HSA Health Insurance Company

Utah

Master Policy
[Company Name]

*HSA Health Insurance Company is domiciled in, and subject to the laws of Utah

This Master Policy is an agreement between HSA Health Insurance Company and [Company Name] for the benefit of the eligible employees of [Company Name], and their eligible dependents. This Master Policy doesn't extend benefits to any other person or entity.

This policy provides benefits for the length of time of [Policy duration] and for services received by Members from [Beginning Date] until 11:59 PM Mountain Time on [Ending Date]. Claims for such benefits must be received within 12 months of the date of service unless a member was reasonably unable to provide such claim, in which case the member shall furnish all documents needed for the claim as soon as reasonably possible.

HSA Health Insurance Company is not a fiduciary of [Company Name].

Examination Period

The Master Policyholder has the right to return the Master Policy for any reason within 10 days after its delivery. "Return" means delivery to HSA Health Insurance Company or its agent or mailing of the Master Policy to either, properly addressed and stamped for first class handling, with a written statement on the Master Policy or an accompanying communication that it is being returned for termination of coverage. A Master Policy returned is void from the beginning and a Master Policyholder returning his Master Policy is entitled to a refund of any premium paid.

The rights and obligations of HSA HEALTH INSURANCE COMPANY and its Members are set forth in this Master Policy. If any term of this Master Policy is found to be in violation of any state or federal law, or is unenforceable for any reason, that term shall be null and void and severable from the Master Policy and shall not render the Master Policy null and void as a whole. This contract is governed by, and will be interpreted and enforced according to, the laws of the State of Utah.

This contract and all matters incorporated herein, including but not limited to benefit summaries and Enrollment forms, contains the entire agreement, and it is binding upon Subscribers and Members, as well as their heirs, successors, personal representatives, and assignees in regard to their applicable benefit plan. There are no promises, terms, conditions, or obligations other than those contained herein. This contract supersedes all prior communications, representations, or agreements, either verbal or written, between the parties.

Upon renewal of this contract, HSA HEALTH INSURANCE COMPANY may modify rates, benefits, Exclusions, Limitations, and/or service by providing Master Policy holders with advance notice of change. Paragraph headings appearing in this contract are not to be construed as interpretation of the text, but are only for the convenience of reference for the reader.

Contract Provisions

Contract amendments

HSA HEALTH INSURANCE COMPANY may unilaterally change this contract upon plan renewal and upon 30 days written notice to HSA HEALTH INSURANCE COMPANY Subscribers.

No assignability

HSA HEALTH INSURANCE COMPANY may designate an affiliated company to administer some or all of the benefit plan. However, members have no right to assign any obligations under this contract.

Availability Of contract for Review

Members may request a hard copy of this contract from HSA HEALTH INSURANCE COMPANY.

No vested Rights

Members are only entitled to receive benefits from HSA HEALTH INSURANCE COMPANY while this contract is in effect. Members do not have any permanent or vested interest in any benefits under this contract, and benefits may change or terminate as this contract is renewed, modified or terminated from year to year. Members only have rights to benefits under this contract when they are properly enrolled and recognized by HSA HEALTH INSURANCE COMPANY as Members. Unless otherwise expressly stated in this contract, all benefits end when this contract ends. Members have no right to receive any care, services, treatments, drugs, medications, supplies, or equipment from or through HSA HEALTH INSURANCE COMPANY except in strict compliance with this entire contract.

Acceptance Of this contract

As a condition to receiving Coverage from HSA HEALTH INSURANCE COMPANY, Members are presumed and required to accept, comply with, and agree to, the terms of this contract. Subscribers are also presumed to agree to the terms of this contract on behalf of eligible Dependents who enroll as Members.

HSA Health Insurance Company determines eligible services

Merely because a physician or other Provider orders or recommends care, services, treatments, drugs, medications, supplies, or equipment for a Member does not mean that HSA HEALTH INSURANCE COMPANY will recognize the procedure as being either Medically Necessary or

covered by HSA HEALTH INSURANCE COMPANY under this contract . This is true whether the physician or other Provider is a Contracted or non-contracted Provider.
Benefits under the Master Policy will be paid only if HSA HEALTH INSURANCE COMPANY decides that the Member is entitled to them. HSA HEALTH INSURANCE COMPANY also has discretion to determine Eligibility for benefits, to require verification of any claim for Eligible Benefits and to interpret the terms and conditions of the benefit plan.

Agency

Neither the Employer, nor any Member has authority to act as agent for HSA HEALTH INSURANCE COMPANY. HSA HEALTH INSURANCE COMPANY is not the agent of Employer for any purpose. For purposes of this contract, the Employer acts as the agent of its Subscribers (Employees) and Subscribers act as the agent of their eligible Dependent Members.

Provider agency

Providers contracting with HSA HEALTH INSURANCE COMPANY are independent contractors and not Employees or agents of HSA HEALTH INSURANCE COMPANY. HSA HEALTH INSURANCE COMPANY does not control the manner in which Contracted Providers provide professional services. Such Providers are entitled and required to exercise independent professional medical judgment in providing care and services to Members.
HSA HEALTH INSURANCE COMPANY does not promise, represent, warrant, or otherwise guarantee that care or services provided to Members by Providers will achieve any particular result or be provided in any particular manner or at any particular level of care.
It is understood and agreed that HSA HEALTH INSURANCE COMPANY will not be liable for any claim or demand on account of injuries or damages of any kind arising out of or in any manner connected with any conditions or injuries suffered by a Member and resulting from care or services rendered, withheld, covered, limited, excluded, or otherwise provided or not under this Master Policy. Subscribers and Members agree that Providers are solely responsible to Members for care or services rendered, limited, or withheld by such Providers.

Managed care

Members agree to the managed care features that are a part of the health benefit program in which they are enrolled.

Benefits are limited

Coverage under this contract is limited in defined ways. It is the responsibility of each Member to know the requirements, conditions, Limitations and Exclusions that apply to their Coverage, and to know the Limitations and requirements that apply to their choice of Providers and Hospitals and the timing of their health care services.
Members are responsible for payment for any care, service, treatment, drug, medication, supply, or equipment that they obtain that is not covered or limited by this contract, or is obtained from

Providers or Hospitals that are not authorized to be paid by HSA HEALTH INSURANCE COMPANY. Members are not responsible to pay for claims that are the responsibility of HSA HEALTH INSURANCE COMPANY.

Administrative provisions

HSA HEALTH INSURANCE COMPANY will from time to time adopt and enforce reasonable rules, regulations, policies, procedures, and protocols to help it in the administration of this Master Policy and in providing covered services to Members. Employers and Members are subject to such rules, regulations, policies, procedures, and protocols in connection with obtaining covered services and other matters under this Master Policy.

Notice of COBRA Rights

HSA HEALTH INSURANCE COMPANY is providing you and your Dependents notice of your rights and obligations under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") to temporarily continue health and /or dental Coverage if you are an Employee of an Employer with 20 or more Employees and you or your eligible Dependents, (including newborn and /or adopted children) in certain instances would lose HSA HEALTH INSURANCE COMPANY Coverage. Both you and your spouse should take the time to read this notice carefully. If you have any questions please call the HSA HEALTH INSURANCE COMPANY at 844-234-4472 (844-234-4HSA).

Compliance Responsibilities

Each party is responsible for its own compliance with applicable laws, rules and regulations.

Changes in member contact information

It is the Member's responsibility to keep HSA HEALTH INSURANCE COMPANY informed of any change of address, phone number, and email address of the Subscriber or any eligible Dependent. Members should keep copies of any notices sent to HSA HEALTH INSURANCE COMPANY.

Requests for information

As a condition of receiving benefits under this Master Policy, Members shall provide HSA HEALTH INSURANCE COMPANY with all information at HSA HEALTH INSURANCE COMPANY's request, including, but not limited to, providing releases for prior Medical Records. Failure by a Member to provide information to HSA HEALTH INSURANCE COMPANY at HSA HEALTH INSURANCE COMPANY's request under this section shall be a breach of this Master Policy and may result in forfeiture of benefits, termination of Coverage, or HSA HEALTH INSURANCE COMPANY having

the right to hold payment of claims for the Member or the Member's dependents until the requested information is received by HSA HEALTH INSURANCE COMPANY.

Notices

Any notice required of HSA HEALTH INSURANCE COMPANY under this Master Policy will be sufficient if mailed by first class mail to the Member or Subscriber at the address appearing on the records of HSA HEALTH INSURANCE COMPANY. Notice to an eligible Dependent will be sufficient if given to the Subscriber under whom the Member is enrolled. Any notice to HSA HEALTH INSURANCE COMPANY will be sufficient if mailed to the principal office of HSA HEALTH INSURANCE COMPANY in Utah. Each Subscriber agrees to promptly notify his/her Dependents of all benefit and other plan changes.

Qualified Beneficiary

A Qualified Beneficiary is an individual who is covered under the Employer group health plan the day before a COBRA Qualifying Event.

Who Can Be Covered under COBRA

Employees

If you have group health Coverage with HSA HEALTH INSURANCE COMPANY, you have a right to continue this Coverage if you lose Coverage or experience an increase in the cost of the premium because of a reduction in your hours of employment or the voluntary or involuntary termination of your employment for reasons other than gross misconduct on your part.

Spouse of Employees

If you are the spouse of an Employee covered by HSA HEALTH INSURANCE COMPANY, and you are covered the day prior to experiencing a Qualifying Event, you are a "Qualified Beneficiary" and have the right to choose continuation Coverage for yourself if you lose group health Coverage under HSA HEALTH INSURANCE COMPANY for any of the following five reasons:

1. The death of your spouse;
2. The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse;
4. Your spouse becoming entitled to Medicare; or
5. The commencement of certain bankruptcy proceedings, if your spouse is retired.

Dependent Children

A Dependent child of an Employee who is covered by HSA HEALTH INSURANCE COMPANY on the day prior to experiencing a Qualifying Event, is also a "Qualified Beneficiary" and has the right to continuation Coverage if group health Coverage under HSA HEALTH INSURANCE COMPANY is lost for any of the following six reasons:

1. The death of the covered parent;
2. The termination of the covered parent's employment (for reasons other than gross misconduct) or reduction in the covered parent's hours of employment;
3. The parents' divorce or legal separation;
4. The covered parent becoming entitled to Medicare;
5. The Dependent ceasing to be a "Dependent child" under HSA HEALTH INSURANCE COMPANY; or
6. A proceeding in a bankruptcy reorganization case, if the covered parent is retired. A child born to, or placed for adoption with, the covered Employee during a period of continuation Coverage is also a Qualified Beneficiary.

Secondary Event

A Secondary Event means one Qualifying Event occurring after another. It allows a Qualified Beneficiary who is already on COBRA to extend COBRA Coverage under certain circumstances, from 18 months to 36 months of Coverage. The Secondary Event extends Coverage for up to 36 months from the date of the original Qualifying Event.

Your Duties Under The Law

It is the responsibility of the covered Employee, spouse, or Dependent child to notify the Employer or Plan Administrator in writing within sixty (60) days of a divorce, legal separation, child losing Dependent status or secondary qualifying event, under the group health/dental plan in order to be eligible for COBRA continuation Coverage. HSA HEALTH INSURANCE COMPANY can be notified by Customer Service at 844-234-4HSA (844-234-4472). Appropriate documentation must be provided, such as: divorce decree, marriage certificate, etc. Keep HSA HEALTH INSURANCE COMPANY informed of address changes to protect you and your family's rights. It is important for you to notify HSA HEALTH INSURANCE COMPANY at the above address if you have changed marital status, or you, your spouse or your Dependents have changed addresses.

In addition, the covered Employee or a family Member must inform HSA HEALTH INSURANCE COMPANY of a determination by the Social Security Administration that the covered Employee or covered family Member was disabled during the 60-day period after the Employee's termination of employment or reduction in hours, within 60 days of such determination and before the end of the original 18-month continuation Coverage period. (See "Special rules for disability," below.) If, during continued Coverage, the Social Security Administration determines that the Employee or family Member is no longer disabled, the individual must inform HSA HEALTH INSURANCE COMPANY of this redetermination within 30 days of the date it is made.

Employers' Duties Under The Law

Your Employer has the responsibility to notify HSA HEALTH INSURANCE COMPANY of the Employee's death, termination of employment or reduction in hours, or Medicare eligibility. Notice must be given to HSA HEALTH INSURANCE COMPANY within 60 days of the occurrence of the above-listed events. When HSA HEALTH INSURANCE COMPANY is notified that one of these events has happened, HSA HEALTH INSURANCE COMPANY in turn will notify you and your Dependents that you have the right to choose continuation Coverage. Under the law, you and your Dependents have up to 60 days from the date you would lose Coverage because of one of the events to inform HSA HEALTH INSURANCE COMPANY that you want continuation Coverage or 60 days from the date of your Election Notice.

Election of Continuation Coverage

Members have 60 days from either termination of Coverage or date of receipt of COBRA election notice to elect COBRA. If no election is made within 60 days, COBRA rights are deemed waived and will not be offered again. If you choose continuation Coverage, your Employer is required to give you Coverage that, as of the time Coverage is being provided, is identical to the Coverage provided under the plan to similarly situated Employees or family Members. If you do not choose continuation Coverage within the time period described above, your group health insurance Coverage will end.

Premium Payments

Payments must be made retroactively to the date of the qualifying event and paid within 45 days of the date of election. There is no grace period on this initial premium. Subsequent Payments are due on the first of each month with a thirty (30) day grace period. Delinquent
Payments will result in a termination of Coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation Coverage due to a disability, 150 percent) of the cost to the group health plan (including both Employer and Employee contributions) for Coverage of a similarly situated plan participant or beneficiary who is not receiving continuation Coverage. Claims paid in error by ineligibility under COBRA will be reviewed for collection. Ineligible premiums paid will be refunded.

How Long Coverage May Last

The law requires that you be afforded the opportunity to maintain COBRA continuation Coverage for 36 months, unless you lose group health Coverage because of a termination of employment or reduction in hours. In that case, the required COBRA continuation Coverage period is 18 months. Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) may occur while the continuation Coverage is in effect. Such events may extend an 18-month COBRA continuation period to 36 months, but in no event will COBRA Coverage extend

beyond 36 months from the date of the event that originally made the Employee or a qualified beneficiary eligible to elect COBRA Coverage. You should notify HSA HEALTH INSURANCE COMPANY if a second qualifying event occurs during your COBRA continuation Coverage period.

