

UNIVERSITY OF UTAH  
EMPLOYEE HEALTH CARE PLAN

DENTAL OPTION - TYPE 1LN

SUMMARY PLAN DESCRIPTION

Claims Administrator:

Regence BlueCross BlueShield of Utah

2890 East Cottonwood Parkway  
Salt Lake City, Utah 84121-7035

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Salt Lake City, Utah 84130-0270

Plan Administrator:

University of Utah  
Benefits Department

420 Wakara Way, Suite 105  
Salt Lake City, Utah 84108

HANDY PHONE NUMBERS  
AND OTHER INFORMATION

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And visit the Regence BCBSU on the internet:	<a href="http://www.ut.regence.com">www.ut.regence.com</a>	

University of Utah Benefits  
Department

Phone (801) 581-7447  
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**Notice of Privacy Practices:** Regence BlueCross BlueShield of Utah has a Notice of Privacy Practices that is available by calling Customer Service or visiting the website listed above.

## HOW TO USE THIS SUMMARY PLAN DESCRIPTION

This University of Utah Employee Health Care Plan Dental Option Summary Plan Description describes the terms and benefits of coverage effective July 1, 2005, or the date after that on which Your coverage became effective. This Summary Plan Description replaces any dental benefit description or booklet previously issued by the Plan Administrator and makes it void.

The University of Utah Employee Health Care Plan Master Plan Document contains all the terms of coverage. Your Plan Administrator has a copy. If the Plan Document and this Summary Plan Description differ, the Plan Document will prevail.

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

As You read this Summary Plan Description, please keep in mind that references to "You" and "Your" refer to both the Plan Participant and Enrolled Dependents. The term "Family" refers to the Plan Participant and all individuals enrolled as his/her Eligible Dependents. The term "Claims Administrator" refers to Regence BlueCross BlueShield of Utah ("Regence BCBSU"). The term "Plan" refers to this Dental Option available as part of the University of Utah Employee Health Care Plan. "University" means the University of Utah whose employees may participate under this Plan. Other terms are defined in the DEFINITIONS Section at the back of this Summary Plan Description or where they are first used.

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

The University reserves the right to amend or terminate this Plan in whole or in part, at any time, regardless of Your or Your Enrolled Dependents' health or treatment status. Amendment or termination may result in modification or termination of Your coverage and/or the coverage of Your Enrolled Dependents. Covered Services and Eligible Dental Expenses incurred prior to the Plan's amendment or termination will be paid as provided under the terms of the Plan as it existed at the time they were incurred.

## UNDERSTANDING YOUR PLAN

This Plan is a dental benefit plan. The Plan pays benefits at a percentage of the Eligible Dental Expenses for Covered Services.

It is important for You to understand how the Plan works before You need dental services. Please read this material carefully. If You have any questions about benefits or procedures, please contact the Claims Administrator's Customer Service Department (see the handy phone numbers page located at the front of this Summary Plan Description or the Regence BCBSU website [www.ut.regence.com](http://www.ut.regence.com) for the phone number).

### PARTICIPATING DENTISTS

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The Plan will pay Participating Dentists directly for Covered Services. Participating Dentists have agreed to accept Eligible Dental Expenses as full compensation for Covered Services. Your share of Eligible Dental Expenses is any amount You must pay due to Coinsurance. You may be required to pay Your share at the time You receive care or treatment from a Participating Dentist.

**IT IS GENERALLY TO YOUR FINANCIAL ADVANTAGE TO USE PARTICIPATING DENTISTS. WHEN A PARTICIPATING DENTIST IS USED, YOU ARE RESPONSIBLE TO PAY ONLY COINSURANCE FOR COVERED SERVICES. WHEN NONPARTICIPATING DENTISTS ARE USED, YOU ARE RESPONSIBLE NOT ONLY FOR COINSURANCE FOR COVERED SERVICES, BUT ALSO FOR THE DIFFERENCE BETWEEN ELIGIBLE DENTAL EXPENSES AND THE BILLED CHARGES.**

Refer to the CONTRACT AND CLAIMS ADMINISTRATION Section for additional information about Participating Dentists.

