Employee Health Care Plan
Dental Plan Option
NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD).

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

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ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS: 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711)まで、お電話にてご連絡ください。

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY: 711)まで、お電話にてご連絡ください。

Note: This is a translation of the same text in different languages. The original text is in English, and the translations are provided in various languages such as Spanish, Chinese, Korean, French, and Japanese. The text is about language assistance services available in various languages, including Spanish, French, and Chinese. The text also provides phone numbers for people who need to contact language assistance services.
UNIVERSITY OF UTAH

EMPLOYEE HEALTH CARE PLAN

BLUE CROSS BLUE SHIELD DENTAL PLAN OPTION

SUMMARY PLAN DESCRIPTION

GROUP NUMBER: 10002211

Regence BlueCross BlueShield
2890 East Cottonwood Parkway
Salt Lake City, UT 84121
regence.com
Customer Service (800) 262-9712
TTY: 711
Case Management (866) 543-5765

University of Utah Human Resources
Department
250 East 200 South Suite 125
Salt Lake City, UT 84111
www.hr.utah.edu/benefits

UBenefits: https://hr.apps.utah.edu/ubenefits
Phone (801) 581-7447
Fax (801) 585-7375

Regence
100 Southwest Market Street
P.O. Box 1271
Portland, OR 97207
regence.com
Customer Service (800) 262-9712

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 Web site listed above. The University’s Notice of Privacy Practices is at the end of this SPD.
Introduction

NOTE: THIS SUMMARY PLAN DESCRIPTION PROVIDES DENTAL BENEFITS ONLY. REVIEW YOUR SUMMARY PLAN DESCRIPTION CAREFULLY.

This University of Utah Employee Health Care Plan Summary Plan Description (SPD) provides the written description of the terms and benefits of coverage available under the Plan. The administrative services contract between Your employer and Regence BlueCross BlueShield of Utah (called the "Agreement") contains all the terms of coverage. Your Plan Sponsor has a copy.

This SPD describes benefits effective July 1, 2021, or the date Your coverage became effective. This SPD replaces any dental plan description, SPD previously issued by the Plan Sponsor and makes it void. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your Provider before receiving care.

In this SPD, the term "Claims Administrator" refers to Regence BlueCross BlueShield of Utah (Regence BCBSU), and the term "Plan Sponsor" refers to Your employer. References to "You" and "Your" refer to both the Participant and enrolled Dependents. The term "Family" refers to the Plan Participant and all individuals enrolled as his/her eligible Dependents. 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 or where they are first used and are designated by the first letter being capitalized.

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.

CONTACT INFORMATION
Customer Service: 1 (800) 262-9712
(TTY: 711)

Phone lines are open Monday–Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m. Pacific Time.

Contact Customer Service:

- if You have questions;
- if You would like to learn more about Your coverage;
- if You would like to request written or electronic information regarding any other plan that the Claims Administrator offers;
- to talk with one of the Claims Administrator's Customer Service representatives;
- via the Claims Administrator's Web site, regence.com, to chat live with a Customer Service representative;
- to request a copy of Your identification card (or print a copy via the Claims Administrator's Web site); or
- for assistance in a language other than English.
Using Your Summary Plan Description

ACCESSING PROVIDERS
You are not restricted in Your choice of Dentist for dental care or treatment. You control Your out-of-pocket expenses by choosing between "In-Network Dentist" and "Out-of-Network Dentist."

- **In-Network Dentist.** Choosing In-Network Dentists saves You the most in Your out-of-pocket expenses. In-Network Dentists will not bill You for balances beyond any Coinsurance for Covered Services.

- **Out-of-Network Dentist.** Choosing Out-of-Network Dentists means Your out-of-pocket expenses will be generally higher than choosing an In-Network Dentist. Also, an Out-of-Network Dentist may bill You for balances beyond any Coinsurance. This is referred to as balance billing.

For each benefit, the Dentist You may choose and Your payment amount for each provider option is indicated. See the Definitions Section for a complete description of In-Network Dentist and Out-of-Network Dentist. You can go to regence.com for further provider network information.

ADDITIONAL ADVANTAGES OF PARTICIPATION
The Claims Administrator provides access to discounts on select items and services, personalized health/dental care planning information, health-related events and innovative health/dental decision tools, as well as a team dedicated to Your personal dental care needs. You also have access to regence.com to help You navigate Your way through treatment decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE UNIVERSITY OF UTAH EMPLOYEE HEALTH CARE PLAN, BUT ARE NOT INSURANCE.**

- **Go to regence.com.** You can use the Claims Administrator's secure Web site to:
  - view recent claims, benefits and coverage;
  - find a contracting dental provider;
  - participate in online wellness programs and use tools to estimate upcoming healthcare costs; and
  - discover discounts on select items and services*

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by this Plan, that also may create savings or administrative fees for the Claims Administrator. Any such discounts or coupons are complements to the Plan, but are not insurance.
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UNIVERSITY OF UTAH TRANSITIONAL PLAN, 10002211, EFFECTIVE JULY 1, 2021
Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits and Coinsurance. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the Dental Benefits Section to see what Your benefits are.

MAXIMUM BENEFITS
Some Covered Services may have a specific Maximum Benefit. Those Covered Services will be provided until the specified Maximum Benefit (which may be a number of days, visits, services, supplies, dollar amount or specified time period) has been reached. Refer to the Dental Benefits Section to determine if a Covered Service has a specific Maximum Benefit.