Special Rules For Disability

If the Employee or covered family Member is disabled at any time during the first 60 days of COBRA continuation Coverage, the continuation Coverage period may be extended to 29 months for all family Members, even those who are not disabled. The criteria that must be met for a disability extension is:

1. Employee or family Member must be determined by the Social Security Administration to be disabled.
2. Must be determined disabled during the first 60 days of COBRA Coverage.
3. Employee or family Member must notify HSA HEALTH INSURANCE COMPANY of the disability no later than 60 days from the later of:

    1. the date of the Social Security Administration disability determination;
    2. the date of the Qualifying Event;
    3. the loss of Coverage date; or
    4. the date the Qualified Beneficiary is informed of the obligation to provide the disability notice.

    Employee or family Member must notify Employer within the original 18 month continuation period.

    If an Employee or family Member is disabled and another qualifying event occurs within the 29-month continuation period (other than bankruptcy of your Employer), then the continuation Coverage period is 36 months after the termination of employment or reduction in hours.

Special Rules For Retirees

In the case of a retiree or an individual who was a covered surviving spouse of a retiree on the day before the filing of a Title 11 bankruptcy proceeding by your Employer, Coverage may continue until death and, in the case of the spouse or Dependent child of a retiree, 36 months after the date of death of a retiree.

Continuation Coverage May Be Terminated

The law provides that your continuation Coverage may be cut short prior to the expiration of the 18, 29, or 36 month period for any of the following reasons:

1. Your Employer no longer provides group health Coverage to any of its Employees.

2. The premium for continuation Coverage is not paid in a timely manner (within the applicable grace period).
3. The individual becomes covered, after the date of election, under another group health plan (whether or not as an Employee) that does not contain any Exclusion or Limitation with respect to any preexisting condition of the individual.
4. The date in which the individual becomes entitled to Medicare, after the date of election.
5. Coverage has been extended for up to 29 months due to disability (see "Special rules for disability") and there has been a final determination that the individual is no longer disabled.
6. Coverage will be terminated if determined by HSA HEALTH INSURANCE COMPANY that the Employee or family Member has committed any of the following: fraud upon HSA HEALTH INSURANCE COMPANY or Utah Retirement Systems, forgery or alteration of prescriptions; criminal acts associated with COBRA Coverage; misuse or abuse of benefits; or breach of the conditions of the Plan Master Master Policy. You do not have to show that you are insurable to choose COBRA continuation Coverage. However, under the law, you may have to pay all or part of the premium for your continuation Coverage plus two percent. The law also states that, at the end of the 18, 29, or 36 month COBRA continuation Coverage period, you are allowed to enroll in an individual conversion health plan provided by HSA HEALTH INSURANCE COMPANY. This notice is a summary of the law and therefore is general in nature. The law itself and the actual Plan provisions must be consulted with regard to the application of these provisions in any particular circumstance.

Separate Election

If there is a choice among types of Coverage under the plan, each of you who is eligible for continuation of Coverage is entitled to make a separate election among the types of Coverage. Thus, a spouse or Dependent child is entitled to elect continuation of Coverage even if the covered Employee does not make that election. Similarly, a spouse or Dependent child may elect a different Coverage from the Coverage that the Employee elects.

HSA Health Insurance Company employee Responses

Without the consent of HSA HEALTH INSURANCE COMPANY Administration, individual Employees of HSA HEALTH INSURANCE COMPANY do not have the authority to:

1. Modify the terms and conditions of this Master Policy;
2. Extend or modify the benefits available under this Master Policy, either intentionally or unintentionally;
3. Waive or modify any Exclusion or Limitation; or
4. Waive compliance with HSA HEALTH INSURANCE COMPANY requirements, such as the use of Contracted Providers or the necessity of obtaining Preauthorizations.

Your Duties under the Law

It is the responsibility of the covered Subscriber, spouse, or Dependent child to notify the Employer or Plan Administrator in writing within sixty (60) days of a divorce, legal separation, child losing Dependent status or other qualifying event, under the plan in order to be eligible to make changes under the plan. Keep HSA HEALTH INSURANCE COMPANY informed of address changes to protect you and your family's rights. It is important for you to notify HSA HEALTH INSURANCE COMPANY if you have changed marital status, or you, your spouse or your Dependents have changed addresses.

Premium Payments

Payments must be made retroactively to the date of the qualifying event and paid within 45 days of the date of election. There is no grace period on this initial premium other than allowed under federal rules. Subsequent Payments are due on the first of each month with a thirty (30) day grace period. Delinquent Payments will result in a termination of Coverage. However, claims may not be paid during the entire grace period when premiums have not been paid.

Notice of Women's Health and Cancer Rights Act (WHCRA)

In accordance with The Women's Health and Cancer Rights Act of 1998, HSA HEALTH INSURANCE COMPANY covers mastectomy in the treatment of cancer and Reconstructive Surgery after a mastectomy. If you are receiving benefits in connection with a mastectomy, Coverage will be provided according to HSA HEALTH INSURANCE COMPANY's Medical Case Management criteria and in a manner determined in consultation with the attending physician and the patient, for:

All stages of reconstruction on the breast on which the mastectomy has been performed;
Surgery and reconstruction of the other breast to produce a symmetrical appearance;
Prostheses; and
Treatment of physical Complications in all stages of mastectomy, including lymphedemas.

Coverage of mastectomies and breast reconstruction benefits are subject to applicable Deductibles and Coinsurance Limitations consistent with those established for other benefits.
Following the initial reconstruction of the breast(s), any additional modification or revision to the breast(s), including results of the normal aging process, will not be covered.
All benefits are payable according to the Outline of Coverage, based on this plan. Regular Preauthorization requirements apply.

Definitions

Accident, accidental

A single unpremeditated event of violent and external means, which happens suddenly, is unexpected, and is identifiable as to time and place. Injuries resulting from a willful action including lifting, pushing, pulling, bending, or straining are not considered within the definition

of an Accident. Life threatening conditions may not be considered within the meaning of an Accident.

Ambulatory surgical facility

Any licensed establishment with an organized medical staff of physicians, with permanent facilities equipped and operated primarily for the purpose of performing Ambulatory Surgical Procedures and with continuous physician services whenever a Member is in the facility but does not provide services or other accommodations for Members to stay overnight.

Benefits Review committee

A Committee which may consist of the Medical Director, Claims Managers, Claims Supervisors or other appropriate HSA HEALTH INSURANCE COMPANY personnel which has the authority to review and approve or deny, based on established criteria, claims for Eligible Benefits.

Break in coverage

A period of 63 days or more in which an individual is without creditable health insurance Coverage.

Coinsurance

The percentage portion of the cost of Eligible Benefits that a Member is obligated to pay under the plan(s), after Deductible.

Community standard

The standard accepted for consensus decisions will be determined by published peer-reviewed medical data, in journals sponsored by professional societies and associations, patterns of care within HSA HEALTH INSURANCE COMPANY database, professional review organizations, and consultations with experts who are Board Certified by the American Board of Medical Specialists. The Community Standard is not necessarily a prevailing level of practice.

Complication

A medical condition, illness, or injury related to, or occurring as a result of another medical condition, illness, injury, Surgical Procedure, or drug.

Contracted hospital

A Hospital with whom HSA HEALTH INSURANCE COMPANY has a current contractual agreement to render care to covered Members for a specific fee.

Contracted provider

A Provider with whom HSA HEALTH INSURANCE COMPANY has a current contractual agreement to render care to covered Members for a specific fee.

Coordination Of benefits

The Coordination of Eligible Benefits between two or more plans under which an individual is covered after primary and secondary Coverage determination is made.

Cosmetic procedure

Any procedure performed to improve appearance or to correct a deformity without restoring a physical bodily function.

Coverage

The eligibility of a Member for benefits provided under this Master Policy, subject to the terms, conditions, Limitations and Exclusions of this Master Policy.

Services must be provided:

When this Master Policy is in effect; and
Prior to the date that termination occurs.

Creditable coverage
Any comprehensive health insurance plan such as a group health plan; health insurance Coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act; Chapter 55 of Title 10 of the United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 of the United States Code; a public health plan; or, a health benefit plan under Section 5(e) of the Peace Corps Act (22 U .S .C . 2504(e) Creditable Coverage does not include Excepted Benefits. (Excepted Benefits defined below).

Custodial care

Services, supplies, or accommodations for care rendered which:

1. Do not provide treatment of injury or illness;
2. Could be provided by persons without professional skills or qualifications;

3. Are provided primarily to assist a Member in activities of daily living;
4. Are for convenience, contentment, or other non-therapeutic purposes; or
5. Maintain physical condition when there is no prospect of affecting remission or restoration of the Member to a condition in which care would not be required.

Deductible

The amount paid by a Member for eligible charges before any benefits will be paid under the plan.

Dependent

"Dependent" means:

The Subscriber's lawful spouse under Utah State Law. Adequate legal documentation may be required. A person of the opposite sex to whom you are not formally married is your lawful spouse only if he or she qualifies as a common law spouse under Utah State Law. In Utah, you must obtain a court or administrative agency order establishing the common law marriage. Eligibility may not be established retroactively. In cases of court or administrative orders purporting to retroactively either establish or annul/declare void a marriage or divorce, HSA HEALTH INSURANCE COMPANY will consider the change effective on the date the court or administrative order was signed by the court or administrative agency, or the date the order is received by HSA HEALTH INSURANCE COMPANY, whichever is later.

Children or stepchildren of the Subscriber up to the age of 26 who have a Parental Relationship with the Subscriber. Adequate legal documentation may be requested.

Legally adopted children, who are adopted prior to turning 18 years old, foster children, and children through legal guardianship up to the age of 26 are eligible subject to HSA HEALTH INSURANCE COMPANY receiving adequate legal documentation. (Legal guardianship must be court appointed.)

Children who are incapable of self-support because of an ascertainable mental or physical impairment, and who are claimed as a Dependent on the Subscriber's federal tax return, upon attaining age 26, may continue Dependent Coverage, while remaining Totally Disabled, subject to the Subscriber's Coverage continuing in effect. Periodic documentation is required but no more often than every two years unless there was a change in the Dependent's condition related to their disability. Subscriber must furnish written notification of the disability to HSA HEALTH INSURANCE COMPANY no later than 31 days after the date the Coverage would normally terminate. In the notification, the Subscriber shall include the name of the Dependent, date of birth, a statement that the Dependent is unmarried, and details concerning the condition that led to the Dependent's physical or mental disability; Income, if any, earned by the Dependent; and the capacity of the Dependent to engage in employment, attend school, or engage in normal daily activities. If proof of disability is approved, the Dependent's Coverage may be continued as

long as he/she remains Totally Disabled and unable to earn a living, and as long as none of the other causes of termination occur. At the time of a Dependent's approval for continued HSA HEALTH INSURANCE COMPANY Coverage, HSA HEALTH INSURANCE COMPANY shall provide the Subscriber with a date of renewal for their Dependent. At the time of their renewal, the Subscriber shall provide proof of Dependent's continued disability 30 days prior to the renewal date. If the Subscriber fails to provide proof of disability 30 days prior to the date of renewal, the Dependent's Coverage will terminate on the renewal date.

When you or your lawful spouse are required by a court or administrative order to provide health coverage for a child, the child will be enrolled in your coverage according to HSA HEALTH INSURANCE COMPANY guidelines and only to the minimum extent required by applicable law. A Qualified Medical Child Support Order (QMCSO) can be issued by a court of law or by a state or local child welfare agency. If ordered, you and your Dependent child may be enrolled without regard to annual enrollment restrictions. The effective date for a qualified order will be the start date indicated in the order

In the event of divorce, Dependent children for whom the Subscriber is required to provide medical insurance as ordered in a divorce decree may continue Coverage. The former spouse and/or stepchildren may not continue Coverage. HSA HEALTH INSURANCE COMPANY will not recognize Dependent eligibility for a former spouse or stepchildren as a result of a court order or divorce decree. Stepchildren who no longer have a Parental Relationship with a Subscriber will no longer be eligible to receive benefits under HSA HEALTH INSURANCE COMPANY.

Dependent does not include an unborn fetus.

Device

Any instrument, apparatus, appliance, material, or other article, whether used alone or in combination, including the software necessary for its proper application intended by the manufacturer to be used for the purpose of:

1. Diagnosis, prevention, monitoring, treatment, or alleviation of illness or injury;
2. Diagnosis, monitoring, treatment, alleviation, or compensation for a handicap;
3. Investigation, replacement, or modification of the anatomy or of a physiological process, or;
4. Which does not achieve its principal intended action in or on the human body by pharmacological, immunological, or metabolic means, but which may be assisted in its function by such means.

Durable medical equipment

Medical equipment that is all of the following:

1. Used only to benefit in the care and treatment of an Illness or injury;
2. Durable and useful over an extended period of time;
3. Used only for a medical purpose rather than convenience or contentment;
4. Is prescribed by a Provider; and
5. Not used by other family members for nontherapeutic purposes.

Elective treatment

Nonemergency services that can be scheduled 48 hours or more after diagnosis.

Eligible benefit

Medical expenses which are covered under this Master Policy.

Emergency care

Care provided for a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health (or the health of an unborn child) in serious jeopardy, serious impairment of bodily function, or serious dysfunction of bodily organs .

Employee

An Employer's Employee who is eligible for Coverage in the Group Insurance Program.

Employer

Any entity which has an employee-employer relationship with the Employees for which they are providing health benefit coverage.

Enrollment
The process whereby a subscriber makes written application for Coverage directly or indirectly by agent or exchange to HSA HEALTH INSURANCE COMPANY, subject to specified time periods and plan provisions.

Excepted benefits

Benefits not subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). They are as follows Coverage for Accident, or disability income insurance; Coverage issued as a supplement to liability insurance; liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; Coverage for onsite medical clinics; similar insurance Coverage under which benefits for medical care are

secondary or incidental to other insurance benefits. The following benefits are not subject to requirements if offered separately limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community based care, or any combination; other similar limited benefits. The following benefits are not subject to requirements if offered as independent non-coordinated benefits Coverage only for a specified disease or illness; Hospital indemnity or other fixed indemnity insurance. The following benefits are not subject to requirements if offered as a separate insurance Master Policy Medicare supplemental Health insurance (as de fined under section 1882(g)(1) of the Social Security Act), Coverage supplemental to the Coverage provided under Chapter 55 of Title 10, United States Code, and similar supplemental Coverage provided .

Exclusions

Those services or supplies incurred by the Member, which are not eligible under this Master Policy.

