Employee Health Care Plan
Comprehensive Plan Option
UNIVERSITY OF UTAH
EMPLOYEE HEALTH CARE PLAN
BLUECROSS BLUESHIELD COMPREHENSIVE OPTION

SUMMARY PLAN DESCRIPTION

GROUP NUMBER: 10002211

Regence BlueCross BlueShield
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Salt Lake City, UT 84121

www.Regence.com
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(800) 926-9619

Notice of Privacy Practices: Regence BlueCross BlueShield of Utah has a Notice of Privacy Practices that is available by calling Customer Service or visiting the website listed above. The University’s Notice of Privacy Practices is at the end of this SPD.

Effective July 1, 2016
Introduction

This University of Utah Employee Health Care Plan Summary Plan Description describes the terms and benefits of coverage effective **July 1, 2016**, or the date after that on which Your coverage became effective. This Summary Plan Description replaces any plan description or Summary Plan Description previously issued by the Plan Sponsor and makes it void.

As You read this Summary Plan Description, please keep in mind that references to “You” and “Your” refer to both the Plan Participant and Enrolled Dependents. The term “Family” refers to the Plan Participant and all individuals enrolled as his/her Eligible Dependents. The term “Claims Administrator” refers to Regence BlueCross BlueShield of Utah (“Regence BCBSU”). The term “Agreement” refers to the administrative services contract between the Plan and the Claims Administrator. The term “Plan” refers to the University of Utah Employee Health Care Plan. “Plan Sponsor” and “University” mean The University of Utah, whose employees may participate under this Plan. Other terms are defined in the Definitions Section at the back of this Summary Plan Description or where they are first used.

Regence BCBSU provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except in the case of claims that exceed certain amounts which may be reinsured.

The University reserves the right to amend or terminate this Plan in whole or in part, at any time, regardless of Your or Your Enrolled Dependents’ health or treatment status. You will be given a 60-day notice of any amendment or termination that reduces coverage during the Plan Year. Amendment or termination may result in modification or termination of Your coverage and/or the coverage of Your Enrolled Dependents. Covered Services and Allowed Amounts incurred prior to the Plan’s amendment or termination will be paid as provided under the terms of the Plan as it existed at the time they were incurred.

The University also reserves the right to interpret the Plan’s coverage and meaning in the exercise of its sole discretion.

For assistance in a language other than English, please call the Customer Service telephone number.
Using Your Summary Plan Description

YOUR PARTNER IN HEALTH CARE

The University of Utah Employee Health Care Plan has three separate medical plan options, Advantage, Comprehensive, and Consumer Directed Health Plan, each described in a separate Summary Plan Description. If You do not have Your applicable Summary Plan Description or are unsure of Your medical plan option, contact the Claims Administrator or the University Benefits Department.

It is important for You to understand how the Plan works before You need health care services. Please read this material carefully. If You have any questions about benefits or procedures, please contact the Claims Administrator's Customer Service Department or check the Regence website.

YOU SELECT YOUR PROVIDER AND CONTROL YOUR OUT-OF-POCKET EXPENSES

Your Plan allows You to control Your out-of-pocket expenses, such as Coinsurance, for each Covered Service. You control Your out-of-pocket expenses by choosing Your Provider under two choices called: "In-Network" and "Out-of-Network."

- **In-Network.** You choose to see an In-Network Provider and save the most in Your out-of-pocket expenses. Choosing this provider option means You will not be billed for balances for Covered Services beyond any Deductible and Coinsurance.

- **Out-of-Network.** You choose to see an Out-of-Network Provider that does not have a participating contract with the Claims Administrator and Your out-of-pocket expenses will generally be higher than seeing an In-Network Provider. Also, choosing this provider option means You may be billed for balances beyond any Deductible and Coinsurance. This is sometimes referred to as balance billing.

For each benefit in this Summary Plan Description, You may choose an In-Network or Out-of-Network Provider and Your payment amount for each provider option is indicated. See the Definitions Section of this Summary Plan Description for a complete description of In-Network and Out-of-Network. You can go to www.Regence.com for further Provider network information.

GUIDANCE AND SERVICE ALONG THE WAY

This Summary Plan Description was designed to provide information and answers quickly and easily.

- **Learn more and receive answers about Your coverage.** Call Customer Service: 1 (800) 262-9712 to talk with one of the Claims Administrator's Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. - 6 p.m. You may also visit the Claims Administrator's website at: www.Regence.com.

- **Case Management.** You can request that a case manager be assigned or You may be assigned a case manager to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. Call Case Management at 1 (866) 543-5765.

- **BlueCard® Program.** The BlueCard® Program enables You to access Hospitals and Providers when traveling outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world.
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UUIHSPPOSPD
UNIVERSITY OF UTAH, 10002211, EFFECTIVE JULY 1, 2016
Understanding Your Benefits

Under this section, You will discover information to help You understand what is meant by Your Maximum Benefits, Deductibles, if any, Coinsurance and Out-of-Pocket Maximum. Other terms are defined in the Definitions Section at the back of this Summary Plan Description or where they are first used, and are designated by the first letter being capitalized.

MAXIMUM BENEFITS

Benefits under the Plan may be limited to Maximum Benefits for specified Covered Services. For specified Covered Services, payments are made as indicated until the Maximum Benefit applicable to a specified Covered Service has been provided. Any benefits paid on Your behalf, or on behalf of Your Covered Dependents, under any University of Utah Health Plan shall be applied toward the Maximum Benefit amount of the Plan.

OUT-OF-POCKET MAXIMUM

Claimants can meet the specified Out-of-Pocket Maximums by payments of Deductible and/or Coinsurance for all Covered Services as specifically indicated in the Medical or Prescription Medications Summary of Benefits. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximums. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximums, even after You reach the specified Out-of-Pocket Maximum amounts of the Plan.

Once You reach an Out-of-Pocket Maximum, benefits will be paid at 100% of the Allowed Amount for the remainder of the Contract Year. The Coinsurance for some benefits of the Plan does not apply to the Out-of-Pocket Maximums and remains at the same payment level through the Plan Year. Those exceptions are specifically noted in the applicable Summaries of Benefits.

The Family Out-of-Pocket Maximum(s) for a Contract Year is satisfied when the total of the Family members' Coinsurance for that Contract Year meet the Family's Out-of-Pocket Maximum(s) amounts as specified in each Summary of Benefits. One Claimant will not be required to pay more than the individual Out-of-Pocket Maximum amounts for Medical and Prescription Medications Covered Services.

Benefits provided under the Prescription Medication Benefits Section and Summary of Behavioral Health Benefits do not apply toward the Out-of-Pocket Maximum of the Summary of Medical Benefits.

PERCENTAGE PAID UNDER THE PLAN (COINSURANCE)

The Plan pays a percentage of the Allowed Amount for Covered Services You receive under the Plan, up to the maximum shown in each Summary of Benefits. See the Definitions Section for a detailed description of what is meant by Allowed Amount. When the payment is less than 100 percent, the remaining percentage is Your Coinsurance. The percentage paid by the Plan varies, depending on the kind of service or supply You received and who rendered it.

The Plan does not pay Providers for charges above the Allowed Amount. However, a Provider will not charge You for any balances for Covered Services beyond Your Deductible or Coinsurance amount if You choose an In-Network Provider. Out-of-Network Providers, however, may bill You for balances over the Plan payment level in addition to any Deductible or Coinsurance amount. See the Definitions Section for descriptions of Providers.

Refer to the Summaries of Medical Benefits, Prescription Medication Benefits, and Behavioral Health Benefits for a description of percentages paid, cost-sharing, and Out-of-Pocket Maximum amounts.

DEDUCTIBLES

The Plan will begin to pay benefits for Covered Services in any Contract Year only after a Claimant satisfies any applicable Contract Year Deductible. A Claimant satisfies the Deductible by incurring expenses for Covered Services during the Contract Year for which the Allowed Amounts total the Deductible.
The Family Contract Year Deductible is satisfied when the total of the Family members' Allowed Amounts for that Contract Year meet the Family Deductible amount. One Claimant will not be required to pay more than the individual Deductible amount.

The Plan does not pay for services applied toward the Deductible. Refer to the Summaries of Benefits to see if a particular service is subject to a Deductible. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not count toward the Deductible.

**HOW CONTRACT YEAR BENEFITS RENEW**

Many provisions of the Plan (for example, Deductibles, Out-of-Pocket Maximum, and certain benefit maximums) are calculated on a Contract Year basis. Each July 1, those Contract Year maximums begin again.

Some benefits of the Plan have a separate Maximum Benefit based upon a Claimant’s Lifetime and do not renew every Contract Year. Those exceptions are specifically noted in the benefits sections of this Summary Plan Description.
Summary of Medical Benefits – Comprehensive Plan

In this section, You will learn about Your health plan's benefits and how Your coverage pays for Covered Services. While there are no referrals required before You can use any of the benefits of this coverage, including women's health care services, Your Provider may be required to seek preauthorization for certain services. For Your ease in finding the information regarding benefits most important to You, these benefits have been listed alphabetically.

All covered benefits are subject to the limitations, exclusions and provisions of this Plan. To be covered, medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Also, a Provider practicing within the scope of his or her license must render the service. Please see the Definitions Section in the back of this Summary Plan Description for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

A Health Intervention may be medically indicated yet not be a Covered Service under the Plan.

If benefits under the Plan change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

<table>
<thead>
<tr>
<th>CONTRACT YEAR OUT-OF-POCKET MAXIMUM</th>
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</thead>
<tbody>
<tr>
<td>Per Claimant: $2,000</td>
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<tr>
<td>Per Family: $5,000</td>
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<table>
<thead>
<tr>
<th>COINSURANCE</th>
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<tbody>
<tr>
<td>Coinsurance is listed in the tables for Covered Services for each applicable benefit.</td>
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<table>
<thead>
<tr>
<th>CONTRACT YEAR DEDUCTIBLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Claimant: $350</td>
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<tr>
<td>Per Family: $700</td>
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</table>

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<tr>
<th>ALLERGY TREATMENT</th>
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<tbody>
<tr>
<td>Provider: University of Utah Hospitals and Clinics</td>
</tr>
<tr>
<td>The Plan pays 95% and You pay 5% of the Allowed Amount. Your 5% payment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
<tr>
<td>Provider: In-Network</td>
</tr>
<tr>
<td>After Deductible, the Plan pays 75% and You pay 25% of the Allowed Amount. Your 25% payment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
<tr>
<td>Provider: Out-of-Network</td>
</tr>
<tr>
<td>After Deductible, the Plan pays 65% of the Allowed Amount and You pay 35% of billed charges. Your 35% payment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
</tbody>
</table>

The plan covers allergy treatment including allergy testing, allergy serum and necessary injections.

<table>
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<tr>
<th>AMBULANCE SERVICES</th>
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<tbody>
<tr>
<td>Provider: University of Utah Hospitals and Clinics</td>
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<tr>
<td>After Deductible, the Plan pays 75% and You pay 25% of the Allowed Amount. Your 25% payment will be applied toward the Out-of-Pocket Maximum.</td>
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<tr>
<td>Provider: Out-of-Network</td>
</tr>
<tr>
<td>After Deductible, the Plan pays 75% and You pay 25% of billed charges. Your 25% payment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
</tbody>
</table>

The Plan covers ambulance services to the nearest Hospital equipped to provide treatment, when any other form of transportation would endanger Your health and the purpose of the transportation is not for personal or convenience purposes. Covered ambulance services include licensed ground and air ambulance Providers.
# Applied Behavior Analysis (ABA) Therapy Services

<table>
<thead>
<tr>
<th></th>
<th>Provider: University of Utah Hospitals and Clinics</th>
<th>Provider: In-Network</th>
<th>Provider: Out-of-Network</th>
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</thead>
<tbody>
<tr>
<td><strong>Outpatient Services</strong></td>
<td>After $5 Copayment per day, the Plan pays 100% of the Allowed Amount. Your $5 Copayment will be applied toward the Out-of-Pocket Maximum.</td>
<td>After $10 Copayment per day, the Plan pays 100% of the Allowed Amount. Your $10 Copayment will be applied toward the Out-of-Pocket Maximum.</td>
<td>The Plan pays 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
<tr>
<td><strong>Inpatient Services</strong></td>
<td>The Plan pays 95% and You pay 5% of the Allowed Amount. Your 5% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>After Deductible, the Plan pays 75% and You pay 25% of the Allowed Amount. Your 25% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>After Deductible, the Plan pays 65% of the Allowed Amount and You pay balance of billed charges. Your 35% payment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
</tbody>
</table>

**Limited to Claimants through age 25**

- **Early Intervention Therapy limit for Claimants through age 7:** 20 hours per week for Claimants diagnosed with autism.
- **Behavioral Intervention Therapy limit for Claimants 8-25 years of age:** 12 hours per week for Claimants diagnosed with autism.

The Plan covers services and supplies for Claimants diagnosed with autism once preauthorization has been obtained through UNI BHN. Please contact UNI BHN at (801) 587-9319 to obtain preauthorization prior to services being received.

## Approved Clinical Trials

The Plan covers Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating subject to the Deductible, Coinsurance and/or Copayments and Maximum Benefits as specified in the Medical Benefits and Prescription Medications Benefits in this Summary Plan Description. Additional specified limits are as further defined. If a Provider is participating in the Approved Clinical Trial and will accept You as a trial participant, these benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If the Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care.

### Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Approved Clinical Trials benefit:

- **Approved Clinical Trial** means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to prevention, detection, or treatment of cancer or other Life-threatening Condition and that is a study or investigation:
  - Approved or funded by one or more of:
    - The National Institutes of Health (NIH), the CDC, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid, or a cooperative group or center of any of those entities or of the Department of Defense (DOD) or the Department of Veteran’s Affairs (VA);
    - A qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or
    - The VA, DOD, or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review; or
• Conducted under an investigational new drug application reviewed by the Food and Drug Administration or that is a drug trial exempt from having an investigational new drug application.

Life-threatening Condition means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Routine Patient Costs means items and services that typically are Covered Services for a Claimant not enrolled in a clinical trial, but do not include:

• An Investigational item, device, or service that is the subject of the Approved Clinical Trial;
• Items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Claimant;
• A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis; or
• Services, supplies or accommodations for direct complications or consequences of the Approved Clinical Trial.

BARIATRIC SERVICES

<table>
<thead>
<tr>
<th>Provider: University of Utah Hospitals and Clinics</th>
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<th>Provider: Out-of-Network</th>
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<tr>
<td>The Plan pays 95% and You pay 5% of the Allowed Amount. Your 5% payment will be applied toward the Out-of-Pocket Maximum.</td>
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<td>After Deductible, the Plan pays 65% of the Allowed Amount and You pay balance of billed charges. Your 35% payment will be applied toward the Out-of-Pocket Maximum.</td>
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</table>

The Plan covers office visits, nutritional counseling, diagnostic testing and laboratory services related to the diagnosis of obesity and Morbid Obesity. The Plan also covers services and supplies related to certain surgical services to treat Morbid Obesity that are preauthorized and are determined to be Medically Necessary based on the Plan's medical policy, including, but not limited to, gastric bypass, gastric stapling and sleeve gastrectomy.

The Plan covers Medically Necessary post-surgical care determined by the Claims Administrator to be appropriate and essential to the long-term success of the bariatric surgery, including support, facilitation and communication between You and Your health care team during Your recovery.

For the purpose of this benefit, Morbid Obesity means a severe state of obesity, as defined in the Claims Administrator's published medical policies.

BLOOD BANK

<table>
<thead>
<tr>
<th>Provider: University of Utah Hospitals and Clinics</th>
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</table>
The Plan covers the services and supplies of a blood bank, excluding storage costs.

**CLOTTING FACTOR PRODUCTS – OUTPATIENT**

<table>
<thead>
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The Plan covers plasma-derived and recombinant clotting factor products used in outpatient replacement therapy for hemophilia, Von Willebrand disease, and similar clotting disorders provided by In-Network Providers. This benefit also does not cover these products when provided by a retail Pharmacy.

**DENTAL SERVICES**

<table>
<thead>
<tr>
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</tr>
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The Plan covers inpatient and outpatient dental services and supplies (including anesthesia), required as a result of damage to or loss of sound natural teeth due to an Accidental Injury (other than from chewing).

The Plan covers inpatient and outpatient services for temporomandibular joint (TMJ) disorders which have one or more of the following characteristics:

- an abnormal range of motion or limitation of motion of the TMJ;
- arthritic problems with the TMJ;
- internal derangement of the TMJ; and/or
- pain in the musculature associated with the TMJ.

"Covered services" for the purposes of this TMJ benefit, mean those services that are:

- reasonable and appropriate for the treatment of a disorder of the TMJ, under all the factual circumstances of the case;
- effective for the control or elimination of one or more of the following, caused by a disorder of the TMJ: pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food;
- recognized as effective, according to the professional standards of good medical practice; and
- not investigational or primarily for Cosmetic purposes.

**DIABETES SUPPLIES AND EQUIPMENT**

The Plan covers supplies and equipment for the treatment of diabetes. Please refer to the Other Professional Services, Diabetic Education, Durable Medical Equipment, Orthotic devices or Prescription Medications benefits of this Summary Plan Description for coverage details of such covered supplies and equipment.
DIABETIC EDUCATION

<table>
<thead>
<tr>
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<td>The Plan pays 95% and You pay 5% of the Allowed Amount. Your 5% payment will be applied toward the Out-of-Pocket Maximum.</td>
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<td>After Deductible, the Plan pays 65% of the Allowed Amount and You pay balance of billed charges. Your 35% payment will be applied toward the Out-of-Pocket Maximum.</td>
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The Plan covers services and supplies for diabetic self-management training and education, including nutritional therapy when requested by the attending physician, if provided by an accredited or certified program.

DURABLE MEDICAL EQUIPMENT

<table>
<thead>
<tr>
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<tr>
<td>The Plan pays 95% and You pay 5% of the Allowed Amount. Your 5% payment will be applied toward the Out-of-Pocket Maximum.</td>
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Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Claimant's home. Examples include diabetic equipment, oxygen equipment and wheelchairs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

<table>
<thead>
<tr>
<th>Provider: University of Utah Hospitals and Clinics</th>
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</tr>
</tbody>
</table>

The Plan covers emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. For the purpose of this benefit, "stabilization" means to provide Medically Necessary treatment: 1) to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during, or to result from, the transfer of the member from a facility; and 2) in the case of a covered female member, whom is pregnant, to perform the delivery (including the placenta). Emergency room services do not need to be pre-authorized. See the Hospital Care benefit in this Summary of Medical Benefits for coverage of inpatient Hospital admissions. For treatment of a qualifying Emergency Medical Condition received by Out-of-Network Providers, the Allowed Amount will be the same as the billed charges. Your responsibility will be calculated from the billed charges. The Plan will cover a Claimant's visit to an Out-of-Network Provider's Hospital emergency department as if the services were received at an In-Network Hospital emergency department for Emergency Medical Conditions. If, due to an Emergency Medical Condition, a Claimant is admitted to an Out-of-Network Provider's Hospital through the emergency department and cannot be transported safely to an In-Network Hospital, the Plan will cover the services as if the services were...
received at an In-Network Hospital, until such time as the Claimant can be safely transported to an In-Network Hospital. Please contact Customer Service for further information and guidance.

