Employee Health Care Plan
Advantage Plan Option
UNIVERSITY OF UTAH
EMPLOYEE HEALTH CARE PLAN
BLUECROSS BLUESHIELD ADVANTAGE OPTION
SUMMARY PLAN DESCRIPTION

GROUP NUMBER: 10002211

Regence BlueCross BlueShield
2890 East Cottonwood Parkway  www.myregence.com
Salt Lake City, UT 84121
Customer Service (888) 370-6159
Case Management (800) 624-6519

University of Utah Benefits Department
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Customer Service (800) 966-5772

Employee Assistance Program (EAP) (801) 587-9319
(800) 926-9619

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

Effective July 1, 2012
Introduction

This University of Utah Employee Health Care Plan Summary Plan Description describes the terms and benefits of coverage effective July 1, 2012, or the date after that on which Your coverage became effective. This Summary Plan Description replaces any plan description or Summary Plan Description previously issued by the Plan Sponsor and makes it void.

The University of Utah Employee Health Care Plan Master Plan Document contains all the terms of coverage. Your Plan Sponsor has a copy. This summary is not meant to interpret, extend, or change the provisions of the Plan in any way. Benefits under this Plan will be paid only if the Plan Sponsor decides, in their sole discretion, that you are entitled to them. Prior to amendments, the Master Plan Document is the Summary Plan Description. If the Master Plan Document and this Summary Plan Description differ, the provisions of the Master Plan Document will prevail.

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

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

The University reserves the right to amend or terminate this Plan in whole or in part, at any time, regardless of Your or Your Enrolled Dependents’ health or treatment status. 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.
Using Your Summary Plan Description

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

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

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

Your Plan gives You broad access to Providers and allows You to control Your out-of-pocket expenses, such as Copayments and Coinsurance, for each Covered Service. You control Your out-of-pocket expenses by choosing Your Provider under three choices called: "Category 1", "Category 2" and "Category 3."

- **Category 1 – ValueCare Network (PPO) Provider.** You choose to see a ValueCare Provider and save the most in Your out-of-pocket expenses. Choosing this category means You will not be billed for balances for Covered Services beyond any Copayment or Coinsurance.
- **Category 2 – Participating BCBS Traditional Network Provider (not in ValueCare Network).** You choose to see a Participating (Traditional Network) Provider and Your out-of-pocket expenses will generally be a little higher than if You chose a Category 1 Provider because larger discounts with Category 1 Providers may be negotiated that will result in lower-out-of-pocket amounts for You. Choosing this category means You will not be billed for balances for Covered Services beyond any Copayment or Coinsurance.
- **Category 3 – Out-of-Network Provider.** You choose to see a Provider that does not have a participating contract with the Claims Administrator and Your out-of-pocket expenses will generally be higher. Also, choosing this category means You may be billed by the Category 3 Provider for balances beyond any Copayment or Coinsurance. This is sometimes referred to as balance billing.

For each benefit in this Summary Plan Description, Your payment amount for Providers in each Category is indicated. Categories 1, 2 and 3 are also in the Definitions Section of this Summary Plan Description. You can go to [www.myRegence.com](http://www.myRegence.com) for further Provider network information and to find Category 1 and Category 2 network Providers.

GUIDANCE AND SERVICE ALONG THE WAY

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

- **Learn more and receive answers about Your coverage.** Call Customer Service: 1 (888) 370-6159 to talk with one of the Claims Administrator's Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. - 6 p.m. You may also visit the Claims Administrator’s website at: [www.myRegence.com](http://www.myRegence.com).
- **Case Management.** You can request that a case manager be assigned or You may be assigned a case manager to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. Call Case Management at 1 (800) 624-6519.
- **BlueCard® Program.** The BlueCard® Program enables You to access Hospitals and Providers when traveling outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world.
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UUIHSPPOSPD
UNIVERSITY OF UTAH, 10002211, EFFECTIVE JULY 1, 2012
Understanding Your Benefits

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

MAXIMUM BENEFITS
The Plan pays a percentage of Allowed Amount after You pay any applicable Coinsurance amount, up to the Annual Maximum Benefit amount shown in the Summary Of Medical Benefits for each Claimant. The Annual Maximum Benefit amount includes amounts paid for benefits provided under all medical options of the University of Utah Employee Health Care Plan, the University of Utah ERIP Health Care Plan, and the University of Utah Retiree Health Care Plan, and earlier Plans issued by the University. When a Claimant's benefits cumulatively total the Annual Maximum Benefit amount, coverage under all University of Utah Health Care Plans will terminate with respect to that Claimant for the remainder of the Contract Year.

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

OUT-OF-POCKET MAXIMUM
Claimants can meet the Out-of-Pocket Maximum by payments of Coinsurance and Copayments for all network Provider Categories as specifically indicated in the Summary Of Medical Benefits. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum amounts of the Plan.

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

The Family Out-of-Pocket Maximum for a Contract Year is satisfied when three or more Family members’ Coinsurance and Copayments for that Contract Year total and meet the Family's Out-of-Pocket Maximum amount. One Claimant will not be required to pay more than the individual Out-of-Pocket Maximum amount.

Benefits provided under the Summary Of Drug Benefits and Summary Of Behavioral Health Benefits do not apply toward the Out-of-Pocket Maximum of the Summary Of Medical Benefits.

COPAYMENTS
Copayments are the fixed dollar amount that You must pay directly to the Provider for Office Visits and emergency room visits each time You receive a specified service. Once You have paid any applicable Copayment, the Plan pays 100% of the remaining Allowed Amount for Covered Services You receive, up to any Maximum Benefit. The Copayment will be the lesser of the fixed dollar amount or the Allowed Amount for the service or medication. Refer to the Summary Of Medical Benefits to understand what Copayments You are responsible for.

PERCENTAGE PAID UNDER THE PLAN (COINSURANCE)
The Plan pays a percentage of the Allowed Amount for Covered Services You receive under the Plan, up to the maximum shown in the Summary Of Medical Benefits. See the Definitions Section for a detailed description of what is meant by Allowed Amount. When the payment is less than 100 percent, the
remaining percentage is Your Coinsurance. The percentage paid by the Plan varies, depending on the kind of service or supply, and the Provider's network Category.

The Plan does not pay Providers for charges above the Allowed Amount. Category 1 and Category 2 network Providers will not charge You for any balances for Covered Services beyond Your applicable Copayment or Coinsurance amount. Category 3 out-of-network Providers, however, may bill You for balances over the Plan payment level in addition to any Copayment and Coinsurance amount. See the Definitions Section for descriptions of Providers.

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

**HOW CONTRACT YEAR BENEFITS RENEW**

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

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

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

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

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

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

ANNUAL MAXIMUM BENEFIT
Per Claimant: $2,000,000

CONTRACT YEAR OUT-OF-POCKET MAXIMUM
Per Claimant: $1,500
Per Family: $4,500

CONTRACT YEAR DEDUCTIBLE
None

COPAYMENTS AND COINSURANCE
Copayments and Coinsurance are listed in the tables for Covered Services for each applicable benefit.

AMBULANCE SERVICES

<table>
<thead>
<tr>
<th>Categories: 1 and 2</th>
<th>Category: 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>ValueCare and BlueCross BlueShield Traditional Network Providers</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>The Plan pays 85% and You pay 15% of the Allowed Amount. Your 15% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>The Plan pays 85% and You pay 15% of billed charges. Your 15% payment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
</tbody>
</table>

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

BLOOD BANK

<table>
<thead>
<tr>
<th>Categories: 1 and 2</th>
<th>Category: 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>ValueCare and BlueCross BlueShield Traditional Network Providers</td>
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<tr>
<td>The Plan pays 85% and You pay 15% of the Allowed Amount. Your 15% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>The Plan pays 85% and You pay 15% of billed charges. Your 15% payment will be applied toward the Out-of-Pocket Maximum.</td>
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The Plan covers the services and supplies of a blood bank, excluding storage costs.
### CHIROPRACTIC CARE

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<tr>
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<th>Category: 1</th>
<th>Category: 2</th>
<th>Category: 3</th>
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</thead>
<tbody>
<tr>
<td><strong>Office Visit</strong></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>ValueCare Network Provider</td>
<td>BlueCross BlueShield Traditional Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>After $25 Copayment per visit, the Plan pays 100% of the Allowed Amount. Your $25 Copayment will be applied toward the Out-of-Pocket Maximum.</td>
<td>After $35 Copayment per visit, the Plan pays 100% of the Allowed Amount. Your $35 Copayment will be applied toward the Out-of-Pocket Maximum.</td>
<td>The Plan pays 65% of the Allowed Amount and You pay balance of billed charges. Your 35% payment will be applied toward the Out-of-Pocket Maximum.</td>
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</tr>
<tr>
<td><strong>Outpatient Facility</strong></td>
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</tr>
<tr>
<td>The Plan pays 85% and You pay 15% of the Allowed Amount. Your 15% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>The Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>The Plan pays 65% of the Allowed Amount and You pay balance of billed charges. Your 35% payment will be applied toward the Out-of-Pocket Maximum.</td>
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**Limit:** 20 spinal manipulations per Claimant per Contract Year performed by any Provider

### CLOTTING FACTOR PRODUCTS – OUTPATIENT

<table>
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<tr>
<th></th>
<th>Category: 1</th>
<th>Category: 2</th>
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<tr>
<td><strong>ValueCare Network Provider</strong></td>
<td></td>
<td></td>
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<td>The Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>You pay 100% of billed charges. Your payment will not be applied toward the Out-of-Pocket Maximum.</td>
<td></td>
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</tbody>
</table>

For Category 1 and Category 2, the Plan covers plasma-derived and recombinant clotting factor products used in outpatient replacement therapy for hemophilia, Von Willebrand disease, and similar clotting disorders. For Category 3, no coverage is provided for plasma-derived or recombinant clotting factor products. This benefit also does not cover these products when provided by a retail Pharmacy.
### DENTAL SERVICES

<table>
<thead>
<tr>
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<tbody>
<tr>
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<td><strong>BlueCross BlueShield Traditional Network Provider</strong></td>
<td><strong>Out-of-Network Provider</strong></td>
</tr>
<tr>
<td>The Plan pays 85% and You pay 15% of the Allowed Amount. Your 15% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>The Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>The Plan pays 65% of the Allowed Amount and You pay balance of billed charges. Your 35% payment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
</tbody>
</table>

The Plan covers inpatient and outpatient dental services and supplies (including anesthesia), required as a result of damage to or loss of sound natural teeth due to an Accidental Injury (other than from chewing), if hospitalization in an ambulatory surgical center or Hospital is necessary to safeguard Your health. Benefits are not available for the charges of a dentist or for services received in a dentist's office.

The Plan covers inpatient and outpatient temporomandibular joint (TMJ) disorders which have one or more of the following characteristics:
- an abnormal range of motion or limitation of motion of the TMJ;
- arthritic problems with the TMJ;
- internal derangement of the TMJ; and/or
- pain in the musculature associated with the TMJ.

