RETIREE DENTAL PLAN

Regence

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

University of Utah
Retiree Dental Plan
BlueCross BlueShield Dental Plan Option
Booklet and Plan Document

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 Web site listed above. The University's Notice of Privacy Practices is at the end of this Booklet.

Effective January 1, 2021

Introduction

NOTE: THIS BOOKLET PROVIDES DENTAL BENEFITS ONLY. REVIEW YOUR BOOKLET CAREFULLY.

This University of Utah Retiree Dental Plan Booklet provides the written description of the terms and benefits of coverage available under the Plan. The administrative services contract between the University of Utah and Regence BlueCross BlueShield of Utah (called the "Agreement") contains all the terms of coverage. The University of Utah has a copy.

This Booklet describes benefits effective **January 1, 2021**, or the date Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Regence BlueCross BlueShield of Utah and makes it void. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your provider before receiving care.

In this Booklet, the term "Claims Administrator" refers to Regence BlueCross BlueShield of Utah, and the term "Plan Sponsor" and "University" mean the University of Utah, whose retirees may participate under this Plan. References to "You" and "Your" refer to the Participant and/or Beneficiaries. Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized.

CONTACT INFORMATION

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

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

Contact Customer Service:

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

Using Your Booklet

ACCESSING PROVIDERS

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

- **In-Network Dentist.** Choosing In-Network Dentists generally saves You the most in Your out-of-pocket expenses. In-Network Dentists will not bill You for balances beyond any Coinsurance for Covered Services.
- **Out-of-Network Dentist.** Choosing Out-of-Network Dentists means Your out-of-pocket expenses will generally be higher than choosing an In-Network Dentist. Also, an Out-of-Network Dentist may bill You for balances beyond any Coinsurance. This is referred to as balance billing.

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

ADDITIONAL ADVANTAGES OF PARTICIPATION

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

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

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by this Plan, that also may create savings or administrative fees for the Claims Administrator. Any such discounts or coupons are complements to the Plan, but are not insurance.

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Understanding Your Benefits

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

MAXIMUM BENEFITS

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

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

COINSURANCE (PERCENTAGE YOU PAY)

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

HOW CALENDAR YEAR BENEFITS RENEW

Certain Maximum Benefits are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again.

Some benefits have a separate Maximum Benefit based upon a Claimant's Lifetime and do not renew every Calendar Year.

Dental Benefits

This section explains Your benefits for Covered Services. All benefits are listed alphabetically.

MAXIMUM BENEFITS

Basic, Major and Preventive and Diagnostic Dental Services:

Per Claimant: $2,000 per Calendar Year

Orthodontic Dental Services:

Per Claimant: $2,000 per Lifetime

CALENDAR YEAR DEDUCTIBLES

Not applicable

BASIC DENTAL SERVICES

In-Network Dentist	Out-of-Network Dentist
You pay 20% of the Allowed Amount.	You pay 20% of the Allowed Amount and the balance of billed charges.

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

- Adjustment and 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).
- Complex oral surgery procedures including:
  - surgical extractions of teeth;
  - impactions;
  - alveoloplasty;
  - residual root removal.
- Emergency treatment for pain relief.
- Endodontic services consisting of:
  - apicoectomy;
  - debridement;
  - direct pulp capping;
  - pulpal therapy;
  - pulpotomy; and
  - root canal treatment.
- Fillings consisting of composite and amalgam restorations (for other types of fillings such as gold foil, payment is limited to the amount that would have been paid for amalgam restorations).
- General dental anesthesia or intravenous sedation administered for:
  - extractions of partially or completely bony impacted teeth; or
  - to safeguard the Claimant's health (for example, a child under seven years of age).
- Periodontal services including:
  - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery);
  - debridement limited to once per Claimant in a three-year period;
  - gingivectomy and gingivoplasty;
  - scaling and root planing limited to once per Claimant per quadrant in a Calendar Year.
  - periodontal maintenance limited to two* per Claimant per Calendar Year (however, in any Calendar Year a Claimant will be entitled to no more than two* cleanings whether periodontal maintenance or standard cleaning);

*A third periodontal maintenance may be covered, in the same Calendar Year, for a Claimant with one or more of the following conditions:

- coronary atherosclerosis;
- diabetes;
- hypertensive heart disease; or
- pregnancy.