You will be responsible for the total billed charges for Covered Services that are in excess of any Maximum Benefits. You will also be responsible for charges for any other services or supplies not covered by this Plan, regardless of the provider rendering such services or supplies.

COINSURANCE (PERCENTAGE YOU PAY)
Your Coinsurance is the percentage You pay when the Plan's payment is less than 100 percent. The Coinsurance varies, depending on the service or supply You received and who rendered it. Your Coinsurance applies for Covered Services up to any Maximum Benefit. Your Coinsurance will be based upon the lesser of either the billed charges or the Allowed Amount. The Plan does not reimburse Dentists for charges above the Allowed Amount.

HOW PLAN YEAR BENEFITS RENEW
The Deductible and certain Maximum Benefits are calculated on a Plan Year basis. Each July 1, those Plan Year maximums begin again. Some benefits have a separate Maximum Benefit based upon a Claimant's Lifetime and do not renew every Plan Year.
Summary of Dental Benefits

This section explains Your benefits and cost-sharing responsibilities for Covered Services. For ease of finding the information regarding dental benefits most important to You, these dental benefits have been listed alphabetically.

MAXIMUM BENEFITS

Basic, Major and Preventive and Diagnostic Dental Services:
Per Claimant: $2,000 per Plan Year

Orthodontic Dental Services:
Per Claimant: $2,000 per Lifetime

BASIC DENTAL SERVICES

<table>
<thead>
<tr>
<th>Provider: In-Network Dentist</th>
<th>Provider: Out-of-Network Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment: You pay 20% of the Allowed Amount.</td>
<td>Payment: You pay 20% of the Allowed Amount and the balance of billed charges.</td>
</tr>
</tbody>
</table>

Basic dental services are covered, subject to any specified limits as explained in the following:

- Adjustment and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within one year of insertion.
- Complex oral surgery procedures including:
  - surgical extractions of teeth;
  - impactions;
  - alveoloplasty; and
  - residual root removal.
- Emergency treatment for pain relief.
- Endodontic services:
  - apicoectomy;
  - debridement;
  - direct pulp capping;
  - pulpal therapy;
  - pulpotomy; and
  - root canal treatment.
- Fillings consisting of composite and amalgam restorations.
- General dental anesthesia or intravenous sedation administered for:
  - extractions of partially or completely bony impacted teeth; or
  - to safeguard the Claimant's health (for example, a child under seven years of age).
- Periodontal services including:
  - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery);
  - debridement limited to once per Claimant in a three-year period;
  - gingivectomy and gingivoplasty;
  - periodontal maintenance limited to two* per Claimant per Plan Year (however, in any Calendar Year a Claimant will be entitled to no more than two* cleanings whether periodontal maintenance or standard cleaning).
  *A third periodontal maintenance may be covered, in the same Calendar Year, for a Claimant with one or more of the following conditions:
    - coronary atherosclerosis;
- diabetes;
- hypertensive heart disease; or
- pregnancy.

In this instance, a Claimant will be entitled to no more than three cleanings in a Calendar Year, whether periodontal maintenance or standard cleaning.

- scaling and root planing limited to once per Claimant per quadrant per Plan Year.

- Repair of dentures and bridges, limited to every 5 years per tooth (must have a lapse of at least 6 months from the date of service); and
- Uncomplicated oral surgery procedures including removal of teeth, incision and drainage.

<table>
<thead>
<tr>
<th>MAJOR DENTAL SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider:</strong> In-Network Dentist</td>
</tr>
<tr>
<td><strong>Payment:</strong> You pay 50% of the Allowed Amount.</td>
</tr>
</tbody>
</table>

Major dental services are covered, subject to any specified limits as explained in the following:

- Bridges (fixed partial dentures), limited to every five years per tooth.
- Crowns, crown build-ups, inlays and onlays (for gold inlays, onlays and crowns, payment is limited to the amount that would have been paid for plastic inlays, onlays and crowns unless special need is demonstrated for use of gold), except that benefits will not be provided for any of the following:
  - any crown, inlay or onlay replacement made fewer than five years after placement per tooth (or subsequent replacement) whether or not originally covered in this SPD; and
  - additional procedures to construct a new crown under an existing partial denture framework.
- Dental implant crown and abutment related procedures.
- Dentures, full and partial, including:
  - denture rebase; and
  - denture relines.
- Denture benefits will **not** be provided for:
  - any denture replacement made fewer than five years after denture placement (or subsequent replacement) whether or not originally covered in this SPD.
  - interim partial or complete dentures; or
  - pediatric dentures.
- Endosteal implants;
- Recement crown, inlay or onlay;
- Repair of crowns is limited to every five years per tooth;
- Repair of implant supported prosthesis or abutment;
- Veneers; and
- Vestibuloplasty.

<table>
<thead>
<tr>
<th>ORTHODONTIC DENTAL SERVICES</th>
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</thead>
<tbody>
<tr>
<td><strong>Provider:</strong> All Dentists</td>
</tr>
<tr>
<td><strong>Payment:</strong> You pay 50% of the Allowed Amount and the balance of billed charges.</td>
</tr>
<tr>
<td><strong>Limit:</strong> $2,000 per Claimant Lifetime</td>
</tr>
</tbody>
</table>

Orthodontic dental services are covered, subject to any specified limits as explained in the following:
• The initial and subsequent installations of orthodontic appliances and all non-surgical orthodontic treatments concerned with the reduction or elimination of an existing malocclusion, subject to the submission of a treatment plan (submitted by the attending provider). The treatment plan should include all of the following information:
  - a diagnosis indicating an abnormal occlusion that can be corrected by orthodontic treatment;
  - the estimated length of required treatment;
  - the initial banding fee; and
  - the total orthodontic treatment charge.

