THE UNIVERSITY OF UTAH

BOOKLET FOR:

University of Utah Voluntary Dental

Group Number: 10007250

ExpressionsSM Dental Plan

Regence BlueCross BlueShield of Utah
Introduction

Regence BlueCross BlueShield of Utah

2890 East Cottonwood Parkway
Salt Lake City, UT 84121

P.O. Box 30272
Salt Lake City, UT 84130-0272

This Booklet provides the evidence and a description of the terms and benefits of coverage. The agreement between the Group and Regence BlueCross BlueShield of Utah (called the "Contract") contains all the terms of coverage. Your plan administrator has a copy.

This Booklet describes benefits effective January 1, 2011, or the date after that on which Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Us and makes it void.

As You read this Booklet, please keep in mind that references to "You" and "Your" refer to both the Enrolled Employee and Enrolled Dependents (except that in the eligibility and continuation of coverage sections, the terms "You" and "Your" mean the Enrolled Employee only). The terms "We," "Us" and "Our" refer to Regence BlueCross BlueShield of Utah and the term "Group" means the organization whose employees may participate under this coverage. Other terms are defined in the Definitions Section at the back of this Booklet or where they are first used and are designated by the first letter being capitalized.

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 below.

CONTACT INFORMATION

Customer Service: 1 (888) 370-6159

And visit Our Web site at: www.myRegence.com

Using Your Regence Expressions<sup>SM</sup> Booklet

YOUR PARTNER IN DENTAL CARE
Regence BlueCross BlueShield of Utah is pleased that Your Group has chosen Us as Your partner in dental care. It's important to have continued protection against unexpected dental care costs. Thanks to the purchase of Regence Expressions, You have coverage that's comprehensive, affordable and provided by a partner You can trust in times when it matters most.

ADDITIONAL MEMBERSHIP ADVANTAGES
When Your Group purchased Regence Expressions, You were provided with more than just great coverage. You also acquired Regence membership, which offers additional valuable services. The advantages of Regence membership include access to 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 www.myRegence.com, powered by the Regence Engine, an interactive environment that can help You navigate Your way through treatment decisions. THESE ADDITIONAL VALUABLE
SERVICES ARE A COMPLEMENT TO THE GROUP DENTAL PLAN, BUT ARE NOT INSURANCE.

- Go to www.myRegence.com. Have Your Member card handy to log on. Use the Web site to view recent claims, get guidance and support, get access to local events, use tools for annual planning and earn redeemable points with Regence Rewards. It is a health power source that can help You lead a healthy lifestyle, become a well-informed health/dental care shopper and increase the value of Your dental care dollar.

GUIDANCE AND SERVICE ALONG THE WAY
This Booklet was designed to provide information and answers quickly and easily. Be sure to understand Your benefits before You need them. You can learn more about the unique advantages of Regence Expressions dental care coverage and the rewards of Regence membership throughout this Booklet. We realize that You may still have some questions about Your Regence Expressions coverage, so please contact Us if You do.

- Learn more and receive answers about Your coverage or any other plan that We offer. Just call 1 (888) 370-6159 to talk with one of Our Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. - 6 p.m. You may also visit Our Web site at: www.myRegence.com.
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Understanding Your Benefits

In this section, You will discover information to help You understand what We mean by Your Maximum Benefits, Deductibles and Coinsurance. Other terms are defined in the Definitions Section at the back of this Booklet or where they are first used and are designated by the first letter being capitalized.

MAXIMUM BENEFITS
Benefits for some Covered Services may be limited to Maximum Benefits. For those Covered Services, We will provide benefits until the specified Maximum Benefit (which may be a dollar amount and/or a specified time period) has been reached. Refer to the benefits sections to determine if a Maximum Benefit applies to a Covered Service.

DEDUCTIBLES
We will begin to pay benefits for Covered Services in any Calendar Year only after a Member satisfies the Deductible (if applicable). A Member satisfies the Deductible by incurring Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible. We do not pay for services applied toward the Deductible. Refer to the benefits sections to see if a particular service is not subject to the Deductible.

The Deductible for a Calendar Year will no longer apply to the Family when three or more covered family Members’ Allowed Amounts for that Calendar Year total and meet the Family Deductible amount. One Member may not contribute more than the individual amount.

PERCENTAGE PAID UNDER THE CONTRACT (COINSURANCE)
Once You have satisfied any applicable Deductible, We pay a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When Our payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). The percentage We pay varies, depending on the kind of service or supply You received and who rendered it.

We do not reimburse Dentists for charges above the Allowed Amount. However, a Participating Dentist will not charge You for any balances for Covered Services beyond Your Deductible and/or Coinsurance amount. Nonparticipating Dentists, however, may bill You for any balances over Our payment level in addition to any Deductible and/or Coinsurance amount. See the Definitions Section for descriptions of Participating and Nonparticipating Dentists.

HOW CALENDAR YEAR BENEFITS RENEW
Many provisions of the Contract (for example, Deductibles and certain benefit maximums) are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again.

Some benefits of this Contract have a separate Lifetime Maximum Benefit and do not renew every Calendar Year. Those exceptions are specifically noted in the benefits sections of this Booklet.
Dental Benefits

In this section, You will learn how Your dental coverage works. The explanation includes information about Maximum Benefits, Deductibles, Coinsurance, Covered Services and payment. Preventive Dental Services are listed first, followed by all other Covered Services in alphabetical order.

**MAXIMUM BENEFITS**

**Preventive, Basic and Major Dental Services:**

Per Member per Calendar Year: $1,000

After any applicable Deductible is met, We pay a portion of the Allowed Amount for Covered Services, up to the Maximum Benefit amount for each Member each Calendar Year.

**CALENDAR YEAR DEDUCTIBLES**

Per Member: $50
Per Family: $150

The dental Deductible is calculated separately from any other Deductible of the Contract.