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

- Uncomplicated oral surgery procedures including removal of teeth, incision and drainage.

MAJOR DENTAL SERVICES

In-Network Dentist	Out-of-Network Dentist
You pay 50% of the Allowed Amount.	You pay 50% of the Allowed Amount and the balance of billed charges.

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

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

ORTHODONTIC DENTAL SERVICES

In-Network and Out-of-Network Dentists
You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: $2,000 per Claimant Lifetime

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

- The initial and subsequent installations of orthodontic appliances and all non-surgical orthodontic treatments concerned with the reduction or elimination of an existing malocclusion, subject to the submission of a treatment plan (submitted by the attending provider). The treatment plan should include all of the following information:
    - a diagnosis indicating an abnormal occlusion that can be corrected by orthodontic treatment;
    - the estimated length of required treatment;
    - the initial banding fee; and
    - the total orthodontic treatment charge.
- If treatment stops before the end of the prescribed treatment period, benefits will end on the last day of the month during which the treatment was discontinued.

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

Provider: In-Network Dentist	Provider: Out-of-Network Dentist
Payment: You pay 20% of the Allowed Amount.	**Payment:** You pay 20% of the Allowed Amount and the balance of billed charges.

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

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

  *A third cleaning may be covered, in the same Calendar Year, for a Claimant with one or more of the following conditions:

    - coronary atherosclerosis;
    - diabetes;
    - hypertensive heart disease; or
    - pregnancy.

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

- The following services are limited to one per Claimant in a three-year period:
    - complete intra-oral mouth x-rays; and
    - panoramic mouth x-rays.
- Bitewing x-ray series.
- Problem-focused oral examinations.
- 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.
- Space maintainers for Claimants under 13 years of age.

General Exclusions

The following are the general exclusions from coverage, other exclusions may apply as described elsewhere in this Booklet.

SPECIFIC EXCLUSIONS

The following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**, are not covered. However, these exclusions will not apply with regard to a Covered Service for an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law.

Aesthetic Dental Procedures

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

Antimicrobial Agents

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

Collection of Cultures and Specimens

Collection of cultures and specimens, including, but not limited to:

- saliva; or
- tissue of the oral cavity.

Conditions Caused by Active Participation in a War or Insurrection

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

Conditions Incurred in or Aggravated During Performances in the Uniformed Services

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

Connector Bar or Stress Breaker

Cosmetic/Reconstructive Services and Supplies

Except for the following, cosmetic and/or reconstructive services and supplies are not covered:

- Dentally Appropriate services and supplies to treat a congenital anomaly; or
- to restore a physical bodily function lost as a result of Illness or Injury.

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

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

Desensitizing

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

Diagnostic Casts or Study Models

Duplicate X-Rays

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

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

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

- charges for shipping and handling, postage, interest or finance charges that a Dentist might bill;
- excise, sales or other taxes;
- surcharges;
- tariffs;
- duties;
- assessments; or
- other similar charges whether made by federal, state or local government or by another entity.

Fractures of the Mandible (Jaw)
Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-Foil Restorations

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

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

Home Visits

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

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

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

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

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

Indirect Pulp Capping and Pulp Vitality Tests

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

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

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

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

- automobile medical;
- personal injury protection (PIP);
- automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, the Claims Administrator's Coordination of Benefits provision shall apply);
- underinsured or uninsured motorist coverage;
- homeowner's coverage;
- commercial premises coverage;
- excess coverage; or
- similar contract or insurance.

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

Nitrous Oxide

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

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

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

- occlusal analysis and adjustments; and
- occlusal guards.

Oral Hygiene Instructions

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

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

Photographic Images

Pin Retention in Addition to Restoration

Precision Attachments

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

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

Provisional Splinting

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

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

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

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

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

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

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

"Immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings; and
- Your child's or stepchild's spouse or domestic partner.

Services Performed in a Laboratory

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

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

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

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

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

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

Travel and Transportation Expenses

Veneers
Veneers are not covered, except for Dentally Appropriate veneers.