### NONPARTICIPATING DENTISTS

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Before You will be entitled to payments under the Plan for Covered Services provided by a Nonparticipating Dentist, the Claims Administrator must receive all forms, information, statements, and certificates necessary or appropriate to process such claim. Most payments for Covered Services provided by a Nonparticipating Dentist will be made directly to You. You will be responsible to ensure that the Nonparticipating Dentist is paid in full. **Please note when Nonparticipating Dentist are used, You are responsible not only for any Coinsurance for Covered Services, but also for the difference between Eligible Dental Expenses and the Nonparticipating Dentist's billed charges.**

Refer to the CONTRACT AND CLAIMS ADMINISTRATION Section for additional information about Nonparticipating Dentists.

### BENEFITS AND LIMITATIONS

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Become familiar with the benefits, limitations and exclusions of Your Plan. Dentists may render or recommend care that may not be covered. Payment for these services will be Your responsibility.



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## SUMMARY OF DENTAL BENEFITS - DENTAL OPTION TYPE 1LN

This section is an outline of the benefits of the Plan. The sections following this SUMMARY OF BENEFITS describe the benefits and other terms of the Plan in detail. This Plan includes benefits for Participating and Nonparticipating Dentists.

NOTE: It is important to use Participating Dentists in order to receive the maximum benefit available under the Plan.

### Contract Year

All benefit limits, except those specified as Lifetime Maximums, accumulate on a Contract Year basis, beginning **July 1** and ending **June 30**.

### Maximum Benefits

<b>Preventive and Diagnostic, Basic and Prosthodontic Dental Services:</b> Per Claimant each Contract Year	<b>\$2,000</b>
<b>Orthodontic Dental Services:</b> Per Claimant Lifetime	<b>\$2,000</b>

### Contract Year Deductible

There is no Deductible for Dental Benefits.

### Percentage Plan Pays For Covered Services (Listed In The Following Paragraphs)

Benefits are paid as follows:

#### Participating Dentist

The Plan pays benefits for Covered Services of a Participating Dentist at the percentage listed. For Covered Services provided by a Participating Dentist, You pay only the Coinsurance.

#### Nonparticipating Dentist

The Plan pays Eligible Dental Expenses for Covered Services of a Nonparticipating Dentist at the percentage listed. For Covered Services provided by a Nonparticipating Dentist, in addition to the Coinsurance, **You pay the difference between Eligible Dental Expenses and billed charges (the "balance of billed charges")**.

NOTE: All payments for Covered Services as detailed in the following summary are based upon Eligible Dental Expenses, expressed as "EDE." EDE may differ based on the type of Provider rendering services and whether they are Participating or Nonparticipating with Regence BCBSU.

### Basic Dental Services

#### Participating Dentist

Plan pays 80% of EDE and You pay 20% of EDE.

#### Nonparticipating Dentist

Plan pays 80% of EDE and You pay balance of billed charges.

### Orthodontic Dental Services

#### Participating Dentist

Plan pays 50% of EDE and You pay 50% of EDE.

#### Nonparticipating Dentist

Plan pays 50% of EDE and You pay balance of billed charges.

### Preventive and Diagnostic Dental Services

#### Participating Dentist

Plan pays 80% of EDE and You pay 20% of EDE.

#### Nonparticipating Dentist

Plan pays 80% of EDE and You pay balance of billed charges.

### Prosthodontic Dental Services

#### Participating Dentist

Plan pays 50% of EDE and You pay 50% of EDE.

#### Nonparticipating Dentist

Plan pays 50% of EDE and You pay balance of billed charges.

## BENEFITS

This Plan is a traditional dental benefit plan. Under a traditional dental benefit plan, the Plan pays benefits at a percentage of the Eligible Dental Expenses for Covered Services.

The other key points about how the coverage under the Plan works, such as how Covered Services are paid are explained in the following sections.

### MAXIMUM BENEFITS

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The Plan pays a percentage of Eligible Dental Expenses up to the Maximum Benefit amount shown in the SUMMARY OF BENEFITS for each Claimant.

### PERCENTAGE PAID UNDER THE PLAN/COINSURANCE

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The Plan pays a percentage of the Eligible Dental Expenses for Covered Services You receive under the Plan, up to the maximum shown in the SUMMARY OF BENEFITS. See the DEFINITIONS Section for a detailed description of what is meant by Eligible Dental Expenses. When the Plan's payment is less than 100%, the remaining percentage is Your Coinsurance. The percentage the Plan pays varies, depending on the kind of service or supply and who rendered it. Refer to the SUMMARY OF BENEFITS for a description of percentages paid and cost-sharing.