Experimental, investigational, OR unproven

Those services, supplies, devices, or pharmaceutical (drug) products which are not recognized or proven to be effective for treatment of illness or injury in accordance with generally accepted standards of medical practice as determined by HSA HEALTH INSURANCE COMPANY .

Coverage for members participating in approved clinical trials may be eligible for benefits. The term “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

FEDERALLY FUNDED TRIALS- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

a. The National Institutes of Health.
b. The Centers for Disease Control and Prevention.
c. The Agency for Health Care Research and Quality.
d. The Centers for Medicare & Medicaid Services.
e. Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. The Department of Veterans Affairs.
    h. The Department of Defense.
    i. The Department of Energy.
    j. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

k. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

For experimental services, regular cost sharing of similar services will apply.

FDA approved

Pharmaceuticals, Devices, or Durable Medical Equipment which have been approved by the FDA for a particular diagnosis.

Formulary

A list of selected prescription medications reviewed by an independent Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is an independent group of accomplished health care professionals comprised of physicians with various medical specialties and clinical pharmacists who assist in developing the Formulary. The P&T Committee reviews medications in all therapeutic categories relevant to the prescription drug benefit and evaluates them based on safety and efficacy. The Committee reviews new and existing drugs on a regular basis and the Formulary is revised accordingly.

Global fee

An amount negotiated for a specific procedure (such as an organ transplant) including multiple Providers, within a specified time frame.

High deductible health plan

A plan with a lower premium and higher deductible than a traditional health plan, which is compatible with a Health Savings Account as defined by and in accordance with Federal Law.

Holiday

Holiday is defined as “any legal holiday of the State of Utah as defined in Utah Code Ann. §63G1301(1).

Hospice care

A program of supportive care that addresses the spiritual, social, and psychological needs of terminally ill patients and their families. The Global per diem benefit for Hospice includes home care nursing, nursing aides, oral medication, Durable Medical Equipment, social worker, counseling, respite care, physical, occupational, and speech therapies provided for purposes of symptoms control or to enable the patient to maintain activities of daily living and basic functional skills .

Hospital

A Hospital is defined as:

1. An institution which is licensed by the state in which it resides and maintains Medicare and Medicaid approval for services;
2. Any other institution which is operated pursuant to law, under the supervision of a staff of physicians and with twenty-four hour per day nursing service, which is primarily engaged in providing general inpatient medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or under its control; or
3. Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including x-ray and laboratory) on its premises, under its control, or through a written agreement or with a specialized Provider of those facilities.

In no event shall the term Hospital include a facility operated primarily as an outpatient or free standing unit, or a convalescent nursing home or an institution or part thereof which is used principally as a convalescent, rest, or nursing facility or facility for the aged, or which furnishes primarily domiciliary or Custodial Care, including training in the routines of daily living, or which is operated primarily as a school. Hospitals are considered Providers in accordance with this Master Policy.

Immediate family member

Immediate Family Members are considered to be (for purposes of this Master Policy) spouse, children, son-in-law, daughter-in-law, brother, sister, brother-in-law, sister in law, mother, father, mother-in-law, father-in-law, stepparents, stepchildren, grandparents, grandchildren, uncles, aunts, nieces, nephews, domestic partners, and adult designees .

Industrial claim

An illness or injury arising out of or in the course of employment covered by the Worker's Compensation Fund or Employer Liability laws.

Life threatening

The sudden and acute onset of an illness or injury where delay in treatment would jeopardize the Member's life or cause permanent damage to the Member's health such as, but not limited to, loss of heartbeat, loss of consciousness, limb threatening or organ threatening, cessation or severely obstructed breathing, massive and uncontrolled bleeding. The determination of a Life threatening event will be made by HSA HEALTH INSURANCE COMPANY on the basis of the final

diagnosis and medical review of the records. HSA HEALTH INSURANCE COMPANY reserves the right to solely determine whether or not a situation is Life threatening.

Limitations

Provisions in the plan indicating services or supplies that are not fully covered or covered only when specific criteria is met.

Maximum allowable fee

The maximum fee allowable for a given procedure, established by HSA HEALTH INSURANCE COMPANY and accepted by Contracted Providers.

Medical case management

The active involvement by request of HSA HEALTH INSURANCE COMPANY of a nurse coordinator or case manager working with the Member, Member's family and Provider(s) to coordinate a comprehensive, medically appropriate treatment plan with prudent use of benefit dollars.

Medical Records

Medical reports, clinical information, and Hospital records relating to the care, treatment, and relevant medical history of the Member.

Medically necessary/ medical necessity

Any healthcare services, supplies or treatment provided for an illness or injury which is consistent with the Member's symptoms or diagnosis provided in the most appropriate setting that can be used safely, without regard for the convenience of a Member or Provider. However, such healthcare services must be appropriate with regard to standards of good medical practice in the state of Utah and could not have been omitted without adversely affecting the Member's condition or the quality of medical care the Member received as determined by established medical review mechanisms, within the scope of the Provider's licensure, and/or consistent with and included in policies established and recognized by HSA HEALTH INSURANCE COMPANY. Any medical condition, treatment, service, equipment, etc. specifically excluded in the Master Policy is not an "Eligible Benefit" regardless of Medical Necessity.

Member

A Subscriber, a Subscriber's spouse, a Subscriber's Dependents who are enrolled in active Coverage.

Mental health

Mental Health Coverage shall include diagnosis code numbers 290319 (Mental Disorders) as described in the ICD9 (International Classification of Disease) or Mental Disorders as described in ICD10 (International Classification of Disease), except where otherwise described or excluded in the Master Policy.

Package fee

The cost benefit of "package" surgical services, which include the operation per se; local infiltration, metacarpal/digital block or topical anesthesia when used and normal, uncomplicated follow-up care. Normal, un complicated follow-up care would cover the period of Hospitalization and office follow-up for progress checks or any service directly related to the Surgical Procedure as per standard medical guidelines. The only exception would be if the service relates to Complications, exacerbations or recurrences of other diseases or injuries requiring additional or separate services. When an additional Surgical Procedure(s) is carried out within the listed period of follow-up care for a previous Surgery, the follow-up periods will continue concurrently to their normal termination.

Parental Relationship

The relationship between a natural child or stepchild and a parent while the child or stepchild is dependent on the parent for Coverage. Stepchildren will no longer be eligible to receive benefits when the marriage between their natural parent and the subscriber step parent is terminated for any reason.

Payment

Amount paid by the Subscriber for the purchase of a Medical benefits plan.

PBM

Pharmacy Benefit Manager.

Preauthorization

The administrative process whereby a Member and Provider can learn, in advance of treatment, the level of benefits provided by the Master Policy for the proposed treatment plan. The process, prior to service, that the Member and the treating Provider must complete in order to obtain authorization for specified benefits of this Master Policy which may be subject to Limitations and to receive the maximum benefits of this Master Policy for Hospitalization, Surgical Procedures, Durable Medical Equipment, pharmaceutical drug products, or other services as required. Preauthorization does not guarantee payment should Coverage terminate, should there be a change in benefits, should benefit limits be used by submission of claims in the interim, or should actual circumstances of the case be different than originally submitted.

Pre-notification

The process the Member must follow in order to notify HSA HEALTH INSURANCE COMPANY of any impending Hospital admission as required by this Master Policy.

Primary care provider

A Provider acting within the scope of the Provider's practice limited to the following:

Family Practice (FP)
Internal Medicine (IM)
Pediatrician (MD)
Obstetrics and Gynecology (OBGYN)
Gynecologist (GYN)
Geriatrician (MD)
Osteopath (DO)
Advanced Practical Registered Nurse (APRN)
Nurse Practitioner (NP)
Certified Nurse Midwife (CNM)

and other Providers performing services for Members for the above Provider types including:

Registered Nurse (RN)
Physician's Assistant (PA)

Preexisting condition

Any injury, illness or condition for which a Member received medical treatment, consultation or diagnostic testing within the twelve-month period prior to the Member's effective date of Coverage as established by review of the Medical Records or other documentation.

Provider

A licensed practitioner of the healing arts acting within the scope of the Provider's practice, limited to the following: Medical Doctor (MD), Chiropractor (DC), Osteopath (DO), Podiatrist (DPM), Psychologist (PhD), Licensed Clinical Social Worker (LCSW), Psychiatric Nurse Specialist (RN, NS), Doctor of Medical Dentistry (DMD), Dentist (limited) (DDS), Registered Nurse (RN), Advanced Practical Registered Nurse (APRN), Nurse Practitioner (NP), Physician Assistant (PA), Licensed Practical Nurse (LPN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), Optometrist (limited [OD]), Audiologist, Licensed Professional Counselor (LPC), and Registered Dietician.

Reconstructive surgery

Non-Cosmetic Surgery performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, which restores bodily function.

Rehabilitation/habilitation therapy

The treatment of disease, injury, developmental delay or other cause, by physical agents and methods to assist in the Rehabilitation/habilitation of normal physical bodily function, that is goal oriented and where the Member has the potential for functional improvement and ability to progress.

Skilled nursing facility

An institution, or distinct part thereof, that is licensed pursuant to state law and is operated primarily for the purpose of providing skilled nursing care for individuals recovering from illness or injury as an inpatient, and has organized facilities for medical treatment and provides 24hour nursing service under the full time supervision of a physician or a graduate registered nurse; maintains daily clinical records on each patient and has available the services of a physician under an established agreement; provides appropriate methods for dispensing and administering drugs and medicines; and has transfer arrangements with one or more Hospitals, a utilization review plan in effect, and operation policies developed in conjunction with the advice of a professional group including at least one Provider . Any institution that is, other than incidentally, a rest home, a home for the aged, or a place for the treatment of mental disease, drug addiction, or alcoholism, is not considered a Skilled Nursing Facility .

Specialist

A Provider acting within the scope of the Provider's practice, limited to all other provider types not defined as Primary Care Providers.

Specialty drug

Drugs determined by HSA HEALTH INSURANCE COMPANY and its PBM to be payable only through the Specialty Drug Program based on one or more of the following:

- Special administration requirements.
- Special handling requirements.
- Special clinical support requirements.
- Product accessibility.
- High cost of medication.

Availability of medication through HSA HEALTH INSURANCE COMPANY's Specialty Drug vendor.
Other drugs at HSA HEALTH INSURANCE COMPANY's discretion.

Subrogation

HSA HEALTH INSURANCE COMPANY's right to recover payments it has made on behalf of a covered Member because of an injury caused by a liable party.

Subscriber

An Employee that applies and is approved by HSA Health Insurance Company to obtain this Master Policy and the benefits contained herein, and completes all other requirements to properly enroll in this plan.

Surgical procedure or surgery

Cutting , suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, tapping (paracentesis), applying plaster casts, administering pneumothorax, or endoscopy.

Totally disabled

The complete inability, due to medically determinable physical or mental impairment, to engage in any gainful occupation.

Unbundling

The practice of using numerous procedure codes to identify procedures that normally are covered by a single code. (Also known as "fragmentation," "exploding," or "a la carte" medicine.)

Urgent condition

An acute health condition with a sudden, unexpected onset, which is not Life threatening but which poses a danger to the health of the Member if not attended by a physician within 24 hours; e .g., serious lacerations, fractures, dislocations, marked increase in temperature, etc.

Verbal preauthorization

Prior approval obtained by calling HSA HEALTH INSURANCE COMPANY Customer Service in advance of treatment as required for some specific services and as documented by HSA HEALTH INSURANCE COMPANY.

Waiting Period

Waiting Period is a time that an employee is employed before they are eligible for the Employers' health plan. Waiting periods may not be longer than 90 days from the time the employee is hired or otherwise eligible before they are eligible.

Enrollment, Eligibility & Termination

General

Employees and their Dependents are eligible for Cover age as set forth herein. All Employees are required to enroll by completing and submitting a HSA HEALTH INSURANCE COMPANY Enrollment form or by completing an electronic Enrollment form through HSA HEALTH INSURANCE COMPANY's online Enrollment portal. All information gathered and the information contained on the Enrollment form is incorporated into this contract. Any Enrollment or Coverage changes must be done in writing, by completing and submitting a HSA HEALTH INSURANCE COMPANY Enrollment form or by completing an electronic Enrollment form through HSA HEALTH INSURANCE COMPANY's online Enrollment portal.

Eligibility

The eligibility of Employees and eligible Dependents is determined based on the Employer's personnel policies and the Employee's representations made on their verified individual Enrollment form, which form is a part of this contract. Copies of Member's completed Enrollment forms are available upon request. Members who commit fraud or any other crime against HSA HEALTH INSURANCE COMPANY are not eligible for Coverage.

Enrollment period

A subscriber must enroll during the annual enrollment period as set forth by the plan rules of their employer. Special enrollment periods may be offered through the federal exchange, or as allowed by a qualifying life event.

Newly eligible Dependents may be enrolled within 60 days from the date of birth, or placement in your home, or from the date of marriage. For such Dependents, Coverage will become effective on the date of birth, placement in home, or the date of marriage. If not enrolled during this time period, Dependents must wait until the next annual Enrollment period to enroll and Coverage will become effective on the Subscriber's annual renewal date.

Special enrollment

Eligible persons who do not enroll themselves or their eligible Dependents during the initial Enrollment period, may enroll in Coverage prior to the next annual Enrollment period if they meet the qualifications for a special Enrollment period. HSA HEALTH INSURANCE COMPANY shall allow special Enrollment in the following circumstances:

Loss of Other Coverage

The eligible Subscriber and/or their eligible Dependents declined to enroll in this Coverage due to the existence of other health plan Coverage; and the eligible Subscriber and/or eligible Dependents who lost the other Coverage must enroll in this Coverage within 60 days after the date the other Coverage is lost.
Proof of loss of the other Coverage (Certificate of Credit able Coverage) must be submitted to HSA HEALTH INSURANCE COMPANY at the time of application. Proof of loss of other Coverage or other acceptable documentation, must be submitted before any benefits will be paid on applicable Members. In the absence of a Certificate of Creditable Coverage, HSA HEALTH INSURANCE COMPANY will accept the following:

A letter from a prior employer indicating when Group coverage began and ended;
Any other relevant documents that evidence periods of Coverage; or;
A telephone call from the other Insurer to HSA HEALTH INSURANCE COMPANY verifying dates of Coverage.