### FAMILY PLANNING

<table>
<thead>
<tr>
<th>Provider: University of Utah Hospitals and Clinics</th>
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</tbody>
</table>

The Plan covers certain professional Provider contraceptive services and supplies, including, but not limited to, vasectomy, tubal ligation and insertion of IUD or Norplant. Certain women's contraceptive services and supplies are covered by the Plan at 100% as required by federal law. See the Prescription Medication Benefits Section for coverage of prescription contraceptives. Other items may not be covered. Please see General Exclusions for more information.

### GENETIC TESTING

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<thead>
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</table>

The Plan covers genetic testing when determined to be Medically Necessary based on the Plan’s medical policy.

### HEARING EXAMINATIONS

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</table>

Limit: one routine hearing examination per Claimant per Contract Year

### HOME HEALTH CARE

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</table>
The Plan covers home health care when provided by a licensed agency or facility for home health care. Home health care includes all services for homebound patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility.

**HOSPICE CARE**

<table>
<thead>
<tr>
<th>Provider: University of Utah Hospitals and Clinics</th>
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</table>

Limit: 14 inpatient or outpatient respite care days per Claimant Lifetime

The Plan covers hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and his or her family during the final stages of Illness. In order to qualify for hospice care, the patient's Physician must certify that the patient is terminally ill and is eligible for hospice services. Respite care: The Plan covers respite care to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant. Respite days that are applied toward Deductible are considered provided and are applied against any Maximum Benefit limit on these services. Respite days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered under the Durable Medical Equipment benefit in this Summary Plan Description.

**HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER**

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<thead>
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</table>

The Plan covers the inpatient and outpatient services and supplies of a Hospital or the outpatient services and supplies of an Ambulatory Surgical Center for Injury and Illness (including services of staff providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. However, You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance. See the Emergency Room benefit in this Summary of Medical Benefits for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

If benefits under the Plan change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.
# MATERNITY CARE

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<thead>
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The Plan covers pre-natal and post-natal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy, and related conditions for all female Claimants.

# MEDICAL FOODS (PKU)

<table>
<thead>
<tr>
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The Plan covers medical foods for inborn errors of metabolism including, but not limited to, formulas for Phenylketonuria (PKU).

# NEURODEVELOPMENTAL THERAPY

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Limit effective August 1, 2016 and after: $5,000 per Claimant per Contract Year for occupational therapy; $5,000 per Claimant per Contract Year for speech therapy; $5,000 per Claimant per Contract Year for physical therapy; all neurodevelopmental therapy services are limited to Claimants age 18 and under.

The Plan covers inpatient and outpatient neurodevelopmental therapy services. To be covered, such services must be to restore and/or improve function for a Claimant age 18 and under with a neurodevelopmental delay. For the purposes of this provision, neurodevelopmental delay means a delay in normal development that is not related to any documented Illness or Injury. Covered Services include only physical therapy, occupational therapy and speech therapy and maintenance services, if significant deterioration of the Claimant’s condition would result without the service. You will not be eligible for both the Rehabilitative Services benefit and this benefit for the same services for the same condition. Speech therapy services as a result of congenital anomaly for Claimants age 18 and under are included in the annual neurodevelopmental therapy maximum. Outpatient neurodevelopmental therapy visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.
NEWBORN CARE

<table>
<thead>
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<th>Provider: University of Utah Hospitals and Clinics</th>
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The Plan covers services and supplies, under the newborn's own coverage, in connection with nursery care for the natural newborn or newly adoptive child. The newborn child must be eligible and enrolled as explained later in the Who Is Eligible, How to Enroll and When Coverage Begins Section. The attending physician will determine an appropriate discharge time in consultation with the mother. For the purpose of this provision, "newborn care" means the medical services provided to a newborn child following birth including Hospital nursery charges, the initial physical examination and a PKU test.

OFFICE VISITS

<table>
<thead>
<tr>
<th>Provider: University of Utah Hospitals and Clinics</th>
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The Plan covers Office Visits. An Office Visit means the evaluation and management of a patient for treatment of an Illness or Injury. See Preventive Care for benefits for Office Visits for preventive care services. The Plan covers services for diagnostic radiology, ultrasound, nuclear medicine, laboratory, pathology, electronic diagnostic medical procedures, as well as, medical services, surgical services, including local anesthesia and supplies, and therapeutic injections provided by a professional Provider when received in the Provider's office and when billed as such. All other professional services performed in the office are subject to the applicable benefit specified elsewhere in this Summary of Medical Benefits for such service.

ORTHOTIC DEVICES

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The Plan covers benefits for the purchase of braces, splints, orthopedic appliances and orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body. Benefits under the Plan may be reduced for a less costly alternative item. The Plan does not cover foot orthotics (other than Medically Necessary foot orthotics immediately following foot surgery), off-the-shelf shoe inserts or orthopedic shoes.
## OTHER PROFESSIONAL SERVICES

<table>
<thead>
<tr>
<th>Provider: University of Utah Hospitals and Clinics</th>
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The Plan covers services and supplies provided by a professional Provider. Deductible and Coinsurance and any specified limits as explained in the following paragraphs:

### Medical Services

The Plan covers professional services and supplies that are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury, including the services of a Provider whose opinion or advice is requested by the attending Provider. Services and supplies also include those to treat a congenital anomaly for Claimants up to age 18.

### Professional Inpatient

The Plan covers professional inpatient services for Illness or Injury. If pre-arranged procedures are performed by an In-Network Provider and You are admitted to an In-Network Hospital, the Plan will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by Out-of-Network Providers at the In-Network benefit level. However, You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact the Claims Administrator's Customer Service for further information and guidance.

### Diagnostic Procedures

The Plan covers services for diagnostic procedures including cardiovascular testing, pulmonary function studies, sleep studies and neurology/neuromuscular procedures. The Plan also covers routine diagnostic procedures such as colonoscopies. Note: when the procedures are billed as preventive care, benefits under the Plan will be paid according to the Preventive Care benefit. CT Scans will be covered in accordance with the guidelines being used by CMS at the time of the procedure.

### Surgical Services

The Plan covers surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist.

## PALLIATIVE CARE

<table>
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**Limit:** 30 visits per Claimant per Contract Year

The Plan covers palliative care when a Provider has assessed that a Claimant is in need of palliative services. For the purpose of this benefit, "palliative care" means specialized services received from a Provider in a home setting for counseling and home health aide services for activities of daily living. Palliative care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.
PREVENTIVE CARE
The following Preventive Care benefits are covered by the Plan in accordance with the Patient Protection and Affordable Care Act ("PPACA"), as amended by the Health Care and Education Reconciliation Act. As required by PPACA, Preventive Care benefits of the Plan are covered in accordance with recommendations by the United States Preventive Service Task Force ("USPSTF") with an A or B rating in the current recommendations, the Health Resources and Services Administration ("HRSA"), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC"). In the event of any conflict between PPACA and this Preventive Care benefit section, the minimum requirements of PPACA will govern. In the event any of these bodies adopts a new or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit. For a list of services covered under this benefit, please visit www.Regence.com or contact Customer Service at 1 (800) 262-9712. NOTE: Certain covered preventive services that do not meet this criteria may be covered under this Preventive Care benefit when received and billed as preventive care. Covered Services that do not meet this criteria will be covered the same as any other Illness or Injury.

<table>
<thead>
<tr>
<th>Provider: Network (including University of Utah Hospitals and Clinics)</th>
<th>Provider: Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit / Professional Exam / Routine Screening Procedures</td>
<td>The Plan pays 100% of the Allowed Amount, not subject to the Deductible.</td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td>The Plan pays 100% of the Allowed Amount.</td>
</tr>
</tbody>
</table>

The Plan covers the preventive care services provided by a professional Provider or facility. Preventive care services include routine well-baby care, routine physical examinations, routine women's care, routine immunizations, routine health screenings and routine vision examinations for children ages 3 and 4. The Plan covers immunizations for adults and immunizations for children (up to 18 years of age), according to, and as recommended by, the USPSTF and the CDC as well as immunizations necessary for travel. Also included is Provider counseling for tobacco use cessation and Generic Medications prescribed for tobacco use cessation. Coverage for all such services is provided only for preventive care as designated above (which designation may be modified from time to time).

PROSTHETIC DEVICES

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The Plan covers prosthetic devices for functional reasons to replace a missing body part, including artificial limbs, maxillofacial prostheses, and external or internal breast prostheses following a mastectomy, complication of a covered surgery or other injury and maxillofacial prostheses. The Plan covers penile prostheses to treat sexual impotence resulting from a covered medical condition. The Plan does not cover penile implant/testicular prosthesis procedures and related supplies for psychological impotence. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility benefit (Hospital - Inpatient Care or Hospital - Outpatient and Ambulatory Surgical Center care) in this Summary of Medical Benefits. Repair or replacement of a prosthetic device due to normal use or growth of a child will be covered under the Plan.

**RADIOLOGY AND LABORATORY SERVICES - OUTPATIENT**

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The Plan covers diagnostic services for treatment of illness, injury or preventive care. Note that when treatment is for preventive care, benefits under the Plan will be paid according to the Preventive Care benefit.

**REHABILITATION SERVICES**

<table>
<thead>
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<th>Provider: University of Utah Hospitals and Clinics</th>
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**Inpatient Limit:** 30 days per Claimant per Contract Year

The Plan covers inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services only) and accommodations as appropriate and necessary to restore or improve lost function caused by injury or illness. Rehabilitation days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the neurodevelopmental therapy benefit and this benefit for the same services for the same condition.
### SKILLED NURSING FACILITY (SNF) CARE

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The Plan covers the inpatient services and supplies of a Skilled Nursing Facility for Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary.

### SPINAL MANIPULATIONS

<table>
<thead>
<tr>
<th>Provider: University of Utah Hospitals and Clinics</th>
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Limit: 20 office visits for spinal manipulation per Claimant per Contract Year performed by any licensed Provider

The Plan covers spinal manipulations performed by any Provider. Spinal manipulations that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Manipulations of extremities are covered under the Neurodevelopmental Therapy and Rehabilitation Services benefits in this Medical Benefits Section.

### TELEMEDICINE

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<thead>
<tr>
<th>Provider: University of Utah Hospitals and Clinics</th>
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</table>

The Plan covers telemedicine (audio and video communication) services between a distant-site Physician, the patient and a consulting Practitioner when the originating (distant) site is a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services.
**TRANSGERDER SERVICES**

<table>
<thead>
<tr>
<th>Provider: University of Utah Hospitals and Clinics</th>
<th>Provider: In-Network</th>
<th>Provider: Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plan pays 95% and You pay 5% of the Allowed Amount. Your 5% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>After Deductible, the Plan pays 75% and You pay 25% of the Allowed Amount. Your 25% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>After Deductible, the Plan pays 65% of the Allowed Amount and You pay balance of billed charges. Your 35% payment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
</tbody>
</table>

The Plan covers transgender services effective August 1, 2016 and after.

**TRANSPLANTS**

<table>
<thead>
<tr>
<th>Provider: University of Utah Hospitals and Clinics</th>
<th>Provider: In-Network</th>
<th>Provider: Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plan pays 95% and You pay 5% of the Allowed Amount. Your 5% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>After Deductible, the Plan pays 75% and You pay 25% of the Allowed Amount. Your 25% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>Not Covered.</td>
</tr>
</tbody>
</table>

The Plan covers services and supplies for covered transplants. A transplant recipient who is covered under this Plan and fulfills Medically Necessary criteria will be eligible for the following transplants: heart, lung, kidney, pancreas, liver, cornea, multivisceral, small bowel, islet cell and hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors, for example, either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions). This list of transplants is subject to change. Claimants can contact the Claims Administrator for a current list of covered transplants.

**NOTE:** The Plan does not cover services, supplies or accommodations in connection with heart; heart/lung; lung (single or double); liver, and pancreas transplants not received at the University of Utah Hospitals. However, benefits may be available in the following instances:

- Based on review by appropriate medical professionals at the University of Utah Hospitals, it is determined the covered procedure cannot be performed at the University of Utah Hospitals. Medically Necessary Covered Services will be a benefit when performed at another, more appropriate facility; or

- The Claimant receiving transplant benefits has another insurance that is considered their Primary Plan and this Plan is the Secondary Plan.

**Donor Organ Benefits**

The Plan covers donor organ procurement costs if the recipient is covered for the transplant under this Plan. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ and other such procurement costs that are determined to be paid under the Plan.
**VISION EXAMINATION**

<table>
<thead>
<tr>
<th>Provider: University of Utah Hospitals and Clinics</th>
<th>Provider: In-Network</th>
<th>Provider: Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plan pays 95% and You pay 5% of the Allowed Amount. Your 5% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>After Deductible, the Plan pays 75% and You pay 25% of the Allowed Amount. Your 25% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>After Deductible, the Plan pays 65% of the Allowed Amount and You pay balance of billed charges. Your 35% payment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
</tbody>
</table>

**Limit:** one routine eye examination per Claimant per Contract Year

The Plan does not cover charges for contact fitting.
Other Benefits

CASE MANAGEMENT
Because of Regence’s involvement as the Claims Administrator, You have access to Case Management, which will provide one-on-one help and support in the event You have a serious or sudden Illness or Injury. An experienced, compassionate case manager will serve as Your personal advocate during a time when You need it most. Your case manager is a licensed health care professional who will help You understand Your treatment options, show You how to get the most out of Your available Plan benefits and work with Your Physician to support Your treatment plan. To the extent any part of this program (for example, medications for smoking cessation) is also a benefit under the Medical Benefits or other benefit of the Plan, the Medical Benefits or other benefit applies first and until that benefit is exhausted.

To learn more or to make a referral to case management, please call 1 (866) 543-5765.

ADOPTION BENEFIT
After Deductible, the Plan will pay 75% of expenses You incur for an eligible adoption up to a maximum of $4,000.

An adoption benefit is available when a Participant meets all of the following conditions:

- The newborn child is enrolled under this health plan.
- The Participant’s coverage under this Plan is in effect on the date a newborn child is placed for the purpose of adoption.
- The newborn child is placed for the purpose of adoption with the Participant within 90 days after the child’s birth.
- The Participant submits a written request for the adoption benefit along with evidence of expenses paid and proof of placement for adoption. Proof of placement will be a copy of the court order or its equivalent (for example, a letter from the adoption agency) showing the date of placement for adoption. The written request must contain the child’s name, date of birth and a statement regarding any other health coverage of the adoptive parent(s). The written request will be addressed to:
  
  Regence BlueCross BlueShield of Utah  
  P.O. Box 30272  
  Salt Lake City, UT 84130-0272

In the event a Participant adopts more than one newborn from a single pregnancy (for example, twins), only a single $4,000 adoption benefit is available (subject to reduction for other coverage below).

In the event the Participant and/or the Participant’s spouse are covered by more than one compliant health benefit plan, the adoption benefit will be prorated between or among the plans. The full amount provided by both or all of the plans will not exceed $4,000 per pregnancy.

In the event the post-placement evaluation disapproves the adoption placement and a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child’s health or safety, the Participant will be liable for repayment of the adoption benefit. The Participant will refund the full amount of such benefit to the Plan within 30 days after the date the child is removed from placement.
Prescription Medication Benefits

In this section, You will learn how Your Prescription Medication coverage works, including information about Deductibles (if any), Copayments, Coinsurance, Covered Services and payment, as well as definitions of terms specific to this Prescription Medication Benefits Section.

All terms and conditions of the Plan apply to this Prescription Medication Benefits Section, except as otherwise noted. Benefits covered under this Prescription Medication Benefits Section and the Medical Benefits Section may be paid under either benefit, but not both.

PRESCRIPTION MEDICATION CONTRACT YEAR DEDUCTIBLES

Not applicable

COPAYMENTS AND COINSURANCE

You are responsible for paying the following Coinsurance amounts, subject to a $3.00 minimum (at the time of purchase, if the Pharmacy submits the claim electronically). (See below for information on claims that are not submitted electronically and for information on maximum quantities.)

For Prescription Medications from a Pharmacy

<table>
<thead>
<tr>
<th></th>
<th>University of Utah Health Care Pharmacies</th>
<th>Other Participating Pharmacies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic and Brand Name Medications on the Formulary</td>
<td>20% (not to exceed $150) per 30 day fill</td>
<td>25% (not to exceed $150) per 30 day fill</td>
</tr>
<tr>
<td>Brand-Name Medications not on the Formulary</td>
<td>20% (not to exceed $150) per 30 day fill</td>
<td>35% (not to exceed $150) per 30 day fill</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>20% (not to exceed $150) per 30 day fill</td>
<td>20% (not to exceed $150) per 30 day fill</td>
</tr>
</tbody>
</table>

Brand-Name Prescription Medication Instead of Generic

If an equivalent Generic Medication is available and You choose to fill a Prescription Order with a Brand-Name Medication, You will be responsible for paying the difference in cost. The difference is calculated at the time of purchase based upon the difference in price between the equivalent Generic Medication and the applicable Brand-Name Medication, in addition to the Coinsurance (as applicable). When the prescribing Provider specifies that the Brand-Name Medication must be dispensed, You will not be responsible for payment of the difference in cost.

PRESCRIPTION MEDICATION CONTRACT YEAR MAXIMUM COINSURANCE

Per Claimant: $2,000  
Per Family: $4,000

Your Coinsurance for Prescription Medications obtained from University of Utah Health Care Pharmacies and other Participating Pharmacies will be waived during the remainder of a Contract Year once Your Maximum Coinsurance amount is met.

In order for the Coinsurance to be waived, You must present Your Plan identification card to a University of Utah Health Care Pharmacy or Participating Pharmacy at the time of purchase and the University of Utah Health Care Pharmacy or Participating Pharmacy must submit the claim electronically.

Coinsurance You pay to a University of Utah Health Care Pharmacy, Participating and Nonparticipating Pharmacies count toward the Maximum Coinsurance. Any additional charges, such as the difference between the price of a Brand-Name Medication and its equivalent Generic Medication, or costs in excess of the Covered Prescription Medication Expense charged by a Nonparticipating Pharmacy, do not count...
toward the Maximum Coinsurance and You will continue to be responsible for these amounts, even after You reach the Maximum Coinsurance.

**COVERED PRESCRIPTION MEDICATIONS**

Benefits under this Prescription Medication Benefits Section are available for the following:

- diabetic supplies (including test strips, glucagon emergency kits, insulin and insulin syringes). However, insulin pumps and their supplies are covered under the Durable Medical Equipment benefit;
- Prescription Medications, including drugs, biological and compound prescription used to treat an Illness or Injury and not specifically excluded herein;
- certain preventive medications (including, but not limited to, aspirin, fluoride, iron and Generic Medications for tobacco use cessation) according to, and as recommended by, the USPSTF, when obtained with a Prescription Order;
- women’s contraception methods as recommended by the HRSA;
- immunizations for adults and children according to, and as recommended by, the CDC as well as immunizations required for travel; and
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Compound and Injectable Medications).