• If treatment stops before the end of the prescribed treatment period, benefits will end on the last day of the month during which the treatment was discontinued.

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

<table>
<thead>
<tr>
<th>Provider: In-Network Dentist</th>
<th>Provider: Out-of-Network Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment:</strong> You pay 20% of the Allowed Amount.</td>
<td><strong>Payment:</strong> You pay 20% of the Allowed Amount and the balance of billed charges.</td>
</tr>
</tbody>
</table>

Preventive and diagnostic dental services are covered, subject to any specified limits as explained in the following:

• The following services are limited to two per Claimant per Plan Year:
  - preventive oral examinations; and
  - topical fluoride application for Claimants under 26 years of age;
  - cleanings (however, in any Plan Year a Claimant will be entitled to no more than two* cleanings whether standard cleaning or periodontal maintenance).

  *A third cleaning may be covered, in the same Calendar Year, for a Claimant with one or more of the following conditions:
  - coronary atherosclerosis;
  - diabetes;
  - hypertensive heart disease; or
  - pregnancy.

In this instance, a Claimant will be entitled to no more than three cleanings in a Calendar Year, whether standard cleaning or periodontal maintenance.

• The following services are limited to one per Claimant in a three-year period:
  - complete intra-oral mouth x-rays; and
  - panoramic mouth x-rays.

• Bitewing x-ray sets;
• Problem-focused oral examinations.
• Sealants, limited to once per tooth and:
  - to deciduous teeth only on the chewing surface of the first and second molars; and
  - permanent teeth only on the chewing surface, excluding wisdom teeth.

• Space maintainers for Claimants under 13 years of age.
General Exclusions

The following are limitations and exclusions from coverage, other exclusions may apply as described elsewhere in this SPD.

LIMITATIONS

Optional Techniques
In all cases in which there are optional techniques carrying different fees, the Plan will only be liable for the treatment carrying the lesser fee.

Transfer of Care
In the event the Claimant transfers from the care of one Dentist to that of another Dentist during the course of treatment, or if more than one Dentist renders services for one dental procedure, the Plan will be liable for not more than the amount the Plan would have been liable for if only one Dentist rendered the service.

SPECIFIC EXCLUSIONS

The following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them, are not covered. However, these exclusions will not apply with regard to a Covered Service for 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.

Aesthetic Dental Procedures
Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.

Antimicrobial Agents
Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.

Appliances and Restorations for Malalignment of The Teeth
Appliances or restorations necessary to increase vertical dimensions or restore occlusion including equilibration; periodontal splinting; and restoration for malalignment of the teeth.

Charges that Exceed the Allowed Amount
Any charge for services and supplies that exceed the Allowed Amount.

Collection of Cultures and Specimens
Collection of cultures and specimens, including, but not limited to:
- saliva; or
- tissue of the oral cavity.

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

Conditions Incurred in or Aggravated During Performances in the 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.

Connector Bar or Stress Breaker

Cosmetic/Reconstructive Services and Supplies
Except for the following, cosmetic and/or reconstructive services and supplies are not covered:
- Dentally Appropriate services and supplies to treat a congenital anomaly; or
- to restore a physical bodily function lost as a result of Illness or Injury.
“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.

**Court-Ordered or Court-Related Services/Services in Connection with Legal Proceedings**

Services, supplies, examinations, reports, or appearances in connection with legal proceedings or court ordered or court-related services.

**Dentist Practicing Beyond Scope of License**

Services rendered by a Dentist practicing beyond the scope of his or her license.

**Desensitizing**

Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.

**Diagnostic Casts or Study Models**

**Duplicate X-Rays**

**Expenses Before Coverage Begins or After Coverage Ends**

Services and supplies incurred before Your Effective Date under the Plan or after Your termination under the Plan.

**Facility Charges**

Services and supplies provided in connection with facility services, including hospitalization for dentistry and extended-care facility visits.

**Fees, Taxes, Interest**

Except as required by law, the following fees, taxes and interest are not covered:

- charges for shipping and handling, postage, interest or finance charges that a Dentist might bill;
- 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.

**Fractures of the Mandible (Jaw)**

Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

**Gold-Foil Restorations**

**Government Programs**

Except as required by state law (such as cases of medical emergency or coverage provided by Medicaid) or for facilities that contract with the Claims Administrator, benefits that are covered (or would be covered in the absence of this Plan) by any federal, state or government program are not covered.

Additionally, except as required by law for emergency services, government facilities or government facilities outside the service area are not covered.

**Home Visits**
Illegal Activity
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by a Claimant's voluntary participation in an activity where the Claimant is found:

- guilty of an illegal activity in a criminal proceeding; or
- liable for the activity in a civil proceeding.

A guilty finding includes a plea of guilty, a no contest plea, and a plea in abeyance.

Implants
Except as provided in the Dental Benefits Section, implants and any associated services and supplies are not covered (whether or not the implant itself was covered), including, but not limited to:

- interim endosseous implants;
- eposteal and transosteal implants;
- implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
- radiographic/surgical implant index; and
- unspecified implant procedures.