Family Status Change

HSA HEALTH INSURANCE COMPANY shall also allow a Subscriber and/or Dependents to enroll if the Subscriber gains an eligible Dependent through marriage, birth, adoption or placement for adoption. At the time the Subscriber enrolls his/her Dependents, the Subscriber may also be enrolled. In the case of birth or adoption of a child, the Subscriber may also enroll the Subscriber's eligible spouse, even if he/she is not newly eligible as a Dependent. However, special Enrollment is permitted only when the Enrollment takes place within 60 days of the marriage, birth, adoption or placement for adoption. HSA HEALTH INSURANCE COMPANY must receive a copy of the adoption/placement papers before a Dependent who has been adopted or placed for adoption can be enrolled in Coverage .If a divorce decree is set aside by a court of competent jurisdiction, HSA HEALTH INSURANCE COMPANY shall treat the Dependent(s) as eligible for reenrollment on the date the decree was set aside. Dependent(s) shall not be eligible during the time the divorce decree was in effect.
Legal guardianship

Dependent children who are under age 26 and who are placed under the legal guardianship (through testamentary appointment or court order) of the Subscriber or the Subscriber's lawful spouse are eligible to be enrolled for Coverage. The Subscriber must enroll any such children within 60 days of receiving legal guardianship.

Military Activation

Members called to active duty in the military are excluded from Coverage under this Master Policy while they are in active duty. Dependents will remain eligible for benefits under this Master Policy as long as all other eligibility requirements are met.

Termination Of coverage

Coverage for a Member will terminate if the Member ceases to be eligible for the following reasons:

1. Dependent child turns age 26 – Coverage will terminate at the end of the month after their 26th birthday.
2. Divorce – Coverage will terminate for ex-spouses and stepchildren at the end of the day prior to the date on the court signed divorce decree.
3. Death of Subscriber – Coverage will terminate at the end of the last day of the month.
4. Failure to make timely Payment of Rates to HSA HEALTH INSURANCE COMPANY – Coverage will terminate at the end of the day through which previous Payment has been received by HSA HEALTH INSURANCE COMPANY.

It is the Subscriber's responsibility to make written notification when a Dependent is no longer eligible for Coverage. HSA HEALTH INSURANCE COMPANY will not refund Payments made for ineligible Dependents. The Subscriber will be held responsible to reimburse HSA HEALTH INSURANCE COMPANY for the claims processed beyond eligible service dates.

Pursuant to Utah Code Annotated, anyone who fails to notify HSA HEALTH INSURANCE COMPANY of Dependents ineligibility for Coverage is committing insurance fraud, a Class B Misdemeanor, punishable by fines or imprisonment.

HSA HEALTH INSURANCE COMPANY shall have the right to deny claims, terminate any or all Coverages of a Member and seek reimbursement of claims paid upon the determination by HSA HEALTH INSURANCE COMPANY that the Member has committed any of the following:

1. Fraud upon HSA HEALTH INSURANCE COMPANY;
2. Forgery or alteration of prescriptions;
3. Criminal acts associated with Coverage;
4. Misuse or abuse of benefits; or
5. Breached the conditions of this Master Policy.

Liability for services after termination

All care, services, treatments, drugs, medications, supplies, or equipment obtained after the date of termination are the responsibility of the Member or the subsequent carrier or other Provider of Coverage, and not the responsibility of HSA HEALTH INSURANCE COMPANY, no matter when the condition arose and despite care or treatment anticipated or already in progress .

Premium Payments

Payments must be made by the Member and paid within 45 days. There is no grace period on this initial premium. Subsequent Payments are due on the first of each month with a 30 day grace period. Delinquent Payments will result in a termination of Coverage. HSA HEALTH INSURANCE COMPANY will collect on claims paid in error because of ineligibility for continuation Coverage. Ineligible rates paid by the Member for continuation Coverage will be refunded.

Coordination Of benefits with other carriers

The Coordination of Benefits provision applies when a Subscriber or the Subscriber's covered eligible Dependents have health care Coverage under more than one health benefit plan, except those specifically excluded in Coordination of Benefits will be administered in accordance with Utah Insurance Code rules. When a Subscriber or Subscribers covered Eligible Dependents have health Coverage under more than one benefit plan, one plan shall pay benefits as the primary plan and the other plan shall pay benefits as the secondary plan.

The Subscriber must inform HSA HEALTH INSURANCE COMPANY of other medical Coverage in force. If applicable, the Subscriber will be required to submit court orders or decrees. Subscribers must also keep HSA HEALTH INSURANCE COMPANY informed of any changes in the status of other Coverage.

Order Of benefit determination

HSA HEALTH INSURANCE COMPANY determines the order of benefits using the first of the following rules that applies:

1. The benefits of the plan that covers the person as an employee, or Subscriber, are determined before those of the plan that covers the person as a Dependent.
2. Dependent Child—Parents not separated or Divorced

The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are as follows:

a. The benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the year. (The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.)

b. If both parents have the same birthday, benefits of the plan that covered the parent longer are determined before the shorter Coverage.

3. Dependent Child— Parents Separated or Divorced

If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

a. First, the plan of the parent who is ordered by divorce decree to maintain Coverage. If neither or both parents are ordered, the plan of the Sub scriber whose birthday falls earlier in the calendar year;

b. Then, the plan of the spouse of the parent who is ordered by divorce decree to maintain Coverage. If neither or both parents are ordered, the plan of the Subscriber whose birthday falls second among Subscribers in the calendar year;

c. Then the plan of the parent who is not ordered by divorce decree to maintain coverage. If neither or both parents are ordered, the plan of the Sub scriber whose birthday falls third among Sub scriber in the calendar year;

d. Finally, the plan of the spouse of the parent who is not ordered by divorce decree to maintain Coverage. If neither or both parents are ordered, the plan of the Subscriber whose birthday falls last among Subscribers in the calendar year.

After the Dependent turns 18, the plan of the parent with whom the Dependent resides shall be the primary payer. If the Dependent does not reside with either parent, all Subscriber's birthdates will be considered. A copy of the divorce decree may be requested for file documentation. There are many circumstances that affect order of benefit determination. Please contact HSA HEALTH INSURANCE COMPANY Customer Service for further clarification.

Coordination Of benefits Rules

When HSA HEALTH INSURANCE COMPANY is the primary plan, its Eligible Benefits are paid before those of the other health benefit plan and without considering the other health plan's benefits.

When HSA HEALTH INSURANCE COMPANY is the secondary plan, its Eligible Benefits are determined after those of the other health benefit plan and may be reduced to prevent duplication of benefits. When secondary, HSA HEALTH INSURANCE COMPANY calculates the amount of Eligible Benefits it would normally pay in the absence of the primary plan coverage, including Deductible, Coinsurance, and the application of credits to any Master Policy maximums. HSA HEALTH INSURANCE COMPANY then determines the amount the Member is responsible to pay after the primary carrier has applied its allowed contracted amount. HSA HEALTH INSURANCE COMPANY will then pay the amount of the Member's responsibility after the primary plan has paid, up to the maximum amount it would have paid as the primary carrier. In no event will HSA HEALTH INSURANCE COMPANY pay more than the Member is responsible to pay after the primary carrier has paid the claim. Medical and pharmacy claims will be subject to all plan provisions as described in this Master Policy, including, but not limited to, Preauthorization/Pre-notification requirements, benefit Limitation, step therapy requirements, quantity level rules, etc., regardless of whether HSA HEALTH INSURANCE COMPANY is the primary or secondary payer.

Coverage under this Master Policy is primary only when required to be primary by law or by this Master Policy. If the other health benefit plan does not have rules for Coordination of Benefits, then Coverage under the other plan will be primary to Coverage under this Master Policy.
When a payment between HSA HEALTH INSURANCE COMPANY and a Provider/facility has been coordinated incorrectly, HSA HEALTH INSURANCE COMPANY will make proper payment adjustment if the request is submitted to HSA HEALTH INSURANCE COMPANY within 12 months from the date of adjudication.

Dual coverage

When a Dependent enrolls on a second HSA HEALTH INSURANCE COMPANY plan creating "dual Coverage" (a combination of two or more HSA HEALTH INSURANCE COMPANY plans), eligible Benefits will be adjudicated in the same order as any other Coordination of Benefits.

Correction Of payment in error

HSA HEALTH INSURANCE COMPANY shall have the right to pay to any organization making payments under other plans that should have been made under this Master Policy, any amount necessary to satisfy the payment of claims under this Master Policy. Amounts so paid by HSA HEALTH INSURANCE COMPANY shall be considered benefits paid under this Master Policy, and HSA HEALTH INSURANCE COMPANY shall be fully discharged from liability under this Master Pol icy to the extent of such payments. Corrections will be made a maximum of 24 months from date of service except in the cases of Medicaid, Medicare, or when ordered by a hearing officer or court of competent jurisdiction.

No coordination of benefits with other types of plans

HSA HEALTH INSURANCE COMPANY does not coordinate with school plans, sports plans, Accident only Coverage, specified disease Cover age, nursing home or long term care plans, disability income protection Coverage, Veterans Administration plans, or Medicare Advantage Supplement plans.

Coordination Of benefits with Medicare

HSA HEALTH INSURANCE COMPANY's Coordination of Benefits with Medicare and its status as primary or secondary payer shall be determined in accordance with applicable Medicare laws and regulations. Benefits shall be considered payable by Medicare for purposes of this provision whether or not the individual eligible for Medicare benefits has enrolled in or applied for Medicare Parts A and B, or has failed to take any other action required by Medicare to qualify for benefits, or would have received benefits payable by Medicare as if the individual received services in a facility to which Medicare would have paid benefits.

When HSA HEALTH INSURANCE COMPANY is secondary to Medicare, benefits otherwise payable under HSA HEALTH INSURANCE COMPANY shall be reduced so that the sum of benefits payable under HSA HEALTH INSURANCE COMPANY and Medicare shall not exceed the total allowable expenses of the primary plan.

General Provisions

Master Policy

This Master Policy, with a complete description of benefits, is maintained by HSA HEALTH INSURANCE COMPANY solely for use by its Members. HSA HEALTH INSURANCE COMPANY does not authorize any other use of this Master Policy. This Master Policy and the applicable Outline of Coverage for your Employer group's Eligible Benefits are intended to work in conjunction with one another. If there is any conflict regarding Eligible Benefits, the Master Policy supersedes the Outline of Coverage.

Authorization to Obtain/Retain/share information

By enrolling with HSA HEALTH INSURANCE COMPANY and accepting or receiving services and/or benefits through HSA HEALTH INSURANCE COMPANY, all Members agree that HSA HEALTH INSURANCE COMPANY and healthcare Providers are authorized to obtain, retain and share information (including but not limited to sensitive medical information contained in Medical Records) necessary or reasonably believed to be necessary to properly diagnose and treat Members, in order to process and evaluate claims for services rendered. HSA HEALTH INSURANCE COMPANY will maintain the confidentiality of such information in its possession as regulated by 45 CFR 160 and 164 as amended. Upon receiving appropriate documentation, HSA HEALTH INSURANCE COMPANY may provide a custodial parent information regarding claims payment for the covered Dependent.

Excess payment or mistaken payments

HSA HEALTH INSURANCE COMPANY will have the right at any time to recover any payment made in excess of HSA HEALTH INSURANCE COMPANY's obligations under this Master Policy, whether such payment was made in error or otherwise. Such right will apply to payments made to Members, Providers or Facilities. If an excess payment is made by HSA HEALTH INSURANCE COMPANY, the Member agrees to promptly refund the amount of the excess. HSA HEALTH INSURANCE COMPANY may, at its sole discretion, offset any future payment against any excess or mistaken payment already made to a Member or for a Member to a Provider or Facility. The making of a payment in error or under a mistaken understanding of the relevant facts is not recognition by HSA HEALTH INSURANCE COMPANY that the service in question is covered under this Master Policy. If a claim incurred due to false pretenses, whether intentional or not, false representation, or actual fraud is discovered, HSA HEALTH INSURANCE COMPANY may deny or seek reimbursement for payment, including associated costs and legal fees made in association with such claim.

Medical case management

Medical Case Management is designed to enhance the value of medical care in cases of complex medical conditions or injudicious use of medical benefits. Under Medical Case Management, a nurse case manager will work with the Member, the Member's family, Providers, outside consultants and others to coordinate a comprehensive, medically appropriate treatment plan. Failure to abide by the treatment plan may result in a reduction or denial of benefits. Claims will be paid according to CPT, RBRVS, global fee, and industry standards and guidelines. HSA HEALTH INSURANCE COMPANY, at its own discretion, may require a Member to obtain Preauthorization for any and all benefits in coordination with Medical Case Management, if HSA HEALTH INSURANCE COMPANY has determined such action is warranted by the Member's claims history.

Covered Benefits

Contracted providers

HSA HEALTH INSURANCE COMPANY offers quality medical care in the state of Utah through Contracted Providers. For emergencies and some limited benefits outside the state of Utah, HSA HEALTH INSURANCE COMPANY has contracted with a network administrator to secure discounts with Provider networks. It is the Member's responsibility to use Contracted Providers. Failure to use Contracted Providers may result in a reduction or denial of benefits. HSA HEALTH INSURANCE COMPANY will make available a current list of Contracted Providers at www.HSAHealthPlan.com or by contacting HSA HEALTH INSURANCE COMPANY. HSA HEALTH INSURANCE COMPANY reserves the right to make changes to the Provider list at any time during a plan year without notice.

When an in-network provider is not available or the covered person is outside the service area, we will ensure that the covered person is able to obtain covered benefits at a cost that is not greater than if the benefit were obtained from network providers. In the event a network provider is not available within our access standards, members should call the Customer Service at **1-844-234-4472** to make arrangements to see another provider.

In general, the Member is responsible to pay the specified Coinsurance(s) at the time of service and the balance will be paid by HSA HEALTH INSURANCE COMPANY according to plan benefits. The Member's HSA HEALTH INSURANCE COMPANY Identification/Prescription must be presented at each visit. The Provider will have a release form that authorizes HSA HEALTH INSURANCE COMPANY to obtain necessary information. This form must be signed by the Member.

Out-of-state/Out-Of-network coverage

Medical Services received from non-contracted Providers will not be paid by HSA HEALTH INSURANCE COMPANY, except under the following circumstances:

> If a Member receives medical services for Emergency Care from a non-contracted Provider inside or outside of Utah, the services will be allowed by HSA HEALTH INSURANCE COMPANY at the Maximum Allowable Fee as determined by the HSA Health Insurance Company, or negotiated fees and paid by HSA HEALTH INSURANCE COMPANY at the amount specified for Contracted Providers by the Member's applicable Outline of Coverage.
>
> In the case of inpatient hospitalization in a non-Contracted medical facility, the Member will be transferred to a Contracted medical facility as soon as medically possible, in coordination with HSA HEALTH INSURANCE COMPANY's Medical Case Management.