You are not responsible for any applicable Deductible, Copayment and/or Coinsurance when You fill prescriptions at a University of Utah Health Care Pharmacy or a Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications, women’s contraceptives, or for immunizations, as specified above or emergency contraception when obtained with a Prescription Order. For a list of such medications, please visit www.Regence.com or contact Customer Service at 1 (800) 262-9712. NOTE: The applicable Deductible, Copayment and/or Coinsurance as listed in this Prescription Medication Benefits Section will apply when You fill preventive medications and immunizations that meet the above criteria, at a Nonparticipating Pharmacy.

**COORDINATION OF BENEFITS – Prescription Medication Benefits Only**

Coordination of Prescription Medication Benefits to 100% of the negotiated charge is only available to Claimants who have primary and secondary coverage in the University of Utah Employee Health Care Plan (Advantage or Comprehensive Health Plan options). Coordination of Prescription Medication Benefits is not available for Claimants who have primary coverage provided by another employer’s group insurance plan (including the University of Utah Hospitals and Clinics’ employee health plan) or if You participate in the Consumer Directed Health Plan option.

**GENERAL PRESCRIPTION MEDICATION BENEFITS INFORMATION (NETWORK, SUBMISSION OF CLAIMS AND MAIL-ORDER)**

In addition to University of Utah Health Care Pharmacies, a nationwide network of Participating Pharmacies are available to You. Pharmacies that participate in this network submit claims electronically.

Your Plan identification card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as a Claimant of Regence BlueCross BlueShield of Utah, a University of Utah Health Care Pharmacy or Participating Pharmacy may charge You more than the Covered Prescription Medication Expense. You can find Participating Pharmacies and a Pharmacy locator on the Claims Administrator’s Web site at www.Regence.com or by contacting Customer Service at 1 (800) 262-9712.

**Claims Submitted Electronically**

You must present Your Plan identification card at a Pharmacy for the claim to be submitted electronically. You must pay any required Coinsurance at the time of purchase. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, the Claims Administrator will pay the Nonparticipating Pharmacy directly. Nonparticipating Pharmacies, however, may charge amounts in excess of Covered Prescription Medication Expenses. If that happens, You will be responsible for the excess amounts, as well as any Coinsurance shown electronically to the Nonparticipating Pharmacy at the time of purchase.
Claims Not Submitted Electronically
When a claim is not submitted electronically, You must pay for the Prescription Medication in full at the time of purchase. For reimbursement, simply complete a Prescription Medication claim form and mail the form and receipt to the Claims Administrator. The Claims Administrator will reimburse You based on the Covered Prescription Medication Expense, less the applicable Coinsurance that would have been required had the medication been purchased from and submitted electronically by the University of Utah Health Care Pharmacy or a Participating Pharmacy. The Claims Administrator will send payment directly to You.

It is best to use a University of Utah Health Care Pharmacy or Participating Pharmacy so Your claims can be submitted electronically, and so You won't have to pay the difference between the Pharmacy's charges and the Covered Prescription Medication Expense in addition to Your Coinsurance.

Mail-Order
You can use mail-order services to purchase covered Prescription Medications.


LIMITATIONS
The following limitations apply to this Prescription Medication Benefits Section, except for certain preventive medications as specified in the Covered Prescription Medications section:

Maximum 90-Day Supply Limit
A 90-day supply is the largest allowable quantity of a Prescription Medication that You may purchase from a Pharmacy and for which a single claim may be submitted. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities. The largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Pharmacy is the smallest multiple-month supply packaged by the manufacturer for dispensing by Pharmacies. The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The maximum supply covered for these products is a 90-day supply (even if the packaging includes a larger supply). The Coinsurance is based on each 30-day supply within that multiple-month supply.

Maximum Quantity Limit
For certain Prescription Medications, the Claims Administrator establishes maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. The Claims Administrator uses information from the United States Food and Drug Administration (FDA) and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a University of Utah Health Care Pharmacy or a Participating Pharmacy or request a Prescription Medication refill and use Your Plan identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service at 1 (800) 262-9712. The Plan does not cover any amount over the established maximum quantity, except if it is determined the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

Refills
The Plan will cover refills from a Pharmacy when You have taken 75 percent of the previous prescription (however, based upon state law, certain controlled substances may be refilled only after You have taken 80 percent of the previous prescription). If You choose to refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward Your Maximum Coinsurance. If You feel You need a refill sooner than allowed, a refill exception will be considered at the Claims Administrator's discretion on a case-by-case basis. You may request an exception by calling Customer Service at 1 (800) 262-9712.

Prescription Medications Dispensed by Excluded Pharmacies
A Pharmacy may be excluded if it has been investigated by the Office of the Inspector General (OIG) and appears on the OIG's exclusion list. If You are receiving medications from a Pharmacy that is later
determined by the OIG to be an excluded Pharmacy, You will be notified, after Your claim has been processed, that the Pharmacy has been excluded, so that You may obtain future Prescription Medications from a non-excluded Pharmacy. The Claims Administrator does not permit excluded Pharmacies to submit claims after the excluded Pharmacies have been added to the OIG list.

EXCLUSIONS
In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Prescription Medication Benefits Section:

**Acne Medication**
Prescription Medications for the treatment of acne in Claimants over age 39.

**Anabolic Steroids**

**Biological Sera, Blood or Blood Plasma, Plasma-derived and Recombinant Clotting Factor Products**
Coverage for these may be provided under the Medical Benefits section of the Summary Plan Description.

**Cosmetic Purposes**
Prescription Medications used for cosmetic purposes, including, but not limited to: removal, inhibition or stimulation of hair growth; reduce the signs of aging; or repair of sun-damaged skin.

**Devices or Appliances**
Devices or appliances of any type, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Medical Benefits Section of the Summary Plan Description).

**Food Supplements, Special Formulas and Special Diets**
Coverage for these may be provided under the Medical Benefits section of the Summary Plan Description.

**Foreign Prescription Medications**
Foreign Prescription Medications, except those associated with an Emergency Medical Condition while You are traveling outside the United States, or those You purchase while residing outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.

**Growth Hormones**
Growth hormones, unless they are preauthorized under the Plan.

**Impotence Medications**
Impotence medications in excess of 6 doses in a 25-day period (except Cialis 2.5 mg which is approved for daily use).

**Insulin Pumps and Pump Administration Supplies**
Coverage for insulin pumps and supplies is provided under the Medical Benefits Section of the Summary Plan Description.

**Investigational/Experimental Medications**

**Medications The Plan Does not Consider Self-Administerable**
Coverage for these medications may otherwise be provided under the Medical Benefits Section of the Summary Plan Description.
Non-Medicinal Substances
Therapeutic devices or appliances, including hypodermic needles, syringes (excluding insulin syringes), support garments and other non-medicinal substances, regardless of intended use. (In some cases, items may be covered under the Medical Benefits section of the Summary Plan Description)

Nonprescription Medications
Medications that by law do not require a Prescription Order and which are not included in the Claims Administrators definition of Prescription Medications, shown below, unless included on the Claims Administrators Formulary.

Other Party Liability
Prescription Medications which an eligible person is entitled to receive without charge under any worker's compensation laws, or any municipal, state, or federal program.

Over-the-Counter Medications
Pigmenting/Depigmenting Agents
Except as required to treat photosensitive conditions, such as psoriasis.

Prescription Medications Dispensed in a Facility
Prescription Medications dispensed to You while You are a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed under this benefit if obtained from a Pharmacy.

Prescription Medications Dispensed in Connection with Participation in a Clinical Trial

Prescription Medications for Treatment of Infertility

Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order

Prescription Medications Not within a Provider's License
Prescription Medications prescribed by Providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.

Prescription Medications with No FDA Proven Therapeutic Indication

Professional Charges for Administration of Any Medication
May be covered under the Medical Benefits section of the Summary Plan Description.

Refills
Any Prescription Medication refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original Prescription Order.

DEFINITIONS
In addition to the definitions in the Definitions Section, the following definitions apply to this Prescription Medication Benefits Section:

Brand-Name Medication means a Prescription Medication that is marketed and sold by limited sources or is listed in widely accepted references (or as specified by the Plan) as a Brand-Name Medication based on manufacturer and price.

Compound Medication means two or more medications that are mixed together by the Pharmacist. To be covered, Compound Medications must contain a Prescription Medication that has been approved by the FDA.

Covered Prescription Medication Expense means the total payment a Participating Pharmacy or Mail-Order Supplier has contractually agreed to accept as full payment for a Prescription Medication. A Participating Pharmacy or Mail-Order Supplier may not charge You more than the Covered Prescription Medication Expense for a Prescription Medication.
Formulary means the Claims Administrator’s list of selected Prescription Medications. The Claims Administrator established and routinely reviews and updates the Formulary. It is available on the Claims Administrator’s Web site at www.Regence.com or by calling Customer Service at 1 (800) 262-9712. Medications are reviewed and selected for inclusion in the Formulary by an outside committee of Providers, including Physicians and Pharmacists.

Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references (or specified by the Plan) as a Generic Medication. For the purposes of this definition, “equivalent” means the FDA ensures that the Generic Medication has the same active ingredients, meets the same manufacturing and testing standards, and is as safe and as effective as the Brand-Name Medication. If listings in widely accepted references are conflicting or indefinite about whether a Prescription Medication is a generic or Brand-Name Medication, the Plan will decide.

Mail-Order Supplier means a mail-order Pharmacy with which the Claims Administrator has contracted for mail-order services.

Nonparticipating Pharmacy means a Pharmacy with which the Claims Administrator neither has a contract nor has contracted access to any network it belongs to. Nonparticipating Pharmacies may not be able to or choose not to submit claims electronically.

Participating Pharmacy means either a Pharmacy with which the Claims Administrator has a contract or a Pharmacy that participates in a network for which the Claims Administrator has contracted to have access. Participating Pharmacies have the capability of submitting claims electronically.

Pharmacist means an individual licensed to dispense Prescription Medications, counsel a patient about how the medication works and its possible adverse effects and perform other duties as described in his or her state’s Pharmacy practice act.

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed.

Prescription Medications (also Prescribed Medications) means medications and biologicals that relate directly to the treatment of an Illness or Injury, legally cannot be dispensed without a Prescription Order and by law must bear the legend: "Prescription Only," or as specifically included the Claims Administrator’s Formulary.

Prescription Order means a written prescription or oral request for Prescription Medications issued by a Provider who is licensed to prescribe medications.

Self-Administrable Prescription Medications (also Self-Administrable Medications, or Self-Administrable Injectable Medication) means, a Prescription Medication, determined by the Claims Administrator, which can be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician office or clinic) and that does not require administration by a Provider. In determining what are considered Self-Administrable Medications, the Claims Administrator refers to information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that is considered a relevant and reliable indication of safety and acceptability. Your status, such as Your ability to administer the medication, will not be considered when determining whether a medication is self-administrable.
Summary of Behavioral Health Benefits – Employee Health Care Plan

Behavioral Health Benefits are administered through Blomquist Hale Consulting Employee Assistance Program (EAP) and UNI BHN, not through Regence BCBSU. For maximum benefits and to avoid benefit reduction all care should be coordinated through the EAP. Call (801) 587-9319, (801) 262-9619 or (800) 926-9619.

BEHAVIORAL HEALTH CONTRACT YEAR DEDUCTIBLE

Services Coordinated Through The EAP: $0
Services Not Coordinated Through The EAP: $200 for Inpatient Services per admission
$300 for Chemical Dependency per Course of Treatment¹

BEHAVIORAL HEALTH CONTRACT YEAR OUT-OF-POCKET MAXIMUM

Per Claimant: $2,000
Per Family: $4,000

This Behavioral Health Out-of-Pocket Maximum is calculated separately from any other Out-of-Pocket Maximum in the Summary Plan Description. Behavioral Health Coinsurance amounts do not apply toward any medical or prescription Out-of-Pocket Maximum amounts outlined in the applicable Summary of Benefits.

Employee Assistance Program

The EAP provides no specific visit limit for brief, solution-focused counseling sessions for any family member residing in Your home. The EAP also provides referral services for You and Your Enrolled Dependents for the additional Behavioral Health Services listed below.

NOTE: Eligibility for the EAP does not guarantee eligibility for mental health and chemical dependency benefits through the Plan.

The EAP is available 24 hours a day, 7 days a week to handle any emergency situation. If an Emergency Inpatient admission is required, please contact the EAP at the time of admission for authorization.

MENTAL HEALTH SERVICES

<table>
<thead>
<tr>
<th></th>
<th>When You Use EAP Referral</th>
<th>When You Don't Use EAP Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient:</td>
<td>Upon referral from EAP, Plan pays 80% and You pay 20% of Allowed Amount.</td>
<td>After Deductible, Plan pays 50% of Allowed Amount and You pay balance of billed charges.</td>
</tr>
<tr>
<td>Limited to 30 days per Claimant per Contract Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient:</td>
<td>Upon referral from EAP, You pay $25 per visit. After Copayment, Plan pays 100% of Allowed Amount.</td>
<td>Plan pays 50% of Allowed Amount and You pay balance of billed charges.</td>
</tr>
<tr>
<td>Limited to 20 visits per Claimant per Contract Year</td>
<td></td>
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</tr>
</tbody>
</table>

¹ Chemical Dependency Services are limited to 2 Courses of Treatment per Claimant per Lifetime. A Course of Treatment is defined as continuous treatment/services (without a break in participation of 90 days or more) to address a chemical dependency disorder that may involve several levels of treatment.

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UNIVERSITY OF UTAH, 10002211, EFFECTIVE JULY 1, 2016
### CHEMICAL DEPENDENCY SERVICES*

<table>
<thead>
<tr>
<th>Service Type</th>
<th>When You Use EAP Referral</th>
<th>When You Don't Use EAP Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Services</strong></td>
<td>Upon referral from EAP, Plan pays 80% and You pay 20% of Allowed Amount.</td>
<td>After Deductible, Plan pays 50% of Allowed Amount and You pay balance of billed charges.</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td>Upon referral from EAP, Plan pays 80% and You pay 20% of Allowed Amount.</td>
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*Chemical Dependency Services are limited to 2 Courses of Treatment per Claimant per Lifetime. A Course of Treatment is defined as continuous treatment/services (without a break in participation of 90 days or more) to address a chemical dependency disorder that may involve several levels of treatment.

### AUTISM SERVICES

<table>
<thead>
<tr>
<th>Service Type</th>
<th>When You Use EAP Referral</th>
<th>When You Don't Use EAP Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Testing for Autism Spectrum Disorder</strong></td>
<td>Upon referral from EAP, You pay $25 Copayment and the Plan pays the balance of the Allowed Amount.</td>
<td>After Deductible, Plan pays 50% of Allowed Amount and You pay balance of billed charges.</td>
</tr>
<tr>
<td><strong>Social Skills Group Therapy for Individuals with Autism Spectrum Disorder</strong></td>
<td>Upon referral from EAP, You pay $15 Copayment per day and the Plan pays the balance of the Allowed Amount.</td>
<td>Plan pays 50% of Allowed Amount and You pay balance of billed charges.</td>
</tr>
</tbody>
</table>

Social Skills Group Therapy is limited to 15 weeks per Plan Year.

Please contact the EAP at (801) 587-9319 to obtain preauthorization and a referral prior to services being received.
Covered Behavioral Health Benefits

Behavioral Health Benefits are administered through Blomquist Hale Consulting Employee Assistance Program (EAP) and UNI BHN, not through Regence BCBSU. For maximum benefits and to avoid benefit reduction all care should be coordinated through the EAP. Call (801) 587-9319, (801) 262-9619 or (800) 926-9619.

EMPLOYEE ASSISTANCE PROGRAM (EAP)
An Employee Assistance Program provides confidential short-term counseling benefits at no cost to You. The EAP can assist with a broad range of life challenges such as emotional difficulties, family problems, marital or relationship difficulties, depression/anxiety, financial or legal matters, work-site issues, alcohol/drug problems, and day-care and eldercare concerns. The EAP is completely confidential and no patient information will be shared with the University. Any member of Your household is eligible for EAP benefits; however eligibility for EAP benefits does not guarantee eligibility for Behavioral Health Benefits (mental health and chemical dependency) through the Plan. Eligibility for Behavioral Health Benefits beyond the EAP is limited to You and Your Enrolled Dependents.

The EAP provides the following services:

- Short-Term Counseling – Private, solution-focused counseling sessions will be provided by the EAP counselor at no cost to You and will not count as one of the 20 visits available under Your Behavioral Health Benefit.
- Referral – When necessary, Your EAP counselor may refer You to another source including, but not limited to, a private therapist, counselor, or treatment group in the area. Referrals beyond the EAP are not a covered EAP benefit and will be covered by the Plan as a Behavioral Health Benefit, up to the limits listed in the Summary of Behavioral Health Benefits.

MENTAL HEALTH SERVICES AND CHEMICAL DEPENDENCY SERVICES
Inpatient and Outpatient benefits are subject to the dollar and visit limits and the Lifetime Maximums listed in the Summary of Behavioral Health Benefits.

NOTE: You always have a choice. When You coordinate care through the EAP You will receive the maximum Behavioral Health Benefits provided by the Plan. When You do NOT coordinate care through the EAP, Covered Services will be paid as When You Don't Use EAP Referral benefits. See Summary of Behavioral Health Benefits for more details.

LIMITATIONS AND EXCLUSIONS
The EAP program offers access to brief, solution-focused, problem solving intervention for any life problem without exception. The following limitations and exclusions apply to Behavioral Health Benefits outside the EAP.

Care or Treatment of the Following Conditions:
- ADD/ADHD, except for the purpose of assessment and medication management;
- adjustment disorder;
- conduct disorders;
- enuresis and encopresis;
- gambling addiction;
- grief;
- kleptomania;
- learning disabilities;
- mental or emotional conditions without manifest psychiatric disorder;
- mental retardation;
- non-specific conditions;
- oppositional disorders;
- paraphilias;
• personality disorders;
• psychosexual disorders;
• pyromania; and
• Tourette's.

The Following Costs and Services:
• behavioral modification;
• biofeedback;
• couples/marital/family therapy
• court committed treatment or court ordered services;
• custodial care;
• diagnostic work-ups to rule out organic disorders;
• encounter groups;
• fitness for duty;
• hospital charges while on leave of absence;
• hypnosis;
• long-term acute hospitalization;
• massage;
• methadone maintenance treatment;
• office calls in conjunction with repetitive therapeutic injections;
• psychiatric consults while admitted to a medical unit;
• psychological evaluations for legal purposes;
• psychotherapy while in a Skilled Nursing Facility;
• residential treatment;
• smoking cessation;
• treatment therapies for developmental delay or child developmental programs;
• Vagus nerve stimulation;
• vocational counseling; and
• weight control training.