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

### DIABETIC EDUCATION

<table>
<thead>
<tr>
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<td>After $35 Copayment per visit, the Plan pays 100% of the Allowed Amount. Your $35 Copayment will be applied toward the Out-of-Pocket Maximum.</td>
<td>The Plan pays 65% of the Allowed Amount and You pay balance of billed charges. Your 35% payment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
</tbody>
</table>

The Plan covers services and supplies for diabetic self-management training and education, including nutritional therapy if provided by Providers with expertise in diabetes.

### DIABETES SUPPLIES AND EQUIPMENT

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

<table>
<thead>
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<td>The Plan pays 85% and You pay 15% of the Allowed Amount. Your 15% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>The Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>The Plan pays 65% of the Allowed Amount and You pay balance of billed charges. Your 35% payment will be applied toward the Out-of-Pocket Maximum.</td>
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</tbody>
</table>

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is appropriate for use in the Claimant's home. Examples include oxygen equipment and wheelchairs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

<table>
<thead>
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<tr>
<td>ValueCare Network Provider</td>
<td>BlueCross BlueShield Traditional Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>After $100 Copayment per visit, the Plan pays 100% of the Allowed Amount. Your $100 Copayment will be applied toward the Out-of-Pocket Maximum.</td>
<td>After $100 Copayment per visit, the Plan pays 100% of the Allowed Amount. Your $100 Copayment will be applied toward the Out-of-Pocket Maximum.</td>
<td>After $100 Copayment per visit, the Plan pays 100% of the Allowed Amount. Your $100 Copayment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
</tbody>
</table>

The Plan covers emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be pre-authorized. The Copayment is waived when admitted for an emergency/urgent medical condition and the applicable Coinsurance amount applies. See the Hospital Care benefit in this Summary Of Medical Benefits for coverage of inpatient Hospital admissions. For treatment of a qualifying Emergency Medical Condition received by Category 3 Out-of-Network providers, the Allowed Amount will be the same as the billed charges. Your responsibility will be calculated from the billed charges. The Plan will cover a Claimant's visit to a Category 3 Out-of-Network Hospital emergency department as if the services were received at a Category 1 Hospital emergency department for Emergency Medical Conditions. If, due to an Emergency Medical Condition, a Claimant is admitted to a Category 3 Out-of-Network Hospital through the emergency department and cannot be transported safely to a Category 1 Hospital, the Plan will cover the services as if the services were received at a Category 1 Hospital, until such time as the Claimant can be safely transported to a Category 1 Hospital.

FAMILY PLANNING

<table>
<thead>
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The Plan covers certain professional Provider contraceptive services and supplies, including, but not limited to, vasectomy, tubal ligation and insertion of IUD or Norplant. See the Prescription Medication Benefits Section for coverage of prescription contraceptives.
### GENETIC TESTING

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

### HEARING EXAMINATIONS

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

### HOME HEALTH CARE

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

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

The Plan covers hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and his or her family during the final stages of illness. In order to qualify for hospice care, the patient's Physician must certify that the patient is terminally ill and is eligible for hospice services. Respite care: The Plan covers respite care to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant.

HOSPITAL CARE - INPATIENT

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<thead>
<tr>
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The Plan covers inpatient services and supplies of a Hospital for Injury and Illness (including services of staff providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. See the Emergency Room benefit in this Summary Of Medical Benefits for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

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

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The Plan covers outpatient services and supplies of a Hospital or the outpatient services and supplies of an Ambulatory Service Facility for Injury and Illness (including services of staff providers billed by the Hospital). See the Emergency Room benefit in this Summary Of Medical Benefits for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

## MATERNITY CARE – INPATIENT HOSPITAL SERVICES

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## MATERNITY CARE – OUTPATIENT HOSPITAL AND PHYSICIAN SERVICES

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The Plan covers pre-natal and post-natal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy, and related conditions for all female Claimants. There is no limit for the mother's length of inpatient stay. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit in this Summary Plan Description to see how the care of Your newborn is covered.
### MEDICAL FOODS (PKU)

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

### NEURODEVELOPMENTAL THERAPY

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**Limit:** $1,500 per Claimant per Contract Year for all neurodevelopmental therapy services combined including speech therapy services as a result of congenital anomaly for Claimants up to age 18.

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

### NEWBORN CARE

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The Plan covers services and supplies, under the newborn's own coverage, in connection with nursery care for the natural newborn or newly adoptive child. The newborn child must be eligible and enrolled as explained later in the Who Is Eligible, How to Enroll and When Coverage Begins Section. There is no limit for the newborn's length of inpatient stay. For the purpose of this provision, "newborn care" means the medical services provided to a newborn child following birth including well-baby Hospital nursery charges, the initial physical examination and a PKU test.
OFFICE VISITS

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The Plan covers Office Visits. An Office Visit means the evaluation and management of a patient for treatment of an Illness or Injury. See Preventive Care for benefits for Office Visits for preventive care services. The Copayment applies to visits in the office, home or Hospital outpatient department only. The Plan covers services for diagnostic radiology, ultrasound, nuclear medicine, laboratory, pathology, electronic diagnostic medical procedures, as well as, medical services, surgical services, including local anesthesia and supplies, and therapeutic injections provided by a professional Provider when received in the Provider's office and when billed as such. Coverage does not include services specifically covered elsewhere in the Summary Plan Description, such as but not limited to, outpatient Rehabilitation Services. All other professional services performed in the office are subject to the applicable benefit specified elsewhere in the Summary Of Medical Benefits for such service.

ORTHOTIC DEVICES

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

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The Plan covers services and supplies provided by a professional Provider. Coinsurance and any specified limits as explained in the following paragraphs:

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

Professional Inpatient
The Plan covers professional inpatient services for Illness or Injury.

Radiology and Laboratory
The Plan covers services for treatment of Illness, Injury or preventive care. Note that when treatment is for preventive care, benefits under the Plan will be paid according to the Preventive Care benefit.

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

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

The following Preventive Care benefits are covered by the Plan in accordance with the Patient Protection and Affordable Care Act ("PPACA"), as amended by the Health Care and Education Reconciliation Act. As required by PPACA, Preventive Care benefits of the Plan are covered in accordance with recommendations by the United States Preventive Service Task Force ("USPSTF") with an A or B rating in the current recommendations, the Health Resources and Services Administration ("HRSA"), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC:"). In the event of any conflict between PPACA and this Preventive Care benefit section, the minimum requirements of PPACA will govern. In the event any of these bodies adopts a new or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit. For a list of services covered under this benefit, please visit www.myRegence.com or contact Customer Service at 1 (888) 370-6159. NOTE: Certain covered preventive services that do not meet this criteria may be covered under this Preventive Care benefit when received and billed as preventive care. Covered Services that do not meet this criteria will be covered the same as any other Illness or Injury.

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<td><strong>PROSTHETIC DEVICES</strong></td>
<td><strong>Limit:</strong> $500 per Claimant per five year period for wigs (synthetic, human hair or blend) for hair loss due to chemotherapy or radiation treatment.</td>
<td><strong>ValueCare Network Provider</strong></td>
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The Plan covers prosthetic devices for functional reasons to replace a missing body part, including artificial limbs, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility provision (Hospital - Inpatient Care or Hospital - Outpatient and Ambulatory Service Facility Care) in this Summary Of Medical Benefits. Repair or replacement of a prosthetic device due to normal use or growth of a child will be covered under the Plan.
### REHABILITATION SERVICES

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**Inpatient Limit:** 60 days per Claimant per Contract Year

The Plan covers inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services only) and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness. You will not be eligible for both the neurodevelopmental therapy benefit and this benefit for the same services for the same condition.

### SKILLED NURSING FACILITY (SNF) CARE

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

### TELEMEDICINE

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</table>

The Plan covers telemedicine (audio and video communication) services between a distant-site Physician, the patient and a consulting Practitioner when the originating (distant) site is a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services.
The Plan covers services and supplies for covered transplants. A transplant recipient who is covered under this Plan and fulfills Medically Necessary criteria will be eligible for the following transplants: heart, lung, kidney, pancreas, liver, cornea, multivisceral, small bowel, islet cell and hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors, i.e., either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions). This list of transplants is subject to change. The Plan does not cover services, supplies or accommodations in connection with heart; heart/lung; lung (single or double); liver, and pancreas transplants not received at the University of Utah Hospitals provided, however, if based on review by appropriate medical professionals at the University of Utah Hospitals, it is determined the covered procedure cannot be performed at the University of Utah Hospitals, Medically Necessary Covered Services will be a benefit when performed at another, more appropriate facility. Claimants can contact the Claims Administrator for a current list of covered transplants.

**Donor Organ Benefits**

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

**VISION EXAMINATION**

<table>
<thead>
<tr>
<th>Category: 1</th>
<th>Category: 2</th>
<th>Category: 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>ValueCare Network Provider</td>
<td>BlueCross BlueShield Traditional Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>After $25 Copayment per visit, the Plan pays 100% of the Allowed Amount.</td>
<td>After $35 Copayment per visit, the Plan pays 100% of the Allowed Amount.</td>
<td>The Plan pays 65% of the Allowed Amount and You pay balance of billed charges. Your 35% payment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
</tbody>
</table>

Limit: one routine eye examination per Claimant per Contract Year
Other Benefits

CARE MANAGEMENT PROGRAM
Because of Regence’s involvement as the Claims Administrator, You have access to the following Group-sponsored care management program. Your employer has chosen to provide this benefit to You. To the extent any part of this program (e.g., medications for smoking cessation) is also a benefit under the Medical Benefits or other benefit of the Plan, the Medical Benefits or other benefit applies first and until that benefit is exhausted.

CASE MANAGEMENT
Receive one-on-one help and support in the event You have a serious or sudden Illness or Injury. An experienced, compassionate case manager will serve as Your personal advocate during a time when You need it most. Your case manager is a licensed health care professional who will help You understand Your treatment options, show You how to get the most out of Your available Plan benefits and work with Your Physician to support Your treatment plan.

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

ADOPTION BENEFIT
The Plan will pay 85% of expenses You incur for an eligible adoption up to a maximum of $4,000.

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

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

  Regence BlueCross BlueShield of Utah  
P.O. Box 30272  
Salt Lake City, UT 84130-0272

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

In the event the Participant and/or the Participant’s spouse are covered by more than one compliant health benefit plan, the adoption benefit will be prorated between or among the plans. The full amount provided by both or all of the plans will not exceed $4,000 per pregnancy. In the event the post-placement evaluation disapproves the adoption placement and a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child’s health or safety, the Participant will be liable for repayment of the adoption benefit. The Participant will refund the full amount of such benefit to the Plan, upon request, within 30 days after the date the child is removed from placement.
Summary Of Prescription Drug Benefits – Employee Health Care Plan

Prescription Drug Benefits are administered through CVS Caremark, not through Regence BCBSU. Please contact CVS Caremark at (800) 966-5772 for information on Prescription Drug coverage.

CONTRACT YEAR DEDUCTIBLE – Prescription Drug Benefits Only
There is no Deductible amount applicable to Prescription Drug Benefits.

CONTRACT YEAR OUT-OF-POCKET MAXIMUM – Prescription Drug Benefits Only
Your specific Out-of-Pocket Maximum will vary depending on whether You purchase Your Prescription Drugs from a University Health Care Pharmacy or from a CVS Caremark Participating Pharmacy, and whether or not Your Prescription Drugs are generic, preferred brand or non-preferred brand (see "How the Plan Pays" below).