Deductible does not apply to the following:

- Preventive dental services

**PREVENTIVE DENTAL SERVICES**

<table>
<thead>
<tr>
<th>Provider: Participating Dentist</th>
<th>Provider: Nonparticipating Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment:</strong> We pay 80% and You pay 20% of the Allowed Amount.</td>
<td><strong>Payment:</strong> We pay 80% of the Allowed Amount and You pay balance of billed charges.</td>
</tr>
</tbody>
</table>

We cover the following preventive dental services:

- Bitewing x-rays, limited to two per Member per Calendar Year.
- Complete intra-oral mouth x-rays, limited to one in a three-year period.
- Oral examinations, limited to two per Member per Calendar Year.
- Panoramic mouth x-rays, limited to one in a three-year period.
- Cleanings, limited to two per Member per Calendar Year. (However, in no Calendar Year will any Member be entitled to more than two exams whether cleaning or periodontal maintenance.)
- Sealants, limited to permanent bicuspids and molars of Members under 18 years of age.
- Space maintainers for Members under 12 years of age.
- Topical fluoride application for Members under 18 years of age, limited to two treatments per Member per Calendar Year.

**BASIC DENTAL SERVICES**

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<tr>
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</tr>
</tbody>
</table>

We cover the following basic dental services:

- Complex oral surgery procedures including surgical extractions of teeth, impactions, alveolectomy, vestibuloplasty and residual root removal.
- Emergency treatment for pain relief.
• Endodontic services consisting of:
  - apicoectomy;
  - debridement;
  - direct pulp capping;
  - pulpal therapy;
  - pulpotomy; and
  - root canal treatment.

• Endodontic benefits will not be provided for:
  - indirect pulp capping; and
  - pulp vitality tests.

• Fillings consisting of composite and amalgam restorations.

• General dental anesthesia or intravenous sedation administered in connection with the extractions of partially or completely bony impacted teeth and to safeguard the Member’s health (for example, a child under seven years of age).

• Periodontal services consisting of:
  - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastastic surgery) limited to once per Member per quadrant in a five-year period;
  - debridement limited to once per Member in a three-year period;
  - gingivectomy and gingivoplasty limited to once per Member per quadrant in a three-year period;
  - periodontal maintenance limited to two per Member per Calendar Year. (However, in no Calendar Year will any Member be entitled to more than two exams whether periodontal maintenance or cleaning); and
  - scaling and root planing limited to once per Member per quadrant in a two-year period.

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

**MAJOR DENTAL SERVICES**

<table>
<thead>
<tr>
<th>Provider: Participating Dentist</th>
<th>Provider: Nonparticipating Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment:</strong> After Deductible, We pay 50% and You pay 50% of the Allowed Amount.</td>
<td><strong>Payment:</strong> After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges.</td>
</tr>
</tbody>
</table>

We cover the following major dental services:

• Adjustment and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within one year of insertion.

• Bridges (fixed partial dentures), except that benefits will not be provided for replacement made fewer than seven years after placement.

• Crowns, crown build-ups, inlays and onlays, except that benefits will not be provided for any of the following:
  - any crown, inlay or onlay replacement made fewer than seven years after placement (or subsequent replacement) whether or not originally covered under the Contract; and
  - additional procedures to construct a new crown under an existing partial denture framework.

• Dental implant crown and abutment related procedures, limited to one per Member per tooth in a seven-year period.

• Dentures, full and partial, including:
  - denture rebase, limited to one per Member per arch in a three-year period; and
- denture relines, limited to one per Member per arch in a three-year period.

Denture benefits will not be provided for:

- any denture replacement made fewer than seven years after denture placement (or subsequent replacement) whether or not originally covered under the Contract;
- interim partial or complete dentures; or
- pediatric dentures.

- Endosteal implants, limited to four per Member Lifetime.
- Recement crown, inlay or onlay.
- Repair of crowns is limited to one per tooth per Member Lifetime.
- Repair of implant supported prosthesis or abutment, limited to one per tooth per Member Lifetime.
General Exclusions
The following are the general exclusions from coverage under the Contract. Other exclusions may apply and, if so, will be described elsewhere in this Booklet. We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise Covered Service for 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

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

Conditions Incurred In or Aggravated During Performances In the Uniformed Services
The treatment of any Member'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
Cosmetic and/or reconstructive services and supplies, except for Dentally Appropriate services and supplies to treat a congenital anomaly and to restore a physical bodily function lost as a result of Injury or Illness.

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 generally performed to restore function, but, in the case of significant malformation, also may be 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 Contract or after Your termination under the Contract.
Facility Charges
Services and supplies provided in connection with facility services, including hospitalization for dentistry and extended-care facility visits.

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

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

Gold-Foil Restorations

Government Programs
Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or government program, except for facilities that contract with Us and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. We do not cover government facilities outside the service area (except as required by law for emergency services).

Home Visits

Implants
Services and supplies provided in connection with implants, whether or not the implant itself is covered, including the following:

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

Investigational Services
Investigational treatments or procedures (Health Interventions) and services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section of this Contract.

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

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

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

- appointments scheduled and not kept ("missed appointments");
- charges for preparing medical reports;
- itemized bills or claim forms (even at Our request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

Occlusal Treatment
Services and supplies provided in connection with dental occlusion, including the following:

- occlusal analysis and adjustments; and
- occlusal guards.

Oral Hygiene Instructions

Oral Surgery
Oral surgery treating any fractured jaw, and orthognathic surgery. By "orthognathic surgery," We mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

Orthodontic Dental Services
Services and supplies provided in connection with orthodontics, including the following:

- correction of malocclusion;
- craniomandibular orthopedic treatment;
- other orthodontic treatment;
- preventive orthodontic procedures; and
- procedures for tooth movement, regardless of purpose.

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

Photographic Images

Pin Retention in Addition to Restoration

Precision Attachments

Prosthesis
Services and supplies provided in connection with dental prosthesis, including the following:

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

Provisional Splinting

Replacements
Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.
Riot, Rebellion and Illegal Acts
Services and supplies for treatment of an Illness, Injury or condition caused by a Member’s voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion or sustained by a Member arising directly from an act deemed illegal by an officer or a court of law.