Costs for Discontinuing Treatment
Costs incurred for discontinuing treatment or program against medical advice.

Services Not Coordinated Through the EAP:
Any Behavioral Health Service NOT coordinated through the EAP will be covered as a When You Don't Use EAP Referral benefit, regardless of whether or not the Provider/Hospital has an existing contract with the UNI BHN network.
Appeals Process – Behavioral Health Benefits Only

FIRST LEVEL – COMPLAINT/GRIEVANCE/RECONSIDERATION
You may initiate an Appeal through either a written or oral request. Written Appeal requests should be mailed to: 650 Komas, Suite 207A, Salt Lake City, Utah 84108. Oral requests can be made by calling (801) 581-7931. "First Level - Complaint/Grievance/Reconsideration" is a review by the Director of Clinical Services. A written notice of the decision will be sent within 30 calendar days of receipt of the "First Level - Complaint/Grievance/Reconsideration" and within 5 business days of the decision being made. If Your Provider requests reconsideration of a denial of preauthorization, a peer-to-peer discussion with the Director of Clinical Services will be arranged within 1 working day of the request.

SECOND LEVEL – COMMITTEE APPEAL
If You disagree with the decision made in the "First Level - Complaint/Grievance/Reconsideration," You may request further Appeal to the "Second Level - Committee Appeal." The Appeal request must be made in writing or orally within 180 calendar days after You receive notice of the decision at the "First Level - Complaint/Grievance/Reconsideration". Failure to request a “Second Level - Committee Appeal" within this time period will preclude Your right to further Committee Appeal of the decision. The written Appeal request, including any additional information or comments, must be made to the Director of Clinical Services, 650 Komas, Suite 207A, Salt Lake City, Utah 84108. "Second Level - Committee Appeal" is a review by the Clinical Management Committee, which is comprised of the Director of Clinical Services, the Medical Director and at least one other member of the Claims Administrator’s officers. You or Your Representative, on Your behalf, will be given a reasonable opportunity to personally appear or participate via telephone, video conference, or other technology, and/or to provide written materials. A written notice of the decision will be sent within 30 calendar days of receipt of the "Second Level - Committee Appeal" and within 5 business days of the decision being made.

OPTIONAL APPEALS – BEHAVIORAL HEALTH BENEFITS ONLY
The following levels of Appeal are optional and You should know that other forums may be utilized as the final level of Appeal to resolve a dispute You have with the Plan. The optional levels of Appeal below are available to You after You have exhausted all of the applicable non optional levels of Appeal. If Your Appeal is based on the Medical Necessity of services or services that are investigational or experimental in nature, You may submit Your Appeal to either the “Optional External Appeal,” OR to “Optional Arbitration.” If Your Appeal is not based on the Medical Necessity of services or services that are not investigational or experimental in nature, You may submit Your Appeal to “Optional Arbitration.”

OPTIONAL EXTERNAL APPEAL (MEDICAL NECESSITY ISSUES ONLY)
If You disagree with the decision made in the "Second Level - Committee Appeal", and the issue on Appeal is the Medical Necessity of services or services that are investigational or experimental in nature, You may request further Appeal to the "Optional External Appeal." The Appeal request must be made in writing or orally within 180 calendar days after You receive notice of the decision at the "Second Level - Committee Appeal." Failure to request an "Optional External Appeal" within this time period will preclude the Claimant’s right to further appeal of the decision through this optional level. The written Appeal request, including any additional information or comments must be made to the Director of Clinical Services, 650 Komas, Suite 207A, Salt Lake City, Utah 84108. "Optional External Appeal" will be coordinated by the Director of Clinical Services while the decision is made by an Independent Review Organization (IRO) at no cost to You. The IRO is an independent physician review organization that is unbiased, independent and not controlled by the Claims Administrator or the Plan. Within the IRO, there will be clinical expertise, use of evidence-based decision making, maintenance of confidentiality, and adequate administration and training capacity. Within 5 calendar days of receipt of the request for a "Optional External Appeal," the Director of Clinical Services will determine if the Appeal concerns Medical Necessity. If the Director of Clinical Services determines the Appeal concerns Medical Necessity, he or she will provide the IRO with the Appeal documentation within 3 business days and a written notice of the IRO’s decision and this section. Choosing the “Optional External Appeal” for the settlement of an Appeal as the final level will be binding in accordance with the IRO’s decision and this section.

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OPTIONAL ARBITRATION
Voluntary arbitration is available as a level of Appeal for a dispute You have with the Plan. All other (non-optional) levels of this Appeal Process must be exhausted before arbitration is available. Choosing arbitration as the final level for the settlement of such disputes will be binding in accordance with the Arbitration provision of this section. The Director of Clinical Services can assist You with procedures for initiating and participating in an arbitration.
General Exclusions

The following are the general exclusions from coverage under the Plan. Other exclusions may apply and, if so, will be described elsewhere in this Summary Plan Description.

PREEXISTING CONDITIONS
This coverage does not have an exclusion period for Preexisting Conditions. A Preexisting Condition normally means a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within a specified period of time before the enrollment date.

GENERAL EXCLUSION EXAMPLES
The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under the Plan, including related secondary medical conditions and are not inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
  - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
  - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- complications that result from an Injury or Illness resulting from active participation in illegal activities as determined by the plan administrator.

SPECIFIC EXCLUSIONS
The Plan will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise Covered Service for: 1) an Injury if the Injury results from an act of domestic violence or a medical condition, including physical and mental and regardless of whether such condition was diagnosed before the Injury, as required by federal law; or 2) a preventive service as specified under the Preventive Care and Immunizations benefit in the Medical Benefits Section.

Alternative Care
The Plan does not cover alternative care, including, but not limited to, the following:

- acupuncture and acupressure;
- holistic and homeopathic treatment;
- massage or massage therapy;
- faith healing;
- milieu therapy;
- hypnosis;
- sensitivity training;
- behavior modification;
- biofeedback;
- electrohypnosis, electrosleep therapy, or electronarcosis;
- ecological or environmental medicine; and
- other therapies: scream therapy; psychic surgery, channeling, sensory deprivation; rolfing; thermography; music, art, dance, or recreation therapy; crystal therapy; and hypertherapy (therapeutically induced fever) for the treatment of cancer.
Behavioral Health Services
Behavioral Health Services are administered through Blomquist Hale Consulting and UNI BHN. See the Covered Behavioral Health Services Section for the specific limitations and exclusions of Behavioral Health Benefits.

Cosmetic/Reconstructive Services and Supplies
Cosmetic and/or reconstructive services and supplies, except in the treatment of the following:

- to treat a congenital anomaly for Claimants up to age 18;
- to restore a physical bodily function lost as a result of Injury or Illness;
- required as a result of an Accidental Injury, Illness, or therapeutic intervention and services are rendered or planned (as specifically documented in the Claimant's medical record) within 12 months of the cause or onset of the Injury, Illness or therapeutic intervention (generally performed to restore function, but may also be done to restore a normal appearance); or
- related to breast reconstruction following a Medically Necessary mastectomy.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

Reconstructive means services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Counseling
Charges for counseling a Claimant, including the following:

- marital counseling;
- family counseling;
- educational, social, occupational, or religious counseling;
- counseling in the absence of Illness or Injury; and
- counseling with a patient's family, friend(s), employer, school counselor, or school teacher.

This exclusion does not apply to services for counseling a Claimant when incidentally provided, without separate charge, in connection with Covered Services. (Behavioral Health Services are administered through Blomquist Hale Consulting and UNI BHN. See the Covered Behavioral Health Benefits Section for specific information regarding covered Behavioral Health Benefits.)

Custodial Care
The Plan does not cover non-skilled care and helping with activities of daily living.

Dental Services
Dental Services provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Expenses Before Coverage Begins or After Coverage Ends
Services and supplies incurred before Your Effective Date under the Plan or after the termination of your enrollment under the Plan.

Fees, Taxes, Interest
Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. The Plan also does not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Foot Care (Routine)
Routine foot care, including, but not limited to: treatment of corns and calluses and trimming of nails, except as medically necessary, determined in accordance with Medicare guidelines.
Gastric Procedures
Services and supplies for or in connection with gastric or intestinal bypass, gastric stapling, or other similar surgical procedure (except certain surgical treatments of Morbid Obesity), or for or in connection with reversal or revision of such procedures.

Government Programs
Benefits that are covered, or would be covered in the absence of this Plan, by any federal, state or government program, except for facilities that contract with the Claims Administrator and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. Expenses from government facilities outside the service area are not covered under the Plan (except for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).

Growth Hormone Therapy
Growth hormone therapy, once bone growth is complete.

Hearing Care
Except as provided under the Hearing Examinations benefit in this Summary Plan Description, the Plan does not cover hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion does not apply to cochlear implants.

Investigational Services
Except as provided under the Approved Clinical Trials benefit in this Summary Plan Description or for Claimants receiving treatment or procedures related to the diagnosis and/or treatment of high-risk osteogenic sarcoma prior to July 1, 2013, the Plan does not cover Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). Also excluded are any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section of this Summary Plan Description.

Motor Vehicle Coverage and Other Available Insurance
Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, Benefits will be provided according to the Summary Plan Description.

Non-Direct Patient Care
Services that are not direct patient care, including:

- appointments scheduled and not kept ("missed appointments");
- charges for preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at the Claims Administrator's request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges), except as provided under the telemedicine benefit.

Nutritional Counseling
This exclusion does not apply to services and supplies for Diabetic Education, obesity, morbid obesity or as required under PPACA.

Orthognathic Surgery
Except for orthognathic surgery for class II and class III skeletal deformities not correctable by orthodontic means, the Plan does not cover services and supplies for orthognathic surgery.
Over-the-Counter Contraceptives
The Plan does not cover over-the-counter contraceptive supplies and oral contraceptives.

Personal Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps and light boxes are not covered.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment, including hot tubs or membership fees at spas, health clubs or other such facilities. This exclusion applies even if the program, equipment or membership is recommended by the Claimant's Provider.

Prescription Drugs and Other Medications
Outpatient prescription drugs and over-the-counter drugs and medications, vitamins, and minerals. Also excluded are special formulas, food supplements, or special diets, except as provided by a Hospital or Skilled Nursing Facility during a confinement for which benefits are available and as required for inborn metabolic errors. (Coverage for outpatient Prescription Drugs is administered by Regence. See the Summary of Prescription Medication Benefits section for coverage information.)

Private-Duty Nursing
Private-duty nursing, including ongoing shift care in the home.

Psychoanalysis/Psychotherapy
Psychoanalysis or psychotherapy credited toward earning a degree or furthering a Claimant's education or training.

Reproductive Services
The Plan does not cover assisted reproductive services or treatment of infertility (except to the extent Covered Services are required to diagnose such condition). Non-covered treatment includes, but is not limited to, all assisted reproductive technologies (for example, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception) and fertility drugs and medications.

Reversals of Sterilizations
Services and supplies related to reversals of sterilization.

Riot, Rebellion and Illegal Acts
Services and supplies for treatment of an Illness, Injury or condition caused by a Claimant's voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion or sustained by a Claimant arising directly from an act deemed illegal by an officer or a court of law.

Self-Help, Self-Care, Training or Instructional Programs
Except as may be specifically provided in the Summary Plan Description or required under PPACA, the Plan does not cover self-help, non-medical self-care, training programs, including:

- diet and weight monitoring services;
- childbirth-related classes including infant care; and
- instruction programs including those that teach a person how to use Durable Medical Equipment or how to care for a family member.

This exclusion does not apply to services for training or educating a Claimant when provided without separate charge in connection with Covered Services.

Services and Supplies for Which No Charge is Made or No Charge is Normally Made
Services and supplies for which a Claimant is not required to make payment or for charges that in the absence of this Plan there would be no obligation to pay. This would include but is not limited to:
• services or supplies for which a Claimant cannot be held liable because of an agreement between the 
  Provider rendering the service and another third-party payor which has already paid for such service 
  or supply;
• services for which the Claimant incurs no charge or has no legal obligation to pay; and
• charges for services or supplies provided by the University or any of its employees or agents.

**Services and Supplies Provided by a Member of Your Family**
Services and supplies provided to You by a member of Your immediate family. For purposes of this 
 provision, “immediate family” means:
• You and Your parents, parents’ spouses or domestic partners, spouse or domestic partner, children, 
  stepchildren, siblings and half-siblings;
• Your spouse’s or domestic partner’s parents, parents’ spouses or domestic partners, siblings and 
  half-siblings;
• Your child's or stepchild's spouse or domestic partner; and
• any other of Your relatives by blood, marriage or who shares a residence with You.

**Services and Supplies Provided by a School or Halfway House**
Services and supplies provided by any public or private school or halfway house, or by their employees 
 and services provided solely to satisfy institutional requirements.

**Services and Supplies That are Not Medically Necessary**
Services and supplies that are not Medically Necessary (refer to Definitions section) for the treatment of 
 an Illness or Injury, except for preventive care benefits specifically provided under the Plan.

**Sexual Dysfunction**
Services and supplies for or in connection with sexual dysfunction regardless of cause. The exclusion 
 does not apply to prosthetic devices and impotence medications in accordance with the Plan's coverage 
 rules.

**Termination of Pregnancy**
Services and supplies in connection with the performance of any induced abortion services except in the 
 following circumstances in accordance with the Utah prohibition against public funding for abortions 
 (U.C.A. 76-7-331): (a) in the professional judgment of the pregnant woman's attending physician, the 
  abortion is necessary to save the pregnant woman's life; (b) the pregnancy is the result of rape or incest 
  reported to law enforcement agencies, unless the woman was unable to report the crime for physical 
  reasons or fear of retaliation; or (c) in the professional judgment of the pregnant woman's attending 
  physician, the abortion is necessary to prevent permanent, irreparable, and grave damage to a major 
  bodily function of the pregnant woman provided that a caesarian procedure or other medical procedure 
  that could also save the life of the child is not a viable option; or (d) the fetus is not viable, or the fetus has 
  a defect that is uniformly diagnosable and uniformly lethal, provided that public funds are not used by the 
  Plan to pay for the procedure.

**Third-Party Liability**
Services and supplies for treatment of Illness or Injury for which a third-party is or may be responsible.

**Travel and Transportation Expenses**
Travel and transportation expenses other than covered ambulance services provided under the Plan.

**Uniformed Services**
The treatment of any Claimant's condition that the Secretary of Veterans Affairs determines to have been 
 incurred in, or aggravated during, performance of service in the uniformed services of the United States.

**Vision Care**
Except for vision benefits as may be provided in this Summary Plan Description, the Plan does not cover 
 routine eye exam or vision hardware.
Visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.

**War or Insurrection**
The treatment of any condition caused by or arising out of a Claimant's active participation in a war or insurrection.

**Work-Related Conditions**
Expenses for services and supplies incurred as a result of any work-related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. The Claims Administrator may require the Claimant to file a claim for workers’ compensation benefits before providing any benefits under this coverage. The only exception is if a Claimant is exempt from state or federal workers’ compensation law.
Claims Administration

This section explains a variety of matters related to administering benefits and/or claims, including situations that may arise when Your health care expenses are the responsibility of a source other than the Plan.

PREAUTHORIZATION
In-Network Providers may be required to obtain preauthorization from the Claims Administrator in advance for certain services provided to You. You will not be penalized if the In-Network Provider does not obtain those approvals from the Claims Administrator and the service is determined to be not covered under the Plan. Out-of-Network Providers are not required to obtain preauthorization from the Claims Administrator in advance for services so You may be liable for costs if You elect to seek services from Out-of-Network Providers and those services are considered not Medically Necessary and not covered under the Plan. You may request that an Out-of-Network Provider preauthorize services on Your behalf to determine Medical Necessity prior to services being rendered.

PLAN IDENTIFICATION CARD
When Participants enroll in the Plan, they will receive Plan identification cards. The identification card will include important information such as the Participant's identification number, group number and name.

It is important to keep Your Plan identification card with You at all times. Be sure to present it to Your Provider before receiving care.

If You lose Your card, or if it gets destroyed, You can get a new one by calling the Claims Administrator's Customer Service department at: 1 (800) 262-9712. You can also view or print an image of Your Plan identification card by visiting the Claims Administrator's website at www.Regence.com on Your PC or mobile device. If the Plan terminates, Your Plan identification card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT
The Claims Administrator will decide whether to pay You, the Provider or You and the Provider jointly. Benefit payments may be made for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child.

You will be responsible for the total billed charges for benefits in excess of Maximum or Contract Year Maximum Benefits, if any, and for charges for any other service or supply not covered under this Plan, regardless of the Provider rendering such service or supply.

Timely Filing of Claims
Written proof of loss must be received within one year after the date of service for which a claim is made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. A claim that is not filed in a timely manner will be denied unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. You may, however, appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner. (If You were covered by more than one health plan on the date of service, see the text of Primary Health Plan Benefits in the Coordination of Benefits provision for an exception to this timely filing rule.)

Freedom of Choice of Provider
Nothing contained in the Summary Plan Description is designed to restrict You in selecting the Provider of Your choice for care or treatment of an Illness or Injury.

In-Network Provider Claims
You must present Your Plan identification card when obtaining Covered Services from an In-Network Provider. You must also furnish any additional information requested. The Provider will furnish the Claims Administrator with the forms and information needed to process Your claim.
In-Network Provider Reimbursement
The Plan will pay an In-Network Provider directly for Covered Services. These Providers have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount will be determined by whether You see a University of Utah Health Care Provider or any other In-Network Provider and is any amount You must pay due to Deductible or Coinsurance. These Providers may require You to pay Your share at the time You receive care or treatment.

Out-of-Network Provider Claims
In order for the Claims Administrator to pay for Covered Services, You or the Out-of-Network Provider must first send the Claims Administrator a claim. Be sure the claim is complete and includes the following information:

- an itemized description of the services given and the charges for them;
- the date treatment was given;
- the diagnosis; and
- the patient's name, the group number, and identification numbers.

If the treatment is for an Injury, include a statement explaining the date, time, place and circumstances of the Injury when You send the Claims Administrator the claim.

Out-of-Network Provider Reimbursement
In most cases, You will be paid directly for Covered Services provided by an Out-of-Network Provider.