COINSURANCE
Except as provided in Special Provisions below, You are responsible to pay the following Coinsurance amounts (subject to a $3 minimum):

**University Health Care Pharmacies:**

<table>
<thead>
<tr>
<th></th>
<th>Generic</th>
<th>Preferred Name Brand</th>
<th>Non-Preferred Name Brand</th>
<th>Diabetic Supplies</th>
<th>Non-covered Prescription Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20%</td>
<td>of negotiated</td>
<td></td>
<td>20%</td>
<td>100%</td>
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<td></td>
<td></td>
<td>Prescription Drug</td>
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<td></td>
<td></td>
<td>charge up to a 90-day supply</td>
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</tbody>
</table>

**CVS Caremark Participating Pharmacies:**

<table>
<thead>
<tr>
<th></th>
<th>Generic</th>
<th>Preferred Name Brand</th>
<th>Non-Preferred Name Brand</th>
<th>Diabetic Supplies</th>
<th>Non-covered Prescription Drugs</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td>Prescription Drug</td>
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<td></td>
<td></td>
<td>charge up to a 90-day supply</td>
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</table>

**Prescription Mail Order Program¹:**

<table>
<thead>
<tr>
<th></th>
<th>University Health Care Mail Order Program</th>
<th>Generic</th>
<th>Preferred Name Brand</th>
<th>Non-Preferred Name Brand</th>
<th>Diabetic Supplies</th>
<th>20% of negotiated Prescription Drug charge up to a 90-day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CVS Caremark Mail Order Program (non-Utah residents ONLY)</td>
<td>Generic</td>
<td>Preferred Name Brand</td>
<td>25%</td>
<td></td>
<td>20% of negotiated Prescription Drug charge up to a 90-day supply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Preferred Name Brand</td>
<td>35%</td>
<td></td>
<td></td>
<td>20% of negotiated Prescription Drug charge up to a 90-day supply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diabetic Supplies</td>
<td>20%</td>
<td></td>
<td></td>
<td>20% of negotiated Prescription Drug charge up to a 90-day supply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-covered Prescription Drugs</td>
<td>100%</td>
<td></td>
<td></td>
<td>20% of negotiated Prescription Drug charge up to a 90-day supply</td>
</tr>
</tbody>
</table>

¹ The Prescription Mail Order Program is an exclusive contract with University Health Care. The Plan does not cover Prescriptions filled by other Mail Order programs (including, but not limited to, Foreign Pharmacies), except for Claimants residing outside the State of Utah. Non-Utah residents must use the CVS Caremark Mail Order Program.
Over-the-counter medications required to be covered under PPACA will be covered by the Plan at 100% of the allowable amount with a Prescription Order for the item(s).

**HOW THE PLAN PAYS:**
The Prescription Drug Out-of-Pocket Maximum refers to the amount of claims paid by the Plan for covered retail and mail order Prescription Drugs combined. Once the Plan has paid $4,000 for an individual member (regardless of the coverage tier in which they are enrolled: single, two-party, or family coverage), the Plan will begin to pay 100% of all eligible charges for that individual member for the remainder of that Contract Year (July 1 through June 30). An individual member will not be required to continue to pay coinsurance toward the purchase of a prescription drug once the Plan has paid $4,000 for that individual member, regardless of the individual’s coverage tier.

For family tier coverage, once the Plan has paid out a total of $12,000 (the Family Accumulation maximum), the Plan will begin to pay 100% of eligible charges for all covered members of that family, regardless of whether they have met the Individual Accumulation maximum, or not. Once an individual meets the $4,000 Individual Accumulation maximum, the individual's charges in excess of $4,000 will not be applied toward the Family Accumulation maximum.

The Prescription Drug Coinsurance amounts do not apply toward any medical Out-of-Pocket Maximum amounts outlined in the Summary Of Medical Benefits.

**COORDINATION OF BENEFITS – Prescription Drug Benefits Only**
Coordination of Prescription Drug Benefits to 100% of the negotiated charge is only available to Claimants who have primary and secondary coverage in the University of Utah Employee Health Care Plan (Advantage, Comprehensive or High Deductible Health Plan options). Coordination of Prescription Drug Benefits is not available for Claimants who have primary coverage provided by another employer’s group insurance plan.

**SPECIAL PROVISIONS**
The following are Special Provisions applicable to Your Prescription Drug Benefit:

- If You request a name brand Prescription Drug in place of its generic equivalent, the Plan will pay the amount it would have paid for the generic equivalent and You will be responsible for the Coinsurance You would have paid for the generic equivalent, plus the difference in price between the name brand Prescription Drug and the generic equivalent.
- When using Your Health Plan Identification Card, You may be eligible for a discounted rate for non-covered Prescription Drugs. You pay 100% of discounted rate.
- Coverage of Prescription Drug Benefits described herein does not apply to those enrolled in the University of Utah Retiree Health Care Plan and their Enrolled Dependents.

Additional information, including claim forms, may be obtained on the internet at: 
[www.hr.utah.edu/ben/cob/](http://www.hr.utah.edu/ben/cob/).
Covered Prescription Drug Benefits

Prescription Drug Benefits are administered through CVS Caremark, not through Regence BCBSU. Please contact CVS Caremark at (800) 966-5772 for information on Prescription Drug Benefits.

When You incur expenses for Prescription Drugs purchased from a duly licensed pharmacy pursuant to a Prescription Order, Prescription Drug Benefits will be provided, as follows:

- when You present Your Prescription Order and use Your Health Plan Identification Card at a Participating Pharmacy, You will be required to pay only the applicable Coinsurance amounts specified in the Summary Of Prescription Drug Benefits, to be paid at the time of purchase; and
- when You present Your Prescription Order, but do not use Your Health Plan Identification Card and/or You go to an Out-of-network Pharmacy, You will be required to pay the entire cost of the Prescription Drug and file a claim for reimbursement of eligible expenses with CVS Caremark for the Coinsurance amount to be paid by the Plan, specified in the Summary Of Prescription Drug Benefits, not to exceed the amount the Plan would have paid a Participating Pharmacy if You had used Your Health Plan Identification Card.

COVERED PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are available for the following:

- Prescription Drugs, including drugs, biologicals, and compounded prescriptions used to treat an Illness or Injury and not specifically excluded herein;
- insulin and prescribed oral agents for controlling blood glucose levels;
- diabetic supplies including test strips, lancets, alcohol swabs, and syringes (subject to 20% coinsurance); and
- prescription contraceptives.

Limitations And Exclusions

The following limitations and exclusions apply to Prescription Drug Benefits:

A Non-Legend Patent or Proprietary Medicine

Anabolic Steroids

Charges for the Administration or Injection of Any Drug

Cosmetic Hair Growth and Removal Products

Emergency Contraceptives (e.g., Preven and Plan B)

Food Supplements, Special Formulas, and Special Diets

Immunization Agents, Biological Sera, Blood, or Blood Plasma

Impotence Medication: In excess of 6 doses in a 25-day period (except Cialis 2.5 mg which is allowed up to 30 tablets in a 25-day period).

Infertility Medications

Investigational or Experimental Drugs: Drugs labeled “Caution – limited by federal law to investigational use”, or experimental drugs, even though a charge is made to the individual.

Mail Order Prescription Drugs from a Non-University Health Care Pharmacy: For Utah residents, any Prescription Drug purchased through a mail order program other than the University Health Care Mail Order Program. For non-Utah residents, any Prescription Drug purchased through a mail order program other than the CVS Caremark Mail Order Program.

Medication Not Requiring a Prescription Order, Other than Insulin
Medication Taken or Administered While a Patient: Medication which is taken by or administered to an individual, in whole or in part, while he or she is a patient in a doctor’s office, hospital, rest home, sanatorium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals. (In some cases, this medication is covered under the Medical Benefits portion of the Plan.)

Non-Medicinal Substances: Therapeutic devices or appliances, including hypodermic needles, syringes (excluding insulin syringes), support garments, and other non-medicinal substances, regardless of intended use. (In some cases, items may be covered under the Medical Benefits portion of the Plan.)

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

Over-the-Counter Medication: Over-the-counter medications, vitamins and/or minerals, or item(s) purchased at a pharmacy other than Prescription Drugs whether or not there is a Prescription Order for the item(s), except as required under PPACA.

Pigmenting/Depigmenting Agents: Except as required to treat photosensitive conditions, such as psoriasis.

Prescription Drugs for a Non-FDA Approved Purpose or Dosage: Any Prescription Drug prescribed for use other than its FDA-approved purpose or in a dosage other than the standard dosage for an FDA-approved purpose. However, if a Prescription Drug is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the Prescription Drug may be provided when so used, as determined by the Claims Administrator.

Prescription Drugs In Excess of a 90 Day Supply

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

DEFINITIONS
In addition to the definitions in the Definitions Section of this Summary Plan Description, the following definitions apply to this Covered Prescription Drug Benefits Section:

Health Plan Identification Card means the identification card issued to You by the Claims Administrator, which includes information regarding Your medical, behavioral health and prescription drug benefits.

Out-of-network Pharmacy means a pharmacy which has no network agreement with CVS Caremark.

Participating Pharmacy means a duly licensed pharmacy with which CVS Caremark has a network agreement. A roster of Participating Pharmacies can be obtained from CVS Caremark or the University.

Prescription Drug means a drug or medicine which can only be obtained by a Prescription Order and bears the legend “Caution, Federal Law prohibits dispensing without a prescription” or which is restricted by State law, or insulin.

Prescription Order means a written or oral order for a Prescription Drug issued by a Physician or Practitioner within the scope of his or her professional license.
Summary Of Behavioral Health Benefits – Employee Health Care Plan

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

**CONTRACT YEAR DEDUCTIBLE**

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

**CONTRACT YEAR OUT-OF-POCKET MAXIMUM**

There is no Out-of-Pocket Maximum amount applicable to Behavioral Health benefits. Behavioral Health Coinsurance amounts do not apply toward any medical Out-of-Pocket Maximum amounts outlined in the Summary Of Medical Benefits.

**Employee Assistance Program**

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

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

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

Access to the EAP described herein does not apply to those enrolled in the University of Utah Retiree Health Care Plan and their Enrolled Dependents.

**MENTAL HEALTH SERVICES**

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

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

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UNIVERSITY OF UTAH, 10002211, EFFECTIVE JULY 1, 2012
CHEMICAL DEPENDENCY SERVICES*

<table>
<thead>
<tr>
<th>Services</th>
<th>When You Use EAP Referral</th>
<th>When You Don't Use EAP Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Services</td>
<td>Upon referral from EAP, Plan pays 80% and You pay 20% of Allowed Amount.</td>
<td>After Deductible, Plan pays 50% of Allowed Amount and You pay balance of billed charges.</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>Upon referral from EAP, Plan pays 80% and You pay 20% of Allowed Amount.</td>
<td>Plan pays 50% of Allowed Amount and You pay balance of billed charges.</td>
</tr>
</tbody>
</table>

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

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

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

The EAP provides the following services:

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

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

NOTE: You always have a choice. When You coordinate care through the EAP You will receive the maximum Behavioral Health Benefits provided by the Plan. When You do NOT coordinate care through the EAP, Covered Services will be paid as Without EAP Referral benefits. See Summary Of Behavioral Health Benefits for more details.