Charges in excess of Eligible Dental Expenses are not reimbursable under the Plan. Participating Dentists will not charge You for any balances beyond any Coinsurance amount for Covered Services. Nonparticipating Dentists, however, may bill You for any balances over the Plan's payment level in addition to the Coinsurance amount. **Please note when Nonparticipating Dentists are used, You are responsible not only for the Coinsurance for Covered Services, but also for the difference between Eligible Dental Expenses and the Nonparticipating Dentist's billed charges.**

## COVERED DENTAL SERVICES

The following sections describe the Covered Services under the Plan.

Dental services are those required to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues or structures.

### BASIC DENTAL SERVICES

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- repair of dentures and bridges (must have a lapse of at least 6 months from the date of service);
- palliative emergency treatment;
- fillings consisting of silver amalgam, silicate, and plastic restorations (for other types of fillings such as gold foil, payment is limited to the amount that would have been paid for amalgam restorations);
- apicoectomy;
- extractions, including soft tissue, simple and surgical extraction of bone impacted teeth and general dental anesthesia administered in connection with Covered Dental Services;
- periodontic services which consist of surgical periodontic examinations, subgingival and gingival curettage, gingivectomy and gingivoplasty, osseous surgery including flap entry and closure, mucogingivoplastic surgery, management of acute infections and oral lesions; and
- endodontic services consisting of pulpotomy, pulp capping and root canal treatment.

### ORTHODONTIC DENTAL SERVICES

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

### PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

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- oral examinations limited to 2 per Claimant per Contract Year;
- dental x-rays as required, except that complete mouth x-rays are limited to 1 in a three-year period, unless special need is shown for more frequent complete mouth x-rays;
- topical fluoride application for Claimants under 26 years of age, limited to 2 treatments per Claimant per Contract Year;
- prophylaxis, including cleaning, scaling, and polishing, limited to 2 per Claimant per Contract Year;
- space maintainers; and

- sealants limited to once per tooth. Deciduous teeth only on the chewing surface of the first and second molars. Permanent teeth only on the chewing surface, excluding wisdom teeth.

## PROSTHODONTIC DENTAL SERVICES

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

## GENERAL LIMITATIONS AND EXCLUSIONS

The following are the limitations and exclusions from coverage under the Plan. Other limitations and exclusions may apply and, if so, will be described elsewhere in the Summary Plan Description.

### LIMITATIONS

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#### Optional Techniques

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

#### Transfer Of Care

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

### EXCLUSIONS

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

#### Aesthetic Services

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

#### Appliances And Restorations For Malalignment Of The Teeth

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

#### Automobile Personal Injury Protection Coverage

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

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

#### Benefits Not Stated

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

#### Charges That Exceed Eligible Dental Expenses

Any charge for services and supplies that exceed Eligible Dental Expenses.

### Cosmetic/Reconstructive Services And Supplies

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

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

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

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

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

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

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

### Dentist Practicing Beyond Scope Of License

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

### Expenses Incurred After Coverage Ends

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

### Expenses Incurred Before Coverage Begins

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

### Experimental Or Investigational Services

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

### Fees, Taxes, Interest, Etc.

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

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

#### Gold Foil Restoration

#### Military Service-Related Conditions

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

#### Orthodontic Appliances

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

#### Orthodontic Services

Orthodontic services to the extent that:

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

#### Orthognathic Surgery

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

#### Other Party Liability

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

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

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

#### Personal Comfort Items

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

#### Preparation Of Forms/Missed Appointments

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

Replacement Of Lost Or Stolen Dentures (full or partial)

Riot, Rebellion, War And Illegal Acts

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

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

Self-help, non-dental self-care, training, educational, or instructional programs unless specifically described as a benefit. This exclusion does not apply to services for training or educating a Claimant when incidentally provided, without separate charge, in connection with Covered Services.

Services And Supplies For Which No Charge Is Made Or No Charge Is Normally Made

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

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

Services And Supplies Otherwise Available From A Governmental Agency Or Program

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

Services And Supplies Provided By A Member Of Your Family

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

Services And Supplies Provided Outside Of Utah

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

Services, Supplies And Drugs Not Yet Approved By The FDA

Services, supplies or drugs which have not yet been approved by the United States Food and Drug Administration (FDA).