Out-of-Network Providers have not agreed to accept the Allowed Amount as full compensation for Covered Services. You are responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount in addition to any amount You must pay due to Deductible and/or Coinsurance. For Out-of-Network Providers, the Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

Reimbursement Examples by Provider
Here is an example of how Your selection of In-Network or Out-of-Network Providers affects payment to Providers and Your cost sharing amount. The benefit table from the Summary of Medical Benefits (or other benefits section) would appear as follows:

<table>
<thead>
<tr>
<th>Provider: University of Utah Hospitals and Clinics</th>
<th>Provider: In-Network</th>
<th>Provider: Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plan pays 95% and You pay 5% of the Allowed Amount. Your 5% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>After Deductible, the Plan pays 75% and You pay 25% of the Allowed Amount. Your 25% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>After Deductible, the Plan pays 65% of the Allowed Amount and You pay balance of billed charges. Your 35% payment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
</tbody>
</table>

Now, let’s assume that the Provider’s charge for a service is $5,000 and the Allowed Amount for that charge is $3,800 for University of Utah Hospitals and Clinics or an In-Network Provider. The Plan will pay claims to an Out-of-Network Provider based on the Allowed Amount for University of Utah Hospitals and Clinics or an In-Network Provider. Finally, let’s assume that You have met the Deductible and that You have not met the Out-of-Pocket Maximum. Here’s how that Covered Service would be paid:

- University of Utah Hospitals and Clinics: the Plan would pay 95% of the Allowed Amount and You would pay 5% of the Allowed Amount, as follows:
  - Amount In-Network Provider must "write-off" (that is, cannot charge You for): $1,200
  - Amount the Plan pays (95% of the $3,800 Allowed Amount): $3,610
  - **Amount You pay** (5% of the $3,800 Allowed Amount): $390
  - Total: $5,000

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In-Network Provider: the Plan would pay 75% of the Allowed Amount and You would pay 25% of the Allowed Amount, as follows:
- Amount In-Network Provider must "write-off" (that is, cannot charge You for): $1,200
- Amount the Plan pays (75% of the $3,800 Allowed Amount): $2,850
- Amount You pay (25% of the $3,800 Allowed Amount): $950
- Total: $5,000

Out-of-Network: the Plan would pay 65% of the In-Network Allowed Amount. Because the Out-of-Network Provider does not accept the Allowed Amount, You would pay 35% of the In-Network Allowed Amount, plus, the difference between the out-of-network Provider's billed charges and the Allowed Amount, as follows:
- Amount the Plan pays (65% of the $4,000 Allowed Amount): $2,600
- Amount You pay (35% of the $4,000 Allowed Amount and the $1,000 difference between the billed charges and the Allowed Amount): $2,400
- Total: $5,000

The actual benefits in the Plan may vary, so please read the benefits sections thoroughly to determine how Your benefits are paid. For example, as explained in the Definitions Section, the Allowed Amount may vary for a Covered Service depending upon Your selected Provider.

Ambulance Claims
When You or Your Provider forwards a claim for ambulance services to the Claims Administrator, it must show where the patient was picked up and where he or she was taken. It should also show the date of service, the patient's name, the patient's group number, and identification numbers.

Claims Determinations
Within 30 days of the Claims Administrator's receipt of a claim, You will be notified of the action taken on it. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When action cannot be taken on the claim due to circumstances beyond the Claims Administrator's control, they will notify You within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when the Claims Administrator expects to act on the claim.
- When action cannot be taken on the claim due to lack of information, the Claims Administrator will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

If the Claims Administrator seeks additional information from You, You will be allowed at least 45 days to provide the additional information. If the Claims Administrator does not receive the requested information to process the claim within the time allowed, the claim will be denied.

OUT-OF-AREA SERVICES
The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain health care services outside of the Claims Administrator's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between the Claims Administrator and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the Claims Administrator's service area, You will obtain care from health care Providers that have a contractual agreement (for example, are "In-Network Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from nonparticipating Providers. The Claims Administrator's payment practices in both instances are described below.

BlueCard Program
Under the BlueCard Program, when You access Covered Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for fulfilling contractual obligations.
However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever You access Covered Services outside the Claims Administrator’s service area and the claim is processed through the BlueCard Program, the amount You pay for Covered Services is calculated based on the lower of:

- The billed covered charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Claims Administrator uses for Your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to Your calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate Your liability for any Covered Services according to applicable law.

**Negotiated National Account Arrangements**

As an alternative to the BlueCard Program, Your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price above) made available to the Claims Administrator by the Host Blue.

**Nonparticipating Providers Outside the Claims Administrator's Service Area**

- **Member Liability Calculation.** When Covered Services are provided outside of the Claims Administrator's service area by nonparticipating Providers, the amount You pay for such services will generally be based on either the Host Blue’s nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.
- **Exceptions.** In certain situations, the Claims Administrator may use other payment bases, such as billed covered charges, the payment the Claims Administrator would make if the health care services had been obtained within the Claims Administrator's service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Claims Administrator will pay for services rendered by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

**BLUECARD WORLDWIDE®**

BlueCard Worldwide coverage is also accessible to You. With BlueCard Worldwide, You have access to inpatient and outpatient Hospital care and Physician services when You’re traveling or living outside the United States or any other areas covered by the domestic BlueCard Program, as well as medical assistance and claims support services.

When You need health care outside of the United States or its territories, follow these simple steps:

- Always carry Your current Plan identification card.
- If You need emergency medical care outside the United States, go to the nearest Hospital.
• If You are admitted, call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177.
• For non-emergency medical care, call the BlueCard Worldwide Service Center. The Service Center will facilitate hospitalization if necessary at a BlueCard Worldwide Hospital or make an appointment with a Physician. BlueCard Worldwide Service Center staff are available to assist You 24 hours a day, 7 days a week.
• You will only be responsible for out-of-pocket expenses such as any applicable Copayment, Coinsurance and non-covered services for Your inpatient care. For outpatient Hospital care or Physician services, You will be responsible for paying the Hospital or Physician at the time of service and then must complete an international claim form and send it to the BlueCard Worldwide Service Center for reimbursement of Covered Services.

You can obtain an international claim form and find additional information about the BlueCard Worldwide program at www.bcbs.com.

NONASSIGNMENT
Only You are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else and You (or a custodial parent or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits or payments to any person, corporation or entity. Any attempted assignment, transfer or delegation of benefits will be considered null and void and will not be binding on the Plan. You may not assign, transfer or delegate any right of representation or collection other than to legal counsel directly authorized by You on a case-by-case basis.

CLAIMS RECOVERY
If a benefit to which You were not entitled is paid under the Plan, or if a person who is not eligible for benefits at all is paid under the Plan, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including a Provider of services. The Plan's right to recovery for an erroneous payment made on the Participant's or any of his or her Dependents behalf includes the right to deduct the mistakenly paid amount from future benefits that would have been provided the Participant or any of his or her Dependents under this Plan, even if the mistaken payment was not made on that person's behalf.

The Claims Administrator regularly works to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, fraudulent claims, etc.). All recovered amounts will be credited to the Plan.

For the recovery of overpayments related to the coordination of Primary and Secondary Health Plan benefits, refer to the Coordination of Benefits provision in this Claims Administration Section.

This claims recovery provision in no way reduces the Plan's right to reimbursement or subrogation. Refer to the other-party liability provision in the Claims Administration Section for additional information.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS
Your personal health information may be requested or disclosed by the Claims Administrator. This information will be used for the purpose of facilitating health care treatment, payment of claims or business operations necessary to administer health care benefits; or as required by law.

The information requested or disclosed may be related to treatment or services received from:

• an insurance carrier or group health plan;
• any other institution providing care, treatment, consultation, pharmaceuticals or supplies;
• a clinic, Hospital, long-term care or other medical facility; or
• a Physician, dentist, Pharmacist or other physical or behavioral health care practitioner.

Health information requested or disclosed by the Claims Administrator may include, but is not limited to:

• billing statements;
claim records;
correspondence;
dental records;
diagnostic imaging reports;
Hospital records (including nursing records and progress notes);
laboratory reports; and
medical records.

The Claims Administrator is required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by calling the Claims Administrator's Customer Service department at: 1 (800) 262-9712 or visiting their Web site www.Regence.com.

You have the right to request, inspect and amend any records that the Claims Administrator has that contain Your personal health information. Please contact the Claims Administrator's Customer Service department to make this request.

NOTE: This provision does not apply to information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services and genetic testing. A specific authorization will be obtained from You in order for the Claims Administrator to receive information related to these health conditions.

LIMITATIONS ON LIABILITY
In all cases, You have the exclusive right to choose a health care Provider. Neither the Plan nor the Claims Administrator is responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since neither the Plan nor the Claims Administrator provides any health care services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither employees nor agents of the Plan and the Claims Administrator.

In addition, the Claims Administrator will not be liable to any person or entity for the inability or failure to procure or provide the benefits in the Plan by reason of epidemic, disaster or other cause or condition beyond the Claims Administrator's control.

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY
Coverage under the Plan will not be provided for any medical (or dental and vision, if applicable) or Prescription Medication expenses You incur for treatment of an Injury or Illness if the costs associated with the Injury or Illness may be recoverable from any of the following:

- a third-party;
- workers' compensation; or
- any other source, including automobile medical, personal injury protection ("PIP"), automobile no-fault, homeowner's coverage, commercial premises medical coverage or similar contract or insurance, when the contract or insurance is either issued to, or makes benefits available to You, whether or not You make a claim under such coverage.

Advancement of Benefits
If You have a potential right of recovery for Illnesses or Injuries from a third-party who may have legal responsibility or from any other source, benefits may be advanced pending the resolution of a claim to the right of recovery if all the following conditions apply:

- By accepting or claiming benefits, You agree that the Plan is entitled to reimbursement of the full amount of benefits paid out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which benefits under the Plan have been provided.
- In addition to the Plan's right of reimbursement, the Claims Administrator may choose instead to achieve the Plan's rights through subrogation. The Claims Administrator is authorized, but not obligated, to recover any benefits paid under the Plan directly from any party liable to You, upon mailing of a written notice to the potential payer, to You or to Your representative.
• The Plan’s rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment or other characterization of the recovery by the Claimant and/or any third-party or the recovery source. The Plan is entitled to reimbursement from the first dollars received from any recovery. This applies regardless of whether:
  - the third-party or third-party’s insurer admits liability;
  - the health care expenses are itemized or expressly excluded in the recovery; or
  - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the Plan.

• Reimbursement or subrogation under the Plan will not be reduced due to Your not being made whole.
• You may be required to sign and deliver all legal papers and take any other actions requested to secure the Plan’s rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third-party or other source). If You are asked to sign a trust agreement or other document to reimburse the Plan from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.
• You must agree that nothing will be done to prejudice the Plan’s rights and that You will cooperate fully with the Claims Administrator, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the Claims Administrator of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:
  - the filing of a lawsuit;
  - the making of a claim against any third-party;
  - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
  - intent of a third-party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Injury or Illness that gives rise to the Plan’s right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).

• You and/or Your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to Your benefit or on Your behalf that in any manner relates to the Injury or Illness giving rise to the Plan’s right of reimbursement or subrogation, until the Plan’s right is satisfied or released.
• In the event You and/or Your agent or attorney fails to comply with any of these conditions, any such benefits advanced for any Illness or Injury may be recovered through legal action.
• Any benefits provided or advanced under the Plan are provided solely to assist You. By paying such benefits, neither the Plan nor the Claims Administrator is acting as a volunteer and is not waiving any right to reimbursement or subrogation.

**Motor Vehicle Coverage**

If You are involved in a motor vehicle accident, You may have rights both under motor vehicle insurance coverage and against a third-party who may be responsible for the accident. In that case, this Right of Reimbursement and Subrogation Recovery provision still applies.

**Workers’ Compensation**

Here are some rules which apply in situations where a workers’ compensation claim has been filed:

• You must notify the Claims Administrator in writing within five days of any of the following:
  - filing a claim;
  - having the claim accepted or rejected;
  - appealing any decision;
  - settling or otherwise resolving the claim; or
  - any other change in status of Your claim.
• If the entity providing workers’ compensation coverage denies Your claim and You have filed an appeal, benefits may be advanced for Covered Services if You agree to hold any recovery obtained in a segregated account for the Plan.

Fees and Expenses
Neither the Plan nor the Claims Administrator is liable for any expenses or fees incurred by You in connection with obtaining a recovery. However, You may request that a proportional share of attorney’s fees and costs be paid at the time of any settlement or recovery to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid under the Plan. The Claims Administrator has discretion whether to grant such requests.

Future Medical Expenses
Benefits for otherwise Covered Services may be excluded when You have received a recovery from another source relating to an Illness or Injury for which the Plan would normally provide benefits. However, the amount of any Covered Services excluded under this provision will not exceed the amount of Your recovery.

COORDINATION OF BENEFITS
If You are covered under any other individual or group medical contract or policy (referred to as “Other Plan” and defined below), the benefits under this Plan and those of the Other Plan will be coordinated in accordance with the provisions of this section.

Benefits Subject to this Provision
All of the benefits provided in this Summary Plan Description are subject to this Coordination of Benefits provision.

Definitions
In addition to the definitions in the Definitions Section, the following are definitions that apply to this Coordination of Benefits:

Allowable Expense means, with regard to services that are covered in full or part by this Plan or any Other Plan(s) covering You, the amount on which that Plan would base its benefit payment for a service, including Coinsurance or Copayments and without reduction for any applicable Deductible, except that the following are examples of expenses that are not an Allowable Expense:

• An expense or portion of an expense not covered by any of Your involved Plans.
• Any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You.
• The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, unless one of Your involved Plans provides coverage for private Hospital rooms.
• Any amount by which a Primary Plan’s benefits were reduced because You did not comply with that Plan’s provisions regarding second surgical opinion or preauthorization.
• If You are covered by two or more Plans that: 1) compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified benefit; or 2) that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
• If You are covered by a Plan that calculates its benefits or services on the basis of usual and customary fees, relative value schedule reimbursement, or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan’s payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan’s payment arrangement and if the Provider’s contract permits, that negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
When a Plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid.

Birthday, for purposes of these coordination of benefits provisions, means only the day and month of birth, regardless of the year.

Custodial Parent means the legal Custodial Parent or the physical Custodial Parent as awarded by a court decree. In the absence of a court decree, Custodial Parent means the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

Group-Type Coverage is a coverage that is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including blanket coverage. Group-Type Coverage does not include an individually underwritten and issued guaranteed renewable coverage, even if the coverage is purchased through payroll deduction at a premium savings to You (since You would have the right to maintain or renew the coverage independently of continued employment with the employer).

Other Plan means any of the following with which this coverage coordinates benefits:

- Individual and group accident and health insurance and subscriber contracts.
- Uninsured arrangements of group or Group-Type Coverage.
- Group-Type Coverage.
- Coverage through closed panel Plans (a Plan that provides coverage primarily in the form of services through a panel of providers that have contracted with or are employed by a Plan and that excludes benefits for services provided by other providers, except in the cases of emergency or referral by a panel member).
- Medical care components of long-term care contracts, such as skilled nursing care.
- Medicare and other governmental coverages, as permitted by law.

Other Plan does not include:

- Hospital indemnity coverage benefits or other fixed indemnity coverage.
- Accident only coverage.
- Specified disease or specified accident coverage.
- Limited benefit health coverage.
- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a “to and from school basis”.
- Benefits provided in long-term care insurance policies for non-medical services (for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and Custodial Care) or for coverages that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
- Medicare supplement coverage.
- A state Plan under Medicaid, or a governmental Plan that, by law, provides benefits that are in excess to those of private insurance or other nongovernmental coverage.

Primary Plan means the Plan that must determine its benefits for Your health care before the benefits of another Plan and without taking the existence of that other Plan into consideration. (This is also referred to as the Plan being “primary” to another Plan.) There may be more than one Primary Plan. A Plan is a Primary Plan with regard to another Plan in any of the following circumstances:

- The Plan has no order of benefit determination provision or its order of benefit determination provision differs from the order of benefit determination provision included herein; or
- Both Plans use the order of benefit determination provision included herein and under that provision the Plan determines its benefits first.

Secondary Plan means a Plan that is not a Primary Plan.
Year, for purposes of this Coordination of Benefits provision, means calendar year (January 1 through December 31).

**Order of Benefit Determination**
The order of benefit determination is identified by using the first of the following rules that applies:

- **Non-dependent or dependent coverage:** A Plan that covers You other than as a dependent, for example as an employee, member, policyholder retiree, or subscriber, will be primary to a Plan under which You are covered as a dependent.

- **Child covered under more than one Plan:** Plans that cover You as a child shall determine the order of benefits as follows:
  - When Your parents are married or living together (whether or not they have ever been married), the Plan of the parent whose birthday falls earlier in the Year is the Primary Plan. If both parents have the same birthday, the Plan that has covered a parent longer is the Primary Plan.
  - When Your parents are divorced or separated or are not living together (if they have never been married) and a court decree states that one of Your parents is responsible for Your health care expenses or health care coverage, the Plan of that parent is primary to the Plan of Your other parent. If the parent with that responsibility has no health care coverage for Your health care expenses, but that parent’s spouse does, the Plan of the spouse shall be primary to the Plan of Your other parent.
  - If a court decree states that both parents are responsible for Your health care expenses or health care coverage, or if a court decree states that the parents have joint custody of You, without specifying that one of the parents is responsible for Your health care expenses or health care coverage, the provisions of the first bullet above (based on parental birthdays) shall determine the order of benefits.
  - If there is no court decree allocating responsibility for Your health care expenses or health care coverage, the order of benefits is as follows:
    - The Plan of Your custodial parent shall be primary to the Plan of Your custodial parent’s spouse;
    - The Plan of Your custodial parent’s spouse shall be primary to the Plan of Your noncustodial parent; and
    - The Plan of Your noncustodial parent shall be primary to the Plan of Your noncustodial parent’s spouse.

If You are covered under more than one Plan and one or more of the Plans provides You coverage through individuals who are not Your parents (for example, a guardian or step-parent), the order of benefits shall be determined, as applicable using the provisions under the first or second bullets above, as if those individuals were Your parents.

- **Active, retired, or laid-off employees:** A Plan that covers You as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee, is primary to a Plan under which You are covered as a laid off or retired employee. If the Other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **COBRA or state continuation coverage:** A Plan that covers You as an employee, member, subscriber or retiree or as a dependent of an employee, member, subscriber or retiree, is primary to a Plan under which You are covered pursuant to COBRA or a right of continuation pursuant to state or other federal law. If the Other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **Longer/shorter length of coverage:** When none of the paragraphs above establishes an order of benefit determination, the benefits of the Plan that has covered You for the longer period of time will be determined before the benefits of the Plan that has covered You for the shorter period of time. To determine the length of time You have been covered under a Plan, two successive Plans will be treated
as one if You were eligible under the second Plan within 24 hours after coverage under the first Plan ended. The start of a new Plan does not include:

- a change in the amount or scope of a Plan's benefits;
- a change in the entity that pays, provides or administers the Plan's benefits; or
- a change from one type of Plan to another (such as from a single-employer Plan to a multiple employer Plan).

Your length of time covered under a Plan is measured from Your first date of coverage under that Plan. If that date is not readily available for a group Plan, the date You first became a member of the group will be used as the date from which to determine the length of time coverage under the present Plan has been in force.

If an order of benefit determination is not identified by the preceding rules, the Plans shall share equally in the Allowable Expenses. Each of the Plans under which You are covered, and each of the benefits within the Plan, will be considered separately in administering this Coordination of Benefits provision.

**Primary Health Plan Benefits**

When, in accordance with the order of benefit determination, this coverage is the Primary Plan, benefits of this Plan will be paid as if no other Plan exists. Despite the provisions of timely filing of claims, where this Plan is the Primary Plan, benefits will not be denied under this Plan on the ground that a claim was not timely submitted if the claim was timely submitted to one or more Secondary Plans and was submitted to the Claims Administrator within 36 months of the date of service.