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

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

Claims Administration

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

SUBMISSION OF CLAIMS AND REIMBURSEMENT

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

In-Network Dentist Claims and Reimbursement

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

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

Out-of-Network Dentist Claims and Reimbursement

In order for the Claims Administrator to pay for Covered Services, You or the Out-of-Network Dentist must first send the Claims Administrator a claim. In most cases, the Plan will pay the Dentist directly for Covered Services provided by an Out-of-Network Dentist. Be sure the claim is complete and includes the following information:

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

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

Timely Filing of Claims

Written proof of loss (submission of a claim) must be received within one year after the date of service. Claims that are not filed in a timely manner will be denied, unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. Benefits or coverage will not be invalidated nor reduced if it can be shown that it was not reasonably possible to file the claim and that the claim was submitted as soon as reasonably possible. You may Appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner. If You were covered by more than one health plan on the date of service, see the text of Primary Health Plan in the Coordination of Benefits provision for an exception to this timely filing rule.

Claim Determinations

Within 30 days of the Claims Administrator's receipt of a claim, the Claims Administrator will notify You of their action. However, this 30-day period may be extended by an additional 15 days due to lack of information or extenuating circumstances. The Claims Administrator will notify You of the extension within the initial 30-day period and provide an explanation of why the extension is necessary.

If the Claims Administrator requires additional information to process the claim, the Claims Administrator must allow You at least 45 days to provide it to them. If the Claims Administrator does not receive the requested information within the time allowed, the Claims Administrator will deny the claim.

CLAIMS RECOVERY

If the Plan pays a benefit to which You or Your Beneficiaries were not entitled, or if the Plan pays a person who is not eligible for benefits at all, the Plan has the right to recover the payment from the person the Plan paid or anyone else who benefited from it, including a Provider of services. The Plan's right to recovery for an erroneous payment made on the Participant's or any of his or her Beneficiary's behalf includes the right to deduct the mistakenly paid amount from future benefits the Plan would provide the Participant or any of his or her Beneficiaries under this Plan.

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

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

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

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

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

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

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

Subrogation

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

Reimbursement

If You receive any payment as a result of an Illness, Injury or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that Illness, Injury or condition, up to and including the full amount of Your recovery. Benefit payments made under the Plan are conditioned upon Your agreement to reimburse the Plan in full from any recovery You receive for Your Illness, Injury or condition.

Constructive Trust
By accepting benefits (whether the payment of such benefits is made to You or made on Your behalf to any Provider) You agree that if You receive any payment as a result of an Illness, Injury or condition, You will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of Your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until this Plan's subrogation and reimbursement interest are fully satisfied.

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

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

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

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

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

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any

settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

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

Workers' Compensation

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

Future Dental Expenses

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

Interpretation

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

Jurisdiction

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

COORDINATION OF BENEFITS

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

Definitions

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

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

- An expense or portion of an expense not covered by any of Your involved Plans.
- Any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You.
- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, unless one of Your involved Plans provides coverage for private Hospital rooms.
- Any amount by which a Primary Plan's benefits were reduced because You did not comply with that Plan's provisions regarding second surgical opinion or preauthorization.
- If You are covered by two or more Plans that: 1) compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified benefit; or 2) that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
- If You are covered by a Plan that calculates its benefits or services on the basis of usual and customary fees, relative value schedule reimbursement, or other similar reimbursement methodology

and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, that negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

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

Birthday means only the day and month of birth, regardless of the year.

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

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

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

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

Plan does not include:

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

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

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

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

Year means Calendar Year (January 1 through December 31).

Order of Benefit Determination

The order of benefit determination is identified by using the first of the following rules that apply:

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

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

- When Your parents are married or living together (whether or not they have ever been married), the Plan of the parent whose Birthday falls earlier in the Year is the Primary Plan. If both parents have the same Birthday, the Plan that has covered a parent longer is the Primary Plan.

- When Your parents are divorced or separated or are not living together (if they have never been married) and a court decree states that one of Your parents is responsible for Your health care expenses or health care coverage, the Plan of that parent is primary to the Plan of Your other parent. If the parent with that responsibility has no health care coverage for Your health care expenses, but that parent's spouse does, the Plan of the spouse shall be primary to the Plan of Your other parent.