Investigational Services
Investigational services are not covered, including, but not limited to:

- services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions); and
- any services or supplies provided by an Investigational protocol.

Medications and Supplies
Charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies.

Motor Vehicle Coverage and Other Available Insurance
When motor vehicle coverage, other available insurance or contract is either issued to, or makes benefits available to a Claimant (whether or not the Claimant makes a claim with such coverage), expenses are not covered for services and supplies that are payable by 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.

Further, the Claimant is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits in such contract or insurance are exhausted or considered to no longer be Injury-related by the no-fault provisions of the contract, benefits will be provided accordingly.

Nitrous Oxide

Non-Direct Patient Care
Non-direct patient care services are not covered, including but not limited to:

- 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).

Occlusal Treatment
Dental occlusion services and supplies are not covered, including but not limited to:

• occlusal analysis and adjustments; and
• occlusal guards.

Oral Hygiene Instructions

Oral Surgery
Ocular surgery treating any fractured jaw and orthognathic surgery. "Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development performed to restore the proper anatomic and functional relationship of the facial bones.

Personal Items
Items that are primarily for comfort, convenience, cosmetics, contentment, hygiene, aesthetics or other nontherapeutic purposes.

Photographic Images

Pin Retention in Addition to Restoration

Precision Attachments

Prosthesis
Dental prosthesis services and supplies are not covered, including, but not limited to:

• maxillofacial prosthetic procedures; and
• modification of removable prosthesis following implant surgery.

Provisional Splinting

Pulp Vitality Tests

Replacements
Replacement of any lost, stolen or broken dental appliance, including, but not limited to, dentures or retainers.

Riot and Rebellion
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by a Claimant's voluntary participation in any of the following:

• a riot;
• an armed invasion or aggression;
• an insurrection; or
• a rebellion.

Self-Help, Self-Care, Training or Instructional Programs
Except for services provided without a separate charge in connection with Covered Services that train or educate a Claimant, self-help, non-dental self-care and training or instructional programs are not covered.

Separate Charges
Services and supplies that may be billed as separate charges (services that should be included in the billed procedure) are not covered, including, but not limited to:

• any supplies;
- local anesthesia; and
- sterilization.

**Services and Supplies Provided by a Member of Your Family**
Services and supplies provided to You by a member of Your immediate family are not covered.

"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; and
- Your child's or stepchild's spouse or domestic partner.

**Services and Supplies Provided Outside of Utah**
Services and supplies provided outside of Utah that would not have been licensed in Utah, or that may not be legally provided in Utah.

**Services Performed in a Laboratory**

**Surgical Procedures**
Surgical procedures and any associated services and supplies are not covered, including, but not limited to:

- exfoliative cytology sample collection or brush biopsy;
- incision and drainage of abscess extraroral soft tissue, complicated or non-complicated;
- radical resection of maxilla or mandible;
- removal of nonodontogenic cyst, tumor or lesion;
- surgical stent; or
- surgical procedures for isolation of a tooth with rubber dam.

**Temporomandibular Joint (TMJ) Disorder Treatment**
Except for surgical correction required as the result of an Injury, TMJ disorder treatment and any associated services and supplies are not covered.

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

**Tooth Transplantation**
Services and supplies provided in connection with tooth transplantation are not covered, including but not limited to:

- reimplantation from one site to another;
- splinting; and/or
- stabilization.

**Travel and Transportation Expenses**

**Veneers**
Except when approved and Dentally Appropriate, veneers are not covered.

**Work-Related Conditions**
Except when a Claimant is exempt from state or federal workers' compensation law, expenses for services or supplies incurred as a result of any work-related Illness or Injury (even if the service or supply is not covered by workers' compensation benefits) are not covered.

If an Illness or Injury could be considered work-related, a Claimant will be required to file a claim for workers' compensation benefits before the Claims Administrator will consider providing any coverage.
Claims Administration

This section explains administration of benefits and claims, including situations that may arise when Your health care expenses are the responsibility of a source other than the Plan.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims are submitted and payment is due, the Claims Administrator decides whether to pay You, the provider or You and the provider jointly. The Plan may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child.

In-Network Dentist Claims and Reimbursement

You must present Your identification card to an In-Network Dentist and furnish any additional information requested. The In-Network Dentist will submit the necessary forms and information to the Claims Administrator for processing Your claim.

The Plan will pay an In-Network Dentist directly for Covered Services. These In-Network Dentists may require You to pay any Deductible, Copayment and/or Coinsurance at the time You receive care or treatment. In-Network Dentists have agreed not to bill You for balances beyond any Deductible, Copayment and/or Coinsurance and to accept the Allowed Amount as payment in full for Covered Services.

Out-of-Network Dentist Claims and Reimbursement

In order for the Claims Administrator to pay for Covered Services, You or the Out-of-Network Dentist must first send the Claims Administrator a claim. In most cases, the Plan will pay the Dentist directly for Covered Services provided by an Out-of-Network Dentist. 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;
- the patient's name;
- Your identification number; and
- the group number.

Out-of-Network Dentists have not agreed to accept the Allowed Amount as payment in full for Covered Services. You are responsible for paying any difference between the amount billed by the Out-of-Network Dentist and the Allowed Amount in addition to any amount You must pay due to any Deductible, Copayment and/or Coinsurance. For Out-of-Network Dentists, 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.