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

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

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- paraphilias;
- personality disorders;
- psychosexual disorders;
- pyromania; and
- tourette’s.

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

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

Services Not Coordinated Through The EAP:
Any Behavioral Health Service NOT coordinated through the EAP will be covered as a Without EAP Referral benefit, regardless of whether or not the Provider/Hospital has an existing contract with the UNI BHN network.
Appeals Process – Behavioral Health Benefits Only

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

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

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

**OPTIONAL EXTERNAL APPEAL (MEDICAL NECESSITY ISSUES ONLY)**
If You disagree with the decision made in the "Second Level - Committee Appeal", and the issue on Appeal is the Medical Necessity of services or services that are investigational or experimental in nature, You may request further Appeal to the "Optional External Appeal." The Appeal request must be made in writing or orally within 180 calendar days after You receive notice of the decision at the "Second Level - Committee Appeal." Failure to request an "Optional External Appeal" within this time period will preclude the Claimant’s right to further appeal of the decision through this optional level. The written Appeal request, including any additional information or comments must be made to the Director of Clinical Services, 650 Komas, Suite 207A, Salt Lake City, Utah 84108. "Optional External Appeal" will be coordinated by the Director of Clinical Services while the decision is made by an Independent Review Organization (IRO) at no cost to You. The IRO is an independent physician review organization that is unbiased, independent and not controlled by the Claims Administrator or the Plan. Within the IRO, there will be clinical expertise, use of evidence-based decision making, maintenance of confidentiality, and adequate administration and training capacity. Within 5 calendar days of receipt of the request for a "Optional External Appeal," the Director of Clinical Services will determine if the Appeal concerns Medical Necessity. If the Director of Clinical Services determines the Appeal concerns Medical Necessity, he or she will provide the IRO with the Appeal documentation within 3 business days and a written notice of the IRO’s decision will be sent to You within 30 calendar days of receipt of the request for "Optional External Appeal." Choosing the “Optional External Appeal” for the settlement of an Appeal as the final level will be binding in accordance with the IRO’s decision and this section.
OPTIONAL ARBITRATION
Voluntary arbitration is available as a level of Appeal for a dispute You have with the Plan. All other (non-optional) levels of this Appeal Process must be exhausted before arbitration is available. Choosing arbitration as the final level for the settlement of such disputes will be binding in accordance with the Arbitration provision of this section. The Director of Clinical Services can assist You with procedures for initiating and participating in an arbitration.
General Exclusions
The following are the general exclusions from coverage under the Plan. Other exclusions may apply and, if so, will be described elsewhere in this Summary Plan Description.

WAITING PERIOD FOR PREEXISTING CONDITIONS
The Plan has a waiting period for Preexisting Conditions. The waiting period for Preexisting Conditions is not imposed on a Claimant who is enrolled prior to reaching 19 years of age. A Preexisting Condition is defined as a physical or mental condition, except for pregnancy, whether diagnosed or misdiagnosed, which within the six-month period before Your Enrollment Date (defined below):

- You incurred expenses, received medical treatment, services or advice, underwent diagnostic procedures, took prescribed drugs or medicine, or consulted a physician or other licensed medical professional; or
- Was discovered or suspected as a result of any medical examination, including a routine medical examination.

Enrollment Date means:
- For individuals who apply during their initial period of eligibility, Your date of hire into a benefit-eligible position with the University.
- For all others (e.g., including those who applied as Late Enrollees or during a special enrollment), the Enrollment Date is the Effective Date of coverage.

Pregnancy and phenylketonuria (PKU) are not considered Preexisting Conditions. Genetic information will not be considered a Preexisting Condition in the absence of a diagnosis related to such information. The Plan will not impose the waiting period for a Preexisting Condition of a newborn child, an adopted child, or a child placed with You for adoption if You complete the paperwork necessary to add the child to Your coverage within 3 months of the birth, adoption or placement, respectively.

The Plan’s payment of a claim related to a Preexisting Condition does not mean that this limitation is waived for that claim or for any subsequent claim if the Plan later determines the condition was preexisting.

Waiting Period Time Limit
The waiting period will end six months following Your Enrollment Date.

Creditable Coverage
The duration of the Preexisting Condition exclusion period will be reduced by the amount of Your combined periods of creditable coverage if You have been covered by creditable coverage. For crediting to apply, there must have been no break in creditable coverage greater than 63 days immediately preceding Your Enrollment Date of coverage under the Plan or between any two successive creditable coverages for which You seek credit. Creditable coverage may still be in force at the time credit for it is sought on this coverage.

You will be allowed a credit against the Preexisting Condition exclusion period under the Plan for the combined amount of prior creditable coverages that You have had. If You have had more than one creditable coverage in effect at the same time, credit is given only for one (that is, a day on which You have creditable coverage in force under two coverages is not counted as two days of creditable coverage). In calculating Your creditable coverage credit, if You have had a break in coverage (that is, a period between the termination date of one creditable coverage and the enrollment date on next creditable coverage) of 63 days or more, no credit will be given for any creditable coverages prior to that break in coverage.

Creditable coverage means any of the following: group coverage (including self-funded plans); individual insurance coverage; S-CHIP; Medicaid; Medicare; CHAMPUS/Tricare; Indian Health Service or tribal organization coverage; state high-risk pool coverage; Federal Employee Health Benefit Plan coverage; and public health plans (including foreign government and US government plans).
Creditable coverage is determined separately for each Claimant.

The following periods do not count in the calculation of the length of a break in coverage:

- days in a waiting period for eligibility for coverage under the Plan; and
- for an individual who elects COBRA continuation coverage during the second election period offered under the Trade Act of 2002, days between the loss of coverage and the first day of that second election period.

You have the right to demonstrate the existence of creditable coverage by providing the Claims Administrator with one or more certificates of creditable coverage from a prior group or individual plan or with other documentation. You may obtain a certificate of creditable coverage from a prior group health plan or insurer by requesting it within 24 months of coverage termination. The Claims Administrator can help you obtain a certificate from a prior plan or insurer or suggest other documents that will serve as alternatives to a certificate of creditable coverage as provided by federal law.

**GENERAL EXCLUSION EXAMPLES**

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

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
  - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
  - related to a congenital disease or anomaly of a covered child that has resulted in functional defect;
- complications relating to services, supplies or medications which have not yet been approved by the United States Food and Drug Administration (FDA) or which are used for purposes other than the FDA-approved purpose; or
- complications that result from an Injury or Illness resulting from active participation in illegal activities as determined by the plan administrator.

**SPECIFIC EXCLUSIONS**

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

**Alternative Care**

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

- acupuncture and acupressure;
- holistic and homeopathic treatment;
- massage or massage therapy;
- naturopathy;
- faith healing;
- milieu therapy;
- hypnosis;
- sensitivity training;
- behavior modification;
- biofeedback;
- electrohypnosis, electrosleep therapy, or electronarcosis;
- ecological or environmental medicine; and
- other therapies: scream therapy; psychic surgery, channeling, sensory deprivation; rolfing; thermography; music, art, dance, or recreation therapy; crystal therapy; and hypertherapy (therapeutically induced fever) for the treatment of cancer.

**Behavioral Health Services**

Behavioral Health Services are administered through Blomquist Hale Consulting and UNI BHN. See the Covered Behavioral Health Services Section for the specific limitations and exclusions of Behavioral Health Benefits.

**Cosmetic/Reconstructive Services and Supplies**

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

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

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

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

**Counseling**

Charges for counseling a Claimant, including the following:

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

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

**Custodial Care**

Non-skilled care and helping with activities of daily living.

**Dental Services**

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

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

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

**Fees, Taxes, Interest**

Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. The Plan also does not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other

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similar charges whether made by federal, state or local government or by another entity, unless required by law.

**Foot Care (Routine)**
Routine foot care, including, but not limited to: treatment of corns and calluses and trimming of nails, except as medically necessary, determined in accordance with Medicare guidelines.

**Gastric Procedures**
Services and supplies for or in connection with gastric or intestinal bypass, gastric stapling, or other similar surgical procedure (except certain surgical treatments of Morbid Obesity), or for or in connection with reversal or revision of such procedures.

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

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

**Hearing Care**
Except as specifically provided under the Hearing Examinations benefit of the Plan. Hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion does not apply to cochlear implants.

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

**Investigational Services**
Investigational treatments or procedures (Health Interventions) and services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). Also excluded are any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section of this Summary Plan Description. This exclusion does not apply to treatment or procedures related to the diagnosis and/or treatment of high-risk osteogenic sarcoma.

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

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

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

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

Obesity or Weight Reduction/Control
Medical or surgical treatment (including reversals), programs, or supplies that are intended to result in weight reduction, regardless of diagnosis or psychological conditions, except certain surgical procedures for the treatment of Morbid Obesity and counseling required under PPACA.

Orthognathic Surgery
Services and supplies for orthognathic surgery. This exclusion does not apply to orthognathic surgery for class II or class III skeletal deformities not correctable by orthodontic means.

Over-the-Counter Contraceptives
Over-the-counter contraceptive supplies and oral contraceptives.

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

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

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

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

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

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

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

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

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

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

**Services and Supplies For Which No Charge Is Made Or No Charge Is Normally Made**

Services and supplies for which a Claimant is not required to make payment or for charges that in the absence of this Plan there would be no obligation to pay. This would include but is not limited to:

- services or supplies for which a Claimant cannot be held liable because of an agreement between the Provider rendering the service and another third party payor which has already paid for such service or supply;
- services for which the Claimant incurs no charge or has no legal obligation to pay; and
- charges for services or supplies provided by the University or any of its employees or agents.

**Services and Supplies Provided by a Member of Your Family**

Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "immediate family" means parents, spouse, children, siblings, half-siblings, in-laws or any relative by blood or marriage who shares a residence with You.

**Services and Supplies Provided By A School Or Halfway House**

Services and supplies provided by any public or private school or halfway house, or by their employees and services provided solely to satisfy institutional requirements.

**Services and Supplies That Are Not Medically Necessary**

Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury, except for preventive care benefits specifically provided under the Plan.

**Sexual Dysfunction**

Services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners when Mental Health Services are covered benefits under the Plan.

**Sexual Reassignment Treatment and Surgery**

Treatment, surgery or counseling services for sexual reassignment.

**Termination of Pregnancy**

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

**Third Party Liability**

Services and supplies for treatment of Illness or Injury for which a third party is or may be responsible.

**Tobacco Addiction Treatment**

Except as specifically provided under the Preventive Care benefit in this Summary Plan Description, the Plan does not cover treatment of tobacco addiction and supportive items for addiction to tobacco, tobacco products or nicotine substitutes.

**Travel and Transportation Expenses**

Travel and transportation expenses other than covered ambulance services provided under the Plan.
Uniformed Services
The treatment of any Claimant's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Vision Care
Routine eye exam and vision hardware, except the first intraocular lenses following cataract surgery and as medically necessary for the treatment of keratoconus.

Visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors(astigmatism), reversals or revisions of surgical procedures which alter the refractive character of the eye.