Self-Help, Self-Care, Training or Instructional Programs
Self-help, non-dental self-care, training programs. This exclusion does not apply to services for training or educating a Member, when provided without separate charge in connection with Covered Services.

Separate Charges
Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following:

- 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. For purposes of this provision, “immediate family” means parents, spouse, children, siblings, half-siblings, in-laws or any relative by blood or marriage who shares a residence with You.

Services Performed in a Laboratory

Surgical Procedures
Services and supplies provided in connection with the following surgical procedures:

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

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

Tooth Transplantation
Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.

Travel and Transportation Expenses
Travel and transportation expenses.

Work-Related Conditions
Expenses for services and supplies incurred as a result of any work related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. We may require the Member to file a claim for workers’ compensation benefits before providing any benefits under the Contract. We do not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers’ compensation benefit. The only exception is if an Enrolled Employee is exempt from state or federal workers’ compensation law.
Contract and Claims Administration

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

MEMBER CARD

When You, the Enrolled Employee, enroll with Regence BlueCross BlueShield of Utah, You will receive a Member card. It will include important information such as Your identification number, Your Group number and Your name.

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

If You lose Your card, or if it gets destroyed, You can get a new one by simply calling Our Customer Service department at 1 (888) 370-6159 or by visiting Our Web site at www.myRegence.com. If coverage under the Contract terminates, Your Member card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

We have the sole right to decide whether to pay You, the provider or You and the provider jointly. We 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.

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

Calendar Year and Contract Year

The Deductible and Maximum Benefit provisions are calculated on a Calendar Year basis. This Contract is renewed, with or without changes, each Contract Year. A Contract Year is the 12-month period following either the Contract's original Effective Date or subsequent renewal date. A Contract Year may or may not be the same as a Calendar Year. When Your Contract renews on other than January 1 of any year, any Deductible You satisfied or amount accumulated toward a Maximum Benefit before the date the Contract renews will be carried over into the next Contract Year. If the Deductible amount increases during the Calendar Year, You will need to meet the new requirement minus any amount You already satisfied under the previous Contract during that same Calendar Year.

Timely Filing of Claims

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

Participating Dentist Claims

You must present Your identification card when obtaining Covered Services from a Participating Dentist. You must also furnish any additional information requested. The Participating Dentist will furnish Us with the forms and information We need to process Your claim.
**Participating Dentist Reimbursement**

We will pay a Participating Dentist directly for Covered Services. Participating Dentists have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount is any amount You must pay due to Deductible and/or Coinsurance. A Participating Dentist may require You to pay Your share at the time You receive care or treatment.

**Nonparticipating Dentist Claims**

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

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

**Nonparticipating Dentist Reimbursement**

In most cases, We will pay the Nonparticipating Dentist directly for Covered Services provided by a Nonparticipating Dentist.

Nonparticipating Dentists have not agreed to accept the Allowed Amount as full compensation for Covered Services. So, You are responsible for paying any difference between the amount billed by the Nonparticipating Dentist and the Allowed Amount in addition to any amount You must pay due to Deductible and/or Coinsurance. For Nonparticipating Dentists, the Allowed Amount may be based upon the billed charges for some services, as determined by Us or as otherwise required by law.

**Reimbursement Examples**

Here is an example of how Your selection of a Participating Dentist or Nonparticipating Dentist affects Our payment and Your cost sharing amount. For purposes of this example, let's assume that Participating Dentist services are subject to a 20 percent Coinsurance and Nonparticipating Dentist services are also subject to a 20 percent Coinsurance. The benefit table from the Dental Benefits Section would appear as follows:

<table>
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</thead>
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<tr>
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<td><strong>Payment:</strong> After Deductible, We pay 80% of the Allowed Amount and You pay balance of billed charges.</td>
</tr>
</tbody>
</table>

Now, let's assume that the Dentist's charge for a service is $500 and the Allowed Amount for that Dentist's charge is $400. Finally, We will assume that You have met the Deductible. Here's how that Covered Service would be paid:

- **Participating Dentist:** We would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:

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

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

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

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

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

**Claims Determinations**
Within 30 days of Our receipt of a claim, We will notify You of the action We have taken on it. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When We cannot take action on the claim due to circumstances beyond Our control, We will notify You within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when We expect to act on the claim.
- When We cannot take action on the claim due to lack of information, We will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

We must allow You at least 45 days to provide Us with the additional information if We are seeking it from You. If We do not receive the requested information to process the claim within the time We have allowed, We will deny the claim.

**NONASSIGNMENT**
Only You are entitled to benefits under the Contract. 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 Us. You may not assign, transfer or delegate any right of representation or collection other than to legal counsel directly authorized by You on a case-by-case basis.

**CLAIMS RECOVERY**
If We pay a benefit to which You or Your Enrolled Dependent was not entitled, or if We pay a person who is not eligible for benefits at all, We have the right, at Our discretion, to recover the payment from the person We paid or anyone else who benefited from it, including a provider of services. Our right to recovery for an erroneous payment made on Your or Your Enrolled Dependent’s behalf includes the right to deduct the mistakenly paid amount from future benefits We would provide You or any of Your Enrolled Dependents under this coverage.

We regularly work 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.). We will credit all amounts that We recover, less Our reasonable expenses for obtaining the recoveries, to Your Group's experience or the experience of the pool under which You or Your Group is rated. Crediting reduces claims expense and helps reduce future premium rate increases.

For the recovery of overpayments related to the coordination of Primary and Secondary Health Plan benefits, refer to the coordination of benefits provision in this Contract and Claims Administration Section.
This claims recovery provision in no way reduces Our right to reimbursement or subrogation. Refer to the other-party liability provision in the Contract and Claims Administration Section for additional information.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND DENTAL RECORDS
It is important to understand that Your personal health information may be requested or disclosed by Us. 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 Us 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.