Hospital benefits

See applicable Outline of Coverage for applicable Coinsurance amounts.

Inpatient hospitalization

Charges for Medically Necessary inpatient Hospitalization (semiprivate room, ICU, and eligible ancillaries) are payable after applicable Coinsurance. Hospital admissions require Pre-notification. When a Hospital stay spans an old and new plan year, charges billed on the hospital claim will be based on the old plan year provisions. Eligible ancillary services such as Inpatient Physician visits, diagnostic tests, laboratory tests, etc. performed during the hospital stay but billed separately from the hospital will apply to the benefits in effect under the plan year on the actual date of service billed.

Outpatient facility benefits

Charges for Medically Necessary Surgical Procedures performed in an Ambulatory Surgical Facility, whether freestanding or Hospital based, are payable after applicable Coinsurance.

Emergency Room services

Medically Necessary emergency room facility services are payable after applicable Coinsurance. Each follow up visit in the emergency room will require an additional emergency room Coinsurance. When emergency room treatment results in an inpatient admission (within 24 hours), benefits are payable as an inpatient stay.

Urgent care facility

Medically Necessary Urgent care facility services are payable, after applicable Coinsurance.

Limitations relating to all inpatient and Outpatient hospital/facility and emergency Room services

The following are Limitations of the Master Policy:

Charges for ambulance services, physician's Hospital or emergency room visits, specialty medications, and Durable Medical Equipment billed on the Hospital bill are payable separately, subject to applicable plan provisions and specified Coinsurances.

Newborn nursery room charges are separate from the mother's claim and the child must be enrolled to be eligible.

When an inpatient Hospital stay can be shortened or charges reduced by transfer to a transitional care unit or Skilled Nursing Facility, HSA HEALTH INSURANCE COMPANY may require the patient to be transferred for Coverage to continue. This benefit is only available through concurrent Medical Case Management and approval by HSA HEALTH INSURANCE COMPANY.

Inpatient benefits for Mental Health require Preauthorization.

Only acute Emergency Care for Life threatening injury or illness is covered in conjunction with attempted suicide or anorexia/bulimia. Other services require Preauthorization through the inpatient Mental Health benefits.

Human Pasteurized Milk is a covered benefit for Newborn ICU babies whose mother's milk supply is inadequate, and in cases of extreme immaturity. Requires Preauthorization.

Inpatient Rehabilitation and Skilled Nursing Facility stays are limited to 30 days per plan year combined.

Exclusions from coverage relating to all inpatient and Outpatient Hospital/facility and emergency Room services

The following are Exclusions of the Master Policy:

1. Ineligible Surgical Procedures or related Complications.
2. Treatment programs for enuresis or encopresis.
3. Services or items primarily for convenience, contentment, or other nontherapeutic purpose, such as guest trays, cots, telephone calls, shampoo, tooth brush, or other personal items .
4. Occupational therapy for activities of daily living, academic learning, vocational or life skills, develop mental delay.
5. Care, confinement or services in a nursing home, rest home or a transitional living facility, community reintegration program, vocational rehabilitation, services to retrain self-care, or activities of daily living.
6. Recreational therapy.
7. Autologous (self) blood storage for future use.
8. Organ or tissue donor charges, except when the recipient is an eligible Member covered under a HSA HEALTH INSURANCE COMPANY plan, and the transplant is eligible.
9. Nutritional analysis or counseling, except in con junction with diabetes education, anorexia, bulimia, or as covered under the Affordable Care Act Preventive Services.
10. Custodial Care and/or maintenance therapy.
11. Take-home medications.
12. Additional fees charged because a robotic surgical system was used during surgery.
13. Mastectomy for gynecomastia.
14. Any eligible Surgical Procedure when performed in conjunction with other ineligible Surgery.
15. Breast reduction.
16. Tests and treatment for infertility.
17. Blepharoplasty (or other eyelid Surgery).
18. All facility claims related to a Hospital stay when the Member is discharged against medical advice.
19. Sclerotherapy of varicose veins.
20. Microphlebectomy (stab phlebectomy).

21. Blood clotting factor.
22. Inpatient or outpatient dental hospitalization.

Surgical benefits

See applicable Outline of Coverage for specific Coinsurance amounts. Medically Necessary Surgical Procedures are payable, after applicable Coinsurance when performed in a physician's office, in a Hospital, or in a freestanding Ambulatory Surgical Facility. HSA HEALTH INSURANCE COMPANY pays for an assistant surgeon when medically Necessary. Services of a co-surgeon, when required and in the absence of an assistant surgeon, are payable up to the combined total amount eligible per Maximum Allowable Fee for the surgeon and an assistant's fee, divided equally . Charges for an assistant surgeon (MD) are allowable up to 20% of Maximum Allowable Fee. Charges for a certified assistant surgical nurse, or physician's assistant at Surgery in lieu of an assistant surgeon (MD) are allowable up to 10% of Maximum Allowable Fee.

Second Opinion and surgical Review

A second opinion evaluation for Surgery is payable (office consultation only). Available Medical Records, including x-rays, should be forwarded to the Provider for the second opinion evaluation.

Limitations relating to surgery

The following are Limitations of the Master Policy:

Multiple Surgical Procedures during the same operative session are allowable at 100% of Maximum Allowable Fee for the primary procedure and 50% of Maximum Allowable Fee for all additional eligible procedures. Incidental procedures are excluded.

Surgical benefits are payable based on surgical Package Fees to include the Surgery and postoperative care per CPT guidelines and RBRVS guidelines.

Breast Reconstructive Surgery is an Eligible Benefit as allowed under WHCRA. Requires written Preauthorization through Medical Case Management.

Maxillary/Mandibular bone or Calcitite augmentation surgery is covered when a Member is edentulous (absence of all teeth) and the general health of the Member is at risk because of malnutrition or possible bone fracture. If the Member elects a more elaborate or precision procedure, HSA HEALTH INSURANCE COMPANY may allow payment for the standard Calcitite placement towards the cost and the Member will be responsible for the difference. Quadrant or individual tooth areas or osseous implants are not eligible. Preauthorization is required.

Exclusions from coverage relating to surgery

The following are Exclusions of the Master Policy:

1. Breast Reconstructive Surgery, augmentation or implants solely for Cosmetic purposes.
2. Capsulotomy, replacement, removal or repair of breast implant originally placed for Cosmetic purposes or any other Complication(s) of Cosmetic or non-covered breast Surgery.
3. Obesity Surgery such as Lap Band, gastric bypass, stomach stapling, gastric balloons, etc., including any present or future complications.
4. Any service or Surgery that is solely for Cosmetic purposes to improve or change appearance or to correct a deformity without restoring a physical bodily function, with the following exceptions
    a. Breast Reconstructive Surgery as allowed under WHCRA for Cosmetic purposes and
    b. Reconstructive Surgery made necessary by an Accidental injury in the preceding five years.
5. Rhinoplasty for Cosmetic reasons is excluded except when related to an Accidental injury occurring in the preceding five years.
6. Assisted reproductive technologies invitrofertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.
7. Surgical treatment for correction of refractive errors.
8. Expenses incurred for Surgery, preoperative testing, treatment, or Complications by an organ or tissue donor, where the recipient is not an eligible Member, covered by HSA HEALTH INSURANCE COMPANY, or when the transplant for the HSA HEALTH INSURANCE COMPANY Member is not eligible.
9. Reversal of sterilization.
10. Gender reassignment Surgery.
11. Rhytidectomy.
12. Surgery that is dental in origin, including care and treatment of the teeth, gums, or alveolar process, extraction of teeth; dental implants and crowns or pontics over implants, reimplantation or splinting, endodontia, periodontia, and orthodontia, including anesthesia or supplies used in such care .
13. Complications as a result of non-covered or ineligible Surgery.
14. Injection of collagen, except as approved for urological procedures.
15. Lipectomy, abdominoplasty, panniculectomy.
16. Repair of diastasis recti.
17. Sperm banking system, storage, treatment, or other such services.
18. Non FDA Approved or Experimental or Investigational procedures, drugs and Devices.

19. Hair transplants or other treatment for hair loss or restoration.
20. Chemical peels.
21. Treatment for spider or reticular veins.
22. Liposuction.
23. Orthodontic treatment or expansion appliance in conjunction with jaw Surgery.
24. Chin implant, genioplasty or horizontal symphyseal osteotomy.
25. Unbundling or fragmentation of surgical codes.
26. Any Surgery solely for snoring.
27. Otoplasty.
28. Abortions, except as in accordance with Utah State Law.
29. Surgical treatment for sexual dysfunction.
30. Subtalar implants.
31. Additional fees charged because a robotic surgical system was used during surgery.
32. Mastectomy for gynecomastia.
33. All treatment of infertility.
34. Any eligible Surgical Procedure when performed in conjunction with other ineligible Surgery.
35. Breast Reduction.
36. Blepharoplasty (or other eyelid Surgery).
37. Circumcision.
38. Infertility surgery.
39. Sclerotherapy of varicose veins.
40. Microphlebectomy (stab phlebectomy).
41. TMJ/TMD/Myofacial Pain.

Anesthesia benefits

See applicable Outline of Coverage for specific Coinsurance amounts. The charges for Medically Necessary anesthesia administered by a Provider (MD or CRNA) in conjunction with Medically Necessary Surgery are payable, after applicable Coinsurance.

Limitations relating to anesthesia

The following are Limitations of the Master Policy:

1. Anesthesia must be administered by a qualified licensed practitioner other than the primary surgeon. Exceptions:
   a. A Provider in a rural area, when an anesthesiologist is not available, may administer anesthesia and will be paid up to 20% of the eligible Surgery fee.
   b. Anesthesia performed by an oral surgeon in conjunction with an eligible medical Surgical Procedure.
2. Anesthesia for labor and delivery is payable on a sliding scale with one base rate (first hour— full time, second hour—half time, quarter time for every hour thereafter) .

3. An epidural block during labor is not payable to the delivering Provider in addition to an anesthesiologist fee.
4. Moderate sedation (conscious sedation) is included in standard colonoscopy and EGD surgery and shall not be reimbursed separately.

Exclusions from coverage relating to anesthesia

The following are Exclusions of the Master Policy:

Anesthesia in conjunction with ineligible Surgery.
Anesthesia administered by the primary surgeon.
Monitored anesthesia care or on call time for consultant.
Additional charges for supplies, drugs, equipment, etc.
Anesthesia performed for any eligible Surgical Procedure when performed in conjunction with other ineligible Surgery.

Medical visit benefits

See applicable Outline of Coverage for specific Coinsurance amounts. Medically Necessary medical visits, including visits in the Provider's office, urgent care facility, emergency room, Hospital, or the Member's home, are payable, after applicable Coinsurances . HSA HEALTH INSURANCE COMPANY pays for other outpatient or office services such as chemotherapy, office Surgery, labs and x-rays, blood "factor" replacement, etc. ., after applicable Coinsurances.

Limitations relating to medical visits

The following are Limitations of the Master Policy:

1. Physical therapy visits may be payable up to plan limits when medically Necessary. See applicable Outline of Coverage for plan limits.
2. Pelvic floor therapy visits may be payable up to plan limits when medically Necessary. See applicable Outline of Coverage for plan limits.
3. Outpatient occupational therapy for fine motor function may be payable up to plan limits when medically Necessary. See applicable Outline of Coverage for plan limits.
4. Only one medical, psychiatric, or physical therapy visit per day for the same diagnosis when billed by Providers of the same specialty for any one Member is allowable. Same day visits by a multidisciplinary team are eligible with applicable Coinsurance(s) per Provider.
5. Therapeutic injections in the Provider's office will not be eligible if oral medication is an effective alternative.
6. Gamma globulin injections are only eligible for documented immunosuppression with absence of Gamma globulin. Depending on the diagnosis, these drugs may be

required to be obtained through the Specialty Drug Program. No benefits are payable for prophylactic purposes or other diagnoses.

7. After hours and/or holidays are payable only when special consultation is Medically Necessary beyond normal business hours or "on call" or shift work requirements.
8. Cardiac Rehabilitation, Phase 2, following heart attack, cardiac Surgery, severe angina (chest pain), and Pulmonary Rehabilitation, Phase 2, resulting from chronic pulmonary disease or Surgery, are payable up to 5 visits combined per plan year .
9. Hepatitis B immunoglobulin is covered if there is a documented exposure or if in conjunction with an eligible liver transplant.

Exclusions from coverage relating to medical visits

The following are Exclusions of the Master Policy:

1. Hospital visits the same day as Surgery or following a Surgical Procedure except for treatment of a diagnosis unrelated to the Surgery.
2. Examinations made in connection with a hearing aid.
3. Services for weight loss or in conjunction with weight loss programs regardless of the medical indications except as allowed under the Affordable Care Act Preventive Services.
4. Sublingual antigens.
5. Services that are dental in origin, including care and treatment of the teeth, gums, alveolar process, extraction of teeth, reimplantation or splinting, endodontia, periodontia, orthodontia, prosthetics, dental implants, crowns or pontics over implants, anesthesia or supplies used in such care.
6. Charges in conjunction with ineligible procedures, including pre or postoperative evaluations.
7. Epidemiological and predictive genetic screening except intrauterine genetic evaluations (amniocentesis or chorionic villi sampling) for high-risk pregnancy or as allowed under the Affordable Care Act Preventive Services.
8. Acupuncture treatment.
9. Physical or occupational therapy primarily for maintenance care.
10. Occupational therapy for activities of daily living, academic learning, vocational or life skills, driver's evaluation or training, developmental delay and recreational therapy.
11. Functional or work capacity evaluations, impairment ratings, work hardening programs or back school.
12. Hypnotherapy or biofeedback.
13. Hair transplants or other treatment for hair loss or restoration.
14. Treatment of TMJ/TMD or Myofacial Pain.
15. Vision therapy.
16. Testing and treatment therapies for developmental delay or child developmental programs.
17. Rolfing or massage therapy.
18. Training and testing in conjunction with Durable Medical Equipment or prosthetics.