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

- If there is no court decree allocating responsibility for Your health care expenses or health care coverage, the order of benefits is as follows:

  - The Plan of Your Custodial Parent shall be primary to the Plan of Your Custodial Parent's spouse;
  - The Plan of Your Custodial Parent's spouse shall be primary to the Plan of Your noncustodial parent; and
  - The Plan of Your noncustodial parent shall be primary to the Plan of Your noncustodial parent's spouse.

If You are covered by 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 by which You are covered as a laid off or retired employee. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

COBRA or state continuation coverage: A Plan that covers You as an employee, member, subscriber or retiree or as a dependent of an employee, member, subscriber or retiree, is primary to a Plan by which You are covered pursuant to COBRA or a right of continuation by state or other federal law. If the other

Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

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

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

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

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

Primary Health Plan Benefits

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

Secondary Health Plan Benefits

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

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

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

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

Right to Receive and Release Needed Information

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

Right of Recovery

If the Plan provides benefits to or on behalf of You in excess of the amount that would have been payable in this Plan by reason of Your coverage with any other Plan(s), the Claims Administrator will be entitled to the excess as follows:

- From You, if payment was made to You. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material 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. If a third-party collection agency or attorney is used to collect the overpayment, You agree to pay collection fees incurred, including, but not limited to, any court costs and attorney fees. If You do not pay, future benefits may be withheld to offset the amount owing to it. The Claims Administrator is responsible for making proper adjustments between insurers and Providers.
- From Providers, if payment was made to them. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentation(s). The Claims Administrator is responsible for making proper adjustments between insurers and Providers.
- From the other Plan or an insurer.
- From other organizations.

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

Appeal Process

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

FILING APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Claims Administrator at: Attn: ASO Appeals and Grievances, Regence BlueCross BlueShield of Utah P.O. Box 91015 Seattle, WA 98111-9115 or facsimile 1 (877) 663-7526. Verbal requests can be made by calling the Claims Administrator's Customer Service.

Each level of Appeal, except voluntary external review, must be pursued within 180 days of Your receipt of the Claims Administrator's determination (or, in the case of the first level, within 180 days of Your receipt of the Claims Administrator's original adverse decision that You are Appealing). If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum.

If You or Your treating provider determine that Your health could be jeopardized by waiting for a decision from the regular Appeal process, You or Your treating provider may specifically request an expedited Appeal. See Expedited Appeals later in this section for more information.

First-Level Appeals

First-level Appeals are reviewed by a Claims Administrator employee or employees who were not involved in the initial decision that You are Appealing. In Appeals that involve issues requiring medical or dental 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.

Second-Level Appeals

Second-level Appeals are reviewed by a Claims Administrator employee or employees who were not involved in, or subordinate to anyone involved in, the initial or the first-level decision. 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 15 days of receipt of the Appeal.

VOLUNTARY EXTERNAL APPEAL – INDEPENDENT REVIEW ORGANIZATION (IRO)

A voluntary Appeal to an IRO is available for issues involving medical or 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 their decision and provide You with a written determination within 45 days of 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 used 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 time frames on a Pre-Service or concurrent care claim either:
- could jeopardize Your life, health or ability to regain maximum function; or
- according to a provider with knowledge of Your medical or dental condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

First-Level Expedited Appeal

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

Voluntary Expedited External Appeal – IRO

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

The Claims Administrator coordinates voluntary expedited external Appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the Appeal documentation. The IRO will provide notice of their decision to You and Your Representative as soon as possible after the decision, but no later than within 72 hours of receipt of Your request. A written notification or their decision will be mailed to You within 48 hours of the verbal notice. Choosing the voluntary expedited Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section, except to the extent other remedies are available under State or Federal law.

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

INFORMATION

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

DEFINITIONS

The following definitions apply to this Appeal Process Section:

Appeal means a written or verbal request from a Claimant or, if authorized by the Claimant, the Claimant's Representative, to change a previous decision made by the Claims Administrator concerning:

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

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

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

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

<u>Representative</u> means someone who represents You for the Appeal. The Representative may be an attorney, Your authorized Representative or a treating provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the Appeal. No authorization is required from the parent(s) or legal guardian of a Claimant who is an unmarried and dependent child and is less than 13 years old. For expedited Appeals only, a health care professional with knowledge of Your medical or dental 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.