We are required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by calling Our Customer Service department or visiting Our Web site www.myRegence.com.

You have the right to request, inspect and amend any records that We have that contain Your personal health information. Please contact Our Customer Service department to make this request.

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

LIMITATIONS ON LIABILITY
In all cases, You have the exclusive right to choose a dental care provider. We are not responsible for the quality of dental care You receive, since all those who provide care do so as independent contractors. Since We do not provide any dental care services, We cannot be held liable for any claim or damages connected with Injuries You suffer while receiving dental services or supplies provided by professionals who are neither Our employees nor agents.

In addition, We will not be liable to any person or entity for the inability or failure to procure or provide the benefits of the Contract by reason of epidemic, disaster or other cause or condition beyond Our control.

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY
We will not provide coverage under the Contract for any medical or dental expenses You incur for treatment of an Injury or Illness if the costs associated with the Injury or Illness may be recoverable from any of the following:
• a third party;
• workers’ compensation; or
• any other source, including automobile medical, personal injury protection ("PIP"), automobile no-fault, homeowner’s coverage, commercial premises medical coverage or similar contract or insurance, when the contract or insurance is either issued to, or makes benefits available to You, whether or not You make a claim under such coverage.

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

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

• We will not reduce Our reimbursement or subrogation due to Your not being made whole, unless applicable state law requires otherwise. Our right to reimbursement or subrogation, however, will not exceed the amount of recovery.
• We may require You to sign and deliver all legal papers and take any other actions requested to secure Our rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third party or other source). If We ask You to sign a trust agreement or other document to reimburse Us from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.
• You must agree that nothing will be done to prejudice Our rights and that You will cooperate fully with Us, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify Us of any facts that may impact Our right to reimbursement or subrogation, including, but not necessarily limited to, the following:
  - the filing of a lawsuit;
  - the making of a claim against any third party;
  - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
  - intent of a third party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Injury or Illness that gives rise to Our right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).
You and/or Your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to Your benefit or on Your behalf that in any manner relates to the Injury or Illness giving rise to Our right of reimbursement or subrogation, until Our right is satisfied or released.

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

Any benefits We have provided or advanced are provided solely to assist You. By paying such benefits, We are not acting as a volunteer and are not waiving any right to reimbursement or subrogation.

**Motor Vehicle Coverage**

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

**Workers’ Compensation**

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

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

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

**Fees and Expenses**

We are not liable for any expenses or fees incurred by You in connection with obtaining a recovery. However, You may request that We pay a proportional share of attorney’s fees and costs at the time of any settlement or recovery to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid by Us. We have discretion whether to grant such requests.

**Future Related Expenses**

We may, at Our discretion, exclude benefits for otherwise Covered Services, as follows:

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

The amount of any exclusion under this provision, however, will not exceed the amount of benefits previously paid in connection with the Illness or Injury for which the recovery has been made.

**COORDINATION OF BENEFITS**

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

**Benefits Subject to this Provision**

All of the benefits provided under the Contract are subject to this coordination of benefits provision.
Definitions
In addition to the definitions in the Definitions Section, the following are definitions that apply to coordination of benefits:

Acceptable Expense means, with regard to services that are covered in full or part by the Contract 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 Acceptable 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 Acceptable 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 Acceptable 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 Acceptable Expense and a benefit paid.

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

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

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

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

- Individual and group accident and health insurance and subscriber contracts.
- Uninsured arrangements of group or Group-Type Coverage.
- Group-Type Coverage.
Coverage through closed panel plans (a plan that provides coverage primarily in the form of services through a panel of providers that have contracted with or are employed by a plan and that excludes benefits for services provided by other providers, except in the cases of emergency or referral by a panel member).

- Medical care components of long-term care contracts, such as skilled nursing care.
- Medicare and other governmental coverages, as permitted by law.

Other Plan does not include:

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

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

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

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

**Year**, for purposes of this coordination of benefits provision, means calendar year (January 1 through December 31).

**Order of Benefit Determination**

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

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

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

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

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

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

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

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

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

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

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

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

If an order of benefit determination is not identified by the preceding rules, the plans shall share equally in the Allowable Expenses. Each of the plans under which You are covered, and each of the benefits within the plan, will be considered separately in administering this coordination of benefits provision.
Primary Health Plan Benefits
When, in accordance with the order of benefit determination, this coverage is the Primary Plan, We will pay the benefits of the Contract as if no Other Plan exists. Despite the provisions of timely filing of claims, where We are the Primary Plan, We will not deny benefits 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 Us 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 the Contract, the benefits of the Contract will be calculated as follows:

We will calculate the benefits that We would have paid for a service if the Contract were the Primary Plan. We will apply that calculated amount to any Allowable Expense under the Contract for that service that is unpaid by the Primary Plan. We 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 Contract’s Deductible (if applicable), any amounts We would have credited for the service if the Contract were the Primary Plan.

Nothing contained in this coordination of benefits provision requires Us to pay for all or part of any service that is not covered under the Contract. Further, in no event will this coordination of benefits provision operate to increase Our payment over what We would have 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. We have the right to decide which facts We need. We 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 Us any information necessary or appropriate to administer this coordination of benefits provision. Receipt of such information by Us will be a condition precedent to Our obligation to provide benefits under the plan.

Right of Recovery
If We provide benefits to or on behalf of You in excess of the amount that would have been payable under the Contract by reason of Your coverage under any Other Plan(s), We 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. We will be entitled to recover the amount of such excess by the reversal of payment from You and You agree to reimburse Us on demand for any and all such amounts. You also agree to pay Us interest at 18 percent per annum until such debt is paid in full, which will begin accruing the date the demand for reimbursement is made. If We use a third-party collection agency or attorney 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 Us, We may withhold future benefits to offset the amount owing to Us. We are 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). We are 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 Us under the Contract and wishes to have it reviewed, You may Appeal. There are two levels of Appeal, as well as additional voluntary Appeal levels You may pursue. Certain matters requiring quicker consideration qualify for a level of expedited Appeal and are described separately later in this section.

