child younger than 19 as a dependent and you are accepted, he or she will have the same effective date (guaranteed issue).

Child Only Policy: A child under age 19 seeking "child-only" coverage must apply to the Utah Comprehensive Health Insurance Pool (HIPUtah) first. If he or she does not qualify for HIPUtah, it will issue a certificate of insurability. Regence offers continuous enrollment to individuals who apply within the guaranteed acceptance period of their certificate of insurability.

Existing Policy Additions: Children younger than 19 may be added (guaranteed issue) to your existing policy during open enrollment. Open enrollment period is annually during the 45 days prior to the policy's renewal. Application to add a spouse, domestic partner, or older child can be made at any time. Additions due to birth, adoption, or adoptive placement must be made within 60 days of birth, adoption, or placement.

If you are currently eligible for Medicare, or will be on the requested effective date of coverage for which you are applying, you are not eligible for private individual or family health coverage and should not be included on this application cover sheet or the Individual Health Insurance Application.

For more information, or to see if there are exceptions to this open enrollment period for which you may qualify, please contact your producer or call our Sales department toll-free at 1-888-REGENCE (1-888-734-3623).

SECTION 3 - PLAN SELECTION (Detailed benefit information can be found online at regence.com)

MEDICAL PLANS (check one):

Evolve Core 2.0 - Deductibles are per member (2 individual deductibles satisfy the family deductible)

\$2,500 \$5,000 \$7,500 \$10,000

Evolve HSA 2.0

Self-Only Deductibles

Family Deductibles

\$1,200 with 60% coinsurance

\$2,400 with 60% coinsurance

\$1,200 with 80% coinsurance

\$2,400 with 80% coinsurance

\$2,000 with 60% coinsurance

\$4,000 with 60% coinsurance

\$2,000 with 80% coinsurance

\$4,000 with 80% coinsurance

\$3,500 with 60% coinsurance

\$7,000 with 60% coinsurance

\$3,500 with 80% coinsurance

\$7,000 with 80% coinsurance

Evolve HSA 100 2.0

Self-Only Deductibles

Family Deductibles

\$3,000 \$5,000

\$6,000 \$10,000

Regence RealValue - Deductibles are per member (3 individual deductibles satisfy the family deductible)

\$2,500 \$5,000 \$7,500 \$10,000

Evolve Plus (NetCare Comparable/Utah Basic Health Plan)

\$1,500 Deductible-Participating Traditional provider network \$1,500 Deductible-Preferred ValueCare provider network

DENTAL OPTIONS (check one)

No Dental

Dental Option 1 - 100/80/50; \$750 annual maximum benefit that may increase over time to \$1,500

Dental Option 2 - 100% of first \$200 and 50% of next \$1,100 (\$750 annual maximum benefit)

PROVIDER NETWORK (check one)

Preferred FocalPoint Preferred ValueCare Preferred BlueOption (Note: This option is not available with the Regence RealValue medical plan)



SECTION 4 - EFFECTIVE DATE

Your application is subject to review and approval by Regence BlueCross BlueShield of Utah. Complete applications received in our office by 5:00 PM Mountain Time on the last business day of the month will be eligible for an effective date of the first of the following month, unless otherwise indicated. Incomplete applications may receive a later effective date.

Requested Effective Date _____

SECTION 5 - MEMBER CARD (check one)

- Family Level Card** (all members listed on the same card)
 Member Level Card (each member on a separate card)

SECTION 6 - MEDICARE

If you or any listed dependents have Medicare, please list family member's name and the Medicare Health Insurance Claim (HIC) number shown on his/her Medicare card:

SECTION 7 - ACKNOWLEDGEMENT

By signing the attached Individual Application, you understand and agree to the terms and conditions set forth on this cover sheet as well as the terms and conditions set forth on the attached application.

SECTION 8 - YOUR PRIVACY

For information about the use and disclosure of health information, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at **regence.com**.

SECTION 9 - PRODUCER INFORMATION**FOR PRODUCER USE ONLY**

Producer Name (please print or type)	Regence Producer Number
Producer's Street Address	Producer's E-Mail Address

PRODUCERS: Please also complete the **Producer Agreement and Compensation Disclosure** in Section J of the Utah Individual Health Insurance Application. Producers will not be compensated if this information is incomplete.



SECTION 10 – PREMIUM BILLING OPTIONS

BILLING ADDRESS (Complete only if billing should be sent to an address other than the Mailing Address listed on the application.)