19. Nutritional analysis or counseling, except in con junction with diabetes education, anorexia, bulimia, or as allowed under the Affordable Care Act Preventive Services.
20. Reports, evaluations, examinations not required for health reasons, such as employment or insurance examinations, or for legal purposes such as custodial rights, paternity suits, etc.
21. Visits in conjunction with palliative care of metatarsalgia or bunions; corns, calluses or toenails, except removing nail roots and care prescribed by a licensed physician treating a metabolic or peripheral vascular disease. See applicable Outline of Coverage for Eligible Benefits.
22. Cardiac Rehabilitation, Phases 3 and 4.
23. Pulmonary Rehabilitation, Phase 3.
24. Chelation therapy.
25. Office visits in conjunction with allergy, contraception, hormone, or repetitive therapeutic injections when the only service rendered is the injection.
26. Fitness programs.
27. Charges for special medical equipment, machines, or Devices in the Provider's office used to enhance diagnostic or therapeutic services in a Provider's practice.
28. Childbirth education classes.
29. Topical hyperbaric oxygen treatment.
30. Chiropractic treatment.
31. Home births

Diagnostic testing, lab and x-ray benefits

See applicable Outline of Coverage for specific Coinsurances. Benefits for Medically Necessary laboratory, x-ray, CT, MRI, MRA, and ultrasound services are payable. A fee for transportation of x-ray equipment is payable when appropriate. Lab and x-ray in conjunction with office Surgery are payable after applicable Coinsurances.

Limitations relating to diagnostic testing, lab and x-ray

The following are Limitations of the Master Policy:

1. Lab and x-rays are only eligible for diagnosing or treating symptomatic illness and must be specific to the potential diagnosis.
2. Laboratory typing/testing for organ transplant donors is eligible only when recipient is an eligible Member, covered under a HSA HEALTH INSURANCE COMPANY plan, and the transplant is eligible.

Exclusions from coverage relating to diagnostic testing, lab and x-ray

The following are Exclusions of the Master Policy:

1. Charges in conjunction with ineligible procedures, including pre or post-operative evaluations.
2. Routine drug screening, except when ordered by a treating physician.
3. Sublingual or colorimetric allergy testing.
4. Charges in conjunction with weight loss programs regardless of Medical Necessity.
5. Epidemiological and predictive genetic counseling except in conjunction with the Affordable Care Act.
6. Probability and predictive analysis and testing.
7. Unbundling of lab charges or panels.
8. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.
9. Hair analysis, trace elements, or dental filling toxicity.
10. Assisted reproductive technologies, including but not limited to: invitrofertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.
11. Sleep Studies for sleep disorders.
12. Services in conjunction with diagnosing infertility.
13. Amniocentesis or chorionic villi sampling, except for high risk pregnancy or as allowed under the Afford able Care Act Preventive Services.
14. Molecular diagnostic (genetic testing) in the course of evaluating a Member for genetic or congenital disease.

Mental health benefits

Mental Health benefits will follow the same cost sharing as other related benefits. They are subject to different but no more restrictive quantitative and qualitative standards that are appropriate for these types of benefits in accordance with The Mental Health Parity and Addiction Equity Act and medical necessity.

Facility and hospital services-Mental health benefits

Medically Necessary services from Contracted Hospitals, inpatient treatment centers, inpatient pain clinics, day treatment facilities or intensive outpatient programs are payable after applicable Coinsurances and must be Preauthorized through the HSA Health Insurance Company. See applicable Outline of Coverage for further details. Failure to Preauthorize will result in denial of benefits. Charges for the full Hospital stay will be prorated into a per diem rate, or as Contracted with specific Providers, for adjudication of daily benefits.

Day treatment or intensive outpatient program may be considered in lieu of inpatient care with two or more days applicable to one inpatient day based on Provider agreements or

Preauthorization. If program is not completed, benefits revert to outpatient coverage. Electro Convulsive Therapy is eligible under Medical benefits. Eating disorders, such as anorexia and/or bulimia, are payable under medical benefits while Life threatening, as determined by HSA HEALTH INSURANCE COMPANY. When the condition is no longer Life threatening, benefits are payable under Mental Health and require Preauthorization. Inpatient provider visits Hospital visits are payable after applicable Coinsurance(s).

Outpatient provider visits-Mental health benefits

Outpatient treatment by a licensed psychologist, licensed clinical social worker, medical Provider or licensed psychiatric nurse specialist is eligible. See applicable Outline of Coverage for further details. Eligible neuropsychological evaluations and testing are payable as medical benefits. Eligible medical management to monitor use of psycho tropic drugs is payable as a medical benefit.

Exclusions from coverage relating to mental health

The following are Exclusions of the Master Policy:

1. Inpatient treatment for Mental Health without Preauthorization, as required by the Member's plan.
2. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, Stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
3. Mental or emotional conditions without manifest psychiatric disorder or nonspecific conditions.
4. Wilderness programs.
5. Inpatient treatment for behavior modification, enuresis, or encopresis.
6. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
7. Occupational or recreational therapy.
8. Hospital leave of absence charges.
9. Sodium amobarbital interviews.
10. Tobacco abuse.
11. Routine drug screening, except when ordered by a treating physician.

Ambulance benefits

See applicable Outline of Coverage for specific Coinsurances. Benefits for eligible ambulance services, including air transport, are payable after applicable Coinsurance.

Limitations relating to ambulance benefits

The following are Limitations of the Master Policy:

1. Benefits are only eligible when ambulance services are necessary due to a medical emergency.
2. Only services to transport to the nearest Hospital where proper medical care is available are eligible.
3. Benefits will be payable for air ambulance only in Life threatening emergencies when a Member could not be safely transported by ground ambulance, and only to the nearest facility where proper medical care is available. If emergency is considered to be non-Life-threatening by HSA HEALTH INSURANCE COMPANY, air ambulance charges will be payable at ground transport rates.

Exclusions from coverage relating to ambulance benefits

The following are Exclusions of the Master Policy:

1. Charges for common or private aviation services.
2. Services for the convenience of the patient or family.
3. After-hours charges.
4. Charges for ambulance waiting time.

Home health and hospice care benefits

See applicable Outline of Coverage for specific Coinsurances. When Preauthorized, Medically Necessary skilled home health, home IV therapy and Hospice services are payable at plan benefits. Hospice benefits may be approved when a Member is no longer receiving any curative treatment, and is only receiving palliative care for pain relief, symptom control and comfort.

Limitations relating to home health and hospice care benefits

The following are Limitations of the Master Policy:

1. Total Enteral Nutrition (TEN) formula requires Preauthorization and must be obtained through the pharmacy card.
2. Physical and/or occupational therapy performed in the home is subject to the outpatient plan limits. See applicable Outline of Coverage for details.
3. A home visit by a Licensed Clinical Social Worker is payable from outpatient Mental Health benefits. See applicable Outline of Coverage for details.
4. Skilled Nursing visits are subject to plan Limitations. One Skilled Nursing visit is defined as up to four hours. See applicable Outline of Coverage for details.
5. Hospice services are subject to plan Limitations. See applicable Outline of Coverage for details.

Exclusions from coverage relating to home health and hospice care

The following are Exclusions of the Master Policy:

1. Nursing or aide services which are requested by or for the convenience of the Member or family, which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services. This Exclusion applies even when services are recommended by a Provider.
2. Private duty nursing.
3. Home health aide.
4. Custodial Care.
5. Respite Care.
6. Travel or transportation expenses, escort services to Provider's offices or elsewhere, or food services.
7. Total Parenteral Nutrition through Hospice.
8. Enteral Nutrition, unless obtained through the pharmacy card.
9. Home births.

Adoption benefits

Adoption benefits for legal or agency fees may be available, subject to plan Limitations. (See applicable Outline of Coverage for details). In order to be eligible for adoption benefits, the adopting parent must have been a Subscriber for three months prior to the placement of the child. At the time of placement, the child must be 17 years of age or younger. These adoption benefits will not be payable until the adoption becomes final and proper documentation is provided.

The Adoption benefits eligible under the Outline of Coverage are the maximum (but not the minimum) benefits HSA HEALTH INSURANCE COMPANY will allow per adoption, even if the Member is enrolled in more than one plan (Dual Coverage), or is also insured by another health insurance Master Policy. If more than one child from the same birth (ex. twins) is placed for adoption with the Subscriber, only one Adoption benefit is payable.

Exclusions from coverage relating to adoption benefits

The following are Exclusions of the Master Policy:

1. Transportation, travel expenses or accommodations, passport fees, translation fees, photos, postage etc.
2. Living expenses, food, and/or counseling for the birth mother.

Autism Spectrum Disorder

Benefits for the diagnosis and treatment of Autism Spectrum Disorder are eligible for coverage for children who are at least 2 years old but younger than 10 years old. See applicable Outline of Coverage for specific Coinsurances. Cost sharing shall be similar to other treatments from similar type providers.

Limitations relating to Autism Spectrum Disorder

1. Benefits are limited to 600 hours of behavior health treatments per Master Policy year.
2. A health care provider shall submit a treatment plan for autism spectrum disorder to the HSA Health Insurance Company within 14 business days of starting treatment for an individual. If an individual is receiving treatment for an autism spectrum disorder, HSA Health Insurance Company shall have the right to request a review of that treatment not more than once every six months. A review of treatment may include a review of treatment goals and progress toward the treatment goals. HSA Health Insurance Company may make a determination to stop treatment as a result of the review if it is shown that the treatment is either inappropriate of ineffective for the specific member.

Prescription and specialty drug benefits

See applicable Outline of Coverage for specific Coinsurances. The HSA HEALTH INSURANCE COMPANY pharmacy benefit provides pharmacy and injectable Coverage through our pharmacy network. Go to www.HSAHealthPlan.com or contact HSA HEALTH INSURANCE COMPANY Customer Service to learn more about the cost of your medication.

HSA HEALTH INSURANCE COMPANY Members will receive a pharmacy Identification card upon Enrollment in the HSA HEALTH INSURANCE COMPANY's Pharmacy program. The Identification card will only list the Subscriber's name but will provide Coverage for each enrolled family Member. Members need to present their pharmacy card or provide their HSA HEALTH INSURANCE COMPANY Identification number to a participating pharmacy along with an eligible prescription and any applicable Coinsurance to receive their prescription medication.

Covered formulary drugs

- Select generic drugs.
- Insulin and diabetic supplies.
- Select brand name drugs.
- Select Specialty injectables.
- Select Specialty oral drugs.

Preauthorization for prescription and specialty medications

HSA HEALTH INSURANCE COMPANY has chosen specific prescription drugs and injectables to require Preauthorization. These medications were chosen due to their high potential for safety issues, adverse reactions, contraindications, misuse, opportunity to use first line therapy and cost. Go to www .HSAHealthPlan.com or contact HSA HEALTH INSURANCE COMPANY's Customer Service for a complete list of medications that require Preauthorization.

To obtain Preauthorization, a Member's physician may obtain a Preauthorization form at www.HSAHealthPlan.com or may contact HSA HEALTH INSURANCE COMPANY's Customer Service to start the Preauthorization process. The Provider will be directed to HSA HEALTH INSURANCE COMPANY's pharmacy Preauthorization phone line. Approval or denial will be communicated to the Provider's office. Members may also phone the HSA HEALTH INSURANCE COMPANY Customer Service Department to receive an update on the status of the physician's request. Preauthorization does not guarantee payment. Coverage is subject to eligibility, benefit Coverage and Preauthorization requirements.

Quantity levels and step therapy

Medications may have specific limits on how much of the drug Members can receive with each prescription or refill to ensure that Members receive the recommended and appropriate dose and length of therapy. HSA HEALTH INSURANCE COMPANY establishes quantity levels based on criteria that includes the maximum dosage levels indicated by the drug manufacturer, duration of therapy, FDA, and the cost of the drug. Members must obtain Preauthorization for any quantity that exceeds a HSA HEALTH INSURANCE COMPANY quantity level limit. Go to www.HSAHealthPlan.com for a complete list of medications that require a quantity level limit.

For some disease states and some drug categories, one or more medications must be tried before a drug will be covered under the pharmacy or injectable benefit. Step therapy ensures that a Member receives the most clinically appropriate and cost-effective medication. Step therapy is based on current medical studies, generic availability, and cost of the medication and FDA recommendations.

Pharmacy coordination of benefits with other carriers

HSA HEALTH INSURANCE COMPANY will coordinate pharmacy benefits with other insurance carriers when claims meet the requirements listed.
If HSA HEALTH INSURANCE COMPANY is the secondary carrier, Members must purchase their prescription medications through their primary insurance carrier. HSA HEALTH INSURANCE COMPANY will coordinate Coverage of eligible Coinsurances and unpaid claim amounts if the pharmacy claim meets HSA HEALTH INSURANCE COMPANY's pharmacy benefit requirements, Coverage rules, Preauthorization requirements and quantity levels. Most pharmacies have the ability to process the secondary pharmacy claims electronically at the point of sale. Members will be required to pay the applicable deductible and copayment amounts after both claims are processed. If the pharmacy is unable to coordinate electronically, the Member must submit an original itemized receipt (a pharmacy printout is not a valid receipt) and a claim form to HSA

Health Insurance Company's. If the primary insurance did not provide any coverage of the claim, the Member must pay for the prescription at the point of sale and provide an explanation of payment or denial from their primary insurance carrier. Members may obtain a claim form at www.HSAHealthPlan.com or by contacting HSA HEALTH INSURANCE COMPANY's Customer Service. Reimbursement will not exceed HSA HEALTH INSURANCE COMPANY's normal discounted rate or any Limitation required by the pharmacy benefit. If the primary insurance requires a Deductible or out-of-pocket maximum, HSA HEALTH INSURANCE COMPANY will recognize the pharmacy claim as unpaid by the primary insurance until the Deductible or out-of-pocket maximum is met. HSA HEALTH INSURANCE COMPANY will administer the claim as a primary insurance and reimburse minus the patient's required retail Coinsurance.

If your Coordination of Benefits request is for a Specialty medication, HSA HEALTH INSURANCE COMPANY will administer your Coordination of Benefits claim under your retail or medical Specialty benefit.

Out Of area prescriptions OR Other cash purchases

If Members are traveling outside the service area, they may contact HSA Health Insurance Company's Customer Service Department for the location of the nearest Contracted pharmacy in the United States. In emergency situations, Members may pay for a prescription and mail a reimbursement form along with a receipt to HSA Health Insurance Company for reimbursement. Reimbursement forms may be obtained from www.HSAHealthPlan.com.

Specialty and injectable drugs

Specialty oral and injectable drugs are typically bio engineered medications that have specific shipping and handling requirements or are required by the manufacturer to be dispensed by a specific facility. HSA HEALTH INSURANCE COMPANY may require that specialty medications be obtained from a designated pharmacy or facility for coverage.

Our specialty pharmacy, VRx, will coordinate with you or your physician to provide delivery to either your home or your provider's office. Preauthorization may be required.