**APPEALS**

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to Us at: Appeals Coordinator, Regence BlueCross BlueShield of Utah, P.O. Box 1271, MS C7B, Portland, OR 97207-1271. Verbal requests can be made by calling Us at 1(888) 370-6159.

Each level of Appeal, including expedited Appeals, must be pursued within 180 days of Your receipt of Our determination (or, in the case of the first level, within 180 days of Your receipt of Our original adverse decision that You are appealing). If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum. When We receive an Appeal request, We will send a written acknowledgement and information describing the entire Appeal process and Your rights.

If Your treating provider determines that Your health could be jeopardized by waiting for a decision under the regular Appeal process, he or she may specifically request an expedited Appeal. Please see Expedited Appeals later in this section for more information.

**First-Level Appeals**

First-level Appeals are reviewed by an employee or employees who were not involved in the initial decision that You are appealing. In Appeals that involve issues requiring medical judgment, the decision is made by Our 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, We will send a written notice of the decision within 14 days of receipt of the Appeal.

**Panel-Level (Second-Level) Appeals**

Second-level Appeals are reviewed by a panel who were not involved in, or subordinate to anyone involved in, the first-level decision. You or Your Representative, on Your behalf, will be given a reasonable opportunity to personally appear or participate via telephone, video conference or other technology and/or 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, We will send a written notice of the decision within 14 days of receipt of the Appeal.

**VOLUNTARY EXTERNAL APPEAL - IRO**

A voluntary Appeal to an Independent Review Organization (IRO) is available only after You have exhausted all of the applicable non-voluntary levels of Appeal, or if We have failed to provide You with a first-level or panel-level Appeal decision within the timeframes given and the issue on Appeal addresses one of the following:

- Dentally Appropriate;
- determination that the treatment is Investigational; or
- treatment of a preexisting condition and the benefit denial is based in whole or in part on a dental review determination by the plan.

We coordinate voluntary external Appeals, but the decision is made by an Independent Review Organization (IRO) at no cost to You. We will provide the IRO with the Appeal documentation. A written notice of the IRO's decision will be sent to You within 30 days of receipt of Your 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.

The voluntary external Appeal by an IRO is optional and You should know that other forums may be utilized as the final level of Appeal to resolve a dispute You have with Us. This includes but is not limited to civil action under Section 502(a) of ERISA, where applicable.

**EXPEDITED APPEALS**

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

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

**Panel-Level (First-Level) Expedited Appeal**

The first-level expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. First-level expedited Appeals are reviewed by a panel who were not involved in, or subordinate to anyone involved in, the initial denial determination. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the expedited Appeals timeframe) to participate via telephone and/or provide written materials. A verbal and written 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.

**Voluntary Expedited Appeal - IRO**

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

We coordinate voluntary expedited Appeals, but the decision is made by an IRO at no cost to You. In order to have the Appeal decided by an IRO, You must sign a waiver granting the IRO access to medical or dental records. We will provide the IRO with the Appeal documentation. Verbal notice of the IRO's decision will be provided to You and Your Representative as soon as possible after the decision, but no later than within 72 hours of Your request. Choosing the voluntary expedited Appeal as the final level to determine an Appeal will be binding in accordance with the IRO’s decision and this section.

The voluntary 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 with Us, including, but not limited to, civil action under Section 502(a) of ERISA, where applicable.

**INFORMATION**

If You have any questions about the Appeal process outlined here, You may contact Our Customer Service department at 1 (888) 370-6159 or You can write to Our Customer Service department at the following address: Regence BlueCross BlueShield of Utah, P.O. Box 30272, Salt Lake City, UT 84130-0272.

**DEFINITIONS SPECIFIC TO THE APPEAL PROCESS**

Appeal means a written or verbal request from a Member or, if authorized by the Member, the Member's Representative, to change a previous decision made by Us 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 Member and Us; 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 expedited external Appeals, through an independent contractor relationship with Us and/or through assignment to Us via state regulatory requirements. The IRO is unbiased and is not controlled by Us.

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

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

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

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

This section contains the terms of eligibility under the Contract for an employee and his or her dependents. It explains how to enroll Yourself and/or Your eligible dependents when first eligible or during an annual enrollment period. It also describes when coverage under the Contract begins for You and/or Your eligible dependents. Of course, payment of any corresponding monthly premiums is required for coverage to begin on the indicated dates.

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS
You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of Your first becoming eligible for coverage under the eligibility requirements in effect with the Group and as stated in the following paragraphs. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

If You and/or Your eligible dependents do not enroll for coverage under the Plan when first eligible or You do not enroll in a timely manner, You and/or Your eligible dependents must wait until the next annual enrollment period to enroll.

Employees
You become eligible to enroll in coverage on the date You have worked for the Group long enough to satisfy any required probationary period.

Dependents
Your Enrolled Dependents are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when We have enrolled them in coverage under the Contract. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your (or Your spouse's) child who is under age 26 and who meets any of the following criteria:
  - Your (or Your spouse's) natural child, step child, adopted child or child legally placed with You (or Your spouse) for adoption;
  - a child for whom You (or Your spouse) have court-appointed legal guardianship; and
  - a child for whom You (or Your spouse) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your spouse's) otherwise eligible child who is age 26 or over and who is a Disabled Dependent due to a Physical Impairment or a Mental Impairment that began before his or her 26th birthday, if You complete and submit Our affidavit of dependent eligibility form, with written evidence of the child's impairment, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
  - he or she is an enrolled child immediately before his or her 26th birthday; or
  - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on accident and health insurance since that birthday.

Our affidavit of dependent eligibility form is available by visiting Our Web site at www.myRegence.com, or by calling Our Customer Service department at 1 (888) 370-6159.