Eligibility and Enrollment

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible, during a period of special enrollment or during an annual enrollment period. It describes when coverage under the Plan begins for You and/or Your eligible dependents. Payment of any corresponding monthly costs is required for coverage to begin on the indicated dates. Applications for coverage should be filed with University Human Resource Management.

INITIALLY ELIGIBLE AND WHEN COVERAGE BEGINS

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 University Human Resource Management within 90 days of Your date of hire, the date You transfer into a benefit-eligible position (if You transferred from an ineligible position), or the date You are appointed in one of the specified affiliated groups.

Employees

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

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

Independent Contractors of Affiliated Groups

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

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

Dependents

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

- The person to whom You are legally married (spouse);
- Your domestic partner, provided that:
  - both You and Your domestic partner are age 18 or older;
  - You and Your domestic partner reside together in a permanent residence and have done so for at least 6 months and will remain members of the same household for the period of coverage.
  - You and Your domestic partner share a committed relationship and intend to continue that relationship indefinitely;
  - You and Your domestic partner are emotionally committed to one another and jointly responsible for the common welfare and financial obligations of the household or one is chiefly dependent upon the other for financial assistance;

- neither You nor Your domestic partner are legally married to anyone else or the domestic partner of anyone else;
- You and Your domestic partner are not related in any way that would prohibit legal marriage in Your state of residence; and
- You have completed and submitted an Employee and Partner Enrollment Form to University Human Resource Management 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.

For an Eligible Surviving Spouse, Eligible Dependents are limited to the following individuals:

- Your unmarried children by birth, placement for legal adoption or foster care, or legal (court-appointed) guardianship granting full guardianship rights, who are under age 26; and
- Children of the deceased employee born to You after the death of the employee.

Dependent Coverage Continuing Beyond Limiting Age

- You may continue coverage for Your (or Your spouse's or Your domestic partner's), unmarried, child at age 26 if the child is currently enrolled in the Plan as Your Eligible Dependent who is a Disabled Dependent (defined below). To do so, You must provide to University Human Resource Management, a written request to continue coverage along with proof that the dependent meets the Plan's definition of Disabled Dependent, as follows:

  - within 90 days after the dependent reaches age 26; and
  - at reasonable times thereafter as the Claims Administrator may consider necessary, but not more often than annually.

- You may continue coverage for Your (or Your spouse's or Your domestic partner's) unmarried, child at age 26 if the child is currently enrolled in the Plan as Your Eligible Dependent and is currently enrolled as a full-time student; and qualifies as Your Qualifying Relative as defined in the United States Internal Revenue Code (the child must meet all dependency tests as set forth by the United States Internal Revenue Code regarding taxability of employer-provided health coverage). To do so, You must provide to University Human Resource Management, a written request to continue coverage along with certification of the dependent's full-time student status, as follows:

  - within 90 days after the dependent reaches age 26; and
  - at reasonable times thereafter as the Claims Administrator may consider necessary, but not more often than annually.

You must promptly furnish or cause to be furnished to University Human Resource Management any information necessary or appropriate to determine the validity of a dependent's status. Receipt of such information by University Human Resource Management 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 University Human Resource Management when the dependent is no longer eligible under these exceptions.

Retirees
If You are an eligible retiree, You may continue coverage for up to 18 months under COBRA.

Surviving Spouse
If You are an eligible surviving spouse, You may continue coverage for up to 18 months under COBRA.

NEWLY ELIGIBLE DEPENDENTS
If You acquire a new dependent by marriage, birth or placement for adoption, You may enroll Yourself, the new dependent, and any other Eligible Dependents not already enrolled in the Employee Health Care Plan by completing and submitting to University Human Resource Management, a signed Health Care Coverage Change Form within 90 days of the date the dependent becomes eligible. If You are already enrolled in the Employee Health Care Plan, the new dependent and any other Eligible Dependents You wish to add will be added to Your existing medical and dental coverage. 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 University Human Resource Management accepts Your completed change form. If the change form is not submitted to University Human Resource Management within 90 days of the date the dependent gains eligibility, You may add the dependent to Your coverage only during the Plan's future Open Enrollment Periods, if any.