Limitations relating to prescription drug benefits

The following are Limitations of the Master Policy:

Drug quantities, dosage levels and length of therapy may be limited to the recommendations of the drug manufacturer, FDA, clinical guidelines, or HSA HEALTH INSURANCE COMPANY's Pharmacy and Therapeutics Committee.

Anabolic steroid Coverage will be limited to hypogonadism or HIV and cancer wasting.

A medication in a different dosage form or delivery system that contains the same active ingredient as an already covered drug may be restricted from Coverage.

When a medication is dispensed in two different strengths or dosage forms, a separate Coinsurance will be required for each dispensed prescription.

If a Member is required by the FDA to be enrolled in a manufacturer Access or Disease Management Program, Coverage may be limited to Member's participation.

Medication quantities and availability may be restricted to a lower allowed day supply when a manufacturers' package size cannot accommodate the normal allowed pharmacy benefit day supply.

Cash paid and Coordination of Benefits claims will be subject to HSA HEALTH INSURANCE COMPANY's preauthorization, step therapy, and benefit Coverage and quantity levels. HSA HEALTH INSURANCE COMPANY will reimburse up to HSA Health Insurance Company's Contracted rate and HSA HEALTH INSURANCE COMPANY's benefit rules.

HSA HEALTH INSURANCE COMPANY will have the ability to limit the availability and filling of any medication, Device or supply. The Pharmacy or Case Management Department may require the following tools:

a) Require prescriptions to be filled at a specified pharmacy.
b) Obtain services and medications in dosages and quantities that are only Medically Necessary as determined by HSA HEALTH INSURANCE COMPANY.
c) Obtain services and medications from only a Specified Provider.
d) Require participation in a specified treatment for any underlying medical condition.
e) Require completion of a drug treatment program.
f) Adhere to a HSA HEALTH INSURANCE COMPANY Limitation or program to help reduce or eliminate drug abuse or dependence.
g) Deny medications or quantities needed to support any dependence, addiction or abuse if a member misuses the health care system to obtain drugs in excess of what is Medically Necessary.

Fluoride tablets are limited to children up to the age of 12 years old.

Enteral formula requires Preauthorization and is limited to the pharmacy network for Coverage.

Retail prescriptions are not refillable until 75% of the total prescription supply within the last 180 days is used. Twenty-three days must pass at a local pharmacy before a prescription can be refilled.

Exclusions from coverage relating to prescription drug benefits

The following are Exclusions of the Master Policy:

1. A prescription that is not purchased from a designated pharmacy (if required) and/or exceeds any quantity levels or step therapy disclosed on HSA HEALTH INSURANCE COMPANY's Preferred Drug List or website.
2. Vitamins, minerals, food supplements, homeopathic medicines and nutritional supplements (Prenatal vitamins and folic acid will be covered for pregnancy).
3. Dental rinses and fluoride preparations. (Fluoride tablets will be covered for children up to the age of 12 years old).
4. Hair growth and hair loss products.
5. Medications or nutritional supplements for weight loss or weight gain.
6. Investigational and non FDA Approved medications.
7. Medications needed to participate in any drug research or medication study.
8. FDA approved medication for Experimental or Investigational indications.
9. Non-approved indications determined by HSA HEALTH INSURANCE COMPANY's Pharmacy and Therapeutics Committee and the HSA HEALTH INSURANCE COMPANY Master Policy.
10. Drugs for athletic and mental performance.
11. New medications released by the FDA until they are reviewed for efficacy, safety and cost effectiveness by HSA HEALTH INSURANCE COMPANY.
12. Oral infant and medical formulas.
13. Therapeutic Devices or appliances unless listed in HSA HEALTH INSURANCE COMPANY's Preferred Drug List.
14. Diagnostic agents.
15. Over-the-counter medications and products unless listed in HSA HEALTH INSURANCE COMPANY's Preferred Drug List.
16. Take-home prescriptions from a Hospital or Skilled Nursing Facility.
17. Biological serum, blood, or blood plasma.
18. Medications and injectables prescribed for Industrial Claims and Worker's Compensation.
19. Medications dispensed from an institution or substance abuse clinic when the Member does not use their pharmacy card at a HSA HEALTH INSURANCE COMPANY Contracted pharmacy are not payable as a pharmacy claim.
20. Compounding fees, powders, and non-covered medications used in compounded preparations.
21. Medications used for Cosmetic indications.
22. Replacement of lost, stolen or damaged medications.
23. Nasal immunizations unless listed in the HSA HEALTH INSURANCE COMPANY Preferred Drug List.
24. Medications for Elective abortions except in accordance with Utah State Law.
25. Drugs for the treatment of nail fungus.
26. Medications for sex change operations.
27. Medications needed to treat Complications associated with Elective obesity Surgery and non-covered services.
28. Hypodermic needles.

29. Oral and nasal antihistamines for allergies.
30. Drugs used for sexual dysfunction or enhancement.
31. Medications for the treatment of infertility.
32. An additional medication that may be considered duplicate therapy defined by the FDA or HSA HEALTH INSURANCE COMPANY.
33. Medications not listed on the HSA HEALTH INSURANCE COMPANY website. For a complete list of covered drugs, refer to the HSA HEALTH INSURANCE COMPANY website.
34. Drugs purchased from nonparticipating Providers over the Internet.

Durable medical equipment/supply benefits

See applicable Outline of Coverage for specific Coinsurances. Durable Medical Equipment requires prior authorization. Please call HSA Health Insurance Company's for prior authorization and for any questions regarding Durable Medical Equipment.

Coverage is provided when the equipment is
Medically Necessary;
Prescribed by a Provider and approved by HSA HEALTH INSURANCE COMPANY; and
Used for medical purposes rather than for convenience or comfort.

HSA HEALTH INSURANCE COMPANY will allow the cost of standard conventional equipment or supplies necessary to treat the medical condition. Additional charges for more elaborate or precision equipment or supplies shall be the responsibility of the Member.

If medical equipment will be required for longer than 60 days, it requires Preauthorization for review of continued rental versus purchase. The total benefits allowable for rental and/or subsequent purchase may not exceed 100% of the allowable purchase price of the equipment.

Limitations relating to durable medical equipment/supply benefits

The following are Limitations of the Master Policy:

1. One lens for the affected eye following eligible corneal transplant Surgery. Contact lenses for documented Keratoconus may be approved as Medically Necessary.
2. One pair of ear plugs within 60 days following eligible ear Surgery.
3. Continuous Passive Motion (CPM) machine rentals may be approved for up to 21 days rental only for total knee or shoulder arthroplasty.
4. All prosthetics must be prior authorized. Artificial eye prosthetic, when made necessary by loss from an injury or illness, the maximum prosthetic benefit available is one in a five-year period. The maximum breast prosthetic benefit available is one per affected breast in a two-year period.

5. Wheelchairs require Preauthorization through Medical Case Management and are limited to one power wheelchair in any five-year period.
6. Knee braces are limited to one per knee in a three year period.

Exclusions from coverage relating to durable medical equipment/supply benefit

The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition:

1. Training and testing in conjunction with Durable Medical Equipment or prosthetics.
2. More than one lens for each affected eye following surgery for corneal transplant.
3. Durable Medical Equipment that is inappropriate for the patient's medical condition.
4. Diabetic supplies, i.e. insulin, syringes, needles, etc. are a pharmacy benefit.
5. Equipment purchased from non-licensed Providers.
6. Used Durable Medical Equipment.
7. TENS Unit.
8. Neuromuscular Stimulator.
9. Hwave Electronic Device.
10. Sympathetic Therapy Stimulator (STS).
11. Limb prosthetics.
12. Machine rental or purchase for the treatment of sleep disorders.
13. Support hose for phlebitis or other diagnosis.

Preventive services

Under the Affordable Care Act, HSA HEALTH INSURANCE COMPANY offers preventive services covered at no cost to you when received from a Contracted Provider. If these services are received from a non-contracted Provider they will be allowed up to the Maximum Allowable Fee and paid by HSA HEALTH INSURANCE COMPANY at the allowed amount specified for non-contracted Providers by the Member's applicable Benefit Summary, if the Member's plan allows the use of non-contracted Providers. If the member's plan does not allow the use of non-contracted Providers, the services will be denied by HSA HEALTH INSURANCE COMPANY.

We process claims based on your provider's clinical assessment of the office visit. If a preventive item or service is billed separately, cost sharing may apply to the office visit. If the primary reason for your visit is seeking treatment for an illness or condition, and preventive care is administered during the same visit, cost sharing may apply.

Certain screening services such as a colonoscopy or mammogram may identify health conditions that require further testing or treatment. If a condition is identified through a preventive

screening, any subsequent testing, diagnosis, analysis, or treatment are not considered preventive services and are subject to the appropriate cost sharing.

Covered preventive services for adults

Preventive office visits including the following services, once per plan year:

1. Blood pressure screening
2. Immunizations vaccines for adult's doses, recommended ages, and recommended populations vary:
    - Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella
3. Abdominal aortic aneurysm onetime screening for men aged 65 to 75 who have ever smoked.
4. Alcohol misuse screening and counseling
5. Anemia screening on a routine basis for pregnant women
6. Bacteriuria urinary tract or other infection screening for pregnant women
7. BRCA counseling about genetic testing for women at higher risk
8. Breast cancer mammography screenings for women age 40 and over, once per plan year
9. Breast cancer chemoprevention counseling for women at higher risk
10. Breast feeding interventions to support and promote breast feeding
11. Cervical cancer screening, once per plan year
12. Chlamydia infection screening
13. Cholesterol screening, once per plan year
14. Colorectal cancer screening for adults aged 5075
15. Depression screening
16. Diabetes screening
17. Diet counseling for adults at higher risk for chronic disease
18. Gonorrhea screening
19. Hepatitis B screening for pregnant women at their first prenatal visit
20. HIV screening
21. Obesity screening and counseling
22. Osteoporosis screening for women age 60 and older
23. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
24. Sexually transmitted infection prevention counseling
25. Syphilis screening
26. Tobacco use screening
27. Type 2 Diabetes screening for adults with high blood pressure
28. Breastfeeding supplies
29. FDA approved contraceptive methods and counseling

30. HPV DNA testing for women over age 30, once per plan year

Covered preventive services for children

1. Preventive office visits with medical history for all children throughout development (as recommended by the American Academy of Pediatrics)
2. Immunizations, vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis, Haemophilus influenza type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella.
3. Alcohol and drug use assessments
4. Autism screening for children at 18 and 24 months
5. Behavioral assessments
6. Cervical dysplasia screening
7. Congenital hypothyroidism screening for newborns
8. Developmental screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children at higher risk of lipid disorders
10. Gonorrhea preventive medication for the eyes of all newborns
11. Hearing screening
12. Height, weight and Body Mass Index measurements for children
13. Hematocrit or hemoglobin screening
14. Hemoglobinopathies or sickle cell screening for newborns
15. HIV screening
16. Lead screening
17. Obesity screening and counseling
18. Oral health risk assessment for young children
19. Phenylketonuria (PKU) screening for this genetic disorder in newborns
20. Sexually transmitted infection (STI) prevention counseling
21. Tuberculin testing for children at higher risk of tuberculosis
22. Routine vision exam for children between age 3 and 5, once per plan year
23. Vision acuity screening for all children

Preauthorization limitations

Certain medical services require Pre-notification or Pre authorization by HSA HEALTH INSURANCE COMPANY before being eligible for payment. While many Contracted and non-contracted Providers will Preauthorize or Pre-notify on your behalf, it is your responsibility to ensure that HSA HEALTH INSURANCE COMPANY has received notice and/or granted approval for any service requiring Pre-notification or Preauthorization prior to the services being received. If you do not preauthorize or Pre-notify services that require such approval, benefits may be reduced or denied by HSA HEALTH INSURANCE COMPANY.

The following services require Pre-notification by calling HSA HEALTH INSURANCE COMPANY Customer Service:

1. All inpatient Hospital admissions
2. All inpatient Hospital Rehabilitation admissions
3. Skilled Nursing Facilities
4. All inpatient mental health admissions

To receive maximum benefits, a Member must call for Pre-notification before being admitted to a Hospital as described below:

Elective Treatment

Treatment for a medical condition that can be scheduled in advance without causing harm or suffering to the Member's health. At least five working days before the admission date or Surgery, call HSA HEALTH INSURANCE COMPANY at 844-234-4HSA (844-234-4472).

Urgent Treatment

Treatment for a medical condition that, if left untreated, may cause unnecessary suffering or prolonged treatment to restore Member's health. At least three working days before the admission date or Surgery, call HSA HEALTH INSURANCE COMPANY at 844-234-4HSA (844-234-4472).

Emergency Treatment

Treatment for a medical condition of an unforeseen nature that, if left untreated, may cause death or permanent damage to the Member's health. Members do not have to call prior to admission. Member or a responsible person must contact HSA HEALTH INSURANCE COMPANY within 72 hours following admission or Surgery (or, if during a weekend or holiday, the first working day following treatment) at 844-234-4HSA (844-234-4472). Failure to call will result in a reduction or denial of benefits. See applicable Outline of Coverage for specific penalties.

Inpatient Treatment for Mental Health

Call HSA HEALTH INSURANCE COMPANY at 844-234-4HSA (844-234-4472) within the time specified above for the type of treatment. See applicable Outline of Coverage for further details. Failure to call will result in denial of benefits.

Out of Area Hospital Admission

Requires Pre-notification by the Member, the physician, the Hospital, or, in an emergency, a responsible person. Call HSA HEALTH INSURANCE COMPANY at 844-234-4HSA (844-234-4472) within the time specified above for the type of treatment. Failure to call will result in a reduction or denial of benefits. See applicable Outline of Coverage for specific penalties.

The following service requires verbal Preauthorization by calling HSA HEALTH INSURANCE COMPANY Customer Service:

Any inpatient maternity stay that exceeds 48 hours following a vaginal delivery or 96 hours following delivery by Cesarean section.