Timely Filing of Claims

Written proof of loss (submission of a claim) must be received within one year after the date of service. Claims that are 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. Benefits or coverage will not be invalidated nor reduced if it can be shown that it was not reasonably possible to file the claim and that the claim was submitted as soon as reasonably possible. You may 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 in the Coordination of Benefits provision for an exception to this timely filing rule.

Claim Determinations

Within 30 days of the Claims Administrator's receipt of a claim, the Claims Administrator will notify You of their action. However, this 30-day period may be extended by an additional 15 days due to lack of information or extenuating circumstances. The Claims Administrator will notify You of the extension within the initial 30-day period and provide an explanation of why the extension is necessary.
If the Claims Administrator requires additional information to process the claim, the Claims Administrator must allow You at least 45 days to provide it to them. If the Claims Administrator does not receive the requested information within the time allowed, the Claims Administrator will deny the claim.

CLAIMS RECOVERY
If the Plan pays a benefit to which You or Your beneficiaries were not entitled, or if the Plan pays a person who is not eligible for benefits at all, the Plan has the right to recover the payment from the person the Plan 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 Dependent's behalf includes the right to deduct the mistakenly paid amount from future benefits the Plan would provide the Participant or any of his or her Dependent's under this Plan.

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.). The Plan will be credited all amounts recovered.

This Claims Recovery provision in no way reduces the Plan's right to reimbursement or subrogation. Refer to the Subrogation and Right of Recovery provision for additional information.

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY
The provisions of this section apply to all current or former Claimants who incur claims and are or have been covered by the Plan. No adult Claimant hereunder, may assign any rights that he or she may have to recover expenses from any tortfeasor or other person or entity to any minor child or children of said adult Claimant without the prior express written consent of the Plan. These provisions will apply to all claims arising from Your Illness, Injury or condition, including, but not limited to, wrongful death, survival or survivorship claims brought on Your, Your estate's or Your heirs' behalf, regardless of whether medical expenses were or could be claimed. "You" or "Your" includes anyone on whose behalf the Plan pays benefits.

The Plan's Right of Subrogation or reimbursement, as set forth below, extend to all insurance coverage available to You due to an Illness, Injury or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

This Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage, excess coverage or similar contract or insurance.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until this Plan's subrogation and reimbursement interest are fully satisfied.

Subrogation
The "Right of Subrogation" means the Plan is entitled to pursue any claims that You may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of Your rights of recovery with respect to any claim or potential claim against any party, due to an Illness, Injury or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement
If You receive any payment as a result of an Illness, Injury or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that Illness, Injury or condition, up to and including the full amount of Your recovery. Benefit payments made under the Plan are conditioned upon Your agreement to reimburse the Plan in full from any recovery You receive for Your Illness, Injury or condition.
Constructive Trust
By accepting benefits (whether the payment of such benefits is made to You or made on Your behalf to any Provider) You agree that if You receive any payment as a result of an Illness, Injury or condition, You will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of Your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until this Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights
Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the Illness, Injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any Illness, Injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, You, Your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment
In order to secure the Plan's recovery rights, You agree to assign to the Plan any benefits or claims or rights of recovery You have in any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim You may have, whether or not You choose to pursue the claim.

First-Priority Claim
By accepting benefits from the Plan, You acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before You receive any recovery for Your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make You whole or to compensate You in part or in whole for the damages sustained. The Plan is not required to participate in or pay Your court costs or attorney fees to any attorney You hire to pursue Your damage claim.

Applicability to All Settlements and Judgments
The terms of this entire Subrogation and Right of Recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than expenses provided by the Plan. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to Your own negligence.

Cooperation
You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is Your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your Illness, Injury or condition. You and Your agents agree to provide the Plan or its representatives notice of any recovery You or Your agents obtain prior to receipt of such recovery funds or within five days if no notice was given prior to receipt of recovery funds. Further, You and Your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and Your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery You receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of Your health benefits or the institution of court proceedings against You.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any
settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan’s subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the Illness, Injury or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

**Workers' Compensation**

If the entity providing workers' compensation coverage denies Your claim and You have filed an appeal, benefits will be advanced for Covered Services provided the Plan is notified of such appeal by the Labor Commission.

**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 in this provision will not exceed the amount of Your recovery.

**Interpretation**

In the event that any claim is made that any part of this Subrogation and Right of Recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator shall have the sole authority to resolve all disputes regarding the interpretation of this provision.

**Jurisdiction**

By accepting benefits from the Plan, You agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, You hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of Your present or future domicile. By accepting such benefits, You also agree to pay all attorneys’ fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to per this provision.

**COORDINATION OF BENEFITS**

If You are covered by any other Plan as defined below), the benefits in this SPD and those of the Other Plan will be coordinated in accordance with the provisions of this section.

**Definitions**

The following are definitions that apply to this Coordination of Benefits provision:

**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, 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 the 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; and
- 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 Medicaid state Plan; 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 by that provision the Plan determines its benefits first.

Secondary Plan means a Plan that is not a Primary Plan.