NOTE: When the addition of a new child by birth, adoption, or placement for adoption does not cause a change in the required health plan premium (as of the date of birth, date of adoption, or date of placement for adoption), You will have 30 days from the date the Claims Administrator first sends a denial of a claim for benefits for such new dependent, to submit to University Human Resource Management, a signed change request.

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

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

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

coverage under this Plan), a loss because premiums were not paid in a timely manner, or termination of coverage because of fraud.

- If You declined coverage for Yourself and/or Your Eligible Dependents when You were first eligible and You and/or one of Your Eligible Dependents loses eligibility for coverage under Medicaid or CHIP, or becomes eligible for premium assistance from Medicaid or CHIP, You become eligible for coverage under this Plan on behalf of Yourself and Your Eligible Dependents on the date of change in eligibility.
- If You declined coverage for Yourself and/or Your Eligible Dependents when You were first eligible and You subsequently marry, You become eligible for coverage under this Plan on behalf of Yourself, Your spouse, and any Eligible children and/or Your Eligible Dependents on the date of marriage.

If You declined coverage for Yourself and/or Your Eligible Dependents when You were first eligible (or You declined coverage for Your spouse when he or she was first eligible) and You subsequently acquire a new child by birth, adoption, placement for legal adoption, or placement for legal guardianship or foster care (if the order requires health coverage for the child), You become eligible for coverage under this Plan along with Your eligible spouse and Eligible children on behalf of Yourself and/or Your Eligible Dependents, including the newly acquired child on date of the birth, adoption, or placement.

ANNUAL 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 Calendar Year.

DOCUMENTATION OF ELIGIBILITY

You must promptly provide (or coordinate) any necessary and appropriate information to determine the eligibility of a dependent. Such information must be received before enrolling a person as a dependent under the Plan.

DEFINITIONS

The following definitions apply to this Eligibility and Enrollment Section:

Disabled Dependent means a child who is and continues to be:

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

Mental Impairment means a mental or psychological disorder such as:

- intellectual disability;
- organic brain syndrome;
- emotional or mental illness; or
- specific learning disabilities as determined by the Claims Administrator.

Physical Impairment means a physiological disorder, condition or disfigurement, or anatomical loss affecting one or more of the following body systems:

- neurological;
- musculoskeletal;
- special sense organs;
- respiratory organs;
- speech organs;

- cardiovascular;
- reproductive;
- digestive;
- genito-urinary;
- hemic and lymphatic;
- skin; or
- endocrine.

When Coverage Ends

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

AGREEMENT TERMINATION

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.

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 Booklet.

Nonpayment of Required Contribution

If You fail to make the required premium payments in a timely manner, Your coverage will end for You and all Enrolled Dependents on the date You fail to make such a required payment and You and Your Enrolled Dependents will not be eligible for COBRA.

Termination by University

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

Death of the Participant

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

WHAT HAPPENS WHEN YOUR BENEFICIARIES 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 Booklet. **You or the dependent must notify University Human Resource Management 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 University Human Resource Management 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 Booklet.

Loss of Dependent Status

- Eligibility ends on the first day of the month following the month in which an eligible dependent exceeds the dependent age limit (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).
- Eligibility ends on the last day of the monthly period in which an enrolled child is removed from placement due to disruption of placement before legal adoption.
- Except when eligibility ends due to the death of the Participant, eligibility will end on the last day of the monthly period in which the enrolled child is no longer an eligible dependent for any other cause.

You or Your dependent must notify University Human Resource Management 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 in this Booklet.

OTHER CAUSES OF TERMINATION

Claimants be terminated for any of the following reasons may be able to continue coverage under the Plan according to the continuation of coverage provisions of this Booklet.

Fraudulent Use of Benefits

If You or Your Enrolled Dependents engage in an act or practice that constitutes fraud in connection with coverage under this Plan or make an intentional misrepresentation of 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. 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.

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 Service member 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 Calendar 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 premiums through University Human Resource Management 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 premiums through University Human Resource Management. 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 Chief Human Resources Officer.

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 University Human Resource Management; 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 percent, for up to 24 months.