**Secondary Health Plan Benefits**

If, in accordance with the order of benefit determination, one or more Other Plans are primary to this Plan, the benefits of this Plan will be calculated as follows:

The benefits that would have been paid under this Plan for a service if this Plan were the Primary Plan will be calculated. That calculated amount will be applied to any Allowable Expense under this Plan for that service that is unpaid by the Primary Plan. The Claims Administrator will:

- reduce payment so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total Allowable Expense for that claim; and
- credit to this Plan’s Deductible (if applicable), any amounts that would have been credited for the service if this Plan were the Primary Plan.

Nothing contained in this Coordination of Benefits provision requires this Plan to pay for all or part of any service that is not covered under this Plan. Further, in no event will this Coordination of Benefits provision operate to increase this Plan's payment over what would have been paid in the absence of this Coordination of Benefits provision.

**Right to Receive and Release Needed Information**

Certain facts are needed to apply Coordination of Benefits provisions. The Claims Administrator has the right to decide which facts they need. The Claims Administrator may get needed facts from, or give them to, any other organization or person as permitted by law, and need not tell or get the consent of any person to do this. You will promptly furnish to the Claims Administrator any information necessary or appropriate to administer this Coordination of Benefits provision. Receipt of such information by the Claims Administrator will be a condition precedent to this Plan's obligation to provide benefits.

**Right of Recovery**

If benefits are paid under this Plan to or on behalf of You in excess of the amount that would have been payable in this Plan by reason of Your coverage under any Other Plan(s), this Plan will be entitled to the excess as follows:

- From You, if payment was made to You. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent
act(s), fraudulent statement(s), or material misrepresentations. This Plan will be entitled to recover the amount of such excess by the reversal of payment from You and You agree to reimburse this Plan on demand for any and all such amounts. You also agree to pay this Plan interest at 18 percent per annum until such debt is paid in full, which will begin accruing the date the demand for reimbursement is made. If a third-party collection agency or attorney is used to collect the overpayment, You agree to pay collection fees incurred, including, but not limited to, any court costs and attorney fees. If You do not pay, future benefits under this Plan may be withheld to offset the amount owing to it. The Claims Administrator is responsible for making proper adjustments between insurers and Providers.

- From Providers, if payment was made to them. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentation(s). The Claims Administrator is responsible for making proper adjustments between insurers and Providers.
- From the Other Plan or an insurer.
- From other organizations.

A Secondary Plan that provides benefits in the form of services may recover the reasonable cash value of the services from the Primary Plan to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by it.
Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action under the Plan and wishes to have it reviewed, You may Appeal. There are two levels of Appeal, as well as additional voluntary Appeal levels You may pursue. Certain matters requiring quicker consideration qualify for a level of expedited Appeal and are described separately later in this section.

APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Claims Administrator at: Appeals Coordinator, Regence BlueCross BlueShield of Utah, P.O. Box 2998 Tacoma, WA 98401-2998. Verbal requests can be made by calling the Claims Administrator at 1 (800) 262-9712.

Each level of Appeal, except voluntary external review, must be pursued within 180 days of Your receipt of the Claims Administrator's determination (or, in the case of the first level, within 180 days of Your receipt of the Claims Administrator's original adverse decision that You are appealing). You, or Your Representative on Your behalf, will be given reasonable opportunity to provide written materials. If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum. When an Appeal request is received, the Claims Administrator will acknowledge it in writing.

If Your health could be jeopardized by waiting for a decision under the regular Appeal process, an expedited Appeal may be requested. Please see Expedited Appeals later in this section for more information.

First-Level Appeals

First-level Appeals are reviewed by a Claims Administrator employee or employees who were not involved in the initial decision that You are appealing. In Appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's staff of health care professionals. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 15 days of receipt of the Appeal. For Appeals involving a post-service Investigational issue, a written notice of the decision will be sent within 20 working days of receipt.

Panel-Level (Second-Level) Appeals

Second-level Appeals are reviewed by a panel of Claims Administrator employees who were not involved in, or subordinate to anyone involved in, the first-level decision. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 15 days of receipt of the Appeal. For Appeals involving a Post-Service Investigational issue, a written notice of the decision will be sent within 20 working days of receipt.

VOLUNTARY EXTERNAL APPEAL - IRO

A voluntary Appeal to an Independent Review Organization (IRO) is available for issues involving medical judgment (including, but not limited to, those based on the Plan’s requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or the determination that a treatment is Investigational, but only after You have exhausted all of the applicable non-voluntary levels of Appeal, or if the Claims Administrator has failed to adhere to all claims and internal Appeal requirements. Voluntary External Appeals must be requested within four months of Your receipt of the notice of the prior adverse decision.

The Claims Administrator coordinates voluntary external Appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the Appeal documentation. The IRO will make its decision and provide You with its written determination within 45 days after receipt of the request. Choosing the voluntary external Appeal as the final level to determine an Appeal will be
binding in accordance with the IRO’s decision and this section, except to the extent other remedies are available under State or Federal law.

The voluntary external Appeal by an IRO is optional and You should know that other forums may be utilized as the final level of Appeal to resolve a dispute You have under the Plan.

EXPEDITED APPEALS
An expedited Appeal is available if one of the following applies:

- the application of regular Appeal timeframes on a Pre-Service or concurrent care claim could jeopardize Your life, health or ability to regain maximum function; or
- according to a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

First-Level Expedited Appeal
The first-level expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. First-level expedited Appeals are reviewed by the Claims Administrator's staff of healthcare professionals who were not involved in, or subordinate to anyone involved in, the initial denial determination. A verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. A written notification of the decision will be mailed to You within three calendar days of the verbal notification.

Voluntary Expedited External Appeal - IRO
If You disagree with the decision made in the first-level expedited Appeal and You or Your Representative reasonably believes that preauthorization remains clinically urgent (Pre-Service), You may request a voluntary expedited external Appeal to an IRO. The criteria for a voluntary expedited external Appeal to an IRO are the same as described above for voluntary external expedited Appeal.

The Claims Administrator coordinates voluntary expedited external Appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the Appeal documentation. Verbal notice of the IRO's decision will be provided to You and Your Representative by the IRO as soon as possible after the decision, but no later than within 72 hours of its receipt of Your request. Choosing the voluntary expedited Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section.

The voluntary external Appeal by an IRO is optional and You should know that other forums may be utilized as the final level of Appeal to resolve a dispute You have under the Plan.

INFORMATION
If You have any questions about the Appeal Process outlined here, You may contact the Claims Administrator’s Customer Service department at Customer Service: 1 (800) 262-9712 or You can write to the Claims Administrator’s Customer Service department at the following address: Regence BlueCross BlueShield of Utah, P.O. Box 2998, Tacoma, WA 98401-2998.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS
Appeal means a written or verbal request from a Claimant or, if authorized by the Claimant, the Claimant's Representative, to change a previous decision made under the Plan concerning:

- access to health care benefits, including an adverse determination made pursuant to utilization management;
- claims payment, handling or reimbursement for health care services;
- matters pertaining to the contractual relationship between a Claimant and the Plan; and
- other matters as specifically required by state law or regulation.

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary expedited Appeals and voluntary expedited external Appeals, through an independent contractor relationship with the Claims Administrator and/or through assignment to the
Claims Administrator via state regulatory requirements. The IRO is unbiased and is not controlled by the Claims Administrator.

Medical Director means for purposes of the Appeal process only, a Physician employed by, or consulted by, the Claims Administrator. The Medical Director will reserve the right, if not appropriately qualified to review a particular procedure, to consult with an outside Practitioner with specialty in the medical condition/procedure involved in the review.

Post-Service means any claim for benefits under the Plan that is not considered Pre-Service.

Pre-Service means any claim for benefits under the Plan which must be approved in advance, in whole or in part, in order for a benefit to be paid.

Representative means someone who represents You for the purpose of the Appeal. The Representative may be Your personal Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the purposes of the Appeal. No authorization is required from the parent(s) or legal guardian of a Claimant who is unmarried and less than 13 years old. For expedited Appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for each Appeal level). If no authorization exists and is not received in the course of the Appeal, the determination and any personal information will be disclosed to You or Your treating Provider only.
Who Is Eligible

This section contains the terms of eligibility under the Plan.

Please Note: In the following sections starting with Who Is Eligible through Other Continuation Options, the terms “You” and “Your” mean the Plan Participant only.

Employees
You are eligible to enroll in this Plan if You are a University of Utah employee in one of the following benefit-eligible positions:

- Faculty members employed in a Tenure-line (Tenured or Tenure-track) position(s) at 50% FTE or greater, or at 37.5% or greater pursuant to a nine-month employment contract which is to be paid out over a twelve-month period. Faculty members employed in a faculty position(s) other than a Tenure-line category (for example, in a Career-line, Adjunct, or Visiting Faculty category position) who have an appointment for nine months or longer at 50% FTE (full-time equivalent) or greater.
- Staff employees who are employed in a position expected to last nine months or longer at 50% FTE or greater.
- Employees who have qualified under one of the first two categories and are currently on an approved Phased Retirement Agreement.
- Employees who are employed at less than 50% FTE and hold a J-1 visa.

Independent Contractors of Affiliated Groups
You are eligible to enroll in this Plan if you are a member or employee of an affiliated group as identified in the list below:

- Members of the Utah State Board of Regents throughout their period of appointment.
- Employees of the Utah Humanities Council, Huntsman Cancer Foundation and Utah System of Higher Education who are employed in positions expected to last nine months or longer at 50% FTE or greater, and eligible for enrollment in other employee benefits through the University of Utah.

Dependents
Your Eligible Dependents (defined below) are eligible for coverage on the date You become eligible for coverage or any applicable date if You add them on subsequent change forms. Eligible Dependents are limited to the following:

- The person to whom You are legally married (spouse);
- Your domestic partner, provided that:
  - both You and Your domestic partner are age 18 or older;
  - You and Your domestic partner reside together in a permanent residence and have done so for at least 6 months and will remain members of the same household for the period of coverage.
  - You and Your domestic partner share a committed relationship and intend to continue that relationship indefinitely;
  - You and Your domestic partner are emotionally committed to one another and jointly responsible for the common welfare and financial obligations of the household or one is chiefly dependent upon the other for financial assistance;
  - neither You nor Your domestic partner are legally married to anyone else or the domestic partner of anyone else;
  - You and Your domestic partner are not related in any way that would prohibit legal marriage in Your state of residence; and
  - You have completed and submitted an Employee and Partner Enrollment Form to the University’s Benefits Department and certified that all the above information is true and correct.
• Your (or Your spouse’s or Your domestic partner’s) children by birth, placement for legal adoption or foster care, or legal (court-appointed) guardianship granting full guardianship rights, who are under age 26;

• a child who is under 18 years of age for whom the noncustodial parent is required by a court order or administrative order to provide health coverage, whether or not the custodial parent is a Plan Participant and whether or not the noncustodial parent, who is eligible for this coverage, has enrolled hereunder. If You are not already enrolled in coverage, upon receipt of a court order, You will automatically be enrolled in the same coverage as the child; and

• a child, as described in the third bullet above, who is any age and incapacitated from earning a living and without sufficient means for whom the noncustodial parent is required by a court order or administrative order to provide health coverage, whether or not the custodial parent is a Plan Participant and whether or not the noncustodial parent, who is eligible for this coverage, has enrolled hereunder. If You are not already enrolled in coverage, upon receipt of a court order, You will automatically be enrolled in the same coverage as the child.

**Dependent Coverage Continuing Beyond Limiting Age**

• You may continue coverage for Your (or Your spouse’s or Your domestic partner’s), unmarried, child at age 26 if the child is currently enrolled in the Plan as Your Eligible Dependent who is a Disabled Dependent (defined below). To do so, You must provide to the University’s Benefits Department a written request to continue coverage along with proof that the dependent meets the Plan’s definition of Disabled Dependent, as follows:
  - within 90 days after the dependent reaches age 26; and
  - at reasonable times thereafter as the Claims Administrator may consider necessary, but not more often than annually.

• You may continue coverage for Your (or Your spouse’s or Your domestic partner’s), unmarried, child at age 26 if the child is currently enrolled in the Plan as Your Eligible Dependent and is currently enrolled as a full-time student; and qualifies as Your Qualifying Relative as defined in the United States Internal Revenue Code (the child must meet all dependency tests as set forth by the United States Internal Revenue Code regarding taxability of employer-provided health coverage). To do so, You must provide to the University’s Benefits Department a written request to continue coverage along with certification of the dependent’s full-time student status, as follows:
  - within 90 days after the dependent reaches age 26; and
  - at reasonable times thereafter as the Claims Administrator may consider necessary, but not more often than annually.

You must promptly furnish or cause to be furnished to the University’s Benefits Department any information necessary or appropriate to determine the validity of a dependent's status. Receipt of such information by the University’s Benefits Department will be a condition precedent to continuing coverage for a person as a dependent under the Plan. In addition, You or the dependent must notify the University’s Benefits Department when the dependent is no longer eligible under these exceptions.

**Retirees**

If You are an eligible retiree, You may enroll in a Retiree Health Care Plan offered through the University or continue coverage for a limited period of time under COBRA.

**DEFINITIONS SPECIFIC TO THE WHO IS ELIGIBLE, HOW TO ENROLL AND WHEN COVERAGE BEGINS SECTION**

Disabled Dependent means a child who is and continues to be: 1) unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable Physical or Mental Impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and 2) dependent on You for more than 50% of their support (food, shelter, clothing, medical and dental care, education and the like).
Mental Impairment means a mental or psychological disorder such as: 1) intellectual disability; 2) organic brain syndrome; 3) emotional or mental illness or 4) specific learning disabilities as determined by the Claims Administrator.

Physical Impairment means a physiological disorder, condition or disfigurement, or anatomical loss affecting one or more of the following body systems: 1) neurological; 2) musculoskeletal; 3) special sense organs; 4) respiratory organs; 5) speech organs; 6) cardiovascular; 7) reproductive; 8) digestive; 9) genito-urinary; 10) hemic and lymphatic; 11) skin or 12) endocrine.
How to Enroll and When Coverage Begins

This section explains how to enroll Yourself and/or Your Eligible Dependents when first eligible, during a period of Special Enrollment, Open Enrollment or as a Late Enrollee. This section also describes when coverage under the Plan begins for You and/or Your Eligible Dependents.

Completed applications for coverage should be filed with the University’s Benefits Department.

WHEN YOU AND YOUR DEPENDENTS ARE INITIALLY ELIGIBLE

You become eligible for coverage on (a) the date You are hired by the University in a benefit-eligible position, (b) the date You are transferred into a benefit-eligible position from an ineligible position (c) the date of your appointment or hire into one of the specified independent contractor/affiliated groups. To enroll Yourself and Your Eligible Dependents You must submit Your completed enrollment form to the University’s Benefits Department within 90 days of Your date of hire, the date You transfer into a benefit-eligible position (if You transferred from an ineligible position), or the date you are appointed in one of the specified affiliated groups.

NEWLY ELIGIBLE DEPENDENTS

If You acquire a new dependent by marriage, birth, or newly qualifying as a domestic partnership, You may enroll Yourself, the new dependent, and any other Eligible Dependents not already enrolled by completing and submitting to the University’s Benefits Department a signed Health Care Coverage Change Form within 90 days of the dependent becoming eligible. Upon acceptance of Your properly completed change form, coverage for Your dependent will be effective retroactive to the date the dependent gained eligibility or, at Your request, coverage may be effective on the date the University’s Benefits Department accepts Your completed change form. If the change form is not submitted to the University’s Benefits Department within 90 days of the date the dependent gains eligibility, You may add the dependent to Your coverage only during the Plan’s future Open Enrollment Periods, if any.

If You acquire a new dependent by placement for adoption, coverage for the newly eligible dependent will be based on the following:

- if the baby is legally placed with You for adoption within 30 days of the date of birth, coverage will be effective the date the baby is born; or
- if the baby is legally placed with You for adoption 31 days or after the date of birth, coverage will begin the date stated in the legal placement order signed by the judge.

NOTE: When the addition of a new child by birth, adoption or placement for adoption does not cause a change in Your required health plan contribution (as of the date of birth, date of adoption, or date of placement for adoption), You will have 30 days from the date the Claims Administrator first sends a denial of a claim for benefits for such new dependent, to submit to the University Benefits Department a signed Health Care Coverage Change form, requesting the child be added to Your coverage.

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your Eligible Dependents if You failed to do so when first eligible and not be considered a Late Enrollee. The Special Enrollment period lasts for 90 days beginning with the day of the triggering event; except the Special Enrollment period following exhaustion of any lifetime maximum on total benefits under a plan other than a plan sponsored by the University, which ends 30 days following the date the first claim is denied on the basis of lifetime maximum exhaustion. In each situation, You must complete a Health Care Coverage Change Form (and Domestic Partnership Certification Form if appropriate), and submit it to the University’s Benefits Department within the Special Enrollment period. If You do not submit Your request within the Special Enrollment period, You may only enroll You and/or Your Eligible Dependents during the Plan’s subsequent Open Enrollment Periods, if any. In these situations, the rules regarding how to apply and when coverage begins are the same as those described earlier:

- If You and/or Your Eligible Dependents lose coverage under another group or individual health benefit plan due to:
  - the exhaustion of federal COBRA or any state continuation coverage;
the loss of eligibility due to legal separation, divorce, cessation of dependent status, death, termination of employment or reduction in hours; termination of the employer contributions; or exhaustion of any lifetime maximum on total benefits;
- a significant curtailment in group coverage that qualifies as a loss of coverage under IRS rules and no other similar coverage is available through that group;
- a significant increase in Your cost of group coverage and no other similar coverage is available through that group; or
- involuntary loss of coverage under Medicare, CHAMPUS/Tricare, a medical care program of an Indian Tribal government, the Indian Health Service, a tribal organization, a State health benefits risk pool, or a Foreign government group health plan;

Then You and/or Your Eligible Dependents become eligible for coverage under this Plan on the date the other coverage ends. To be eligible for this Special Enrollment, each individual must have had coverage under any group health plan or health insurance coverage when coverage under this Plan was previously offered. Note that loss of eligibility does not include a voluntary termination of coverage (unless the other Plan permits participants to make an election for a period of coverage that is different from the period of coverage under this Plan), a loss because premiums were not paid in a timely manner, or termination of coverage because of fraud.

- If You declined coverage for Yourself and/or Your Eligible Dependents when You were first eligible and You and/or one of Your Eligible Dependents loses eligibility for coverage under Medicaid or CHIP, or becomes eligible for premium assistance from Medicaid or CHIP, You become eligible for coverage under this Plan on behalf of Yourself and Your Eligible Dependents on the date of change in eligibility.
- If You declined coverage for Yourself and/or Your Eligible Dependents when You were first eligible and You subsequently marry, You become eligible for coverage under this Plan on behalf of Yourself, Your spouse, and any Eligible children and/or Your Eligible Dependents on the date of marriage.
- If You declined coverage for Yourself and/or Your Eligible Dependents when You were first eligible (or You declined coverage for Your spouse when he or she was first eligible) and You subsequently acquire a new child by birth, adoption, placement for legal adoption, or placement for legal guardianship or foster care (if the order requires health coverage for the child), You become eligible for coverage under this Plan along with Your eligible spouse and Eligible children on behalf of Yourself and/or Your Eligible Dependents, including the newly acquired child on the date of the birth, adoption, or placement.