The following is a list of the most common services requiring written Preauthorization. It is not all inclusive. Call HSA HEALTH INSURANCE COMPANY if you have any questions regarding Preauthorization:

1. Surgery that may be partially or wholly cosmetic
2. Coronary CT angiography
3. Organ or tissue transplants
4. Surgery performed in conjunction with obesity Surgery
5. Implantation of artificial Devices
6. New and Unproven technologies
7. Cochlear implants
8. Durable Medical Equipment with a purchase price over $750 or any rental of more than 60 days
9. Botox injections
10. Maxillary/Mandibular bone or Calcitite augmentation Surgery
11. All out-of-state, out-of-network surgeries/procedures or inpatient admissions that are not Urgent or Life threatening
12. Wound care, except for the diagnosis of burns
13. Home health and Hospice Care
14. Hyperbaric oxygen treatments
15. Intrathecal pumps
16. Spinal cord stimulators
17. Surgical Procedures utilizing robotic assistance
18. Implantable medications, excluding contraception
19. Certain prescription and Specialty Drugs
20. Continuous glucose monitoring Devices and supplies
21. Jaw surgery
22. Dialysis when using non-contracted Providers
23. Human pasteurized milk
24. Stereotactic radiosurgery

25. Magnetoencephalography (MEG)/ magnetic source imaging
26. Breast reconstruction surgery
27. Virtual colonoscopy
28. Transanal endoscopic microsurgery
29. Endovenous ablation therapy (Radiofrequency or laser)
30. Anesthesia during standard colonoscopy or EGD surgery, other than moderate sedation (conscious sedation).

Maximum Out-of-pocket benefits

HSA HEALTH INSURANCE COMPANY has set limits for maximum out-of-pocket expense for Members. After the Member's share of eligible expenses exceeds specified amounts, HSA HEALTH INSURANCE COMPANY will pay further Eligible Benefits incurred during the remaining plan year at 100% of Maximum Allowable Fee. See applicable Outline of Coverage for specific out-of-pocket limits.

Exclusions from coverage relating to maximum Out-of-pocket benefits

Amounts paid by the Member for the following services will not apply to the Member's out-of-pocket maximum:

1. Any service or amount established as ineligible under this Master Policy or considered inappropriate medical care;
2. Charges in excess of Maximum Allowable Fee or contract Limitations;
3. Penalties for failing to obtain Preauthorization or to complete Pre-notification.
4. specific exclusions
5. Specific Exclusions are listed under the most commonly applicable Benefit category, but are not necessarily limited to that category only.

General exclusions from coverage

1. Charges in excess of contract Limitations or Maximum Allowable Fee.
2. All charges for services received as a result of an Industrial Claim (on the job) injury or illness, any portion of which is payable under Worker's Compensation or Employer's liability laws.
3. HSA HEALTH INSURANCE COMPANY will only be liable for Eligible Benefits for which the Member is liable. Payment will not be made for any expense for which the Member is not legally bound.
4. Charges for educational material or literature.

5. Charges for nutritional counseling except for the benefits provided for diabetes education, anorexia, bulimia, or as allowed under the Affordable Care Act Preventive Services.
6. Charges for scholastic education, vocational training, learning disabilities, or behavior modification.
7. Charges for medical care rendered by an Immediate Family Member.
8. Charges prior to Coverage or after termination of Coverage even if illness or injury occurred while a Member.
9. Provider's telephone calls or travel time except in accordance with approved telemedicine services.
10. Charges for services primarily for convenience, contentment, or other nontherapeutic purpose.
11. Overutilization of medical benefits as determined by HSA HEALTH INSURANCE COMPANY.
12. Charges that are not medically necessary to treat the condition, as determined by HSA HEALTH INSURANCE COMPANY, or charges for any service, supply or medication not reasonable or necessary for the medical care of the patient's illness or injury .
13. Charges for Unproven medical practices or care, treatment, Devices or drugs that are Experimental or Investigational in nature or generally considered Experimental or Investigational by the medical profession as determined solely by HSA HEALTH INSURANCE COMPANY.
14. Charges for services without adequate diagnosis or dates of service.
15. Charges for services, supplies or medications to the extent they are provided by any governmental plan or law under which the individual is, or could be covered.
16. Charges for services as a result of an auto related injury and covered under No-fault insurance or would have been covered if Coverage were in effect as required by law.
17. Services, treatments, or supplies furnished by a Hospital or facility owned or operated by the United States Government or any agency thereof.
18. Services or supplies received as a result of an act of war.
19. Any service or supply not specifically identified as a benefit.
20. Charges for commercial or private aviation services, meals, accommodations and car rental.
21. Charges for mileage reimbursement except for eligible ambulance service.
22. Charges by a Provider for case management.
23. Charges for independent medical evaluations and/or testing for the purpose of legal defenses or disputes.
24. Charges for submission of Medical Records necessary for claims review.
25. Delivery, shipping, handling, sales tax, or finance charges.
26. HSA HEALTH INSURANCE COMPANY is not responsible to pay any benefits given verbally or assumed except as written in a Preauthorization, documented by Customer Service or Medical Case Management, or as described in this Master Policy.
27. Charges for remote medical evaluation and management, including prescriptive services provided by the Internet, telephone or catalog unless in conjunction with telemedicine services approved by HSA Health Insurance Company.

28. Autopsy procedures.
29. Complications as a result of any non-covered service, procedure, or drug.
30. Treatment of obesity by means of Surgery, medical services, or prescription drugs, regardless of associated medical, emotional, or psychological condition.
31. Services incurred in connection with injury or illness arising from the commission of
    a. A felony;
    b. An assault, riot or breach of peace;
    c. A Class A misdemeanor;
    d. Any criminal conduct involving the illegal use of firearm or other deadly weapon;
    e. Any other illegal acts of violence.

    This exclusion only applies when the covered member is a voluntary participant.

32. Claims submitted past the timely filing limit allowed per Section 8 .1 of this Master Policy.
33. Charges for expenses in connection with appointments scheduled and not kept.
34. Charges for the treatment of sexual dysfunction.
35. Charges for services received as a result of medical tourism, or for traveling out of the United States to seek medical services or drugs.
36. Medical services, procedures, supplies or drugs used to treat secondary conditions or Complications due to any non-covered medical services, procedures, supplies or drugs are not covered. Such Complications include, but are not limited to

    a. Complications relating to services and sup plies for or in connection with gastric bypass or intestinal bypass, gastric stapling, or other similar Surgical Procedure to facilitate weight loss, or for or in connection with reversal or revision of such procedures, or any direct Complications or consequences thereof;

    b. Complications as a result of a Cosmetic Surgery or procedure, except in cases of Reconstructive Surgery
        i. When the service is incidental to or follows a Surgery resulting from trauma, infection or other diseases of the involved part; or
        ii. Related to a congenital disease or anomaly of a covered Dependent child that has resulted in functional defect;

    c. Complications relating to services, supplies or drugs which have not yet been approved by the FDA or which are used for purposes other than its FDA Approved purpose.
37. Maternity and related medical services for surrogate mothers.
38. Manipulation under anesthesia for any body part.
39. Treatment for TMJ/TMD/Myofacial Pain.
40. Services in conjunction with diagnosing and treating infertility.
41. Medical services to treat or diagnose enuresis and/or encopresis as a physical organic illness.

42. Any dental treatment other than eligible services provided for in accidental dental services.

Subrogation and contractual Reimbursement

Contractual Reimbursement

The Member agrees to seek recovery from any person(s) who may be obligated to pay damages arising from occurrences or conditions caused by the person(s) for which Eligible Benefits are provided or paid for by HSA HEALTH INSURANCE COMPANY and promises to keep HSA HEALTH INSURANCE COMPANY informed of his/her efforts to recover from those person(s). If the Member does not diligently seek such recovery, HSA HEALTH INSURANCE COMPANY, at its sole discretion, reserves the right to pursue any and all claims or rights of recovery on the Member's behalf.

In the event that Eligible Benefits are furnished to a Member for bodily injury or illness, the Member shall reimburse HSA HEALTH INSURANCE COMPANY with respect to a Member's right (to the extent of the value of the Benefits paid) to any claim for bodily illness or injury, regardless of whether the Member has been "made whole" or has been fully compensated for the illness or injury. HSA HEALTH INSURANCE COMPANY shall have a lien against any amounts advanced or paid by HSA HEALTH INSURANCE COMPANY for the Member's claim for bodily injury or illness, no matter how the amounts are designated, whether received by suit, settlement, or otherwise on account of a bodily injury or illness . HSA HEALTH INSURANCE COMPANY's right to reimbursement is prior and superior to any other person or entity's right to the claim for bodily injury or illness, including, but not limited to, any attorney fees or costs the Member chooses to incur in securing the amount of the claim.

Subrogation

The Member agrees to seek recovery from any person(s) who may be obligated to pay damages arising from occurrences or conditions caused by the person(s) for which Eligible Benefits are provided or paid for by HSA HEALTH INSURANCE COMPANY and promises to keep HSA HEALTH INSURANCE COMPANY informed of his/her efforts to recover from those person(s). If the Member does not diligently seek such recovery, HSA HEALTH INSURANCE COMPANY, at its sole discretion, reserves the right to pursue any and all claims or rights of recovery on the Member's behalf. The Member will cooperate fully with HSA HEALTH INSURANCE COMPANY and will sign and deliver instruments and papers and do whatever else is necessary on HSA HEALTH INSURANCE COMPANY's behalf to secure such rights and to authorize HSA HEALTH INSURANCE COMPANY to pursue these rights.

In the event that Eligible Benefits are furnished to a Member for bodily injury or illness, HSA HEALTH INSURANCE COMPANY shall be and is hereby subrogated (substituted) with respect to a Member's right (to the extent of the value of the Benefits paid) to any claim for bodily illness

or injury, regardless of whether the Member has been "made whole" or has been fully compensated for the illness or injury. HSA HEALTH INSURANCE COMPANY shall have a lien against any amounts advanced or paid by HSA HEALTH INSURANCE COMPANY for the Member's claim for bodily injury or illness, no matter how the amounts are designated, whether received by suit, settlement, or otherwise on account of a bodily injury or illness . HSA HEALTH INSURANCE COMPANY's right to reimbursement is prior and superior to any other person or entity's right to the claim for bodily injury or illness, including, but not limited to, any attorney fees or costs the Member chooses to incur in securing the amount of the claim.

Acceptance of benefits and notification

Acceptance of the benefits hereunder shall constitute acceptance of HSA HEALTH INSURANCE COMPANY's rights to reimbursement or Subrogation rights as explained above.

Recoupment of benefit payment

In the event the Member impairs HSA HEALTH INSURANCE COMPANY's reimbursement or Subrogation rights under this contract through failure to notify HSA HEALTH INSURANCE COMPANY of potential liability, settling a claim with a responsible party without HSA HEALTH INSURANCE COMPANY's involvement, or otherwise, HSA HEALTH INSURANCE COMPANY reserves the right to recover from the Member the value of all benefits paid by HSA HEALTH INSURANCE COMPANY on behalf of the Member resulting from the party's acts or omissions.

No judgment against any party will be conclusive between the Member and HSA HEALTH INSURANCE COMPANY regarding the liability of the party or the amount of recovery to which HSA HEALTH INSURANCE COMPANY is legally entitled unless the judgment results from an action of which HSA HEALTH INSURANCE COMPANY has received notice and has had a full opportunity to participate.

Claims Submission & Appeals

HSA HEALTH INSURANCE COMPANY reserves the right to determine whether a claim is an Eligible Benefit or to require verification of any claim for Eligible Benefits. In order to be considered for payment, expenses must be incurred while Member is eligible under the plan. The date the medical service is received shall be the date the medical expenses are incurred. HSA HEALTH INSURANCE COMPANY shall not be responsible for any expenses that are not Eligible Benefits.

HSA HEALTH INSURANCE COMPANY may request Medical Records, operative reports, pathology reports, x-rays, photos, etc. of a Member. The HSA HEALTH INSURANCE COMPANY Benefits Review Committee may review the Medical Records or have the records reviewed by qualified healthcare Providers or other qualified entities to audit claims for eligibility, Preexisting

Condition, Medical Necessity, and appropriateness of services with the Community Standard or usual patterns of care as determined by HSA HEALTH INSURANCE COMPANY .

Benefits are adjudicated in conjunction with the Maximum Allowable Fee and code review systems implemented by HSA HEALTH INSURANCE COMPANY. Claims may be returned for incomplete or improper coding. If, after a second request, necessary records are not received, the claim(s) will be denied for insufficient documentation.

Claims submission

When a Contracted Provider is used, the Provider will submit the claims directly to HSA HEALTH INSURANCE COMPANY. Payment will be made directly to the Contracted Provider. Claims and any other proof of loss must be received by HSA Health Insurance Company within 12 months or as soon as Member is reasonably able to provide such documentation.

Required information for claims submission

The CPT (Current Procedural Terminology); HCPCS (Health Care Financing Administration's Common Procedural Coding System); ICD9 (International Classification of Diseases) and ICD10 code(s) and NDC# (National Drug Code), if applicable, and the Providers charge must be provided. Claims may be submitted electronically, or mailed to:

HSA HEALTH INSURANCE COMPANY
Claims Division

Claims appeal process

If a Member disagrees with a HSA HEALTH INSURANCE COMPANY decision regarding benefits, the Member may request a full and fair review by completing the HSA HEALTH INSURANCE COMPANY Appeal form located on each explanation of benefit statement, or available online at www.HSAHealthPlan.com, and returning the form to HSA HEALTH INSURANCE COMPANY within 30 days after HSA HEALTH INSURANCE COMPANY's initial determination. If the appeal form is not received by HSA HEALTH INSURANCE COMPANY within 30 days, the appeal shall be denied. HSA HEALTH INSURANCE COMPANY shall allow for expedited appeals only when required by federal law and at the request of the Member. The Member shall include with the appeal form all applicable information necessary to assist HSA HEALTH INSURANCE COMPANY in making a determination on the appeal. Requests for a review of claims should be sent to one of the following addresses

HSA Health Insurance Company
453 River Circle
Alpine, Utah 84004
HSA HEALTH INSURANCE COMPANY
Appeals and Master Policy Management Department

HSA HEALTH INSURANCE COMPANY shall review and investigate the appeal. If HSA HEALTH INSURANCE COMPANY requires additional information to investigate the appeal, it shall inform the Member of what information is required, and the Member shall have 45 days to provide the information to HSA HEALTH INSURANCE COMPANY. Unless an expedited appeal or unless HSA HEALTH INSURANCE COMPANY requests additional information from the Member, HSA HEALTH INSURANCE COMPANY shall decide the appeal and inform the Member of the decision within 60 days from its receipt of the appeal form. In any case, no action for denied claims can be taken against HSA Health Insurance Company before 60 days after the denial.

In accordance with federal law, Members may have the right to have our decision reviewed by a health care professional who has no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested. To receive additional information about an independent review, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City UT 84114; by phone at 801 538-3077; or electronically at healthappeals.uid@utah.gov. Following the external reviewer's decision, HSA HEALTH INSURANCE COMPANY shall notify the member of the decision.