Year 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 apply:

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 for 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 by which You are covered pursuant to COBRA or a right of continuation by 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 by a Plan, two successive Plans will be treated as one if You were eligible by the second Plan within 24 hours after 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 by a Plan is measured from Your first date of coverage with 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 with 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 by 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, the Plan will pay the benefits of this coverage as if no Other Plan exists. This Plan is considered to be Primary in relation to pediatric dental benefits of another Plan. Despite the provisions of timely filing of claims, where this Plan is the Primary Plan, benefits will not be denied by 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 Claims Administrator will calculate the benefits that the Plan would have paid for a service if this coverage were the Primary Plan. That calculated amount will be applied to any Allowable Expense for that service that is unpaid by the Primary Plan. The Plan 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 by 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 in this SPD.
Right of Recovery
If the Plan provides benefits to or on behalf of You in excess of the amount that would have been payable in this Plan by reason of Your coverage with any Other Plan(s), this Claims Administrator 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 misrepresentation(s). 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. 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 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 by the Claims Administrator 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 may 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: Attn: ASO Appeals and Grievances, Regence BlueCross BlueShield of Utah, P.O. Box 91015, Seattle, WA 98111-9115 or facsimile 1 (877) 663-7526. Verbal requests can be made by calling the Claims Administrator's Customer Service.

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 a 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.

If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision from the regular Appeal process, You or Your treating Provider may specifically request an expedited Appeal. 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.

**Second-Level Appeals**

Second-level Appeals are reviewed by a Claims Administrator employee or employees who were not involved in, or subordinate to anyone involved in, the initial or 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.

**VOLUNTARY EXTERNAL APPEAL**

The Claims Administrator coordinates voluntary external Appeals, but the decision is made by the external review entity at no cost to You. The Claims Administrator will provide the external review entity with the Appeal documentation. The external review entity will make their decision and provide You with written determination within 45 days of receipt of the request.

A voluntary Appeal to an external review entity 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 voluntary external Appeal to an external review entity is optional and You should know that other forums may be used as the final level of Appeal to resolve a dispute You have under the Plan. The Claims Administrator will coordinate review by the external review entity. You may choose from the following two external review entities:
University of Utah Medically Appropriate Review Committee
A committee consisting of physicians employed by University of Utah Health and one member of Human Resources who is not involved in any employment decision, and a legal advisor from the University’s Office of General Counsel. The committee will not include Your health care provider. Information provided to the committee will be de-identified by the HR member. You may also choose to appeal the decision of this committee to the Independent Review Organization described below. You are not required to appeal to the University of Utah Medically Appropriate Review Committee prior to requesting a review by the Independent Review Organization following a second-level determination.

Independent Review Organization (IRO)
An IRO which is independent from Your health care provider and the Claims Administrator. This level of appeal is also available to You if you choose to have your appeal reviewed by the University of Utah Medically Appropriate Review Committee and wish to appeal their decision. The decision of the IRO is final and binding and may not be appealed further, except to the extent other remedies are available under State and Federal law.

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

• the application of regular Appeal time frames on a Pre-Service or concurrent care claim either:
  - could jeopardize Your life, health or ability to regain maximum function; or
  - according to a Provider 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. 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 notice.

Voluntary Expedited External Appeal – IRO Only
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 or concurrent), 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 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. The IRO will provide verbal notice of their decision to You and Your Representative as soon as possible after the decision, but no later than within 72 hours of receipt of Your request. A written notification of their decision will be mailed to You within 48 hours of the verbal notice. 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, except to the extent other remedies are available under State or Federal law.

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

INFORMATION
If You have any questions about the Appeal Process contact the Claims Administrator's Customer Service or write to the following address: Regence BlueCross BlueShield of Utah, P.O. Box 2998, Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526.

DEFINITIONS
The following definitions apply to this Appeal Process Section:

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UNIVERSITY OF UTAH TRANSITIONAL PLAN, 10002211, EFFECTIVE JULY 1, 2021
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 by the Claims Administrator 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 external Appeals and voluntary external expedited 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.

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

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

Representative means someone who represents You for the Appeal. The Representative may be an
attorney, Your authorized 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 Appeal. No authorization is required from the parent(s) or legal guardian of a Claimant
who is an unmarried and dependent child and is 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, Your
Representative or Your treating Provider only.
Eligibility and Enrollment

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;
- Employees who are employed in a position that is not otherwise eligible for coverage under this Plan; however, they have the option to enroll in health coverage pursuant to Federal or State law, including the Affordable Care Act.

Non-University Employees and Groups
You are eligible to enroll in this Plan if you are a member or employee of one of the following groups as identified in the list below:

- Post-doctoral trainees being paid through a grant and working at the University with other University employees.
- Members of the Utah State Board of Regents throughout their period of appointment.
- Employees for whom the University processes payroll and provides access to employee benefits: 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.

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
  - As part of the enrollment process, You have 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;
- Your (or Your spouse's or Your domestic partner's) child, who is age 26 or older, unmarried and who is a Disabled Dependent due to a Physical Impairment or a Mental Impairment (terms defined below) that began before his or her 26th birthday and who has been covered as Your Dependent on health coverage/insurance with no break in coverage of more than 63 days since that birthday (You must complete and submit Regence’s affidavit of Dependent eligibility form, with written evidence of the child’s impairment, within 90 days of the later of the child’s 26th birthday or Your Effective Date);
- 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 a Disabled Dependent (defined below). To do so, You must provide to the University's Human Resources 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 Human Resources 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 Human Resources Department any information necessary or appropriate to determine the validity of a Dependent's status. Receipt of such information by the University's Human Resources 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 Human Resources 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**

The following definitions apply to this Eligibility and Enrollment Section:

**Disabled Dependent** means a child who is and continues to be:
• 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
• dependent on You for more than 50 percent of their support (food, shelter, clothing, medical and
dental care, education and the like).