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

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

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

PLAN IDENTIFICATION CARD

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

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

If You lose Your card, or if it gets destroyed, You can get a new one by calling the Claims Administrator's Customer Service department at: 1 (888) 370-6159 or by visiting the Claims Administrator's website at www.myRegence.com. If the Plan terminates, Your Plan identification card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

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

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

Timely Filing of Claims

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

Freedom of Choice of Provider

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

Category 1 and Category 2 Claims

You must present Your Plan identification card when obtaining Covered Services from a Network Provider. You must also furnish any additional information requested. The Provider will furnish the Claims Administrator with the forms and information needed to process Your claim.

Category 1 and Category 2 Reimbursement

A Network Provider will be paid directly for Covered Services. These Providers have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount is any amount You must pay due to Copayment and/or Coinsurance. These Providers may require You to pay Your share at the time You receive care or treatment.

Category 3 Claims

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

- an itemized description of the services given and the charges for them;
- the date treatment was given;

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• the diagnosis; and
• the patient's name, the group number, and identification numbers.

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

Category 3 Reimbursement
In most cases, You will be paid directly for Covered Services provided by an Out-of-Network Provider.

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

Reimbursement Examples by Category
Here is an example of how Your selection of Category 1, 2 or 3 affects payment to Providers and Your cost sharing amount. The benefit table from the Summary Of Medical Benefits (or other benefits section) would appear as follows:

<table>
<thead>
<tr>
<th>Category: 1</th>
<th>Category: 2</th>
<th>Category: 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>ValueCare Network Provider</td>
<td>BlueCross BlueShield Traditional Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>The Plan pays 85% and You pay 15% of the Allowed Amount. Your 15% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>The Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.</td>
<td>The Plan pays 65% of the Allowed Amount and You pay balance of billed charges. Your 35% payment will be applied toward the Out-of-Pocket Maximum.</td>
</tr>
</tbody>
</table>

Now, let’s assume that the Provider’s charge for a service is $5,000 and the Allowed Amount for that charge is $3,800 for Category 1 and $4,000 for Category 2. The Plan will pay claims to an Out-of-Network Category 3 Provider based on the Allowed Amount for a Category 1 Provider. Finally, let’s assume that You have not met the Out-of-Pocket Maximum. Here’s how that Covered Service would be paid:

• Category 1: the Plan would pay 85% of the Allowed Amount and You would pay 15% of the Allowed Amount, as follows:
  - Amount Preferred Provider must “write-off” (that is, cannot charge You for): $1,200
  - Amount the Plan pays (85% of the $3,800 Allowed Amount): $3,230
  - Amount You pay (15% of the $3,800 Allowed Amount): $570
  - Total: $5,000

• Category 2: the Plan would pay 80% of the Allowed Amount and You would pay 20% of the Allowed Amount, as follows:
  - Amount participating Provider must “write-off” (that is, cannot charge You for): $1,000
  - Amount the Plan pays (80% of the $4,000 Allowed Amount): $3,200
  - Amount You pay (40% of the $4,000 Allowed Amount): $800
  - Total: $5,000

• Category 3: the Plan would pay 65% of the Category 1 Allowed Amount. Because the out-of-network Provider does not accept the Allowed Amount, You would pay 35% of the Category 1 Allowed Amount, plus, the difference between the out-of-network Provider’s billed charges and the Allowed Amount, as follows:
  - Amount the Plan pays (65% of the $3,800 Allowed Amount): $2,470
The actual benefits of the Plan may vary, so please read the benefits sections thoroughly to determine how Your benefits are paid. For example, as explained in the Definitions Section, the Allowed Amount may vary for a Covered Service depending upon Your selected Provider.

**Ambulance Claims**

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

**Claims Determinations**

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

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

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

**OUT-OF-AREA SERVICES**

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

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

**BlueCard Program**

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

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

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

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

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

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

**Negotiated National Account Arrangements**

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

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

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

- Member Liability Calculation. When Covered Services are provided outside of the Claims Administrator's service area by nonparticipating Providers, the amount You pay for such services will generally be based on either the Host Blue's nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

- Exceptions. In certain situations, the Claims Administrator may use other payment bases, such as billed covered charges, the payment the Claims Administrator would make if the health care services had been obtained within the Claims Administrator's service area or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Claims Administrator will pay for services rendered by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

**BLUECARD WORLDWIDE®**

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

When You need health care outside of the United States or any other areas covered by the domestic BlueCard Program, follow these simple steps:

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

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

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

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

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

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

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

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

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

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

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

- billing statements;
- claim records;
- correspondence;
- dental records;
- diagnostic imaging reports;
- Hospital records (including nursing records and progress notes);
- laboratory reports; and
- medical records.
The Claims Administrator is required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by calling the Claims Administrator's Customer Service department at: 1 (888) 370-6159 or visiting their Web site www.myRegence.com.

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

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

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

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

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

- a third party;
- workers’ compensation; or
- any other source, including automobile medical, personal injury protection ("PIP"), automobile non-fault, homeowner’s coverage, commercial premises medical coverage or similar contract or insurance, when the contract or insurance is either issued to, or makes benefits available to You, whether or not You make a claim under such coverage.

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

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

- Reimbursement or subrogation under the Plan will not be reduced due to Your not being made whole.

- You may be required to sign and deliver all legal papers and take any other actions requested to secure the Plan's rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third party or other source). If You are asked to sign a trust agreement or other document to reimburse the Plan from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.

- You must agree that nothing will be done to prejudice the Plan's rights and that You will cooperate fully with the Claims Administrator, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the Claims Administrator of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:
  - the filing of a lawsuit;
  - the making of a claim against any third party;
  - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
  - intent of a third party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Injury or Illness that gives rise to the Plan's right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).

- You and/or Your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to Your benefit or on Your behalf that in any manner relates to the Injury or Illness giving rise to the Plan's right of reimbursement or subrogation, until the Plan's right is satisfied or released.

- In the event You and/or Your agent or attorney fails to comply with any of these conditions, any such benefits advanced for any Illness or Injury may be recovered through legal action.

- Any benefits provided or advanced under the Plan are provided solely to assist You. By paying such benefits, neither the Plan nor the Claims Administrator is acting as a volunteer and is not waiving any right to reimbursement or subrogation.

**Motor Vehicle Coverage**

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

**Workers' Compensation**

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

- You must notify the Claims Administrator in writing within five days of any of the following:
  - filing a claim;
  - having the claim accepted or rejected;
  - appealing any decision;
  - settling or otherwise resolving the claim; or
  - any other change in status of Your claim.

- If the entity providing workers' compensation coverage denies Your claim and You have filed an appeal, benefits may be advanced for Covered Services if You agree to hold any recovery obtained in a segregated account for the Plan.

**Fees and Expenses**

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

**Future Medical Expenses**

Benefits for otherwise Covered Services may be excluded, as follows:

- When You have received a recovery from another source relating to an Illness or Injury for which benefits under the Plan have been previously paid.
- Until the total amount excluded under this provision equals the third-party recovery.

The amount of any exclusion under this provision, however, will not exceed the amount of benefits previously paid in connection with the Illness or Injury for which the recovery has been made.
COORDINATION OF BENEFITS
If You are covered under any other individual or group medical contract or policy (referred to as "Other Plan" and defined below), the benefits under this Plan and those of the Other Plan will be coordinated in accordance with the provisions of this section.

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

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

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

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

When a plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid.

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

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

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

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

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

Other Plan does not include:

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

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

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

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

Year, for purposes of this Coordination of Benefits provision, means calendar year (January 1 through December 31).

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

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

Child covered under more than one plan: Plans that cover You as a child shall determine the order of benefits as follows:

- When Your parents are married or living together (whether or not they have ever been married), the plan of the parent whose birthday falls earlier in the Year is the Primary Plan. If both parents have the same birthday, the plan that has covered a parent longer is the Primary Plan.
- When Your parents are divorced or separated or are not living together (if they have never been married) and a court decree states that one of Your parents is responsible for Your health care expenses or health care coverage, the plan of that parent is primary to the plan of Your other parent.
If the parent with that responsibility has no health care coverage for Your health care expenses, but that parent’s spouse does, the plan of the spouse shall be primary to the plan of Your other parent.

- If a court decree states that both parents are responsible for Your health care expenses or health care coverage, or if a court decree states that the parents have joint custody of You, without specifying that one of the parents is responsible for Your health care expenses or health care coverage, the provisions of the first bullet above (based on parental birthdays) shall determine the order of benefits.

- If there is no court decree allocating responsibility for Your health care expenses or health care coverage, the order of benefits is as follows:
  - The plan of Your custodial parent shall be primary to the plan of Your custodial parent’s spouse;
  - The plan of Your custodial parent’s spouse shall be primary to the plan of Your noncustodial parent; and
  - The plan of Your noncustodial parent shall be primary to the plan of Your noncustodial parent’s spouse.

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

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

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

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

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

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

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

**Primary Health Plan Benefits**

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

to the Claims Administrator within 36 months of the date of service.

**Secondary Health Plan Benefits**

If, in accordance with the order of benefit determination, one or more Other Plans are primary to this Plan,

the benefits of this Plan will be calculated as follows:

The benefits that would have been paid under this Plan for a service if this Plan were the Primary Plan

will be calculated. That calculated amount will be applied to any Allowable Expense under this Plan for

that service that is unpaid by the Primary Plan. The Claims Administrator will:

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

Nothing contained in this Coordination of Benefits provision requires this Plan to pay for all or part of any

service that is not covered under this Plan. Further, in no event will this Coordination of Benefits

provision operate to increase this Plan’s payment over what would have been paid in the absence of this

Coordination of Benefits provision.

**Right to Receive and Release Needed Information**

Certain facts are needed to apply Coordination of Benefits provisions. The Claims Administrator has the

right to decide which facts they need. The Claims Administrator may get needed facts from, or give them

to, any other organization or person as permitted by law, and need not tell or get the consent of any

person to do this. You will promptly furnish to the Claims Administrator any information necessary or

appropriate to administer this Coordination of Benefits provision. Receipt of such information by the

Claims Administrator will be a condition precedent to this Plan’s obligation to provide benefits.

**Right of Recovery**

If benefits are paid under this Plan to or on behalf of You in excess of the amount that would have been

payable under this Plan by reason of Your coverage under any Other Plan(s), this Plan will be entitled to

the excess as follows:

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

A Secondary Plan that provides benefits in the form of services may recover the reasonable cash value of

the services from the Primary Plan to the extent that benefits for the services are covered by the Primary

Plan and have not already been paid or provided by it.
Appeal Process

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

APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Claims Administrator at: Appeals Coordinator, Regence BlueCross BlueShield of Utah, P.O. Box 2998 Tacoma, WA 98401-2998. Verbal requests can be made by calling the Claims Administrator at 1 (888) 370-6159.

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). If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum. When an Appeal request is received, the Claims Administrator will acknowledge it in writing.

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

First-Level Appeals

First-level Appeals are reviewed by a Claims Administrator employee or employees who were not involved in the initial decision that You are appealing. In Appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's staff of health care professionals. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 14 days of receipt of the Appeal. For Appeals involving a post-service Investigational issue, a written notice of the decision will be sent within 20 working days of receipt.

