



THE
UNIVERSITY
OF UTAH

**Employee Health Care Plan
Dental Plan Option**



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

Regence BlueCross BlueShield of Utah

UNIVERSITY OF UTAH
EMPLOYEE HEALTH CARE PLAN
BLUECROSS BLUESHIELD DENTAL PLAN OPTION
SUMMARY PLAN DESCRIPTION

GROUP NUMBER: 10002211

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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 Dental Option Summary Plan Description describes the terms and benefits of coverage effective July 1, 2011, or the date after that on which Your coverage became effective. This Summary Plan Description replaces any dental benefit 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.

The first part of the Summary Plan Description is the Dental Benefits. While only a summary (the complete benefits, conditions, limitations, and exclusions are described later), it includes some important information that can only be found in the Dental Benefits, such as the percentages paid and Maximum Benefits under the Plan.

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 this Dental Option available as part of the University of Utah Employee Health Care Plan. "Plan Sponsor" and "University" means 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 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.

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

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Using Your Summary Plan Description

It is important for You to understand how the Plan works before You need dental 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 the University's Benefits Department.

GUIDANCE AND SERVICE ALONG THE WAY

This Summary Plan Description was designed to provide information and answers quickly and easily. Be sure to understand Your benefits before You need them. You can learn more about the unique advantages of Your dental care coverage throughout this Summary Plan Description, some of which are highlighted here. If You have questions about Your dental care coverage, please contact the Claims Administrator.

- **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.

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Understanding Your Benefits

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

MAXIMUM BENEFITS

Benefits for some Covered Services also may be limited to Maximum Benefits. For those Covered Services, benefits will be provided until the specified Maximum Benefit (which may be a dollar amount or specified time period) has been reached. Refer to the benefits sections of this Summary Plan Description to determine if a Covered Service has a specific Maximum Benefit.

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%, the remaining percentage is Your Coinsurance. The percentage paid by the Plan varies, depending on the kind of service or supply and the Provider selected.

The Plan does not pay Dentists for charges above the Allowed Amount. Participating Dentists will not charge You for any balances for Covered Services beyond Your Coinsurance amount. Nonparticipating Dentists, however, may bill You for any balances over the Plan payment level in addition to any Coinsurance amount. See the Definitions Section for descriptions of Participating and Nonparticipating Dentists.

HOW CONTRACT YEAR BENEFITS RENEW

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

Some benefits of the Plan do not renew every Contract Year, for example, when there is a Lifetime Maximum Benefit. Exceptions to benefit renewal are specifically noted in the benefits sections of this Summary Plan Description.

Summary of Dental Benefits

In this section, You will learn how Your dental coverage works. The explanation includes information about Maximum Benefits, Coinsurance, Covered Services and payment. For Your ease in finding the information regarding benefits most important to You, these benefits have been listed alphabetically.

MAXIMUM BENEFITS

Preventive, Basic and Major Dental Services:

Per Claimant per Contract Year: \$2,000

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

The Plan pays a portion of the Allowed Amount (or, for Orthodontic Dental Services, a portion of the billed charges) for Covered Services, up to the Maximum Benefit amount for each Claimant each Contract Year.

CONTRACT YEAR DEDUCTIBLE

Not applicable

BASIC DENTAL SERVICES

Participating Dentist	Nonparticipating Dentist
The Plan pays 80% and You pay 20% of the Allowed Amount.	The Plan pays 80% of the Allowed Amount and You pay balance of billed charges.

The Plan covers the following basic dental services:

- uncomplicated oral surgery procedures including removal of teeth, incision and drainage.
- repair of dentures and bridges, limited to every 5 years per tooth (must have a lapse of at least 6 months from the date of service);
- palliative emergency treatment;
- fillings consisting of silver amalgam, silicate, and plastic restorations (for other types of fillings such as gold foil, payment is limited to the amount that would have been paid for amalgam restorations);
- apicoectomy;
- General dental anesthesia or intravenous sedation administered in connection with the extractions of partially or completely bony impacted teeth and to safeguard the Claimant's health (for example, a child under seven years of age);
- periodontic services which consist of surgical periodontic examinations, subgingival and gingival curettage, gingivectomy and gingivoplasty, osseous surgery including flap entry and closure, mucogingivoplastic surgery, management of acute infections and oral lesions; and
- endodontic services consisting of pulpotomy, pulp capping and root canal treatment.