Temporary, Interim Restorations or Prosthodontics

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

Temporomandibular Joint (TMJ) Dysfunction Treatment

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

Travel And Transportation Expenses

Treatment, Procedures, Techniques Or Therapies Outside Accepted Health Care Practice

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

Visits Or Consultations That Are Not In Person

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

DISCLAIMER

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ANYTHING NOT SPECIFICALLY PROVIDED FOR IN THE PLAN IS NOT A COVERED BENEFIT.

## CLAIMS ADMINISTRATION

This section explains various matters having to do with administering benefits and/or claims, including situations that may arise in which Your dental care expenses are the responsibility of a source other than the Plan.

### HEALTH PLAN IDENTIFICATION CARD

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When You, the Plan Participant, enroll under the Plan administered by Regence BCBSU, You will receive a Health Plan Identification Card. It will include important information such as Your identification number, the Claims Administrator's Group numbers and Your name.

It is important to keep Your Health Plan Identification Card with You at all times. Be sure to present it to Your Dentist before receiving care.

If You lose Your card, or if it gets destroyed, You can get a new one by simply calling the Claims Administrator's Customer Service Department (see the handy phone numbers page located at the front of this Summary Plan Description or the Claims Administrator's website at [www.ut.regence.com](http://www.ut.regence.com)). If coverage under the Plan terminates, Your Health Plan Identification Card will no longer be valid.

### SUBMISSION OF CLAIMS AND REIMBURSEMENT

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The Plan has the sole right to decide whether to pay You, the Dentist, or You and the Dentist jointly.

#### Timely Filing Of Claims

To be filed timely, a claim must be received by the Claims Administrator within one year after the date the Covered Service to which the claim relates was provided to You. A claim that is not filed timely will be denied. You may appeal the denial in accordance with the Claimant Appeal process when You can demonstrate that the claim could not have been filed timely.

#### Participating Dentist Claims

When obtaining Covered Services from a Participating Dentist, Your identification card must be presented and You must furnish any additional information requested. The Participating Dentist will furnish to the Claims Administrator the necessary forms and information to process Your claim.

#### Participating Dentist Reimbursement

Participating Dentists have agreed to accept Eligible Dental Expenses as full compensation for Covered Services. Your share of Eligible Dental Expenses is Your Coinsurance amount. A Participating Dentist may require You to pay Your share at the time You receive care or treatment.

**NOTE: It is generally to Your financial advantage to use Participating Dentists. When a Participating Dentist is used, You are responsible to pay only Coinsurance for Covered Services.**

#### Nonparticipating Dentist Claims

Before You will be entitled to payments under the Plan for Covered Services provided by a Nonparticipating Dentist, You must furnish or cause to be furnished to the Claims Administrator with

respect to each such claim all forms, information, statements, and certificates necessary or appropriate to process such claim, including without limitation the following:

- claim information including Your name, age, sex, contract (identification) number, and the medical or other records necessary to establish the services provided, the reason for their provision, Your condition prior to and at the time of treatment, the medical necessity of the treatment, the efficiency and non-investigational status of the treatment, and similar facts and circumstances; and
- statements from the Nonparticipating Dentist itemizing the diagnosis, services provided to You, the date on which each such item was provided, and the charge for each such item. All statements furnished will be in such form and will contain such information as the Claims Administrator may require.

#### Nonparticipating Dentist Reimbursement

All payments for Covered Services provided by a Nonparticipating Dentist will be made directly to You, except that in the event payments are to be made for Covered Services provided by a Nonparticipating Dentist to a child who is an Enrolled Dependent but for whom the Plan Participant is not the custodial parent, such payments will be made to the Enrolled Dependent's custodial parent or state Medicaid agency who or which submitted the claim(s).

- Nonparticipating Dentists have not agreed to accept Eligible Dental Expenses as full compensation for Covered Services. Thus, You are responsible for paying any difference between Eligible Dental Expenses and the amount billed by the Nonparticipating Dentist in addition to any Coinsurance amount You must pay.

**NOTE: When Nonparticipating Dentists are used, You are responsible not only for Coinsurance for Covered Services, but also for the difference between Eligible Dental Expenses and the Nonparticipating Dentist's billed charges.**

Nothing contained in the Plan will be construed to restrict You in exercising full freedom of choice in the selection of a Dentist for dental care or treatment.