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

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

COBRA Continuation of Coverage

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

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, or child must notify University Human Resource Management 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 University Human Resource Management. Alternatively, Your spouse or child may give written notice of the Qualifying Event to University Human Resource Management at 250 E 200 S, Salt Lake City, UT 84111. 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 University Human Resource Management 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 University Human Resource Management 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 University Human Resource Management 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 Human Resource Management within 60 days of the second Qualifying Event and during the original 18-month COBRA coverage period (or 29-month period if there has been a disability extension), in order to extend COBRA coverage to 36 months.

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, 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 University Human Resource Management within **60 days** after the date of the determination. The Social Security Administration determination must occur and You must notify University Human Resource Management before the end of the original 18-month period. **If You do not notify University Human Resource Management 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 percent of the full cost during the extended 11-month coverage period. It is also Your responsibility to provide a written notice to University Human Resource Management 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 University Human Resource Management within 60 days of the second Qualifying Event and during the original 18-month COBRA coverage period (or 29-month period if there has been a disability extension), in order to extend COBRA

coverage to 36 months. The written notice must be sent to University Human Resource Management 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 University Human Resource Management (Health Care Coverage Change Form or written notice) of the birth or placement. Notification must be received within **90 days** of the date of birth or placement (if notification is not received within 90 days 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, or child failed to notify University Human Resource Management 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 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.

COBRA Premium Payments

If You elect COBRA coverage, You will be responsible to pay the full cost of coverage plus a 2 percent 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 University Human Resource Management within **45 days** of the date You elect COBRA coverage. Your first premium payment will include premiums due retroactive to the date You lost coverage as a result of Your Qualifying Event. If Your first payment is not received timely, COBRA coverage will not be effective and You will lose all rights to COBRA coverage.

Subsequent Payments
Payment for each subsequent period is **due on the first day of each month**. You will have a 30-day grace period from the premium due date to make subsequent payments. If 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 date You reach the Maximum Benefit under the Plan;
- The University terminates its group health plan(s);
- You have extended COBRA coverage due to Social Security disability and a final determination is made that You or Your enrolled dependent is 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 (for example, submitting fraudulent claims).

Questions, Notices, And Address Change

This section does not fully describe COBRA coverage. For additional information about Your rights and obligations under the Plan and under federal law, contact University Human Resource Management.

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

If You divorce or legally separate or lose eligibility as a child under the University Health Care Plan, You must provide the required written notice to University Human Resource Management within 60 days.

In order to protect Your Family's rights, You should keep University Human Resource Management informed of any change in address for You, Your spouse, or enrolled children.

General Provisions and Legal Notices

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

CHOICE OF FORUM

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

GOVERNING LAW

The Plan will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the state of Utah without regard to its conflict of law rules. The Claims Administrator is not the Plan Administrator, but does provide claims administration under the Plan.

LIMITATIONS ON LIABILITY

You have the exclusive right to choose a health care Provider. The Plan and the Claims Administrator are not responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since the Plan and the Claims Administrator do not provide any health care services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither employees nor agents of the Plan or the Claims Administrator.

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

NO WAIVER

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

NONASSIGNMENT

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

NOTICES

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

PLAN SPONSOR IS AGENT

The Plan Sponsor is Your agent for all purposes under the Plan and not the Claims Administrator's agent. You are entitled to health care benefits pursuant to the Agreement between the Claims Administrator and the Plan Sponsor. In the Agreement, the Plan Sponsor agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in this Booklet. You,

through the enrollment form signed by the Participant, and as beneficiaries of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Booklet.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

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

REPRESENTATIONS ARE NOT WARRANTIES

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

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

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

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

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

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

The Claims Administrator is required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by visiting the Claims Administrator's Web site or contacting Customer Service.

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

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

TAX TREATMENT

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

WHEN BENEFITS ARE AVAILABLE

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

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

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

UNIVERSITY OF UTAH
EMPLOYEE HEALTH CARE PLAN AND FLEXIBLE BENEFIT PLAN
NOTICE OF PRIVACY PRACTICES

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

THIS NOTICE IS EFFECTIVE SEPTEMBER 20, 2013

YOUR RIGHTS

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

Get a list of those with whom we've shared information

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

Get a copy of this privacy notice

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

Choose someone to act for You

- If You have given someone medical power of attorney or if someone is Your legal guardian, that person can exercise Your rights and make choices about Your health information.
- We will make sure the person has this authority and can act for You before we take any action.