MAJOR DENTAL SERVICES

Participating Dentist	Nonparticipating Dentist
The Plan pays 50% and You pay 50% of the Allowed Amount.	The Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers the following major dental services:

- inlays, onlays and crowns (for gold inlays, onlays and crowns, payment is limited to the amount that would have been paid for plastic inlays, onlays and crowns unless special need is demonstrated for use of gold), limited to every 5 years per tooth;
- bridges, fixed and removable, limited to every 5 years per tooth;
- dental implants;
- vestibuloplasty; and
- dentures, full and partial, except that:
 - benefits will not be provided for any denture replacement made less than 5 years after denture placement or replacement whether or not covered under this Plan;
 - benefits will not be provided for any denture replacement made necessary by reason of loss or theft of a denture; and
 - benefits are limited to the amount that would have been paid for standard procedures for prosthodontic services when You request or the Dentist provides personalized restoration or when the Dentist employs special techniques or procedures.

ORTHODONTIC DENTAL SERVICES

Participating and Nonparticipating Dentists
The Plan pays 50% of billed charges and You pay balance of billed charges.
Limit: \$2,000 per Claimant Lifetime.

The Plan covers the following orthodontic dental services:

- the initial and subsequent installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and its attendant sequelae through the correction of malposed teeth;
- benefits for orthodontic services will be computed on the basis as though such expenses, other than for the initial diagnosis, were incurred prorata during the term of active treatment in progress at the commencement or termination of Your coverage under the Plan, a service will have been deemed to have been rendered on the date performed; and
- in a case which was started prior to the Effective Date of Your coverage under the Plan for such service, the Lifetime Maximum will be prorated in direct relation to the portion of the total treatment period remaining.

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

Participating Dentist	Nonparticipating Dentist
The Plan pays 80% and You pay 20% of the Allowed Amount.	The Plan pays 80% of the Allowed Amount and You pay balance of billed charges.

The Plan covers the following preventive dental services:

- oral examinations limited to 2 per Claimant per Contract Year;
- dental x-rays as required, except that complete mouth x-rays are limited to 1 in a three-year period, unless special need is shown for more frequent complete mouth x-rays;
- topical fluoride application for Claimants under 26 years of age, limited to 2 treatments per Claimant per Contract Year;
- prophylaxis, including cleaning, scaling, and polishing, limited to 2 per Claimant per Contract Year;
- space maintainers for Claimants under 13 years of age; and
- sealants limited to once per tooth. Deciduous teeth only on the chewing surface of the first and second molars. Permanent teeth only on the chewing surface, excluding wisdom teeth.

General Limitations And Exclusions

The following are the limitations and exclusions from the coverage under the Plan.

LIMITATIONS

Optional Techniques

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

Transfer Of Care

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

EXCLUSIONS

No benefits will be provided for any of the following conditions, treatments, services, supplies, or accommodations, or for any direct complications or consequences thereof:

Aesthetic Services

Dental services for congenital malformations and dental services primarily for aesthetic purposes.

Appliances And Restorations For Malalignment Of The Teeth

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

Automobile Personal Injury Protection Coverage

Services and supplies for the treatment of an Illness or Injury that are the responsibility of any automobile personal injury protection ("PIP") coverage, including:

- Coverage up to the minimum amount required by state or federal law, regardless of whether or not such coverage is in force; and
- Any amount of coverage carried in excess of the minimum amount required by state or federal law, regardless of whether or not the Claimant files a claim for benefits under such coverage.

Benefits Not Stated

Services and supplies provided for which there is no stated benefit under the Plan. When a non-covered service or supply is performed or received at the same time as a Covered Service, then only the portion of charges relating to the Covered Service will be considered eligible for payment under this Plan.