Panel-Level (Second-Level) Appeals

Second-level Appeals are reviewed by a panel of Claims Administrator employees who were not involved in, or subordinate to anyone involved in, the first-level decision. You, or Your Representative on Your behalf, will be given a reasonable opportunity to provide written materials. 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 14 days of receipt of the Appeal. For Appeals involving a Post-Service Investigational issue, a written notice of the decision will be sent within 20 working days of receipt.

VOLUNTARY EXTERNAL APPEAL - IRO

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

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

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

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

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

Panel-Level (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 a panel of Claims Administrator’s employees who were not involved in, or subordinate to anyone involved in, the initial denial determination. You, or Your Representative on Your behalf, will be given the opportunity (within the constraints of the expedited Appeals timeframe) to participate via telephone and/or provide written materials. A verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. A written notification of the decision will be mailed to You within three calendar days of the determination.

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

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

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

INFORMATION
If You have any questions about the Appeal process outlined here, You may contact the Claims Administrator’s Customer Service department at Customer Service: 1 (888) 370-6159 or You can write to the Claims Administrator’s Customer Service department at the following address: Regence BlueCross BlueShield of Utah, P.O. Box 2998, Tacoma, WA 98401-2998.

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

- access to health care benefits, including an adverse determination made pursuant to utilization management;
- claims payment, handling or reimbursement for health care services;
- matters pertaining to the contractual relationship between a Claimant and the Plan; and
- other matters as specifically required by state law or regulation.
Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary expedited Appeals and voluntary expedited external Appeals, through an independent contractor relationship with the Claims Administrator and/or through assignment to the Claims Administrator via state regulatory requirements. The IRO is unbiased and is not controlled by the Claims Administrator.

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

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

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

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

This section contains the terms of eligibility under the Plan.

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

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

- Faculty members who have an appointment for nine months or longer at 50% FTE (full-time equivalent) or greater.
- Staff employees who are employed in a position expected to last nine months or longer at 50% FTE or greater.
- Employees who have qualified under one of the first two categories and are currently on an approved Phased Retirement Agreement.
- Employees who are employed at less than 50% FTE and hold a J-1 visa.

**Independent Contractors Of Affiliated Groups**
You are eligible to enroll in this Plan if you are an independent contractor who is a member of an affiliated group identified in the list below:

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

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

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

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

**Dependent Coverage Continuing Beyond Limiting Age**

- You may continue coverage for Your (or Your spouse’s or Your domestic partner’s), unmarried, child at age 26 if the child is currently enrolled in the Plan as Your Eligible Dependent who is a Disabled Dependent (defined below). To do so, You must provide to the University’s Benefits Department a written request to continue coverage along with proof that the dependent meets the Plan’s definition of Disabled Dependent, as follows:
  - within 3 months after the dependent reaches age 26; and
  - at reasonable times thereafter as the Claims Administrator may consider necessary, but not more often than annually.

- You may continue coverage for Your (or Your spouse’s or Your domestic partner’s) unmarried, child at age 26 if the child is currently enrolled in the Plan as Your Eligible Dependent and is currently enrolled as a full-time student; and qualifies as Your Qualifying Relative as defined in the United States Internal Revenue Code (the child must meet all dependency tests as set forth by the United States Internal Revenue Code regarding taxability of employer-provided health coverage). To do so, You must provide to the University’s Benefits Department a written request to continue coverage along with certification of the dependent’s full-time student status, as follows:
  - within 3 months after the dependent reaches age 26; and
  - at reasonable times thereafter as the Claims Administrator may consider necessary, but not more often than annually.

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

**Retirees**

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

**Definitions Specific to the Who is Eligible, How to Enroll and When Coverage Begins Section**

Disabled Dependent means a child who is and continues to be: 1) unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable Physical or Mental Impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and 2) dependent on You for more than 50% of their support (food, shelter, clothing, medical and dental care, education and the like).

Mental Impairment means a mental or psychological disorder such as: 1) mental retardation; 2) organic brain syndrome; 3) emotional or mental illness or 4) specific learning disabilities as determined by the Claims Administrator.

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

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

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

WHEN YOU AND YOUR DEPENDENTS ARE INITIALLY ELIGIBLE

You become eligible for coverage on the first day of the month following the date You are hired by the University in a benefit-eligible position, or on the first day of the month following the date You are transferred into a benefit-eligible position from an ineligible position or on the first day of the month following your appointment or hire into one of the specified independent contractor/affiliated groups. If Your date of hire/transfer/appointment is the first day of the month, You are eligible for coverage on that day. If You hold a J-1 visa and are required under federal law to have coverage on Your date of hire, You become eligible for coverage on your date of hire. Upon first becoming eligible for coverage at the University, You may enroll Yourself and Your Eligible Dependents by submitting Your completed enrollment form to the University’s Benefits Department within 3 months 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 placement for adoption, 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 and submitting to the University’s Benefits Department a signed Health Care Coverage Change Form within 3 months of the date the dependent becomes eligible. Upon acceptance of Your properly completed change form, coverage for Your dependent will be effective retroactive to the date the dependent gained eligibility or, at Your request, coverage may be effective on the date the University’s Benefits Department accepts Your completed change form. If the change form is not submitted to the University’s Benefits Department within 3 months 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.

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

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your Eligible Dependents if You failed to do so when first eligible and not be considered a Late Enrollee. The Special Enrollment period lasts for 3 months beginning with the day of the triggering event; except the Special Enrollment period following exhaustion of any lifetime maximum on total benefits under a plan other than a plan sponsored by the University, which ends 30 days following the date the first claim is denied on the basis of lifetime maximum exhaustion. In each situation, You must complete a Health Care Coverage Change Form (and Domestic Partnership Certification Form if appropriate), and submit it to the University’s Benefits Department within the Special Enrollment period. If You do not submit Your request within the Special Enrollment period, You may only enroll Yourself and/or Your Eligible Dependents during the Plan’s subsequent Open Enrollment Periods, if any. In these situations, the rules regarding how to apply and when coverage begins are the same as those described earlier:

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

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

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

**LATE ENROLLMENT/OPEN ENROLLMENT PERIOD**

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

**TRANSFER DURING ANNUAL OPEN ENROLLMENT PERIOD**

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

**ENROLLMENT BY OTHERS**

In the event Your child is the subject of a court or administrative order requiring You to provide health coverage for the child and You are eligible for health coverage including the child, but fail to make application to cover the child, application for enrollment of the child may be made by the child's other parent, any state Medicaid agency or by the state agency administering 42 U.S.C. 651 through 699 (the child enforcement program). If You are not enrolled in coverage, You will automatically be enrolled and the child will be enrolled as Your Eligible Dependent.
NOTICE OF STATUS CHANGE

In the event You acquire a dependent or a dependent loses eligibility under the Plan, You must give the Plan written notice within 3 months after such date by submitting a Health Care Coverage Change form to the University’s Benefits Department. In order for an individual who loses eligibility for coverage under the Plan to be eligible for continuation of coverage under COBRA, You must submit a Health Care Coverage Change form or otherwise give the Plan written notice within 60 calendar days after such date in order for the dependent to be eligible for continuation of coverage under COBRA.

Leaves of Absence

FAMILY AND MEDICAL LEAVE ACT LEAVE OF ABSENCE

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

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

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

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

MEDICAL LEAVE OF ABSENCE

If You become totally disabled, You may continue coverage by making required contributions through the University’s Benefits Department until You are no longer totally disabled or for up to 30 months from Your date of disability (including any periods of FMLA leave), whichever occurs first, if:

- You are totally disabled as defined by the University’s Long Term Disability Plan or the Social Security Administration; and
- You were employed by the University in a benefit-eligible position and were enrolled in the Plan on the day immediately preceding the date You became totally disabled.
- If You remain totally disabled and are eligible and enrolled in the Plan at the end of the 30-month period and You worked for the University in a benefit-eligible position for:
5 or more consecutive years immediately prior to Your date of disability (including any periods of FMLA leave), then You and Your Enrolled Dependents may enroll in the University of Utah Retiree Health Care Plan or elect to continue coverage for a limited time through COBRA; or

less than 5 consecutive years immediately prior to Your date of disability (including any periods of FMLA leave), then You and Your Enrolled Dependents may be eligible for continuation coverage for a limited time through COBRA.

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

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

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

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

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

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

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

PLAN TERMINATION OR AMENDMENT

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

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

WHEN YOU MAY ELECT TO CANCEL COVERAGE

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

If You and/or Your Enrolled Dependent(s) obtain other similar coverage during the Contract Year (including enrolling in Medicare), You may elect to cancel coverage for such covered individual(s). In order to drop coverage during the Contract Year, You must complete a Health Care Coverage Change Form and submit it to the University’s Benefits Department within 3 months from the date You and/or Your Enrolled Dependent(s) gain other similar coverage. Coverage will be dropped on the date the form is received in the Benefits Department.

In the event You experience a significant increase in Your cost of coverage and no other similar coverage is available, You may choose to drop Your coverage in the Plan for You and all Your Enrolled Dependents. To drop coverage, You must complete a Health Care Coverage Change Form and submit it to the University’s Benefits Department within 3 months from the date of the significant increase in Your cost of coverage. Coverage will be dropped on the date the form is received in the Benefits Department.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

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

Termination Of Your Employment Or Appointment Or Change to an Ineligible Employment Status

If You are no longer eligible under the Plan due to termination of employment or appointment or change to an employment status that is ineligible for benefits, or You are no longer a member of an affiliated group, Your coverage will end for You and all Enrolled Dependents on the last day of the pay period on or following the date on which eligibility ends.

Nonpayment Of Required Contribution

If You fail to make the required contribution in a timely manner, Your coverage will end for You and all Enrolled Dependents on the date You fail to make such a required contribution and You and Your Enrolled Dependents will not be eligible for continuation of coverage under COBRA or for conversion of coverage in connection with such a termination.

Termination By University

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

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

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE
If Your dependents are no longer eligible as explained in the following paragraphs, their eligibility for coverage will end at 12:01 a.m., Mountain Time, on the date of the event that makes them ineligible. However, it may be possible for Your ineligible dependents to continue coverage under the Plan according to the COBRA continuation of coverage provisions of this Summary Plan Description. You must notify the Benefits Department of such dependent's loss of eligibility within 3 months of the date of the event. Any change to your coverage level (e.g., two-party to single coverage), will be effective on the date you submit your completed form. You or the dependent must notify the University's Benefits Department of the ineligibility within 60 days of the event in order to be eligible for COBRA continuation of coverage (see the COBRA Section for additional information).

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

Termination Of Domestic Partnership
In the event Your domestic partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet the requirements outlined in the definition of an Eligible Dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing dependent relationship with You) on the date of termination of the domestic partnership. You are required to complete and submit a Health Care Coverage Change Form within 3 months of the termination of the domestic partnership. In the event the Plan is notified within 60 calendar days of the date of divorce or annulment, Your domestic partner (and domestic partner's children) may continue coverage under the Plan for a limited period of time according to the COBRA continuation of coverage provisions of this Summary Plan Description.