NEWLY ELIGIBLE DEPENDENTS
You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request to Us. Request for enrollment of a new dependent child by birth, adoption or placement for adoption must be made within 60 days of the date of birth, adoption or placement for adoption. Request for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's attaining eligibility.
Coverage for such dependents will begin on their Effective Dates (which, for a new dependent child by birth, adoption or placement for adoption, is the date of birth, adoption or placement for adoption, if enrolled within the specified 60 days).

NOTE: When the addition of a new dependent child by birth, adoption or placement for adoption would not cause a change in the premium amount billed to the Group (as of the date of birth, adoption or placement for adoption), You will have 60 days from the date We first send a denial of a claim for benefits for that new dependent to submit an enrollment request to Us.

ANNUAL ENROLLMENT PERIOD
The annual enrollment period is the period of time before the Group's Renewal Date and is the only time, other than initial eligibility, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form on behalf of all individuals You want enrolled. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY
You must promptly furnish or cause to be furnished to Us any information necessary and appropriate to determine the eligibility of a dependent. We must receive such information before enrolling a person as a dependent under the Contract.

DEFINITIONS SPECIFIC TO THE WHO IS ELIGIBLE, HOW TO ENROLL AND WHEN COVERAGE BEGINS SECTION
Disabled Dependent means a child who is and continues to be: 1) unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable Physical or Mental Impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and 2) dependent on You for more than 50 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: 1) mental retardation; 2) organic brain syndrome; 3) emotional or mental illness or 4) specific learning disabilities as determined by Us.

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

This section describes the situations when coverage will end for You and/or Your Enrolled Dependents. If You lose an Enrolled Dependent, You must notify Us within 30 days.

No person will have a right to receive benefits under the Contract after the date it is terminated. Termination of Your or Your Enrolled Dependent's coverage under the Contract for any reason will completely end all Our obligations to provide You or Your Enrolled Dependent benefits for Covered Services received after the date of termination. This applies whether or not You or Your Enrolled Dependent is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while the Contract was in effect.

CONTRACT TERMINATION

If the Contract is terminated or not renewed by the Group or Us, coverage ends for You and Your Enrolled Dependents on the date the Contract is terminated or not renewed.

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 ends on the last day of the monthly period in which Your eligibility ends. However, it may be possible for You and/or Your Enrolled Dependents to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Contract, Your coverage will end for You and all Enrolled Dependents on the last day of the monthly period in which eligibility ends.

NONPAYMENT OF PREMIUM

If You fail to make required timely contributions to premium, Your coverage will end for You and all Enrolled Dependents.

TERMINATION BY YOU

You have the right to terminate the Contract with respect to Yourself and Your Enrolled Dependents by giving notice to Us. Coverage will end on the last day of the monthly period following the date We receive such notice.

FAMILY AND MEDICAL LEAVE

If Your Group grants You a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA") 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 Contract during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
  - in order to care for Your newly born child;
  - in order to care for Your spouse, child or parent, if such spouse, child or parent has a serious health condition;
  - the placement of a child with You for adoption or foster care; or
  - You suffer a serious physical or mental health condition.

During the FMLA leave, You must continue to pay the monthly premium through the Group on time. The provisions described here will not be available if the Contract terminates.
If You and/or Your Enrolled Dependents elect not to remain enrolled during the FMLA leave, You (and/or Your Enrolled Dependents) will be eligible to be reenrolled under the Contract on the date You return from the FMLA leave. In order to reenroll after You return from a FMLA leave, You must sign a new enrollment form just as if You were a newly eligible employee. In this situation, if You reenroll within the required time, all of the terms and conditions of the Contract will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Enrolled Dependents) will receive credit for any waiting period served before the FMLA leave and You will not have to re-serve any probationary period under the Contract, although You and/or Your Enrolled Dependents will receive no waiting period credits for the period of noncoverage.

Persons entitled to coverage under this provision 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 provision. Entitlement to FMLA leave does not constitute a qualifying event for the purposes of COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

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. This leave provision is available only to groups that are required by law to comply. The Group must keep Us advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

**LEAVE OF ABSENCE**
If You are granted a non-FMLA temporary leave of absence by Your Group, You can continue coverage for up to three months. Premiums must be paid through the Group in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by Your employer at Your request during which You are still considered to be employed and are carried on the employment records of the Group. A leave can be granted for any reason acceptable to the Group. If You are on leave for an FMLA-qualifying reason, You remain eligible under the Contract only for a period equivalent to FMLA leave and may not also continue coverage under a non-FMLA leave.

If You and/or Your Enrolled Dependents elect not to remain enrolled during the leave of absence, You (and/or Your Enrolled Dependents) may reenroll under the Contract only during the next annual enrollment period.

**WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE**
If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the last day of the monthly period in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

**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 last day of the monthly period following the date a divorce or annulment is final.

**If You Die**
If You die, coverage for Your Enrolled Dependents ends on the last day of the monthly period in which Your death occurs.
Loss of Dependent Status

- For an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the monthly period in which the child exceeds the dependent age limit.
- For an enrolled child who is no longer eligible due to disruption of placement before legal adoption and who is removed from placement, eligibility ends on the last day of the monthly period in which the child is removed from placement.
- For an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the monthly period in which the child is no longer a dependent.

OTHER CAUSES OF TERMINATION

Members may be terminated for any of the following reasons. However, it may be possible for them to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

Fraudulent Use of Benefits

If You or Your Enrolled Dependent engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of fact in connection with coverage, coverage under the Contract will terminate for that Member. The Member may reenroll 12 months after the date of discontinuance if the Group's coverage is in effect at the time the Member applies to reenroll.