Charges That Exceed The Allowed Amount

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

Cosmetic/Reconstructive Services and Supplies

Cosmetic and/or Reconstructive services and supplies, except in the case of surgery that is:

- performed to restore a physical bodily function; or
- related to an Accidental Injury.

Cosmetic means services or supplies that are applied to normal structures of the body primarily for the purpose of improving or changing appearance.

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

For the purposes of this Plan, psychological factors (for example, poor self-image, difficult social or peer relations) are not relevant and are not considered a physical bodily function.

Court-Ordered Or Court-Related Services/Services In Connection With Legal Proceedings

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

Dentist Practicing Beyond Scope Of License

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

Expenses Incurred After Coverage Ends

Services and supplies incurred after termination or ineligibility under the Plan except for prosthetic devices which were fitted and ordered prior to termination or ineligibility and were delivered to the Claimant within 30 days after the date of termination or ineligibility.

Expenses Incurred Before Coverage Begins

Services and supplies incurred before enrollment under the Plan. With respect to prosthodontic services in connection with a course of treatment begun prior to enrollment under the Plan, services are excluded even if some such services were rendered after enrollment under the Plan.

Experimental Or Investigational Services

Experimental or investigational treatments or procedures; and services, supplies, and accommodations provided in connection with experimental or investigational treatments or procedures. A treatment or procedure will be considered experimental or investigational if reasonable and substantial scientific evaluation has not been completed, effectiveness has not been established, or the procedure or treatment has not been accepted and generally used by the medical or dental provider community for a period of 5 years. The Claims Administrator's Medical Director will determine whether a treatment or procedure is experimental or investigational. The absence of any alternative treatment or procedure or any effective non-experimental or non-investigational treatment or procedure for an Illness or Injury shall not make or be deemed to make an experimental or investigational treatment or procedure a Covered Service.

Fees, Taxes, Interest, Etc.

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

Gold-Foil Restorations

Military Service-Related Conditions

Services and supplies for treatment of an Illness or Injury caused by or incurred during service in the armed forces of any state or country.

Orthodontic Appliances

Replacement or repair of orthodontic appliances, whether or not such orthodontic appliances were furnished under this Dental Option.

Orthodontic Services

Orthodontic services to the extent that:

- if the orthodontic treatment is terminated before completion of the case for any reason, no coverage will be provided for expenses incurred after the date of termination; or
- such services are rendered after the termination of this Dental Option.

Orthognathic Surgery

Services and supplies to change the position (augmentation or reduction procedures) of a bone of the upper or lower jaw (orthognathic surgery).

Other Party Liability

Services and supplies for treatment of Illness or Injury for which a third party is responsible, including:

- Any work related Injury or Illness, including any claims that are resolved pursuant to a disputed claim settlement for which a Claimant has or had a right to compensation; and
- Any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowners coverage, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to or makes benefits available to a Claimant, whether or not the Claimant, if eligible, files a claim for benefits under such coverage.

Any benefit provided contrary to this exclusion is not a waiver of the Plan's right to reimbursement or subrogation. Refer to the Other Party Liability provision in the CLAIMS ADMINISTRATION Section for additional information.

Personal Comfort Items

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

Preparation Of Forms/Missed Appointments

Charges for preparing medical/dental reports, itemized bills or claims forms; appointments scheduled and not kept ("missed appointments").

Replacement Of Lost Or Stolen Dentures (full or partial)

Riot, Rebellion, War And Illegal Acts

Services and supplies for treatment of an Illness or Injury caused by a **Claimant's unlawful instigation and/or active participation in** a riot or war, including an armed invasion or aggression, insurrection, or rebellion; or sustained by a Claimant while in the act of committing an illegal act.

Self-Help, Self-Care, Training, Or Instructional Programs

Self-help, non-dental self-care, training, educational, or instructional programs unless specifically described as a benefit. This exclusion does not apply to services for training or educating a Claimant when incidentally 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 at no charge by the University or any of its employees or agents.