Mental Impairment means a mental or psychological disorder such as:
• intellectual disability;
• organic brain syndrome;
• emotional or mental illness; or
• 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:
• neurological;
• musculoskeletal;
• special sense organs;
• respiratory organs;
• speech organs;
• cardiovascular;
• reproductive;
• digestive;
• genito-urinary;
• hemic and lymphatic;
• skin; or
• 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 Human Resources Department.

WHEN YOU AND YOUR DEPENDENTS ARE INITIALLY ELIGIBLE
You become eligible for coverage on (a) the date You are hired by the University into a benefit-eligible position, (b) the date You are transferred into a benefit-eligible position from an ineligible position, or (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 complete enrollment within 90 days (or three months, if longer) 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 newly eligible Dependent, and any other eligible Dependents not already enrolled by completing the required enrollment within 90 days (or three months, if longer) of the Dependent becoming eligible. Upon acceptance of Your properly completed enrollment 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 You completed the required enrollment. If the change form is not submitted to the University's Benefits Department within 90 days (or three months, if longer) 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 was 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 contact the University Human Resources Department, 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 (or three months, if longer) 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 the requested enrollment change 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 or qualify as a domestic partnership, You become eligible for coverage under this Plan on behalf of Yourself, Your spouse or domestic partner, and any Eligible children and/or Your eligible Dependents on the date of marriage or the date You and Your domestic partner qualify as a domestic partnership.
- If You declined coverage for Yourself and/or Your eligible Dependents when You were first eligible (or You declined coverage for Your spouse or domestic partner 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 or domestic partner 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 Plan 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 Plan 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 enter the change election within 90 days after such date. In order for an individual who loses eligibility for coverage under the Plan to be eligible for continuation of coverage under COBRA, You must notify the Human Resources Department 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.
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 Plan Year.

If You and/or Your enrolled Dependent(s) obtain other similar coverage during the Plan Year (including enrolling in Medicare), You may elect to cancel coverage for such covered individual(s). In order to drop coverage during the Plan Year, You must complete the enrollment change 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 enrollment change is completed (no refund of premiums will be provided).

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 Plan Year, You must complete the enrollment change 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 enrollment change is completed.

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 the enrollment change within 90 days from the date of the significant increase in Your cost of coverage. Coverage will be dropped on the date the enrollment change is completed.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your enrolled Dependents’ 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 in this SPD.

Termination of Your Employment or Appointment, Change to an Ineligible Employment Status or End of Eligibility Under Law

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, or Your period of coverage required under law expires, 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.
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.

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 SPD. You must make the enrollment change within 90 days of the date of the event. Any change to Your coverage level (for example, two-party to single coverage), will be effective on the date You submit Your completed enrollment change. You or the Dependent must notify the University's Human Resources 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. Complete the enrollment change within 90 days of the date of the event. You or Your former spouse must notify the University's Human Resources 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 SPD.

Death of the Participant
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 or enroll in a University Retiree Health Care Plan, if available. If You die while in the line-of-duty as a public safety officer for the University (as outlined in Utah Code 53-17-201), coverage for Your enrolled Dependents (spouse and/or children) who were covered under the Plan immediately preceding Your death may continue until Your surviving spouse (if applicable) becomes eligible for Medicare, and the first day of the month following the date Your child turns age 26.

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. Complete the enrollment change within 90 days of the date of the event. You or Your former domestic partner must notify the University's Human Resources 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 the 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 SPD.

Loss of Dependent Status
- 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).
- Eligibility ends on the date the child is removed from placement due to disruption of placement prior to legal adoption and the child is removed from placement.
- Eligibility ends on the date the child is no longer an eligible Dependent for any other cause (except by reason of Your death).

You or Your dependent must notify the University's Human Resources 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 SPD.

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.

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 Plan 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 the University’s ERIP Health Care Plan for up to 30
months from Your initial date of disability. If You or Your enrolled Dependents are eligible for Medicare, You will need to enroll in Medicare at that time.

If You remain totally disabled and are eligible and enrolled in the University ERIP Health Care 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 Human Resources 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 Human Resources 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.
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 section contains important information about your right to continue your health care coverage in the University of Utah Employee Health Care Plan.

There may be other coverage options for you and your family including a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan) or coverage through the Health Insurance 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 Human Resource Management 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 University Human Resource Management. Alternatively, your spouse or Dependent child may give written notice of the Qualifying Event to Human Resources at the address listed at the end of this section. 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 Human Resources 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 Beneficiary 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 Dependent 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 Human Resource Management 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 Human Resources 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 Human Resource Management 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 Human Resource Management 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 Human Resource Management 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 Human Resource Management 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 University Human Resource Management 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 dependent (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 section does not fully describe COBRA coverage. For additional information about your rights and obligations under the Plan and under federal law contact University Human Resource Management.

The University's COBRA Administrator is Sandy Robison, 250 East 200 South, Suite 125, Salt Lake City, UT 84111, telephone (801) 581-7447 (the contact person may change from time to time).

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 University Human Resource Management within 60 days.

In order to protect Your Family's rights, You should keep the University Human Resource Management informed of any change in address for You, Your spouse, domestic partner or enrolled children. If You have any questions or need additional information, please contact the University Human Resource Management.
Notices

UNIVERSITY OF UTAH
EMPLOYEE HEALTH CARE PLAN AND FLEXIBLE BENEFIT PLAN
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: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
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](http://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 Human Resources Department**
Attention: Director of Benefits
250 East 200 South, Suite 125
Salt Lake City, UT 84111
General Provisions and Legal Notices

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

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

GOVERNING LAW
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 Claims Administrator is not the Plan Administrator, but does provide claims administration under the Plan.