Loss Of Dependent Status
- For an enrolled child who is no longer an Eligible Dependent due to exceeding the dependent age limit, eligibility ends on the child’s 26th birthday (or the date the child is no longer a full-time student or incapable of self-support because of mental retardation or a physical handicap, if over age 26).
- For an enrolled child who is no longer eligible due to disruption of placement prior to legal adoption and the child is removed from placement, eligibility ends on the date the child is removed from placement.
- For an enrolled child who is no longer an Eligible Dependent for any other cause (except by reason of Your death), eligibility ends on the date the child is no longer an Eligible Dependent.

You or Your dependent must notify the University's Benefits Department of an Enrolled Dependent’s ineligibility under the Plan. In the event You provide written notification to the Plan within 60 calendar days of the date the dependent becomes ineligible under the Plan, the dependent may continue coverage under the Plan according to the COBRA continuation of coverage provisions of this Summary Plan Description.

FRAUDULENT USE OF BENEFITS
If You or Your Enrolled Dependents engage in an act or practice that constitutes fraud in connection with coverage under this Plan or makes an intentional misrepresentation of material fact in connection with coverage, coverage under the Plan may be terminated and You and Your Enrolled Dependents will not be eligible for continuation of coverage under COBRA or for conversion of coverage. In addition, any person who knowingly files a statement of claim containing 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.

CERTIFICATES OF CREDITABLE COVERAGE
Requests for and inquiries about required certificates relating to period(s) of creditable coverage under the University’s Benefits Department or to the Claims Administrator at P.O. Box 2998, Tacoma, WA 98401-2998.
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. Under certain circumstances called Qualifying Events, Claimants may have the right to continue coverage beyond the time coverage would ordinarily have ended. The following rights and obligations regarding continuation of coverage are governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. In the event of any conflict between this continuation of coverage provision and COBRA, the minimum requirements of COBRA will govern. This provision will automatically cease to be effective when federal law requiring continuation of eligibility for coverage no longer applies to the University. This section does not provide a full description of COBRA. For more complete information, contact the University’s Benefits Department.

In order to preserve Your rights under COBRA, You must meet certain notification, election, and payment deadline requirements. Those requirements are described below.

Qualifying Events

Qualifying Events are certain events defined by COBRA regulations 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 Plan Participant’s employment for reasons other than gross misconduct;
- voluntary or involuntary termination of appointment as a member of an affiliated group for reasons other than gross misconduct;
- reduced hours of work for the Plan Participant, resulting in ineligibility for coverage;
- divorce or legal separation of the Plan Participant;
- death of the Plan Participant;
- loss of status as an “Eligible child” under Plan rules;
- the Plan Participant 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 the Retiree Health Care Plan).

The Qualifying Event You experience determines Your notice requirements and the amount of time You may retain COBRA coverage.

When And How You Must Give Notice

You, Your spouse, domestic partner, or child must notify the University's Benefits Department of a
divorce or legal separation, or a child losing dependent status within 60 days of the event. (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.) To provide this notice, You may complete the Health Care Coverage Change Form available on the internet at www.hr.utah.edu/ben/forms or in the University’s Benefits Department. Alternatively, Your spouse, domestic partner, or child may give written notice of the Qualifying Event to the University’s Benefits Department at 420 Wakara Way, Suite 105, Salt Lake City, Utah 84108. The written notice must provide the individual’s name and current mailing address, the specific Qualifying Event and the date of the Qualifying Event. If written notice is not provided to the Benefits Department within 60 days after the date of the Qualifying Event, all rights of that individual to elect COBRA coverage will be lost.

Once the Plan is properly notified of a Qualifying Event, it will send You and/or Your Enrolled Dependents information concerning continuation options, including the necessary COBRA continuation election forms. You and/or Your Enrolled Dependents will have 60 calendar days from the later of the date of the Qualifying Event or when You and/or Your Enrolled Dependent receive notice from the Plan in which to make an election.

If You or one of Your Enrolled Dependents qualifies for a Social Security Disability extension (described below), You must provide written notice to the University’s Benefits Department within 60 days of the date the Social Security Administration determination is made and while still within the 18 month COBRA
Continuation period following a termination or reduction of hours Qualifying Event. You must also provide a written notice to the University’s Benefits Department within 30 days if a final determination is made that You are no longer disabled.

If You experience a Second Qualifying Event (described below), You must provide a written notice to the University’s Benefits Department within 60 days of the second Qualifying Event and during the original 18-month COBRA coverage period (or 29-month period if there has been a disability extension), in order to extend COBRA coverage to 36 months.

Qualified Dependents
Each individual who was covered under the Plan on the day before the Qualifying Event is a “Qualified Dependent” and has independent rights 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 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 child would otherwise have been eligible. Qualified Dependent includes the covered employee, employee’s spouse, domestic partner, and child or children.

Individual Election Rights
Each Qualified Dependent can elect COBRA coverage independently, even if the covered employee chooses not to elect COBRA coverage. COBRA coverage is available to each person who had coverage on the day before the Qualifying Event.

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 Dependents are given the opportunity to 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 or one of Your Enrolled Dependents is 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’s Benefits Department within 60 days after the date of the determination. The Social Security Administration determination must occur and You must notify the University’s Benefits Department before the end of the original 18-month period. If You do not notify the University’s Benefits Department and provide the determination within these time frames, You will not be eligible for the 11-month extension of COBRA coverage. If coverage is extended for an additional 11 months due to Social Security disability, Your COBRA premiums will be adjusted to 150% of the full cost during the extended 11-month coverage period. It is also Your responsibility to provide a written notice to the University’s Benefits Department within 30 days if a final determination is made that You are no longer disabled.

Second Qualifying Event
Qualified Dependents, 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’s Benefits Department within 60 days of the second Qualifying Event and during the original 18-month COBRA coverage period (or 29-month period if there has been a disability extension), in order to extend COBRA
coverage to 36 months. The written notice must be sent to the University’s Benefits Department and 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.**

**When You Acquire A New Child While On COBRA**

A child who is born to or placed for adoption with You while You are enrolled in COBRA coverage can be added to Your COBRA coverage upon proper written notification to the University’s Benefits Department (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 be a Qualified Dependent with an individual right to continue COBRA coverage through Your maximum COBRA period, unless You cancel his or her coverage or one of the events permitting extension or termination occurs.

**If You Are Retired And The University Files Chapter 11 Bankruptcy**

COBRA also allows continuation of coverage if You are retired, the University files a Chapter 11 bankruptcy petition, and You or Your Enrolled Dependent experiences a loss of coverage (or substantial reduction in coverage) within one year before or after the bankruptcy filing. Retired employees, and the surviving spouses of retired employees who died before the bankruptcy, may continue coverage for the remainder of their lifetimes. If You are retired and die after the bankruptcy, Your Enrolled Dependents may continue coverage for up to 36 months after Your death.

**If You Become Entitled To Medicare Before Electing COBRA**

If You become entitled to Medicare before electing COBRA in connection with a termination of employment or reduction in hours Qualifying Event, You may maintain both Medicare and up to 18 months of COBRA coverage and Your Enrolled Dependents will be allowed to continue their COBRA coverage until the later of:

- up to 18 months from the Qualifying Event date, or
- up to 36 months from the date You became entitled to Medicare.

**Electing Coverage**

Qualified Dependents 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 and this paragraph does not apply to You if You, Your spouse, domestic partner, or child failed to notify the University’s Benefits Department of a divorce or legal separation, or a child losing dependent status within **60 days** of the event, as required by COBRA.) If neither You nor Your spouse, domestic partner, or child(ren) elect COBRA continuation 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 and Your dependents will have no right to elect COBRA coverage at a later date. If Claimants are not eligible for COBRA continuation coverage, they may be eligible for an individual conversion-type plan.

**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 the “Notice of Right to Elect Continuation Coverage (COBRA)” that will be sent to You by the University. 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’s Benefits Department within **45 days** of the date You elect COBRA coverage. Your first premium payment will include premiums due retroactive to the date You lost coverage as a result of Your Qualifying Event. If Your first payment is not received timely, COBRA coverage will not be effective and You will lose all rights to COBRA coverage.
Subsequent Payments
Payment for each subsequent period is due on the first day of each month. You will have a 30-day grace period from the premium due date to make subsequent payments. If the COBRA premiums are not paid within the grace period, Your COBRA coverage will terminate as of the end of the last period for which payment was received and You will lose all further rights to continue COBRA coverage.

Trade Adjustment Assistance (TAA)
If You are a TAA-eligible individual and do not elect continuation coverage during the 60-day COBRA election period that was a direct consequence of the TAA-related loss of coverage, You may elect continuation coverage during a second 60-day election period that begins on the first day of the month in which You are determined to be eligible. Provided such election is made not later than 6 months after the date of the TAA-related loss of coverage. Continuation coverage elected during the second election period will begin with the first day of the second election period, and not on the date on which coverage originally lapsed. The time period between the original loss of coverage and the start of the second election period cannot be counted for the purposes of determining whether You had a 63-day break in coverage, which affects pre-existing condition exclusions under HIPAA. In addition, TAA eligible persons could be eligible for a tax credit.

Changes in COBRA Coverage
You will have the same rights to enroll dependents and change elections with respect to the University health plan as similarly situated active employees of the University. Changes to coverage may be made during the University’s Open Enrollment period each year.

Flexible Spending Accounts
If You participated in the University’s Flexible Benefit Plan at the time of Your Qualifying Event and have a positive fund balance in Your flexible spending account, 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.

When COBRA Continuation Coverage Ends
COBRA continuation under the Plan 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;
- 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 Claimants 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 contain any exclusion or limitation for any of Your pre-existing conditions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the extent to which health plans may impose pre-existing condition limitations. If You become covered by another group health plan with a pre-existing condition limitation that affects You, Your COBRA coverage can continue. If the other plan’s pre-existing condition rule does not apply to You by reason of HIPAA’s restrictions on pre-existing conditions clauses, You are no longer eligible to continue COBRA coverage; or
• An event occurs that permits termination of coverage under the University health plan for an individual covered other than pursuant to COBRA (e.g., submitting fraudulent claims).

Conversion Or Transfer To An Individual Policy
At the end of Your applicable maximum COBRA period, You may be allowed to convert Your coverage to an individual insurance policy. See the Conversion Section for details.

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 the University’s Benefits Department.

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

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

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

At the end of Your applicable COBRA continuation coverage period, Claimants will be allowed to convert to an individual insurance policy through the Claims Administrator provided that the following conditions are met:

- coverage for the Claimant is not terminated for any of the reasons indicated in the When Coverage Ends Section which are specified as causing a Claimant to be ineligible for conversion;
- the Claimant has been continuously covered under this Plan or its predecessor offered by the University for at least 6 months immediately prior to termination;
- the Claimant does not acquire other group coverage covering all Preexisting Conditions which are covered under this Plan;
- the Claimant does not establish residence outside the State of Utah or move outside the Claims Administrator's service area;
- the Claimant is not and could not be covered by Medicare; and
- the Claimant's loss of eligibility is not the result of failure to pay any required contribution to the cost of coverage.