Services And Supplies Otherwise Available From A Governmental Agency Or Program

Services and supplies to the extent benefits are provided or covered by any governmental agency (for example, a federal hospital or the Veterans Administration), unless reimbursement under the Plan is otherwise required by law. Also excluded are services covered by programs (such as Medicare) created by the laws of the United States, any state, or any political subdivision of a state, or which would be so covered except for coverage under this Plan. These exclusions apply whether or not the Claimant claims or obtains benefits under such coverage and whether or not the Claimant, if eligible, makes application for such coverage.

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, or in-laws, or any relative by blood or marriage who shares a residence with You.

Services And Supplies Provided Outside Of Utah

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

Services, Supplies And Drugs Not Yet Approved By The FDA

Services, supplies or drugs which have not yet been approved by the United States Food and Drug Administration (FDA). However, if a 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 drug may be provided when so used, as determined by the Plan.

Temporary, Interim Restorations or Prosthodontics

Expenses incurred for precision or semi-precision attachments, surgical implants of any type (including any prosthetic device attached to them), instruction for plaque control or oral hygiene, bite registrations, splinting or dental services that do not have uniform professional endorsements are not covered by this Plan. A temporary dental service will be considered an integral part of the final dental service rather than a separate service.

Temporomandibular Joint (TMJ) Dysfunction Treatment

Services and supplies provided in connection with temporomandibular joint (TMJ) dysfunction other than surgical correction of the TMJ required as a result of Accidental Injury.

Travel And Transportation Expenses**Treatment, Procedures, Techniques Or Therapies Outside Accepted Health Care Practice**

Treatment or prevention of Illness or Injury by means of treatments, procedures, techniques or therapies outside generally accepted health care practice, as determined by the Claims Administrator.

Visits Or Consultations That Are Not In Person

Any telephone, internet (or other electronic communication, including tele-medicine) visits or consultations, whether initiated by You or Your Provider.

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 Dentist 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 Customer Service: 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 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.)

Participating Dentist Claims

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

Participating Dentist Reimbursement

A Participating Dentist will be paid directly for Covered Services. Participating Dentists 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 Coinsurance. A Participating Dentist may require You to pay Your share at the time You receive care or treatment.

Nonparticipating Dentist Claims

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

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

Nonparticipating Dentist Reimbursement

In most cases, the Nonparticipating Dentist will be paid directly for Covered Services they provide.

Nonparticipating Dentists 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 Nonparticipating Dentist and the Allowed Amount in addition to any amount You must pay due to Coinsurance. For Nonparticipating Dentists, the Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

Reimbursement Examples

Here is an example of how Your selection of a Participating Dentist or Nonparticipating Dentist affects payment to providers and Your cost sharing amount. For purposes of this example, let's assume the Dentist's charge for a service is \$500 and the Allowed Amount for that Dentist's charge is \$400. Here's how that Covered Service would be paid:

- Participating Dentist: the Plan would pay 80% of the Allowed Amount and You would pay 20% of the Allowed Amount, as follows:

- Amount Participating Dentist must "write-off" (that is, cannot charge You for):	\$100
- Amount the Plan pays (80% of the \$400 Allowed Amount):	\$320
- Amount You pay (20% of the \$400 Allowed Amount):	\$80
- Total:	\$500

- Nonparticipating Dentist: the Plan would pay 80% of the Allowed Amount. Because the Nonparticipating Dentist does not accept the Allowed Amount, You would pay 20% of the Allowed Amount, plus the difference between the Nonparticipating Dentist's billed charges and the Allowed Amount, as follows:

- Amount the Plan pays (80% of the \$400 Allowed Amount):	\$320
- Amount You pay (20% of the \$400 Allowed Amount and the \$100 difference between the billed charges and the Allowed Amount):	\$180
- Total:	\$500

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 Dentist.

Freedom of Choice of Dentist

Nothing contained in the Agreement is designed to restrict You in selecting the Dentist of Your choice for dental care or treatment.

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.

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 Your or Your 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 coverage.

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.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND DENTAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by the Claims Administrator. This information will be used for the purpose of facilitating health care treatment, payment of claims or business operations necessary to administer health care benefits; or as required by law.