Name (First, Last)

Address

City, State, ZIP Code

PAYMENT OPTIONS (check one):

If no payment option is checked, your policy will automatically default to Monthly Billing.

Monthly Billing Surepay (premium is automatically deducted from your bank account on the 5th of each month).

It may take 45 - 90 days from the approval of your application to set up Surepay. To cover initial month(s) you will receive an invoice and need to make your payment by check in order to keep your account paid current.

If selecting the **Surepay** option:

1. Complete the following **Authorization To My Bank** section.
2. Write 'void' on one of your checks and return your voided check with this application (not a deposit slip). *For savings account, please provide proof of ownership of the account.*

AUTHORIZATION TO MY BANK

As a convenience and on behalf of the Account Holder identified below, I/we hereby request and authorize you to pay and charge to the account identified below, checks or electronic debits drawn on the account by and payable to the order of Regence BlueCross BlueShield of Utah, Salt Lake City, Utah. I/we agree that your rights to each such check or electronic debit shall be the same as if it were an actual check drawn on you and signed by me/us. This authority is to remain in effect until revoked by me/us in writing, and until you actually receive such notice, I/we agree that you shall be fully protected in honoring any such check. I/we further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

Financial Institution or Bank Name

Transit/Routing Numbers

Account Number

Check One: Checking Account Savings Account

Account Holder's Name (please print)

Account Holder's Signature (as it appears on bank records)

Date





UTAH INDIVIDUAL HEALTH INSURANCE APPLICATION

A. APPLICANT INFORMATION

Name (Last) _____ (First) _____ (MI) _____

Marital Status Legally Married Single Divorced Widowed Domestic Partner

Mailing Address _____ Apt. _____ City _____ State _____ Zip _____

Street Address _____ Apt. _____ City _____ State _____ Zip _____

Home (or other) Phone _____ Business Phone _____

Driver's License Number: _____ Email Address: _____

Does any listed proposed insured live, reside, work or attend school outside the state of Utah at any time during the year? Yes No If yes, % of time _____

Please check one of the following boxes: New Application Dependent Addition Re-apply

B. APPLICANT AND DEPENDENT INFORMATION (attach separate sheet if necessary)

In the section below, list yourself and all eligible family members to be included under the policy.

	Social Security # (for internal use only)	Name (Last, First, MI)	Date of Birth	Age	M/F	Weight	Height
Self							
Spouse							
Dependent							
Dependent							
Dependent							
Dependent							

Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, children must be under the age of 26, unmarried, and dependent upon you for 50 percent of their financial support. Financial dependency is not required for court-ordered child coverage. Any dependent not listed will not be considered for coverage.

C. CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health care coverage, including Medicare or Medicaid, in effect within 24 months prior to the proposed effective date of this policy. Each person applying for coverage must be listed below. If no health care coverage was in effect within the past 24 months, please indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care coverage so that the insurer can determine whose coverage is primary.

Enrolling Individual's Name (Non-Medicare)	Insurer (Including policyholder name, insurer name and phone number)	Date of Coverage Month/Day/Year		Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage (Check all that apply) <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
		From	To		
Self				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical

If you were previously insured on a group plan, have you exhausted your COBRA rights? Yes No NA If "Yes" Date Started _____ Date Ended _____

If COBRA was not an option for you, have you exhausted your Utah mini-COBRA rights? Yes No NA If "Yes" Date Started _____ Date Ended _____

Have you ever been or are you currently insured through HIPUtah? Yes No If "Yes" Date Started _____ Date Ended _____

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous insurer. Submission of prior coverage information does not automatically waive any PEC limitation. However, you will be subject to an automatic PEC Waiting Period of up to 12 months until we receive evidence of prior coverage.

D. EMPLOYMENT INFORMATION

Employer _____ Group Insurer _____ Job Title _____ Hrs/Week _____

Spouse's Employer _____ Spouse's Group Insurer _____ Spouse's Job Title _____ Hrs/Week _____

1. Is any employer reimbursing or paying for any portion of this policy? Yes No

2. Are you self-employed? Yes No If self employed, do you have any full or part-time employees? Yes No

E. HEALTH STATEMENT

IF ANY OF THE BELOW CONDITIONS OR QUESTIONS ARE CHECKED "YES" PROVIDE DETAILS IN SECTIONS G. & H. ON THE FOLLOWING PAGE.