The conversion program will be the comprehensive major medical conversion coverage in effect at the date of conversion that is customarily offered by the Claims Administrator to Claimants upon termination of coverage. The conversion coverage will not include dental benefits, and maternity benefits will be available only under a family Plan that is continued through the termination of a covered pregnancy. All Claimants who are covered as part of the same Family under this Plan and who exhaust COBRA continuation coverage at the same time must choose to convert coverage as a Family. This conversion option will be available only after You and/or Your Enrolled Dependents have exhausted all rights to COBRA continuation of coverage under any applicable federal law. The conversion option must be exercised within 60 calendar days following exhaustion of COBRA continuation coverage. When such continuous coverage is maintained, no medical underwriting is required and Preexisting Condition limitations will not be imposed.

NOTE: COBRA continuation coverage is not the same as conversion coverage. Conversion coverage provides an individual policy of health insurance handled directly between the Claimant and the Claims Administrator, provided application for conversion coverage is made within the applicable time limits. Unlike COBRA continuation coverage, conversion coverage does not guarantee coverage identical to this Summary Plan Description and the premium will be paid directly to the Claims Administrator at individual rates.

Transfer Of Coverage

If You establish residence outside the State of Utah and Your applicable COBRA continuation coverage period ends (and You are therefore ineligible for a conversion plan through the Claims Administrator), coverage may be transferred to the Blue Cross and/or Blue Shield organization serving Your new address. The conversion policy will provide coverage without a medical examination or health statement. The premiums and benefits available from the new Blue Cross and/or Blue Shield organization may vary significantly from those offered under this Plan. The new Blue Cross and/or Blue Shield organization may also offer You other types of coverage that are outside of the transfer program.
Notices

UNIVERSITY OF UTAH PRIVACY POLICY REGARDING PROTECTED HEALTH INFORMATION (PHI)

The Plan is required to follow strict federal and state laws regarding the confidentiality of Your protected health information ("PHI"). The University is the Plan Sponsor and Regence BCBSU is the Claims Administrator. The University/Plan Sponsor and the Claims Administrator understand that Your health information is personal and are committed to protecting that information.

Your PHI may be used and disclosed by the Plan without Your written authorization only for the following Plan Administration Functions or as otherwise required by law:

- **Treatment** – The Plan may use and disclose Your PHI for the Plan’s treatment activities, if any, or for the treatment activities of a health care provider. For example, if Your health care provider refers You to a specialist for treatment, the Plan can disclose Your PHI so the specialist can become familiar with those records.
- **Payment** – The Plan may use and disclose Your PHI for payment activities, including but not limited to determining Your eligibility for coverage; obtaining reimbursement for benefits paid while You were ineligible; determining whether particular expenses are covered under the Plan; coordinating benefits (e.g., collection from another plan); and sharing information with third parties who assist the Plan with treatment, payment, and health care operations (such third parties must follow our privacy practices). For example, the Plan may communicate with insurance companies to help You resolve problems relating to payment of claims.
- **Plan Operations** – The Plan may use and disclose Your PHI for internal operations, including providing customer service to You; conducting quality assessment and improvement activities; conducting fraud and abuse detection; reviewing claims for medical necessity; confirming compliance with applicable laws; administering business planning and development; underwriting and rate setting; administration of reinsurance and excess or stop loss insurance and coordination with those insurers; conducting or arranging medical review, legal services, and auditing functions; directing activities to improve health or reduce costs; providing care coordination and education about alternative treatments; and informing You of health services and products that may benefit You. For example, the Plan may use Your PHI to audit claim processing accuracy.
- **Business Associates** – The Plan may disclose Your PHI to third parties ("Business Associates") who perform certain activities for the Plan. The Plan requires those Business Associates receiving PHI to agree to restrictions on the use and disclosure of Your PHI equivalent to those that apply to the Plan.
- **Family Members and Others Involved in Your Care** – The Plan may disclose Your PHI to Your family member, relative, or close friend, or any other person You identify for purposes of assisting in Your care or payment for Your care. For example, if Your spouse calls the University Benefits Department to get information about the processing of a claim for Your care, they may talk with Your spouse to assist You in resolving a problem. If You do not want the Plan to discuss Your PHI with Your family members or others involved in Your care, please contact the University Benefits Department.
- **Research** – The Plan may use and disclose Your PHI for research projects, such as studying the effectiveness of a treatment You received, if an Institutional Review Board approves a waiver of authorization for disclosure. These research projects must go through a special process that protects the confidentiality of Your medical information.
- **As Required by Law** – Federal, state or local laws sometimes require the Plan to disclose PHI. For example, the Plan may be required to release information for a worker’s compensation claim.
- **Law Enforcement** – The Plan may disclose PHI to law enforcement officials as required by law or in compliance with a search warrant, subpoena, or court order. The Plan may also disclose PHI to law enforcement officials in certain circumstances, including, but not limited to the following: to help in locating or identifying a person; to prosecute a violent crime; to report a death that may have resulted from criminal conduct; to report criminal conduct at the offices of the Plan; and to give certain information in domestic violence cases. For example, the Plan may disclose Your PHI to a third party if ordered to do so by a court of law or if the Plan receives a subpoena or search warrant.
● Public Health Activities or Public Safety – The Plan may use and disclose certain PHI for public health purposes such as preventing or lessening a serious and/or imminent threat to an individual or the public.

● Military, Veteran, National Security and Other Governmental Purposes – If you are a member of the armed forces, the Plan may release your PHI as required by military command authorities or to the Department of Veterans Affairs. The Plan may also disclose PHI to federal officials for intelligence and national security purposes, or for Presidential Protective Services.

● Health Oversight Activities – The Plan may disclose PHI to a government agency that oversees the Plan or their personnel, such as the United States Department of Labor, to ensure compliance with state and federal laws.

● Complaint Resolution – The Plan may disclose PHI to the UUHSC Privacy Office if you contact that office or file a complaint with that office regarding your PHI, your rights, and/or the Plan’s obligations under its Notice of Privacy Practices.

The Plan may disclose certain PHI to the University/Plan Sponsor. The University/Plan Sponsor has certified that it will:

a) Not use or further disclose the information other than as permitted or required to perform the Plan Administration Functions listed above or as required by law;

b) Require that any agents to whom it provides your PHI agree to the same restrictions and conditions that apply to the University/Plan Sponsor with respect to such information;

c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the University/Plan Sponsor.

d) Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware.

e) Make Your PHI available to You in accordance with 45 CFR §164.524.

f) Make Your PHI available for amendment and incorporate any amendments to Your PHI in accordance with 45 CFR §164.526.

g) Make available information required to provide an accounting of disclosures.

h) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for the purpose of determining compliance by the Plan with applicable laws and regulations.

i) If feasible, return or destroy all PHI received from the Plan in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, and if not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Only the following employees or classes of employees of the University/Plan Sponsor (the “Designated Employees”) will be given access to PHI to be disclosed:

- University of Utah Chief Human Resources Officer;
- University of Utah Associate Vice President for Human Resources;
- University of Utah Benefits Department personnel; and
- UUHSC Privacy Office.

Access to and use of PHI by the Designated Employees is restricted to the Plan Administration Functions listed above that the University/Plan Sponsor performs for the Plan. The University/Plan Sponsor has implemented appropriate administrative, physical, and technical safeguards to prohibit any employees, other than the Designated Employees, or persons under its control from accessing PHI. Any Designated Employee who fails to comply with the Plan’s Notice of Privacy Practices may be disciplined up to and including termination of employment.
General Provisions
This section explains various general provisions regarding Your benefits under this coverage.

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

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

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

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

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

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

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

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

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

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

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

Allowed Amount means:

- For network Providers (see definitions of “Category 1” and “Category 2” below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For out-of-network Providers (see definition of “Category 3” below) who are not accessed through the BlueCard® Program, the amount the Claims Administrator has determined to be reasonable charges for Covered Services or supplies. The Allowed Amount may be based upon the amount a Category 1 Provider has agreed to accept as payment in full or billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.
- For out-of-network Providers (see definition of “Category 3” below) accessed through the BlueCard® Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to the Claims Administrator as the amount on which it would base a payment to that Provider.

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

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

Ambulatory Service Facility means a facility, licensed by the state in which it is located, that is equipped and operated mainly to do surgeries or obstetrical deliveries that allow patients to leave the facility the same day the surgery or delivery occurs.

Category 1 means the benefit reimbursement level for services that are received from a Provider who has an effective participating contract with the Claims Administrator or one of the Claims Administrator's Affiliates which designates him, her or it as a ValueCare Provider as well as Providers outside the area that the Claims Administrator or one of the Claims Administrator's Affiliates serves, but who have contracted with another Blue Cross and/or Blue Shield organization in the BlueCard® program (designated as a Provider in the “Preferred Provider Organization ("PPO") Network”) to provide services and supplies to Claimants in accordance with the provisions of this coverage. If the Claims Administrator, or one of their Affiliates, have more than one Category 1 Provider network from which the employer Group may choose for benefits under this Plan, then the Providers contracted under the network selected by the employer Group will be considered the only Category 1 Providers for purposes of payment of benefits under this Plan. Category 1 reimbursement is generally at the highest payment level and You will not be charged for balances beyond any Copayment and/or Coinsurance for Covered Services.

Category 2 means the benefit reimbursement level for services that are received from a Provider who has an effective participating contract with the Claims Administrator or one of the Claims Administrator's Affiliates which designates him, her or it as a Blue Cross BlueShield Traditional Par Provider as well as Providers outside the area that one of the Claims Administrator's Affiliates serves, but who have contracted with another Blue Cross and/or Blue Shield organization in the BlueCard® program (designated as a Provider in the “Participating Network”) to provide services and supplies to Claimants in accordance with the provisions of this coverage. Category 2 reimbursement is generally a lower payment level than Category 1, but You will not be charged for balances beyond any Copayment and/or Coinsurance for Covered Services.

Category 3 means the benefit reimbursement level for services that are received from a Provider who does not have an effective participating contract with the Claims Administrator or one of the Claims Administrator's Affiliates to provide services and supplies to Claimants. Category 3 reimbursement is
generally the lowest payment level of all categories, and You may be billed by the Provider for balances beyond any Copayment and/or Coinsurance for Covered Services.

Claimant means a Participant or an Enrolled Dependent.

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

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

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

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

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

Effective Date means the date Your coverage under the Agreement begins after acceptance for enrollment under the Plan.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency room to result in any one of the following:

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

Family means a Participant and his or her Dependents.

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

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

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

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy. Illness does not include any state of mental health or mental disorder.
Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of Illness or any other cause. An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

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

- If a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration (FDA) as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the medication may be provided when so used. To be considered effective for other than its FDA-approved use, it must be determined that the medication is effective for the treatment of that condition; or is determined by the Claims Administrator to be in an Investigational status.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Injury or Illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

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

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

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

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

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

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

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

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

Participant means an employee of the University who is eligible under the terms described in this Summary Plan Description, who has completed an enrollment form and is enrolled under this coverage.

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

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

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

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

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

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

Regence refers to Regence BlueCross BlueShield of Utah.

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

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

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

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

University of Utah
EIN # 87-6000525

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

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

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

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

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

LEGAL PROCESS
Address where a processor may serve legal process:

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

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

Regence BlueCross BlueShield
2890 East Cottonwood Parkway
Salt Lake City, UT 84121
Customer Service (888) 370-6159
Case Management (800) 624-6519

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.