Claims Procedures

The following time frames will be followed as required by the Department of Labor:

For The Following Type of Claim*...	You Must File a Claim Within...	The Claims Administrator must respond within...	
	Initial Claim**	Initial Claim**	Extension Claim***
Pre-service	NA	15 days	30 days
Urgent care	NA	72 hours	NA
Concurrent care	NA	Within a timeframe that provides sufficient opportunity to Appeal in cases of Pre-service care or within 24 hours when related to urgent care	
Post-service	See above Timely Filing of Claims provision	30 days	45 days

\* Definitions are provided in the Appeal Process Section of the Plan

\*\* In the case of urgent and Pre-service care, the initial claim refers to the initial request for services when an actual claim may not be filed.

\*\*\* For Pre-service and Post-service claims, the Claims Administrator may request a one time extension and pend the claim until all the information is received. If the information is provided within 45 days, the Claims Administrator will provide determination within 15 days after the information is received.

NONASSIGNMENT

Only You are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else and You (or a custodial parent or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits or payments to any person, corporation or entity. Any attempted assignment, transfer or delegation of benefits will be deemed null and void and will not be binding on the Claims Administrator. 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 for any reason the Plan pays any amount to or on behalf of You: 1) for services, supplies or accommodations not covered under the Plan; 2) with respect to a person who is not covered under the Plan; 3) which exceed amounts to be paid as benefits under the Plan; 4) as duplicate payments; 5) for payment received from the Plan for the treatment of an Injury or Illness where another person, entity, firm or corporation is legally responsible for payment of Your treatment, then You agree to reimburse the Plan on demand for any and all such amounts. Such demand will be made within 3 years after the date of loss (except in the case of third party responsibility, the Plan will have 3 years from the discovery of the payment to You or on Your behalf by the third party through contract, settlement, judgment or any other means, to make such demand). You also agree to pay the Claims Administrator, on behalf of the Plan, interest at 18% per annum until such debt is paid in full, which will begin accruing the date the demand for reimbursement is made. In the event the Plan uses 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. In the event You do not make payment, the Plan may also withhold future benefits to offset the amount owing to the Plan.

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

This Claims Recovery provision in no way reduces the Plan's right to reimbursement or subrogation. Refer to the Other Party Liability provision in the CLAIMS ADMINISTRATION Section for additional information.

## RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND DENTAL RECORDS

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It is important to understand that health information about You may be requested or disclosed by the Claims Administrator. The information requested or disclosed 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 a:

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

Health information requested or disclosed by the Claims Administrator may include, but is not limited to claim records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

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

## REPLACING EARLIER PLAN

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If this Dental Option replaces a plan previously issued by the University, benefits furnished under the previous plan will apply against the benefit maximums of this Plan as though such benefits had been furnished under this Plan.

## LIMITATIONS ON LIABILITY

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In all cases, You have the exclusive right to choose a dental care provider. The Plan is not responsible for the quality of dental care You receive, since all those who provide care do so as independent contractors. Since the Plan does not provide any dental care services, the Plan 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 employees nor agents of the Plan.

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

## OTHER PARTY LIABILITY

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The Plan does not provide benefits for any medical, prescription drug or time loss expenses resulting from an Injury or Illness, if the costs associated with the Injury or Illness may be recoverable from: 1) a third party; 2) worker's compensation; or 3) any other source, including but not limited to first party payer payments for any automobile personal injury protection or medical payments and uninsured or underinsured motorist coverage. The Plan may choose, at its discretion, reimbursement or subrogation as a means to recovery.

### Recovery Rights

If You have a potential right of recovery for an Injury or Illness for which a third party may have legal responsibility, the Plan may advance benefits pending the resolution of the claim upon the following conditions:

- By accepting or claiming benefits, You agree that the Claims Administrator, on behalf of the Plan, is entitled to reimbursement of the full amount of benefits that the Plan has paid, out of any settlement or recovery from any source, including judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which the Plan has provided benefits.
- This right applies without regard to the characterization as payment for medical expenses or other designation of the recovery by You and/or any third party or the recovery source. The Plan's right to reimbursement, however, will not exceed the amount of recovery.