The federal Genetic Information Nondiscrimination Act prohibits health insurers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. "Genetic information" includes your genetic tests, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by the policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. **Do not report genetic information on this form.** However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.

EACH QUESTION MUST BE CHECKED "YES" OR "NO." This health statement must be complete or the application will be returned. Inaccurate health information may result in the policy being cancelled retroactively. It is your responsibility to notify the insurer of any change in health status while application is pending.							
Respond to the following questions:		YES	NO	Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following (cont.):		YES	NO
1	Pregnancy/Adoption: Are you, your spouse, or any dependent family member pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months?			21	Female Reproductive Conditions/Disorders: Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, pelvic inflammatory disease, or any other disorder of the reproductive system?		
2	Pregnancy/Fertility Related Treatment: Are you, your spouse, or any dependent family member being treated for infertility, fertility evaluation or treatment (including medication), or miscarriage, complications related to pregnancy (including premature births)?			22	Digestive Conditions/Disorders: Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, any other gallbladder or digestive disorder, hemorrhoids, polyps, or any other rectal disorder?		
3	Last Menstrual Period: Have you, your spouse or any dependent (whether or not proposed for insurance) missed her last menstrual period? If yes, provide date of last menstrual cycle on the following page.			23	Nervous, Mental and Behavioral: Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication?		
Within the past 12 MONTHS has any applicant:		YES	NO	Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:		YES	NO
4	Prescriptions/Medications/Immunizations: Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?			24	Gout, arthritis, Rheumatoid arthritis, fibromyalgia, or scleroderma?		
5	Conditions Requiring Follow Up Medical Consult/Treatment: Do you, your spouse or any dependent family member have a condition for which hospitalization, tests, consultation, evaluation, surgery, or medication have been advised, but not completed?			25	Musculoskeletal Conditions/Disorders: Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, spondylosis, or other musculoskeletal disorder?		
6	Medical Consult/Treatment: Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine & wellness care?			26	Digestive Conditions/Disorders: Crohn's disease, Colitis, colostomy, ileostomy, or other digestive disorder?		
7	Conditions Requiring Initial Medical Consult/Treatment: Had a health condition, problem, disorder, or any other medical or mental health conditions not listed for which medical or mental health advice or treatment has not been sought?			27	Alcohol or Drug Use/Abuse: been advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for his/her own alcohol consumption, drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?		
Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:		YES	NO	28	Eating Disorders/Obesity Treatment: including bulimia, anorexia, or obesity and any surgical services for obesity.		
8	Urinary, bladder, incontinence, kidney or liver conditions or disorders: Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?			29	Respiratory Conditions/Disorders: RSV, reactive airway disease, tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, or emphysema?		
9	Neurological Disorders: Recurring headaches, migraines, head injury, epilepsy, seizures, convulsions, or other neurological disorder?			30	Tobacco use (chewing or smoking)? Quit Date: _____		
10	Metabolic and Endocrine Conditions/Disorders: Lupus, thyroid disorder, goiter, or any other lymph system disorder?			Has any applicant EVER been diagnosed with or treated for any of the following:		YES	NO
11	Eyes, ears, nose, sinus, or throat conditions/disorders or any other respiratory system disorder, including allergies or hay fever?			31	Birth Defects/Congenital Abnormalities: premature birth, development or learning disability, mental impairment, Down syndrome, or autism spectrum disorder?		
12	Skin Conditions/Disorders: Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?			32	Nervous, Mental and Behavioral: Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?		
13	Breast Conditions/Disorders: Breast lumps, breast augmentation, or breast reduction?			33	Transplant or Implanted Device: Any organ or tissue transplant, pacemaker, or other implanted device?		
14	Heart Conditions/Disorders: Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?			34	Heart and Circulatory Conditions/Disorders: Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, coronary artery disease, or congestive heart failure?		
15	Back, neck, bone, joint or spinal disorder: bone or joint disorders (including foot, knee, jaw, fracture, dislocation, or joint replacement)?			35	Brain/Nervous System Conditions/Disorders: Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?		
16	Blood Conditions/Disorders: Hemophilia, anemia, blood, or bleeding disorder?			36	Diabetes (type I or II), insulin resistance?		
17	Male Reproductive Conditions/Disorders: Impotence, prostate or testicular disorder, abnormal PSA, or other reproductive disorder?			37	Immune System Conditions/Disorders: Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?		
18	Circulatory System Conditions/Disorders: Varicose veins, or any other circulatory disorder?			38	Cancer/Tumors: (including skin cancer or melanoma) or tumors?		
19	Hospitalization/Surgery: Have you, your spouse, or any dependent family member been hospitalized or had surgery?			39	Urinary/Liver Conditions/Disorders: Cirrhosis, hepatitis, or renal failure?		
20	Sexually transmitted diseases?			OTHER MEDICAL INFORMATION		YES	NO
				40	Any medical condition or treatment that you are unsure of where it fits in above?		