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

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

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

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

The Claims Administrator is required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by calling the Claims Administrator's Customer Service department: 1 (888) 370-6159 or visiting their website 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 dental care provider. Neither the Plan nor the Claims Administrator is responsible for the quality of dental care You receive, since all those who provide care do so as independent contractors. Since neither the Plan nor the Claims Administrator provides any dental care services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving dental 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 expenses You incur for treatment of an Injury or Illness if the costs associated with the Injury or Illness may be recoverable from any of the following:

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

Advancement of Benefits

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

- By accepting or claiming benefits, You agree that the Plan is entitled to reimbursement of the full amount of benefits paid out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which benefits under the Plan have been provided.
- In addition to the Plan's right of reimbursement, the Claims Administrator may choose instead to achieve the Plan's rights through subrogation. The Claims Administrator is authorized, but not obligated, to recover any benefits paid under the Plan directly from any party liable to You, upon mailing of a written notice to the potential payer, to You or to Your representative.
- The Plan's rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment or other characterization of the recovery by the Claimant and/or any third party or the recovery source. The Plan is entitled to reimbursement from the first dollars received from any recovery. This applies regardless of whether:
 - the third party or third party's insurer admits liability;
 - the health care expenses are itemized or expressly excluded in the recovery; or
 - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the Plan.
- Reimbursement or subrogation under the Plan will not be reduced due to Your not being made whole.
- You may be required to sign and deliver all legal papers and take any other actions requested to secure the Plan's rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third party or other source). If You are asked to sign a trust agreement or other document to reimburse the Plan from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.

- You must agree that nothing will be done to prejudice the Plan's rights and that You will cooperate fully with the Claims Administrator, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the Claims Administrator of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:
 - the filing of a lawsuit;
 - the making of a claim against any third party;
 - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
 - intent of a third party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Injury or Illness that gives rise to the Plan's right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).
- You and/or Your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to Your benefit or on Your behalf that in any manner relates to the Injury or Illness giving rise to the Plan's right of reimbursement or subrogation, until the Plan's right is satisfied or released.
- In the event You and/or Your agent or attorney fails to comply with any of these conditions, any such benefits advanced for any Illness or Injury may be recovered through legal action.
- Any benefits provided or advanced under the Plan are provided solely to assist You. By paying such benefits, neither the Plan nor the Claims Administrator is acting as a volunteer and is not waiving any right to reimbursement or subrogation.

Motor Vehicle Coverage

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

Workers' Compensation

The following rules 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 Related 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 if the provider's contract permits, that negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

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

Birthdate, 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 dependent 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 the 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 dental judgment (including, but not limited to, those based on the Plan's requirements for Dental 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 within 72 hours of its receipt of Your request. Choosing the voluntary expedited Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section.

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

INFORMATION

If You have any questions about the Appeal process outlined here, You may contact the Claims Administrator's Customer Service department at Customer Service: 1 (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 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. If Your date of hire/transfer is the first day of the month, You are eligible for coverage on that day.

You must enroll in a medical option of either the University of Utah Employee Health Care Plan or Retiree Health Care Plan to elect dental coverage.

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 Dependent are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when the Claims Administrator has enrolled them in coverage under the Plan. Eligible Dependents are limited to the following:

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

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

Dependent Coverage Continuing Beyond Limiting Age

- You may continue coverage for Your (or Your spouse's or Your domestic partner's), unmarried, child at age 26 if the child is currently enrolled in the Plan as Your Eligible Dependent who is incapable of self-support because of mental retardation or a physical handicap which started before the child reached age 26 and who 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 proof of the dependent's mental retardation or physical handicap, 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

You may enroll in the Retiree Health Care Plan after retirement if You are an eligible retiree. If You wish to remain enrolled in this dental option, You may do so for up to 18 months after Your retirement date. At the end of the 18-month period, You may obtain an individual dental policy through Regence BlueCross BlueShield.

Surviving Spouse

If You enroll in the Retiree Health Care Plan as the surviving spouse of a University employee, You may continue coverage in the dental option for up to eighteen (18) months from the date You enroll in the Retiree Health Care Plan.

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. 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, and You are not currently enrolled in the Employee Health Care Plan and this Dental Option, You may enroll Yourself, the newly eligible new dependent, and any other Eligible Dependents 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. If You are already enrolled in the Employee Health Care Plan, You may enroll the new dependent and any other Eligible Dependents in your existing coverage 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.