### Documents

The Claims Administrator, on behalf of the Plan, may require You to sign and deliver all legal papers and take any other actions the Claims Administrator may ask to secure the Plan's rights (including an assignment of rights for the Plan to pursue Your claim if You fail to pursue the claim Yourself). If the Claims Administrator asks You to sign a trust agreement or other document to reimburse the Plan from the proceeds of any recovery, You may be required to do so as a condition for the advancement of any benefits. If benefits were paid before the agreement is signed, You agree to reimburse the Plan for such paid benefits upon recovery in any form from or on behalf of a third party.

### Agreement

You agree that You will do nothing to prejudice the Plan's rights and will cooperate fully with the Claims Administrator, on behalf of the Plan, including signing any documents and providing prompt notice of any settlement. You are obligated to notify the Claims Administrator as follows:

- When a lawsuit is filed which involves the event which gave rise to the claims You make or will make; or
- When negotiations commence with any party which relate in any way to the claims You make or will make, including notice of when, where and with whom such negotiations will take place; or
- No less than 21 business days before any settlement is negotiated; or
- No less than 5 business days before payment of any kind will be issued to the benefit of or on behalf of, You, from any third party, which is related to the event which gave rise to the claims You make or will make.

You acknowledge that the Claims Administrator is authorized, but not obligated to recover directly from any third party, any benefits paid from any party liable to You upon mailing of a written notice to the potential payer and You or Your representative.

### Expenses

The Plan is entitled to reimbursement from the first dollars received from any recovery. The Plan is not liable for any expenses or fees incurred by You in connection with obtaining a recovery. You, however, may request that the Plan pay a proportional share of attorney's fees and costs at the time of any settlement or recovery or to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid by the Plan.

Advancement of payment for otherwise excluded benefits or review of a request for attorney fees are conditioned upon the retention by Your attorney of funds sufficient to satisfy the Plan's asserted lien in a client trust account, until such lien is satisfied or released. In the event that You and/or Your agent or attorney fail to comply with the terms of these provisions, the Claims Administrator may recover any benefits advanced for any Injury or Illness resulting from the action or omission of a third party through legal action or offsetting of any future benefits owing You or any other individual whose eligibility is established through the same Plan Participant.

Please contact the Claims Administrator or the Plan to obtain third party reimbursement forms and to obtain additional information.

## COORDINATION OF BENEFITS

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In the event You are covered under one or more Health and/or Dental Plans (as defined below), the benefits of the Health and/or Dental Plans will be coordinated in accordance with the following provisions:

### Definitions

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

Health and/or Dental Plan means this coverage and any other similar plan, contract, or policy which has at least one benefit in common with this coverage and which provides benefits for or by reason of care or treatment of an Illness or Injury by or through any of the following:

- group, blanket, individual or franchise insurance or prepayment coverage;
- labor-management trust plan, union welfare plan or employer or employee organization benefit plan coverage;
- trade, professional or cooperative association plan coverage, or any other similar plan that arranges or pays for health benefits;
- group, group type, and individual automobile "no-fault" medical payment coverage in excess of the minimum statutory personal injury protection limit in Utah Code 31A-22-306 through 309 (or any successor thereto or any applicable analogous limit);
- federal, state or other governmental employer or employee (statutory or nonstatutory) plan coverage, including Medicare, or services rendered in a federal hospital or by the Veterans Administration; and
- health maintenance organization coverage.

Health and/or Dental Plan does not include:

- hospital indemnity coverage;
- accident-only coverage, specified disease or specified accident coverage;
- disability income protection coverage;

- nursing home and long-term care coverage;
- any state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time);
- any plan when, by state or federal law, its benefits are excess to those of any private insurance program or other non-governmental program; and
- Medicare supplement policies as defined in Utah Code Title 31A, Chapter 22, Section 620 or any successor thereto.

Primary Health and/or Dental Plan means the Health and/or Dental Plan that must determine its benefits for a person's health care first. There may be more than one Primary Health and/or Dental Plan. A Health and/or Dental Plan is a Primary Health and/or Dental Plan in either of the following conditions:

- the Health and/or Dental Plan has no Order of Benefit Determination provision (see below); or
- all Health and/or Dental Plans which cover the person use the Order of Benefit Determination provision (see below) and under that provision the Health and/or Dental Plan determines its benefits first.