LATE ENROLLMENT/OPEN ENROLLMENT PERIOD
If You wish to enroll and/or add Your Eligible Dependents under the Plan but did not enroll when first eligible or during a previous Open Enrollment Period (Late Enrollee) and You do not qualify for any of the Special Enrollment exceptions, You may enroll in coverage and/or add Your Eligible Dependents only during a future Open Enrollment Period, if any. Coverage for a Late Enrollee will commence on the Effective Date which, for a Late Enrollee, is always the first day of the next Contract Year.

TRANSFER DURING ANNUAL OPEN ENROLLMENT PERIOD
If You and Your Enrolled Dependents are transferring directly to this option from one of the Plan’s other options during an Open Enrollment Period, You must complete an open enrollment form and indicate all Eligible Dependents You want to enroll. If You transfer from one of the Plan’s other options to this option during an Open Enrollment Period, You will not be considered a Late Enrollee. Coverage in this option will commence on the first day of the next Contract Year.

ENROLLMENT BY OTHERS
In the event Your child is the subject of a court or administrative order requiring You to provide health coverage for the child and You are eligible for health coverage including the child, but fail to make application to cover the child, application for enrollment of the child may be made by the child’s other parent, any state Medicaid agency or by the state agency administering 42 U.S.C. 651 through 699 (the child enforcement program). If You are not enrolled in coverage, You will automatically be enrolled and the child will be enrolled as Your Eligible Dependent.
NOTICE OF STATUS CHANGE
In the event You acquire a dependent or a dependent loses eligibility under the Plan, You must give the Plan written notice within 90 days after such date by submitting a Health Care Coverage Change form to the University’s Benefits Department. In order for an individual who loses eligibility for coverage under the Plan to be eligible for continuation of coverage under COBRA, You must submit a Health Care Coverage Change form or otherwise give the Plan written notice within 60 calendar days after such date in order for the dependent to be eligible for continuation of coverage under COBRA.

Leaves of Absence

FAMILY AND MEDICAL LEAVE ACT LEAVE OF ABSENCE
If You are eligible for a leave of absence under the Family and Medical Leave Act (FMLA) of 1993 (Public Law 103-3) the following rules will apply. The Act is generally applicable to private employers of 50 or more employees and public employers of any size. You will be entitled to continued coverage under this provision only to the extent You are eligible for leave under the terms of the FMLA:

- You and Your Enrolled Dependents will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period as provided under the FMLA or up to 26 total weeks if You are approved for Servicemember Family Leave under the FMLA. Persons entitled to coverage under this paragraph will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this paragraph. Entitlement to FMLA leave does not constitute a Qualifying Event for the purposes of COBRA continuation. However, a person not returning to active employment following FMLA leave may be entitled to COBRA continuation coverage, the duration of which will be calculated from the date the person fails to return from the FMLA leave.
- You must make timely payment of Your monthly contribution through the University. The provisions described here will not be available if this Plan terminates.
- If Your FMLA leave is unpaid and You and/or Your Enrolled Dependents elect not to remain enrolled during the leave, You and/or Your Enrolled Dependents will be eligible to be reenrolled under the Plan on the date You return from the FMLA leave if You request reenrollment upon Your return to work. If You return during the same Contract Year, You must be reenrolled in the same medical and dental options You had on the day coverage was terminated.

In this situation, if You reenroll within the required time, all of the terms and conditions of the Plan will resume at the time of reenrollment. If You have a waiting period for pre-existing conditions, You and/or Your Enrolled Dependents will receive credit for any waiting period served prior to the FMLA leave, although You and/or Your Enrolled Dependents will receive no waiting period credits for the period of noncoverage.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern.

MEDICAL LEAVE OF ABSENCE
If You become totally disabled (as defined by the University's Long Term Disability Plan), You may continue coverage through the University by making required contributions. For the first six months, You may continue Your current coverage in this Plan. After six months, if You remain totally disabled and are eligible and enrolled in this Plan, You may enroll in a Retiree Health Plan for up to 30 months from Your initial date of disability.

If You remain totally disabled and are eligible and enrolled in the Plan at the end of the 30-month period and You worked for the University in a benefit-eligible position for:

- 5 or more consecutive years immediately prior to Your date of disability (including any periods of FMLA leave), then You and Your Enrolled Dependents may enroll in the University of Utah Retiree Health Care Plan or elect to continue coverage for a limited time through COBRA; or
• less than 5 consecutive years immediately prior to Your date of disability (including any periods of FMLA leave), then You and Your Enrolled Dependents may be eligible for continuation coverage for a limited time through COBRA.

If You are eligible and enroll in the Retiree Health Care Plan, coverage for You and Your Enrolled Dependents will terminate on the date You are no longer totally disabled; or, for Your Enrolled children, on the date each child loses eligibility under the Plan’s then current definition of an Eligible child, unless You and/or Your Enrolled Dependent(s) become ineligible for or terminate coverage under the Plan on an earlier date.

PERSONAL LEAVE OF ABSENCE
You may continue coverage under the Plan during an approved personal leave of absence by making required contributions through the University’s Benefits Department. Coverage during a personal leave of absence may be continued for up to 12 months from the date the leave of absence began unless an extension is approved by the University of Utah Vice President for Human Resources.

MILITARY LEAVE OF ABSENCE
If You take a leave of absence for active military duty, You may continue coverage under the Plan as follows:

• If the leave of absence is 30 calendar days or less, You may continue coverage as if You were actively at work by paying Your contribution through the University's Benefits Department; or
• If the leave of absence is more than 30 calendar days, You may continue coverage by paying the full contribution rate (including the portion paid for active employees by the University) plus 2%, for up to 24 months.

If You are called to active military duty and You do not elect to continue coverage under the Plan during Your leave, Your coverage will be terminated. You may reenroll in coverage upon Your return to work (if such return is within the time limits set by the Uniformed Services Employment and Reemployment Rights Act “USERRA”), without a pre-existing condition waiting period.

It is the intent of the Plan to comply with all existing regulations of USERRA. If the Plan differs from the actual regulations of USERRA, the Plan reserves the right to administer the Plan in accordance with the USERRA regulations. Coverage under this provision runs concurrently with coverage continued under COBRA.
When Coverage Ends

This section describes the situations when coverage will end for You and/or Your Enrolled Dependents.

PLAN TERMINATION OR AMENDMENT

If the Plan is terminated by the University, coverage for You and Your Enrolled Dependents will end on the date the Plan is terminated. If the terms of eligibility are amended and You are in a class no longer eligible to participate in the Plan, coverage for You and Your Enrolled Dependents will end on the date the terms of eligibility are amended.

No person shall have or acquire a vested right to receive benefits after the date this Plan is terminated or the date they are no longer eligible to participate in the Plan. Termination of Your or Your Enrolled Dependents’ coverage under this Plan for any reason shall completely end all the University’s and the Claims Administrator’s obligations to provide You or Your Enrolled Dependents benefits for Covered Services received after the date of termination whether or not You or Your Enrolled Dependents are then receiving treatment or are in need of treatment for any Illness or Injury incurred or treated before or while this Plan was in effect.

WHEN YOU MAY ELECT TO CANCEL COVERAGE

You may elect to cancel Your coverage and/or coverage for Your Enrolled Dependents during the Plan’s future Open Enrollment Periods, if any. Coverage dropped during Open Enrollment will be terminated effective at the end of the Contract Year.

If You and/or Your Enrolled Dependent(s) obtain other similar coverage during the Contract Year (including enrolling in Medicare), You may elect to cancel coverage for such covered individual(s). In order to drop coverage during the Contract Year, You must complete a Health Care Coverage Change Form and submit it to the University's Benefits Department within 90 days from the date You and/or Your Enrolled Dependent(s) gain other similar coverage. Coverage will be dropped on the date the form is received in the Benefits Department.

If You and/or Your Enrolled Dependent(s) obtain other coverage through the Health Insurance Marketplace, You may elect to cancel coverage for such covered individual(s). In order to drop coverage during the Contract Year, You must complete a Health Care Coverage Form and submit it to the University’s Benefits Department within 90 days from the effective date of coverage through the Health Insurance Marketplace for You and/or Your Enrolled Dependent(s). Coverage will be dropped on the date the form is received in the University Benefits Department.

In the event You experience a significant increase in Your cost of coverage and no other similar coverage is available, You may choose to drop Your coverage in the Plan for You and all Your Enrolled Dependents. To drop coverage, You must complete a Health Care Coverage Change Form and submit it to the University’s Benefits Department within 90 days from the date of the significant increase in Your cost of coverage. Coverage will be dropped on the date the form is received in the Benefits Department.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, Your and Your Enrolled Dependents’ coverage will end as indicated. However, it may be possible for You and/or Your Enrolled Dependents to continue coverage under the Plan according to the COBRA continuation of coverage provisions of this Summary Plan Description.

Termination of Your Employment or Appointment or Change to an Ineligible Employment Status

If You are no longer eligible under the Plan due to termination of employment or appointment or change to an employment status that is ineligible for benefits, or You are no longer a member of an affiliated group, Your coverage will end for You and all Enrolled Dependents on the last day of the pay period on or following the date on which eligibility ends.
Nonpayment of Required Contribution
If You fail to make the required contribution in a timely manner, Your coverage will end for You and all Enrolled Dependents on the date You fail to make such a required contribution and You and Your Enrolled Dependents will not be eligible for continuation of coverage under COBRA in connection with such a termination.

Termination by University
If the University terminates Your coverage for any cause not otherwise specified, Your coverage will end for You and all Your Enrolled Dependents on the date of such a termination.

If You Die
If You die, Your Enrolled Dependents may remain enrolled in the Plan at no cost for 6 months from the date of Your death. Thereafter, they may continue coverage for a limited period of time under COBRA.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE
If Your dependents are no longer eligible as explained in the following paragraphs, their eligibility for coverage will end at 12:01 a.m., Mountain Time, on the date of the event that makes them ineligible. However, it may be possible for Your ineligible dependents to continue coverage under the Plan according to the COBRA continuation of coverage provisions in this Summary Plan Description. You must notify the Benefits Department of such dependent's loss of eligibility within 90 days of the date of the event by completing a Health Care Coverage Change Form. Any change to your coverage level (for example, two-party to single coverage), will be effective on the date you submit your completed form.

You or the dependent must notify the University’s Benefits Department of the ineligibility within 60 days of the event in order to be eligible for COBRA continuation of coverage (see the COBRA Section for additional information).

Divorce or Annulment
Eligibility ends for Your enrolled spouse and the spouse's children (unless such children remain eligible by virtue of their continuing relationship to You) on the date the divorce or annulment is final. You or Your former spouse must notify the University’s Benefits Department of the former spouse’s ineligibility under the Plan. In the event the Plan is notified within 60 calendar days of the date of divorce or annulment, Your former spouse may continue coverage under the Plan for a limited period of time according to the COBRA continuation of coverage provisions of this Summary Plan Description.

Termination of Domestic Partnership
In the event Your domestic partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet the requirements outlined in the definition of an Eligible Dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing dependent relationship with You) on the date of termination of the domestic partnership. You or Your former domestic partner must notify the University's Benefits Department of the domestic partner's (and domestic partner's children's) ineligibility under the Plan. In the event the Plan is notified within 60 calendar days of the date of partnership termination, Your domestic partner (and domestic partner's children) may continue coverage under the Plan for a limited period of time according to the COBRA continuation of coverage provisions of this Summary Plan Description.

Loss of Dependent Status
- For an enrolled child who is no longer an Eligible Dependent due to exceeding the dependent age limit, eligibility ends on the first day of the month following the child’s 26th birthday (or on the date the child is no longer a full-time student or a Disabled Dependent as defined in the Who is Eligible Section, if over age 26).
- For an enrolled child who is no longer eligible due to disruption of placement prior to legal adoption and the child is removed from placement, eligibility ends on the date the child is removed from placement.
- For an enrolled child who is no longer an Eligible Dependent for any other cause (except by reason of Your death), eligibility ends on the date the child is no longer an Eligible Dependent.
You or Your dependent must notify the University's Benefits Department of an Enrolled Dependent’s ineligibility under the Plan. In the event You provide written notification to the Plan within **60 calendar days** of the date the dependent becomes ineligible under the Plan, the dependent may continue coverage under the Plan according to the COBRA continuation of coverage provisions of this Summary Plan Description.

**FRAUDULENT USE OF BENEFITS**

If You or Your Enrolled Dependents engage in an act or practice that constitutes fraud in connection with coverage under this Plan or make an intentional misrepresentation of material fact in connection with coverage, coverage under the Plan may be terminated and continuation of coverage under COBRA may not be available. Claims associated with care obtained under fraudulent circumstances (for example, misrepresentation of patient identity, condition, or symptoms) may be denied or, if paid, refund of payment may be pursued from the provider, recipient, or any individual benefiting from the payment. In addition, any person who knowingly files, or causes to be filed, a statement of claim containing or premised upon any misrepresentation or any false, incomplete, or misleading information may be subject to corrective action up to and including termination of employment with the University, and may be guilty of a criminal act punishable under law and subject to civil penalties.
COBRA Continuation of Coverage

This COBRA Continuation of Coverage Section applies only when the University is subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA.

The right to COBRA coverage was created by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage may become available to you and your family members when you would otherwise lose your health care coverage.

This notice contains important information about your right to continue your health care coverage in the University of Utah Employee Health Care Plan, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. Both you and your spouse should read the information in this notice carefully.

There may be other coverage options for you and your family. You may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Effective January 1, 2014, you’ll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace.

QUALIFYING EVENTS

“Qualifying Events” are certain events that cause an individual to lose health care coverage. Qualifying Events that trigger your right to COBRA coverage are:

- Voluntary or involuntary termination of the covered employee’s employment for reasons other than “gross misconduct”;
- Reduced hours of work for the covered employee, resulting in ineligibility for health coverage;
- Divorce or legal separation of the covered employee;
- Death of the covered employee;
- Loss of status as an “eligible dependent child” under plan rules;
- The covered employee becomes entitled to Medicare, resulting in ineligibility for coverage; or
- The employer files a Chapter 11 bankruptcy (only applicable to retired employees and their dependents covered under a retiree medical program).

Your Qualifying Event determines your notice requirements and the amount of time you may retain COBRA coverage.

WHEN AND HOW YOU MUST GIVE NOTICE

You, your spouse, or dependent child must notify the University Benefits Department within 60 days of one of the following events:

- Divorce or legal separation
- Child losing dependent status
- You experience a Second Qualifying Event
- Disability determination by the Social Security Administration (see Social Security Disability for details)

To provide this notice, you may complete the Health Care Coverage Change Form available on the internet at www.hr.utah.edu/forms/index.php or in the Benefits Department. Alternatively, your spouse or dependent child may give written notice of the Qualifying Event to the Benefits Department at the address listed at the end of this Notice. The written notice must provide the individual’s name and current mailing address, the specific Qualifying Event and the date of the Qualifying Event. If written notice is not provided to the Benefits Department within 60 days after the date of the Qualifying Event, all rights of that
individual to elect COBRA coverage will be lost. The Plan is required to provide notice to you and/or your enrolled dependents of the right to elect COBRA coverage due to any of the other Qualifying Events.

QUALIFIED BENEFICIARIES

Each individual who was covered under the Plan on the day before the Qualifying Event is a “Qualified Beneficiary” and has an independent right to purchase COBRA coverage. An exception to this rule applies if coverage is reduced or eliminated in anticipation of a Qualifying Event. COBRA coverage may still be available to a spouse or dependent child who has been dropped from coverage in anticipation of divorce or legal separation. In this case, COBRA coverage will be effective upon the date of divorce or separation, not the date that coverage was terminated, and will only be available provided that, but for the lost coverage, the spouse or dependent child would otherwise have been eligible. Qualified Dependent includes the covered employee, employee’s spouse, and dependent child or children.

INDIVIDUAL ELECTION RIGHTS

Each Qualified Beneficiary can elect COBRA coverage independently, even if the covered employee chooses not to elect COBRA coverage. The Plan Administrator may terminate your COBRA coverage retroactively if you are determined to have been ineligible for coverage.

LENGTH OF COBRA COVERAGE

The length of COBRA coverage offered depends on your Qualifying Event. If the Qualifying Event is termination of employment or a reduction of work hours, Qualified Beneficiaries may continue COBRA coverage for 18 months. If the Qualifying Event is death of the covered employee, divorce or legal separation, or loss of dependent status, COBRA coverage is available for 36 months. If a Qualified Beneficiary is determined to have been disabled on the date of the Qualifying Event or during the first 60 days of COBRA coverage, additional coverage may be available (see Social Security Disability below).

SOCIAL SECURITY DISABILITY

If your Qualifying Event is termination of employment or reduction in hours and you are determined by the Social Security Administration to have been disabled on the date of the Qualifying Event or during the first 60 days of COBRA coverage, you and/or your enrolled dependents may obtain an extension of coverage from 18 months to 29 months. It is your responsibility to obtain the disability determination from the Social Security Administration and to provide a copy of the determination to the University Benefits Department within 60 days of the date the determination is made and before the end of the original 18-month COBRA period. If you do not notify the Benefits Department and provide the determination within these time frames, you will not be eligible for the 11-month extension of COBRA coverage. If coverage is extended for an additional 11 months due to Social Security disability, your COBRA premiums will be adjusted to 150% of the full cost during the extended 11-month coverage period. It is also your responsibility to provide a written notice to the Benefits Department within 30 days if a final determination is made that you are no longer disabled.

ELECTING COVERAGE

Qualified Beneficiaries have 60 days from the date of the Qualifying Event or if later, from the date of the notice offering COBRA, to elect COBRA coverage. (You are not eligible to elect COBRA coverage if you, your spouse, or dependent child failed to notify the University’s Benefits Department of a divorce, legal separation or a child losing dependent status within 60 days of the event.) If neither you nor your spouse or dependent child(ren) elect COBRA coverage during the applicable election period, your health care coverage will end according to the terms of the Plan. The Plan will not pay claims for services provided on and after the date coverage ends and you, your spouse and your dependents will have no right to elect COBRA coverage at a later date.

COBRA PREMIUM PAYMENTS

If you elect COBRA coverage, you will be responsible to pay the full cost of coverage plus a 2% administration fee. The COBRA premiums, including this fee, will be listed on your “Notice of Right to
Elect Continuation Coverage (COBRA).” Coupons will be provided for premium payments; however, in the event you do not receive coupons, you are responsible for remitting payments timely to avoid termination of coverage.