F. DISABILITY INFORMATION

Are you or any dependent(s) disabled? Yes No If yes, indicate first and last name(s). _____

Reason for disability: _____

Is the disabled dependent unable to perform routine daily functions for two weeks or more? Yes No

Have you or any dependent(s) filed workers' compensation claims or disability claims within the last five years? Yes No

If so, what is the status of the claims? _____

G. ADDITIONAL INFORMATION (Attach a separate sheet for additional information if necessary)

Question #	Name of Individual	Diagnosis, illness, injury, treatment received, testing, medical attention, medications, future treatments	Start Date	End Date	Remaining symptoms or problems	Name & phone of physician or hospital	
			mm/dd/yy	mm/dd/yy		Name	Phone #

H. PRESCRIPTION INFORMATION WITHIN LAST 12 MONTHS (Attach a separate sheet for additional information if necessary)

Question #	Name of individual	Name of Medication	Dosage	Start Date	End Date	Reason for medication	Name & phone of physician or hospital	
				mm/dd/yy	mm/dd/yy		Name	Phone #

I. ACKNOWLEDGMENT & SIGNATURE

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage. When incorporated with the policy, this application will become part of the policy. Once fully signed and executed, insurer and I agree to terms set forth in the policy. In connection with both this application and any coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable underwriting criteria. I also understand that no coverage will be in force until each person listed above is approved; that no benefits will be provided for any services which begin before the policy is effective; and that except as expressly provided in the policy, benefits will not extend beyond the termination of either my coverage or the policy.

CONSENT AT ENROLLMENT. I understand that no producer or insurer representative is allowed to permit me to answer any question inaccurately, untruthfully, or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to the insurer changes in the eligibility of any applicants who become enrolled.

I understand that the data obtained by the use of this authorization will only be used to determine eligibility for coverage and for future benefit administration. I understand that my choice of health care providers whose services will be covered may be restricted by the policy, and I agree that coverage for any services that are obtained without or contrary to required preauthorization/precertification requirements in the policy may be denied. I understand the policy for which I am applying may limit or exclude certain conditions, regardless of whether or not they are pre-existing. I also understand that the policy may limit or exclude conditions for which a family member or I have received, or have been recommended to receive, any medical advice, diagnosis, care, or treatment during the six months immediately preceding the date I apply for coverage, according to the pre-existing conditions limitation provisions of the policy.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE. According to information furnished, you may intend to lapse or otherwise terminate existing accident and health insurance and replace it with a new policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new plan. This could result in a denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present coverage.
2. You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present coverage and replace it with a new policy, be certain to truthfully and completely answer all questions on the application concerning your medical/health history.
4. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though the policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the health information on pages two and three of this application, is correctly recorded, true, and complete. I understand that material omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or could void any coverage issued. **If I subsequently become aware of information different from that provided in this application, I agree to provide that additional information promptly to the insurer. A change of information prior to the effective date of the policy may void an offer to provide coverage.**

I understand there may not be participating providers in all specialty fields.

I understand that credit for prior coverage will be based upon the information contained in this application and/or proof of prior coverage, such as a Certificate of Creditable Coverage that I have obtained from my prior health care insurer(s) and provided to the insurer.

If any information provided is false or incomplete, the insurer may without advance notice pursue any remedies available under state or federal law, including but not limited to: declaring the policy null and void and canceling the policy retroactive to its original effective date; or imposing the pre-existing condition waiting period and denying claims that are pre-existing, subject to credit for prior coverage.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I further certify that all information completed on this form is true, correct and complete and acknowledge the policy is subject to cancellation or other action permissible at law, if any completed information is found to be false or incorrect.

I attest that all information on this form is accurate. I have read the Acknowledgment of this document and agree to its terms. I have also completed an authorization to disclose protected health information, if such form accompanies this application.

Applicant Signature _____ Date _____
(A faxed signature shall be valid as an original signature.)

Spouse Signature _____ Date _____
(Required if applying for coverage. A faxed signature shall be valid as an original signature.)