Secondary Health and/or Dental Plan means a Health and/or Dental Plan which is not a Primary Health and/or Dental Plan. There may be more than one Secondary Health and/or Dental Plan. In the event a person is covered under more than one Secondary Health and/or Dental Plan, the "Order of Benefit Determination" provision (see below) decides the order in which the Secondary Health and/or Dental Plans' benefits are determined in relation to each other.

Allowable Expenses means the amount on which a Health and/or Dental Plan would base its benefit payment for Covered Services in the absence of any other coverage. When a Health and/or Dental Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

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

#### Order Of Benefit Determination

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

- The Health and/or Dental Plan which covers the person as the policyholder or certificate holder (that is, a person other than a dependent) will be determined before the benefits of the Health and/or Dental Plan which covers the person as a dependent;
- When this and another Health and/or Dental Plan cover the same child as a dependent of parents who are not separated or divorced (including parents who are living together):
  - The benefits of the Health and/or Dental Plan of the parent whose birthday falls earlier in the Calendar Year are determined before those of the parent whose birthday falls later in that year; and
  - If both parents have the same birthday, the benefits of the Health and/or Dental Plan which covered the parent longer are determined before those of the Health and/or Dental Plan which covered the other parent for a shorter period of time.
- When this and another Health and/or Dental Plan cover the same child as a dependent of parents who are separated, divorced, or not living together:

- The benefits of the Health and/or Dental Plan which covers the child as a dependent of the parent with custody of the child will be determined first, then the benefits of a Health and/or Dental Plan which covers that child as a dependent of the current spouse of the parent with custody of the child, then the benefits of the Health and/or Dental Plan which covers the child as a dependent of the parent without custody, then the benefits of the Health and/or Dental Plan which covers the child as a dependent of the spouse of the parent without custody;
- Notwithstanding the preceding paragraph, if there is a court decree which would otherwise establish financial responsibility for the child's medical, dental, or other health care or health insurance expenses and the Health and/or Dental Plan of that parent has actual knowledge of those terms, the benefits of that Health and/or Dental Plan will be determined before the benefits of any other Health and/or Dental Plan which covers the child as a dependent child. If the parent with financial responsibility has no coverage for the child's medical, dental, or other health care expenses, but that parent's spouse does, the benefits of the spouse's Health and/or Dental Plan will be determined before the benefits of any other Health and/or Dental Plan which covers the child as a dependent child. This paragraph does not apply with respect to benefits which are paid or provided before the entity has actual knowledge;
- If the specific terms of a court decree state that the parents have joint custody, without stating that one of the parents is responsible for the health care expenses or health insurance coverage of the child and the child's residency is split between the parents, the order of benefit determination outlined in the paragraph above for a child as a dependent of parents who are not separated or divorced will apply. This paragraph does not apply with respect to benefits which are paid or provided before the entity has actual knowledge.
- The benefits of a Health and/or Dental Plan which covers a person as an active employee, member or subscriber are determined before those of a Health and/or Dental Plan which covers that person as an inactive employee, member or subscriber. If the other Health and/or Dental Plan does not have this rule, and if, as a result, the Health and/or Dental Plans do not agree on the order of benefits, this provision is ignored. The period of time a person has been covered by a Health and/or Dental Plan shall be calculated in accordance with the Utah Administrative Code R590-131-4.B.5. or any successor thereto.
- When none of the paragraphs above establish an order of benefit determination, the benefits of the Health and/or Dental Plan which has covered the person for the longer period of time will be determined before the benefits of the Health and/or Dental Plan which has covered the person for a shorter period of time.

#### Primary Health and/or Dental Plan Benefits

When, in accordance with the Order of Benefit Determination, this coverage is the Primary Health and/or Dental Plan, the Plan will pay the benefits of this Health and/or Dental Plan as if no other Health and/or Dental Plan exists.

#### Secondary Health and/or Dental Plan Benefits

This provision applies when, in accordance with the Order of Benefit Determination (see above), this coverage is a Secondary Health and/or Dental Plan. In that event, the benefits of this Health and/or Dental Plan may be reduced.

- When either this Health and/or Dental Plan or the Primary Health and/or Dental Plan has contracted for discounted provider fees, the Plan will limit payment to any Copayment and Deductible owed by You after payment by the Primary Health and/or Dental Plan.

- If none of the Health and/or Dental Plans has contracted for discounted provider fees, the Plan will reduce benefits so that the total benefits paid or provided by all Health and/or Dental Plans for a Covered Service are not more than the highest Allowable Expense of any of the Health and/or Dental Plans for that service.