LIMITATIONS ON LIABILITY
You have the exclusive right to choose a health care Provider. The Plan and the Claims Administrator are not responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since the Plan and the Claims Administrator do not provide 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 or 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.

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 Sponsor's authorized officers.

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.

NOTICES
Any notice to Claimants or to the Plan Sponsor required in the Plan will be considered 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 Sponsor will be addressed to the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address (COA) form for a Participant, the Claims Administrator will update their records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Plan Sponsor if they become aware that the Claims Administrator doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be mailed to the Claims Administrator's Customer Service address. However, notice to the Claims Administrator will be considered to have been given to and received by it if written notice is deposited in the United States mail or with a private carrier.

PLAN SPONSOR IS AGENT
The Plan Sponsor is Your agent for all purposes under the Plan and not the Claims Administrator's agent. You are entitled to health care benefits pursuant to the Agreement between the Claims Administrator and the Plan Sponsor. In the Agreement, the Plan Sponsor agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in this SPD. You, through
the enrollment form signed by the Participant, and as beneficiaries of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this SPD.

**RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION**

The Plan Sponsor on behalf of itself and its Claimants expressly acknowledges its understanding that the Agreement constitutes an agreement solely between the Plan Sponsor and Regence BlueCross BlueShield of Utah, 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 the Claims Administrator to use the Blue Cross and Blue Shield Service Marks in the state of Utah and that the Claims Administrator is not contracting as the agent of the Association. The Plan Sponsor 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 BlueCross BlueShield of Utah and that no person or entity other than Regence BlueCross BlueShield of Utah will be held accountable or liable to the Plan Sponsor or the Claimants for any of the Claims Administrator's obligations to the Plan Sponsor or the Claimants created under the Agreement. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueCross BlueShield of Utah 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 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.

**RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS**

It is important to understand that 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 visiting the Claims Administrator's Web site or contacting Customer Service.

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

TAX TREATMENT
The Claims Administrator does not provide tax advice. Consult Your financial or tax advisor for information about the appropriate tax treatment of benefit payments and reimbursements.

WHEN BENEFITS ARE AVAILABLE
In order for health expenses to be covered, 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 in the Plan; 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 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 only 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 Dentists, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Dentists, the amount the Claims Administrator has determined to be reasonable charges for Covered Services. The Allowed Amount may be based upon billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

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, contact the Claims Administrator's Customer Service.

**Claimant** means a Participant or an enrolled Dependent.

**Covered Service** means those services or supplies that are 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) and are Dentally Appropriate. These services must be received from a Dentist or other provider practicing within the scope of his or her license.

**Dentally Appropriate** means a dental service recommended by the treating Dentist or other provider, who has personally evaluated the patient, and is all of the following:

- appropriate, based upon the symptoms, for determining the diagnosis and management of the condition;
- appropriate for the diagnosed condition, disease or Injury in accordance with recognized national standards of care;
- not able to be omitted without adversely affecting the Claimant's condition; and
- not primarily for the convenience of the Claimant, Claimant's family or provider.

A DENTAL SERVICE MAY BE DENTALLY APPROPRIATE YET NOT BE A COVERED SERVICE UNDER THE PLAN.

**Dentist** means an individual who is duly licensed to practice dentistry in all of its branches (including a doctor of medical dentistry, doctor of dental surgery) or to practice as a dental hygienist who is permitted by his or her respective state licensing board, to independently bill third parties.

**Effective Date** means the date following the Claims Administrator's receipt of enrollment from, as the date coverage begins for You and/or Your Dependents.

**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 or Injury;
- genetic or congenital anomaly;
- pregnancy;
- 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.

**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.

**Illness** means a:

- congenital malformation that causes functional impairment;
- a condition, disease, ailment or bodily disorder, other than an Injury; or
- a pregnancy.

**Injury** means physical damage to the body caused by:

- a foreign object;
- force;
- temperature;
- a corrosive chemical; or
- 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 Dentist** means a Dentist who has an effective participating contract with the Claims Administrator that designates him or her as a Dentist of the Plan Sponsor's network, to provide services and supplies to Claimants in accordance with the provisions of this coverage.

**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:

- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Illness or Injury, 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 at least 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 Sponsor with the Claims Administrator.

**Out-of-Network Dentist** means a Dentist that is not an In-Network Dentist. For Out-of-Network Dentist services, You may be billed for balances over the Plan's payment level in addition to any Deductible, Copayment 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 Plan Sponsor who is eligible under the terms of the Agreement, has completed an enrollment form and is enrolled under this coverage.

**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.
Plan Year means the period from July 1 through June 30 of the following Year; however, the first Plan Year begins with the Claimant's Effective Date.

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.

Summary Plan Description (SPD) is a summary of the benefits provided by the group health plan. A group health plan with different benefit plan options may describe them in one SPD or in separate SPD's 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
250 East 200 South, Suite 125
Salt Lake City, UT 84111
(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.

UUIHSEXPSPD
UNIVERSITY OF UTAH TRANSITIONAL PLAN, 10002211, EFFECTIVE JULY 1, 2021
For more information contact the Claims Administrator at 1 (800) 262-9712 or You can write to P.O. Box 2998, Tacoma, WA 98401-2998

regence.com