SPECIAL ENROLLMENT

If You experience an event that allows a Special Enrollment Period under the Employee Health Care Plan, You may enroll in this Dental Option as follows:

- If You are not currently enrolled in the Employee Health Care Plan and this Dental Option, You may enroll Yourself and any Eligible Dependents by completing and submitting to the University's Benefits Department a signed Health Care Coverage Change Form (and Domestic Partnership Certification Form if appropriate) within 3 months of the date of the event.
- If You are already enrolled in the Employee Health Care Plan and this Dental Option, You may enroll any Eligible Dependents in your existing coverage by completing and submitting to the University's Benefits Department a signed Health Care Coverage Change Form (and Domestic Partnership Certification Form if appropriate) within 3 months of the date of the event.

If You are already enrolled in the Employee Health Care Plan, but not enrolled in this Dental Option, You may enroll in this Dental Option during the next open enrollment period with coverage effective at the beginning of the next Contract Year.

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.

ENROLLMENT BY OTHERS

In the event Your child is the subject of a court or administrative order requiring You to provide dental coverage for the child and You are eligible for health and dental 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 health and dental coverage during the Contract Year (including enrolling in Medicare), You may elect to cancel health and dental coverage for such covered individual(s). In order to drop health and dental 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. Health and dental 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 health and dental coverage in the Plan for You and all Your Enrolled Dependents. To drop health and dental 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.

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 in 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.

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 UHSC 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
- UHSC 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 Sponsor 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 Sponsor will be addressed to the Participant or to the Plan Sponsor 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 administrator or Plan Sponsor 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 2998, Tacoma, WA 98401-2998; 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 Sponsor on behalf of itself and its Claimants expressly acknowledges its understanding that the Agreement constitutes an agreement solely between the Plan Sponsor and Regence, 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 Shield Service Marks in the state of Utah and that Regence is not contracting as the agent of the Association. The Plan Sponsor on behalf of itself and its Claimants further acknowledges and agrees that it has not entered into the Agreement based upon representations by any person or entity other than Regence and that no person or entity other than Regence will be held accountable or liable to the Plan Sponsor or the Claimants for any of Regence's obligations to the Plan Sponsor or the Claimants created under the Agreement. This paragraph will not create any additional obligations whatsoever on the part of Regence 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 the purposes of this Dental Benefits Section only:

- With respect to Participating Dentists, the amount Participating Dentists have contractually agreed to accept as full payment for Covered Services.
- With respect to Nonparticipating Dentists, reasonable charges for Covered Services as determined by the Claims Administrator.

Charges in excess of 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.

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 those services or supplies that are required to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues and are Dentally Appropriate. These services must be performed by a Dentist or other provider practicing within the scope of his or her license.

Dentally Appropriate means a dental service recommended by the treating Dentist or other provider, who has personally evaluated the patient, and determined by the Claims Administrator (or their designee) to be all of the following:

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

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

Dentist means an individual who is licensed to practice dentistry (including a doctor of medical dentistry or doctor of dental surgery). A Dentist also means a dental hygienist who is permitted by his or her respective state licensing board, to independently bill third parties.

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

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

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.

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

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:

- 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 Sponsor with the Claims Administrator.

Nonparticipating Dentist means a Dentist who does not have an effective participating contract with the Claims Administrator to provide services and supplies to Claimants, or any other Dentist that does not meet the definition of a Participating Dentist under this Plan.

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.

Participating Dentist means a Dentist who has an effective participating contract with the Claims Administrator to provide services and supplies to Claimants in accordance with the provisions of the Plan. In addition, if Your employer may select from more than one participating network, then the network through which the Participating Dentist has agreed to provide services and supplies under this Summary Plan Description must also be the network selected by Your employer.

Plan Participant means an employee of the Plan, 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.

Regence refers to Regence BlueCross BlueShield of Utah.

Scientific Evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of a Health Intervention on Health Outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the Health Intervention and Health Outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the

magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

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.