File a complaint if You feel Your rights are violated

- You can complain if You feel we have violated Your rights by contacting us using the information on page 4.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1 (877) 696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against You for filing a complaint.

YOUR CHOICES

For certain health information, You can tell us Your choices about what we share. If You have a clear preference for how we share Your information in the situations described below, talk to us. Tell us what You want us to do, and we will follow Your instructions.

In these cases, You have both the right and choice to tell us to:

- Share information with Your family, close friends, or others involved in payment for Your care;
- Share information in a disaster relief situation:
  - If You are not able to tell us Your preference, for example if You are unconscious, we may go ahead and share Your information if we believe it is in Your best interest. We may also share Your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share Your information unless You give us written permission:

- Marketing purposes;
- Sale of Your information.

OUR USES AND DISCLOSURES

How do we typically use or share Your health information?

We typically use or share Your health information in the following ways.

Help manage the health care treatment You receive

We can use Your health information and share it with professionals who are treating You. Example: A doctor sends our health plan administrator information about Your diagnosis and treatment plan so they can arrange additional services.

Run our organization

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

Pay for Your health services

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

Administer Your plan

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

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share Your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before

we can share Your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about You for certain situations such as:

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

Do research

We can use or share Your information for health research.

Comply with the law

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about You with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about You:

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

Respond to lawsuits and legal actions

We can share health information about You in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

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

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

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about You. The new notice will be available upon request, on our web site, and we will mail a copy to You.

CONTACT US

If You are concerned that Your privacy rights may have been violated, or disagree with a decision that we made about access to Your health information, contact:

University of Utah Human Resource Management
Attention: Manager of Benefits
250 E 200 S
Salt Lake City, UT 84111
Phone: (801) 581-7447
Fax: (801) 585-7375

University of Utah Information Security and Privacy Office
privacy@utah.edu
515 E 100 S
Suite 650
Salt Lake City, UT 84102
Phone: (801) 587-9241
http://privacy.utah.edu/

Definitions

The following are definitions of important terms, other terms are defined where they are first used.

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

Allowed Amount means, for the purpose of this Dental Benefits Section only:

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

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

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

Booklet is the description of the benefits provided by the Group Health Plan (GHP). A GHP with different benefit plan options may describe them in one Booklet or in separate Booklet's for each alternative benefit plan option.

Calendar Year means the period from January 1 through December 31 of the same year; however, the first Calendar Year begins on the Claimant's Effective Date.

Claimant means a Participant or a Beneficiary.

Covered Service means those services or supplies that are provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues (including treatment that restores the function of teeth) and are Dentally Appropriate. These services must be received from a Dentist or other provider practicing within the scope of his or her license.

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

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

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

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

Effective Date means the date coverage begins for You and/or Your Beneficiaries.

Family means a Participant and his or her Beneficiaries.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following:

- disease;
- Illness or Injury;
- genetic or congenital anomaly;
- pregnancy;
- biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or
- to maintain or restore functional ability.

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

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

Illness means a:

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

Injury means physical damage to the body caused by:

- a foreign object;
- force;
- temperature;
- a corrosive chemical; or
- the direct result of an accident, independent of Illness or any other cause.

An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

In-Network Dentist means a Dentist who has an effective participating contract with the Claims Administrator that designates him or her as a Dentist of the Plan Sponsor's network, to provide services and supplies to Claimants in accordance with the provisions of this coverage.

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

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

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

Out-of-Network Dentist means a Dentist that is not an In-Network Dentist. For Out-of-Network Dentist services, You may be billed for balances over the Plan's payment level in addition to any Coinsurance

amount for Covered Services provided inside or outside the area that the Claims Administrator or one of its Affiliates serves.

Participant means an employee of the Plan Sponsor who is eligible under the terms of the Agreement, has completed an enrollment form and is enrolled under this coverage.

Regence refers to Regence BlueCross BlueShield of Utah.

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

For more information contact the Claims Administrator at 1 (800) 262-9712 or You can write to P.O. Box 2998, Tacoma, WA 98401-2998

regence.com

Regence

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