Requested Effective Date _____ (Coverage is not in force until the insurer approves your application and determines the effective date.)

J. PRODUCER AGREEMENT AND COMPENSATION DISCLOSURE (If applicable)

I understand and agree that in acting as the producer for this applicant:

1. The application was completed by the applicant.
2. I am in possession of a valid license issued by the State of Utah that authorizes me to sell and service health insurance;
3. I have no authority to: a) make, alter, interpret, or discharge an application or policy in the name of a insurer; or b) waive any of the terms or conditions of the policy.
4. I have no authority to assign effective dates or to effect member changes.

Producer Name _____ License # _____ Agency _____ Phone _____

Producer Signature _____ Date Signed _____
(A faxed signature shall be valid as an original signature.)

Producer Compensation Disclosure:

(Compensation includes commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration.)

I have received written disclosure that the producer will receive compensation from the insurer or a third party administrator for the placement of insurance, including the amount or type of compensation.

Applicant Signature _____ Date _____



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, you give any carrier identified on the cover sheet of this application the right to gather medical information about you and your dependents for whom you have legal authority to sign (e.g., a minor child). A carrier typically gathers both paper and electronic records. This information, for example, helps a carrier evaluate your application for enrollment and process your medical claims after enrollment.

A. Underwriting Authorization

I authorize any health plan and any health care provider (including any pharmacy) to disclose medical information about me to a carrier for purposes of determining my eligibility for health insurance coverage as requested in this application. The medical information I authorize to be disclosed includes any medical information related to my insurability except for any private genetic information about me or a blood relative of mine. (The law prohibits carriers from using private genetic information for underwriting purposes.)

B. General Acknowledgment

I acknowledge and understand that after enrollment the carrier will have the right to request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the Application form) from time to time for the purpose of facilitating health-care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law. Health information requested or disclosed may be related to treatment or services performed by:

- ◆ a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- ◆ a clinic, hospital, long-term care or other medical facility;
- ◆ any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- ◆ an insurance carrier or health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

C. Information for Applicant and Dependents

I understand the following information:

1. I may refuse to sign this Authorization, or I may revoke it if I have not been enrolled in a plan by sending my written request to the carrier; however, if I do so the carrier may refuse to enroll me and my revocation will not apply to any disclosure made by the Plan prior to my revocation;
2. A health care provider may not condition my treatment on signing this Authorization;
3. Another health plan may not condition payment, enrollment, or eligibility for benefits on my signing this Authorization;
4. I understand that the information the carrier receives because of this Authorization may be redisclosed and no longer protected by federal or state regulation. Items 5 and 6 of this section limit the potential for redisclosure of my information;
5. If enrollment does not occur the carrier may not use or disclose the information it receives because of this Authorization for any purpose other than underwriting, except as may be required by law. (If the carrier denies insurance coverage because of an individual's health condition, Utah law requires the carrier to tell the applicant specifically what this health condition is);
6. If enrollment does occur the carrier will only use information disclosed under this Authorization for purposes described in its notice of privacy practices;
7. This authorization will expire 90 days after it is signed if enrollment does not occur in the plan and 180 days after my coverage terminates if enrollment does occur;
8. If your application contains any material misstatements or omissions, Regence BCBSU may deny coverage, retro-actively terminate coverage, cancel coverage and/or take any other legal action available to us by law.

D. Identifying Signatures for Applicant and Dependents 18 years of age or older

For additional dependents over the age of 18, please attach a separate sheet of paper with Dependent Names, Date of Birth's, Signatures and Date Signed.

Applicant	Date of Birth	Signature*	Date Signed
Spouse	Date of Birth	Spouse's signature or representative with legal authority**	Date Signed
Dependent	Date of Birth	Dependent signature or representative with legal authority**	Date Signed
Dependent	Date of Birth	Dependent signature or representative with legal authority**	Date Signed
Dependent	Date of Birth	Dependent signature or representative with legal authority**	Date Signed
Dependent	Date of Birth	Dependent signature or representative with legal authority**	Date Signed

***If the main applicant's signature is completed by a legally authorized personal representative, please complete the following:**

Personal Representative's Name (please print)_____

Relationship to Individual_____ (if applicable, attach legal documentation)

**Generally, spouses and dependents 18 years of age or older must sign for themselves.



Regence

Individual Plans
P.O. Box 30270
Salt Lake City, UT 84120-0270

1-888-REGENCE (1-888-734-3623)

regence.com