Fraud or Misrepresentation in Application

We have issued the Contract in reliance upon all information furnished to Us by You or on behalf of You and Your Enrolled Dependents. In the event such information, at the time it is furnished, contains any material misrepresentation of fact, We will have the following rights in accordance with Utah Code 31A-22-721 (or any successor thereto):

- In the event of any intentional material misrepresentation of fact or fraud regarding a Member's health status, We may make a retrospective adjustment to the premium amount as would have been appropriate if true, accurate or complete information had been provided at the time of enrollment.
- In the event of any intentional material misrepresentation of fact or fraud regarding a Member (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Group), We will retroactively adjust coverage to the terms that would have existed if true, accurate or complete information had been received. A Member may reenroll 12 months after the date of a discontinuance of coverage, if the Group's coverage is in effect at the time the Member applies to reenroll.

CERTIFICATES OF CREDITABLE COVERAGE

Requests for and inquiries about required certificates relating to period(s) of creditable coverage under the Contract should be directed to the Group, or to Us at P.O. Box 30272, Salt Lake City, UT 84130-0272.
COBRA Continuation of Coverage

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups.

NOTE: If, upon loss of eligibility for coverage, You or Your Enrolled Dependents elect alternative coverage under Utah NetCare, such coverage is in lieu of COBRA Continuation of Coverage.

If Your Group is subject to COBRA, COBRA continuation is available to Your Enrolled Dependents if they lose eligibility because:

- Your employment is terminated (unless the termination is for gross misconduct);
- Your hours of work are reduced;
- You die;
- You and Your spouse divorce or the marriage is annulled;
- You become entitled to Medicare benefits; or
- Your enrolled child loses eligibility as a child under this coverage.

COBRA also is available to You if You lose eligibility because Your employment terminates (other than for gross misconduct) or Your hours of work are reduced. (A special COBRA continuation also applies to You and Your Enrolled Dependents under certain conditions if You are retired and Your Group files for bankruptcy.)

There are some circumstances involving disability or the occurrence of a second one of these events that can result in extension of the limited period of continuation following a termination of employment or reduction in working hours. COBRA also can terminate earlier than the maximum periods.

General Rules

Generally, You or Your Enrolled Dependents are responsible for payment of the full premium for COBRA continuation, plus an administration fee, even if the Group contributes toward the premiums of those not on COBRA continuation. The administration fee is 2 percent or, during any period of extension for disability, 50 percent.

In order to preserve Your and Your Enrolled Dependent's rights under COBRA, You or Your Enrolled Dependents must inform the Group in writing within 60 days of:

- Your divorce or annulment or a loss of eligibility of a child;
- Your initial loss of eligibility due to Your termination of employment or reduction in working hours and You experience another one of the events listed above; or
- a Social Security disability determination that You or Your Enrolled Dependent were disabled for Social Security purposes at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that You or Your Enrolled Dependent is no longer disabled for Social Security purposes, You or Your Enrolled Dependent must provide the Group notice of that determination within 30 days of the date it is made.)

The Group also must meet certain notification, election and payment deadline requirements. It is therefore very important that You keep the Group informed of the current address of all Members who are or may become qualified beneficiaries.

If You or Your Enrolled Dependents do not elect COBRA continuation coverage, coverage under the Contract will end according to the terms of the Contract and We will not pay claims for services provided on and after the date coverage ends. Further, this may jeopardize Your or Your Enrolled Dependents’ future eligibility for an individual plan.
Notice
The Contract includes additional details on the COBRA Continuation provisions outlined here and complete details are available from Your Group.
Non-COBRA Continuation of Coverage

A Group that is not required to offer COBRA Continuation of Coverage must offer a continuation of Group coverage benefits to You and Your Enrolled Dependents upon loss of eligibility for coverage.

NOTE: If, upon loss of eligibility for coverage, You or Your Enrolled Dependents elect alternative coverage under Utah NetCare, such coverage is in lieu of this continuation of Group coverage provision.

The Group must notify You and Your Enrolled Dependents of this continuation right. If You and/or Your Enrolled Dependents do not receive notice, You may contact Us directly within 60 days following termination of coverage and elect continuation of coverage.

If You and/or Your Enrolled Dependents choose to continue coverage under this right, You must enroll in writing and pay the premium for such coverage within 60 days of coverage termination. You will be required to make timely premium payments to the Group. The Group may charge You and Your Enrolled Dependents a premium no higher than the current rate paid for coverage of a comparable Member (or Members) who lost coverage and the Group is not required to make any contribution toward premiums for continuation coverage. Where an enrollment form and premium are received within the 60-day period, the accepting Member's coverage continues, without interruption, from the date the Member's coverage was terminated.

This continuation of coverage will terminate when the first of the following occurs:

- Your and/or Your Enrolled Dependents fail to make payment of premiums for the coverage to the Group within its established timeframe;
- 12 months elapse; or
- the Group's coverage is terminated.

If the Group replaces coverage with a similar plan, those who have continued coverage may obtain coverage under the replacement policy for the balance of the period that they would have been allowed to extend benefits under the replaced coverage.
General Provisions

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

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

**ERISA (IF APPLICABLE)**
This provision applies if the Contract is part of an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA).

The Group intends that the Contract be maintained for the exclusive benefit of the employees.

The Group intends to continue this coverage indefinitely, but it also reserves the right to discontinue or change this coverage at any time. If the Group terminates the Contract for any reason and does not replace the coverage with comparable benefits, employees will receive ample notice. Employees will also receive instructions for converting their coverage to an individual plan.

**Rights and Protection**
Employees are entitled to certain rights and protection under ERISA. ERISA provides that all employees shall be entitled to:

- Examine without charge, at the plan administrator's office, all policy documents, including insurance policies and copies of certain documents filed by the plan administrator with the U.S. Department of Labor, such as detailed annual reports and policy descriptions.
- Obtain copies of documents governing the operation of the plan upon written request to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- Continue, generally at their own expense, health care coverage of themselves, their spouses and children if coverage ends due to certain qualifying events. Review the summary plan description and governing documents of the coverage for rules and other details about such COBRA continuation rights.
- Reduce or eliminate periods that coverage for preexisting conditions is excluded, if they have creditable coverage from another plan. Group plans and health insurance issuers should provide a certificate of creditable coverage, free of charge, when an employee loses that other coverage, when he or she becomes entitled to elect COBRA continuation under it, when COBRA continuation is exhausted and if an employee requests one within 24 months after losing that other coverage.