INITIAL PAYMENT

Payment must be received by the University Benefits Department within 45 days of the date you elect COBRA coverage. Your first premium payment will include premiums due retroactive to the date you lost coverage as a result of your Qualifying Event. If your first payment is not received timely, COBRA coverage will not be effective and you will lose all rights to COBRA coverage.

SUBSEQUENT PAYMENTS

Payment for each subsequent period is due on the first day of each month. You will have a 30-day grace period from the premium due date to make subsequent payments. If COBRA premiums are not paid within the grace period, coverage will terminate as of the end of the last period for which payment was received in full and you will lose all further rights to COBRA coverage.

SECOND QUALIFYING EVENT

Qualified Beneficiaries, other than the employee, who enrolled in COBRA coverage as a result of the employee’s termination of employment or reduction of work hours, who experience another Qualifying Event (divorce, legal separation, death of the covered employee, Medicare entitlement, or loss of dependent status), may extend COBRA coverage beyond 18 months (or 29 months if there has been a disability extension) to 36 months. You must provide a written notice to the University Benefits Department within 60 days of the second Qualifying Event and during the original 18-month COBRA coverage period (or 29-month period if there has been a disability extension) in order to extend COBRA coverage to 36 months. The written notice must provide the individual’s name and current mailing address, the specific Qualifying Event and the date the event occurred. COBRA coverage will never extend beyond 36 months of the date of the original Qualifying Event.

CHANGES IN COBRA COVERAGE

You will have the same rights to enroll dependents and change elections with respect to the University Health Care Plan as active employees of the University. Changes to coverage may be made during the University’s Open Enrollment period each year.

NEWBORNS AND ADOPTEES

A child who is born to or placed for adoption while you are enrolled in COBRA coverage can be added to your COBRA coverage upon proper notification (Health Care Coverage Change Form or written notice) of the birth or placement. Notification must be received within 3 months of the date of birth or placement (if notification is not received within 3 months of the date of birth or placement, you will not be able to add the child to your coverage until the next Open Enrollment period). The child will not have an independent right to purchase COBRA coverage. The child’s COBRA coverage will terminate when your COBRA coverage terminates, unless you terminate his/her coverage voluntarily at an earlier date.

FLEXIBLE SPENDING ACCOUNTS

If you were enrolled in a Health Flexible Spending Account at the time of your Qualifying Event and would like to retain access to any fund balance in your account, please contact the Benefits Department to obtain additional information. You may be allowed to continue participation in the Flexible Benefit Plan through the end of the plan year in which the Qualifying Event occurred. If you fail to make payment, your participation in the Flexible Benefit Plan will terminate and expenses incurred after the termination date will not be eligible for reimbursement.
FINANCIAL AID
Some states offer financial aid to help certain individuals pay for COBRA coverage. Contact your appropriate state agency regarding availability and eligibility requirements.

TERMINATION OF COBRA COVERAGE
Your COBRA coverage will end for you and/or your enrolled dependents if any of the following occurs:

- The required premium payments are not paid within the timeframe allowed;
- You notify the COBRA administrator that you wish to cancel your coverage;
- The applicable period of COBRA coverage ends;
- You become entitled to Medicare benefits (under Part A, Part B, or both);
- The date you reach the Lifetime Maximum Benefit under the Plan;
- The University terminates its group health plan(s);
- You have extended COBRA coverage due to Social Security disability and a final determination is made that you are no longer disabled, coverage for all who had qualified for the disability extension will end as of the later of:  
  - the last day of 18 months of continuation coverage, or  
  - the first day of the month that is more than 30 days following the date of the final determination of the nondisability;
- After the date of your COBRA election, you become covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitations on plans’ imposing a pre-existing condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act); or
- An event occurs that permits termination of coverage under the University Health Care Plan for an individual covered other than pursuant to COBRA (for example, submitting fraudulent claims).

QUESTIONS, NOTICES AND ADDRESS CHANGE
This notice does not fully describe COBRA coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the University Benefits Department.

The University’s COBRA Administrator is Sandy Robison, 420 Wakara Way, Suite 105 Salt Lake City, UT 84108, telephone (801) 581-7447 (the contact person may change from time to time).

If you divorce or legally separate or lose eligibility as a dependent child under the University Health Care Plan, you must provide the required written notice to the University Benefits Department at the address set forth below within 60 days.

In order to protect your Family’s rights, you should keep the University Benefits Department informed of any change in address for you, your spouse, or enrolled dependent children. If you have any questions or need additional information, please contact the University Benefits Department.

If You divorce or legally separate, no longer qualify as a domestic partnership, or lose eligibility as a child under the University Health Care Plan, You must provide the required written notice to the University's Benefits Department within 60 days.

In order to protect Your Family’s rights, You should keep the University’s Benefits Department informed of any change in address for You, Your spouse, domestic partner or enrolled children.
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records
You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we’ve shared information
You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us using the information on page 4.
You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in payment for your care
Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
Marketing purposes
Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you. Example: A doctor sends our health plan administrator information about your diagnosis and treatment plan so they can arrange additional services.

Run our organization
We can use and disclose your information to run our organization and contact you when necessary.
We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This federal rule does not apply to long term care plans.
Example: We use health information about enrolled employees in the aggregate to develop better services for health plan members.

Pay for your health services
We can use and disclose your health information as we pay for your health services. Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan administrator for claims administration.
Example: We contract with health plan administrators to provide network and claims administration for the health plan, and they provide us with certain statistics to calculate the premiums we charge.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we
can share your information for these purposes. For more information see:

**Help with public health and safety issues**
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

**Do research**
We can use or share your information for health research.

**Comply with the law**
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

**Respond to organ and tissue donation requests and work with a medical examiner or funeral director**
We can share health information about you with organ procurement organizations. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers’ compensation, law enforcement, and other government requests**
We can use or share health information about you:

- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**OUR RESPONSIBILITIES**
We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

**CHANGES TO THE TERMS OF THIS NOTICE**
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

**CONTACT US**
If you are concerned that your privacy rights may have been violated, or disagree with a decision that we made about access to your health information, contact:

University of Utah Benefits Department

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Attention: Manager of Benefits
420 Wakara Way, Suite 105
Salt Lake City, UT 84108
(801) 581-7447
Fax: (801) 585-7375

University of Utah Information Security and Privacy Office
650 Komas Drive, Suite 102
Salt Lake City, UT 84108
(801) 587-9241
Fax: (801) 587-9443
http://privacy.utah.edu/
General Provisions

This section explains various general provisions regarding Your benefits under this coverage.

CHOICE OF FORUM
Any legal action arising out of the Plan benefit option described herein must be filed in a court in the state of Utah.

GOVERNING LAW AND DISCRETIONARY LANGUAGE
The Plan will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the State of Utah without regard to its conflict of law rules. The Plan Sponsor, the Plan, delegates the Claims Administrator discretion for the purposes of paying benefits under this coverage only if it is determined that You are entitled to them and of interpreting the terms and conditions of the plan. Final determinations pursuant to this reservation of discretion do not prohibit or prevent a claimant from seeking judicial review of those determinations in federal court. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when You seek judicial review of a determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the plan. The Claims Administrator is not the Plan Sponsor, but does provide claims administration under the Plan, and the court will determine the level of discretion that it will accord the Claims Administrator's determinations.

PLAN IS AGENT
The Plan is Your agent for all purposes under the Plan and not the agent of Regence BlueCross BlueShield of Utah. You are entitled to health care benefits pursuant to the Plan. In the Agreement, the Plan agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in the Summary Plan Description. You, through the enrollment form signed by the Participant, and as Dependents of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Summary Plan Description.

NO WAIVER
The failure or refusal of either party to demand strict performance of the Plan or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the Plan will be considered waived unless such waiver is reduced to writing and signed by one of the Plan's authorized officers.

NOTICES
Any notice to Claimants or to the Plan required in the Plan will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Participant or to the Plan will be addressed to the Participant or to the Plan at the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address form (COA) for a Participant, it will update its records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Plan Sponsor or Plan if it becomes aware that it doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be given by mail addressed to: Regence BlueCross BlueShield of Utah, P.O. Box 30272, Salt Lake City, UT 84130-0272; provided, however that any notice to the Claims Administrator will not be considered to have been given to and received by it until physically received.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION
The Plan on behalf of itself and its Claimants expressly acknowledges its understanding that the Agreement constitutes an agreement solely between the Plan or and Regence, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association), permitting Regence to use the Blue Cross and Blue Shield Service Marks in the state of Utah and that Regence is not contracting as the agent of the Association. The Plan on behalf of itself and its Claimants further acknowledges and agrees that it has not entered into the Agreement based upon representations by any person or entity other than Regence and that no person or entity other than Regence will be held accountable or liable to the Plan or

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the Claimants for any of Regence’s obligations to the Plan or the Claimants created under the Agreement. This paragraph will not create any additional obligations whatsoever on the part of Regence other than those obligations created under other provisions of the Agreement.

**REPRESENTATIONS ARE NOT WARRANTIES**
In the absence of fraud, all statements You make in an enrollment form will be considered representations and not warranties. No statement made for the purpose of obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

**WHEN BENEFITS ARE AVAILABLE**
In order for health expenses to be covered under the Plan, they must be incurred while coverage is in effect. Coverage is in effect when all of the following conditions are met:

- the person is eligible to be covered according to the eligibility provisions described in the Plan Document; and
- the person has enrolled in coverage and has been enrolled by the Claims Administrator.

The expense of a service is incurred on the day the service is provided and the expense of a supply is incurred on the day the supply is delivered to You.
Definitions

The following are definitions of important terms used in this Summary Plan Description. Other terms are defined where they are first used.

Affiliate means a company with which the Claims Administrator has a relationship that allows access to providers in the state in which the Affiliate serves and includes the following companies: Regence BlueShield of Idaho in the state of Idaho, Regence BlueCross BlueShield of Oregon in the state of Oregon and Regence BlueShield in parts of the state of Washington.

Allowed Amount means:

- For In-Network Providers (see definitions of "In-Network" below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For Out-of-Network Providers (see definition of "Out-of-Network" below) who are not accessed through the BlueCard® Program, the amount the Claims Administrator has determined to be reasonable charges for Covered Services or supplies. The Allowed Amount may be based upon the amount an In-Network Provider has agreed to accept as payment in full or billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.
- For Out-of-Network Providers (see definition of "Out-of-Network" below) accessed through the BlueCard® Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to the Claims Administrator as the amount on which it would base a payment to that Provider.

Charges in excess of the Allowed Amount are not considered reasonable charges and are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, please contact the Claims Administrator.

Ambulatory Surgical Center means a facility or that portion of a facility licensed by the state in which it is located, that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission. An Ambulatory Surgical Center must be a freestanding facility, meaning that it exists independently or is physically separated from another health care facility by fire walls and doors and is administered by separate staff with separate records.

Claimant means a Participant or an Enrolled Dependent.

Contract Year means the period from July 1 through June 30 of the following year; however, the first Contract Year begins on the Claimant's Effective Date.

Covered Service means a service, supply, treatment or accommodation that is listed in the benefits sections in the Summary Plan Description.

Custodial Care means care that is for the purpose of watching and protecting a patient, rather than being a Health Intervention. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily for the purpose of separating the patient from others or preventing self-harm.

Dependent means a Participant's eligible dependent who is listed on the Participant's completed enrollment form and who is enrolled under the Plan.

Dental Services means services or supplies (including medications) provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Effective Date means the date Your coverage under the Agreement begins after acceptance for enrollment under the Plan.
Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency room to result in any one of the following:

- placing the Claimant’s health, or with respect to a pregnant Claimant, her health or the health of her unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Family means a Participant and his or her Dependents.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following: disease, Illness, Injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. A Health Intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

Health Outcome means an outcome that affects health status as measured by the length or quality of a person’s life. The Health Intervention’s overall beneficial effects on health must outweigh the overall harmful effects on health.

Hospital means a facility that is licensed as a general acute or specialty Hospital by the state in which the Hospital is located. A Hospital provides continuous 24-hour nursing services by registered nurses. A Hospital has an attending medical staff consisting of one or more Physicians. A Hospital under this definition is not, other than incidentally, a place for rest, a nursing home or a facility for convalescence.

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy. Illness does not include any state of mental health or mental disorder.

Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of Illness or any other cause. An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

In-Network means a Provider that has an effective participating contract with the Claims Administrator that designates him, her, or it as a member of the panel of Providers selected by the Plan Sponsor to provide services and supplies to Claimants in accordance with the provisions of this coverage. In-Network also means a Provider outside the area that the Claims Administrator or one of its Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as a Provider in the "In-Network") to provide services and supplies to Claimants in accordance with the provisions of this Summary Plan Description. For In-Network Provider Reimbursement, You will not be charged for balances beyond any Deductible and/or Coinsurance for Covered Services.

Investigational means a Health Intervention that the Claims Administrator has classified as Investigational. The Claims Administrator will review Scientific Evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is Investigational. A Health Intervention not meeting all of the following criteria is, in the Claims Administrator’s judgment, Investigational:

- If a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration (FDA) as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the medication may be provided when so used.

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To be considered effective for other than its FDA-approved use, it must be determined that the medication is effective for the treatment of that condition; or is determined by the Claims Administrator to be in an Investigational status.

- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Injury or Illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

**Lifetime** means the entire length of time a Claimant is covered under the Plan (which may include more than one coverage) through the Plan with the Claims Administrator.

**Maintenance Therapy** means a Health Intervention after the patient has reached maximum rehabilitation potential or functional level and has shown no significant improvement for one to two weeks, and instruction in the maintenance program has been completed. This is particularly applicable to patients with chronic, stable conditions where skilled supervision/intervention is no longer required and further clinical improvement cannot reasonably be expected from continuous ongoing care. This includes but is not limited to:

- a general exercise program to promote overall fitness;
- ongoing treatment solely to improve endurance and fitness;
- passive exercise to maintain range of motion that can be carried out by non-skilled persons;
- programs to provide diversion or general motivation;
- therapy that is intended to maintain a gradual process of healing or to prevent deterioration or relapse of a chronic condition; or
- therapy that is supportive rather than corrective in nature.

**Medically Necessary** or **Medical Necessity** means health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an Illness or Injury or its symptoms in a manner that is:

- in accordance with generally accepted standards of medical practice in the United States;
- clinically appropriate in terms of type, frequency, extent, site, and duration;
- not primarily for the convenience of the patient, Physician, or other health care Provider; and
- covered under the Plan;

When a medical question-of-fact exists, Medical Necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and that is known to be effective. For Health Interventions not yet in widespread use, the effectiveness shall be based on Scientific Evidence. For established Health Interventions, the effectiveness shall be based on first Scientific Evidence; then professional standards; and then expert opinion.

A HEALTH INTERVENTION MAY BE MEDICALLY INDICATED YET NOT BE A COVERED SERVICE UNDER THE PLAN OR OTHERWISE MEET THIS DEFINITION OF MEDICAL NECESSITY.

**Morbid Obesity** means a severe state of obesity, as defined in the Claims Administrator's published medical policies.

**Out-of-Network** refers to a Provider that does not have an effective contract with the Claims Administrator or one of its Affiliates that designates him, her or it as a member of the panel of Providers selected by the Plan Sponsor for Your benefits under this Plan. This definition also refers to Providers outside the area that the Claims Administrator or one of its Affiliates serves. For reimbursement of these Out-of-Network Provider services, You may be billed for balances over Plan payment level in addition to any Deductible and/or Coinsurance amount for Covered Services provided inside or outside the area that the Claims Administrator or one of its Affiliates serves.
Participant means an employee of the University who is eligible under the terms described in this Summary Plan Description, who has completed an enrollment form and is enrolled under this coverage.

Physician means an individual who is duly licensed to practice medicine and surgery in all of its branches or to practice as an osteopathic Physician and surgeon.

Plan Participant means an employee, member of an affiliated group, or surviving spouse who is eligible under the terms of the Plan, whose application is accepted by the Plan, and who is enrolled under this Plan.

PPACA means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act. In accordance with PPACA, Preventive Care benefits of the Plan are covered in accordance with guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include podiatrists, chiropractors, psychologists, certified nurse midwives, certified registered nurse anesthetists, dentists and other professionals practicing within the scope of his or her respective licenses.

Provider means a Hospital, Skilled Nursing Facility, Ambulatory Surgical Center, Physician, Practitioner or other individual or organization which is duly licensed to provide medical or surgical services.

Rehabilitation Facility means a facility or distinct part of a facility that is licensed as a Rehabilitation Facility by the state in which it is located and that provides an intensive, multidisciplinary approach to rehabilitation services under the direction and supervision of a Physician.

Regence refers to Regence BlueCross BlueShield of Utah.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Skilled Nursing Facility means a facility or distinct part of a facility which is licensed by the state in which it is located as a nursing care facility and which provides skilled nursing services by or under the direction and supervision of a registered nurse.

Summary Plan Description (SPD) is a summary of the benefits provided by the Group Health Plan (GHP). A GHP with different benefit plan options may describe them in one SPD or in separate SPDs for each alternative benefit plan option.
General Plan Information

EMPLOYER
The University's legal name and federal Employer Identification Number (EIN) are:

University of Utah
EIN # 87-6000525

PLAN NAME
The name of the Plan is The University of Utah Employee Health Care Plan.

PLAN YEAR
The Plan year is the twelve month period beginning July 1 and ending on June 30.

TYPE OF PLAN
The Plan is commonly known as an employee welfare benefit plan. The Plan has been adopted to provide You certain benefits as described in this document.

PLAN FUNDING
Funding is derived first from the contributions made by the covered employees and then from general assets of The University. The level of Your contributions will be set by The University. Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received.

PLAN SPONSOR
The University of Utah
420 Wakara Way, Suite 105
Salt Lake City, UT 84108
(801) 585-9144

LEGAL PROCESS
Address where a processor may serve legal process:

University of Utah General Counsel
201 President's Circle, Room 309
Salt Lake City, UT 84112

CLAIMS ADMINISTRATOR
The University has contracted with a Claims Administrator to assist The University with claims adjudication. The Claims Administrator's name, address and telephone number are:

Regence BlueCross BlueShield
2890 East Cottonwood Parkway
Salt Lake City, UT 84121
Customer Service (800) 262-9712
Case Management (866) 543-5765

PLAN SPONSOR'S RIGHT TO TERMINATE
The University reserves the right to amend or terminate this Plan in whole or in part, at any time, regardless of Your or Your Enrolled Dependent's health or treatment status. Amendment or termination may result in modification or termination of Your coverage and/or the coverage of Your Enrolled Dependents. Covered Services and Allowed Amount incurred prior to the Plan’s amendment or termination will be paid as provided under the terms of the Plan as it existed at the time they were incurred.

PLAN SPONSOR'S RIGHT TO INTERPRET THE PLAN
The University reserves the right to interpret the Plan’s coverage and meaning in the exercise of its sole discretion.
For more information contact the Claims Administrator at 1 (866) 240-9580 or P.O. Box 2998, Tacoma, WA 98401-2998

www.Regence.com