**Duties**
In addition to creating rights for employees, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries," have a duty to do so prudently and in the interest of employees and their dependents. No one, including the employer, or any other person, may fire an employee or otherwise discriminate against one in any way to prevent an employee from obtaining a welfare benefit or exercising his or her rights under ERISA.

If an employee's claim for a welfare benefit is denied (or ignored) in whole or in part, he or she must receive a written explanation of the reason for the denial. Employees have the rights to obtain copies of related documents without charge and to Appeal any denial within certain time frames. Under ERISA, there are steps they can take to enforce the above rights. For instance, if an employee requests certain materials from the plan administrator in writing and does not receive them within 30 days, the employee may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay an employee up to $110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the plan administrator.
Denied Claims
If an employee has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or federal court. An employee may also do so if he or she disagrees with a decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order. If fiduciaries misuse money, or if an employee is discriminated against for asserting his or her rights, employees may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If an employee is successful, the court may order the person an employee has sued to pay these costs and fees. If an employee loses, the court may order the employee who sued to pay these costs and fees, for example, if it finds the claim frivolous. If an employee has any questions about the plan, he or she should contact the plan administrator.

If You Need More ERISA Information
If an employee has any questions about this statement or his or her rights under ERISA, or if he or she needs assistance obtaining documents from the plan administrator, the employee should contact the nearest Field Office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in the telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Employees can also obtain publications about their ERISA rights and responsibilities by calling the publications hotline of the Employee Benefits Security Administration.

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

GROUP IS AGENT
The Group is Your agent for all purposes under the Contract and not the agent of Regence BlueCross BlueShield of Utah. You are entitled to health care benefits pursuant to an agreement between Us and the Group. In the Contract, the Group agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in the Contract. You, through the enrollment form signed by the Enrolled Employee, and as beneficiaries of the Contract, acknowledge and agree to the terms, provisions, limitations and exclusions of the Contract.

MODIFICATION OF CONTRACT
We shall have the right to modify or amend the Contract from time to time. However, no modification or amendment will be effective until 30 days after written notice has been given to Members or to the Group, and modification must be uniform within the product line and at the
time of renewal. Exceptions to this modification provision for circumstances beyond Our control are further addressed in the Contract.

NO WAIVER
The failure or refusal of either party to demand strict performance of the Contract 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 Contract will be considered waived by Us unless such waiver is reduced to writing and signed by one of Our authorized officers.

NOTICES
Any notice to Members or to the Group required in the Contract will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Enrolled Employee or to the Group will be addressed to the Enrolled Employee or to the Group at the last known address appearing in Our records. If We receive a United States Postal Service change of address form (COA) for an Enrolled Employee, We will update Our records accordingly. Additionally, We may forward notice for an Enrolled Employee to the Group administrator if We become aware that We don't have a valid mailing address for the Enrolled Employee. Any notice to Us required in the Contract may be given by mail addressed to: Regence BlueCross BlueShield of Utah, P.O. Box 30272, Salt Lake City, UT 84130-0272; provided, however that any notice to Us will not be considered to have been given to and received by Us until physically received by Us.

PREMIUMS
Premiums are to be paid to Us by the Group, in advance, and on or before the premium due date. Failure by the Group to make timely payment of premiums may result in Our terminating the Group's or Member's coverage on the last day of the monthly period through which premiums are paid or such later date as is provided by Utah Code 31A-22-607 (or any successor thereto).

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION
The Group on behalf of itself and its Members expressly acknowledges its understanding that the Contract constitutes an agreement solely between the Group 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 Us to use the Blue Cross and Blue Shield Service Marks in the state of Utah and that We are not contracting as the agent of the Association. The Group on behalf of itself and its Members further acknowledges and agrees that it has not entered into the Contract 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 Group or the Members for any of Our obligations to the Group or the Members created under the Contract. 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 Contract.

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

WHEN BENEFITS ARE AVAILABLE
In order for health expenses to be covered under the Contract, 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 of the Contract;
- the person has enrolled in coverage and has been enrolled by Us; and
- premium for the person for the current month has been paid by the Group on a timely basis.
The expense of a service is incurred on the day the service is provided and the expense of a supply is incurred on the day the supply is delivered to You.
Definitions

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

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

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

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

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

**Booklet** is the description of the benefits for this coverage. The Booklet is part of the Contract between the employer Group and Us.

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

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

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

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

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

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

**Effective Date** means the date specified by Us, following Our receipt of the enrollment form, as the date coverage begins for You and/or Your dependents.

**Enrolled Dependent** means an Enrolled Employee's eligible dependent who is listed on the Enrolled Employee's completed enrollment form and who is enrolled under the Contract.

**Enrolled Employee** means an employee of the Group who is eligible under the terms of the Contract, has completed an enrollment form and is enrolled under this coverage.
Family means an Enrolled Employee and his or her Enrolled Dependents.

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

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

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

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

Investigational means a Health Intervention that We have classified as Investigational. We 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 Our judgment, Investigational:

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

Lifetime means the entire length of time a Member is covered under the Contract (which may include more than one coverage) through the Group with Us.

Member means an Enrolled Employee or an Enrolled Dependent.

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

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

Scientific Evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of a Health Intervention on Health Outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the Health Intervention and Health Outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.
NOTICE OF PROTECTION PROVIDED BY UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that Your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- **Life Insurance**
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values

- **Health Insurance**
  - $500,000 in hospital, medical and surgical insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in disability income insurance benefits
  - $500,000 in other types of health insurance benefits

- **Annuities**
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

**Note:** Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

**Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.**

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association’s website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City, UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City, UT 84114-6901
(801) 538-3800
A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.
For more information call us at 1 (888) 370-6159 or you can write to us at 2890 East Cottonwood Parkway, Salt Lake City, UT 84121

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