If this Health and/or Dental Plan is the Secondary Health and/or Dental Plan according to the Order of Benefit Determination (see above), the Plan will calculate the benefits that the Plan would pay if this was the Primary Health and/or Dental Plan and apply that payable amount to unpaid covered charges owed by You after the Primary Health and/or Dental Plan's payment, including any Deductibles, Coinsurance, and Copayments You owe after the Primary Health and/or Dental Plan's payment. Deductibles, Coinsurance, and Copayments under this Health and/or Dental Plan will be used in the calculation of the benefits that the Plan would pay if this was the Primary Health and/or Dental Plan, but shall not be applied to the unpaid covered charges owed by You after the Primary Health and/or Dental Plan's payment. **Nothing contained in this Coordination of Benefits provision requires the Plan to make payment for all or part of any service that is not covered under the Plan.**

If this Health and/or Dental Plan is the Secondary Health and/or Dental Plan according to the Order of Benefit Determination (see above) and another Health and/or Dental Plan claims to be "always secondary" or uses order of benefit determination rules inconsistent with those above, this Health and/or Dental Plan shall pay its benefits first, but the amount paid shall be calculated as if this Health and/or Dental Plan is a Secondary Health and/or Dental Plan. If the other Health and/or Dental Plan does not provide the Claims Administrator with the information necessary for the Claims Administrator to determine Secondary Health Benefits within a reasonable time after the Claims Administrator's request, the Plan shall assume its benefits are identical to the other plans' and pay Secondary Health and/or Dental Plan Benefits accordingly, subject to adjustment upon receipt of the information requested from the other Health and/or Dental Plan.

#### Benefits For Participants Eligible For Medicare

If You, the Plan Participant, are eligible for Medicare benefits, whether or not You have actually applied for such Medicare benefits, the following rules apply:

The Plan is the primary payer—in other words, Your claims are paid by the Plan first—if:

- You are currently working for University; or
- You are entitled to Medicare benefits because You have end-stage renal disease (ESRD). The Plan is the primary payer for the first 30 months You are eligible for Medicare due to ESRD; at the end of the 30-month period, Medicare will be the primary payer.

The Plan is not the primary payer even though You are entitled for Medicare benefits because You have ESRD if:

- You became entitled to Medicare benefits on the basis of age or disability prior to becoming entitled to Medicare on the basis of ESRD; and
- The Plan is already permissibly paying secondary because You are not covered by virtue of current employment status.

The Plan pays secondary and Medicare is the primary payer if You do not have ESRD and You are not currently working.

If You are over age 65 (and still employed by the University) and the Plan would otherwise be the primary payer, You may elect Medicare as the primary payer of benefits; if You do, benefits under the Plan will terminate.

If Your dependent is eligible for Medicare benefits, whether or not he or she has actually applied for such Medicare benefits, the following rules apply:

The Plan is the primary payer—in other words, Your claims are paid by the Plan first—if:

- You are currently working for the University; or
- Your dependent is entitled for Medicare benefits because Your dependent has end-stage renal disease (ESRD). The Plan is the primary payer for the first 30 months Your dependent is eligible for Medicare due to ESRD; at the end of the 30-month period, Medicare will be the primary payer.

The Plan is not the primary payer even though Your dependent is entitled to Medicare benefits because of ESRD if:

- Your dependent became entitled to Medicare benefits on the basis of age or disability prior to becoming entitled to Medicare on the basis of ESRD; and
- The Plan is already permissibly paying secondary because Your dependent is not covered by virtue of Your current employment status.

The Plan pays secondary and Medicare is the primary payer if Your dependent does not have ESRD and You are not currently working.

If Your dependent is over age 65 (and You are still employed by the University) and the Plan would otherwise be the primary payer, Your dependent may elect Medicare as the primary payer of benefits; if he or she does, benefits under the Plan will terminate.

#### No Expansion Of Benefits

In no event will this Coordination of Benefits provision operate to increase the total benefits that would be provided under the Plan in the absence of this provision.

#### Recovery Of Overpayment

In the event the Plan provides benefits to or on behalf of You in excess of the amount which would have been payable hereunder by reason of Your coverage under another Health and/or Dental Plan, the Plan will be entitled to recover 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 18 months of the overpayment, unless reversal is necessitated by fraudulent acts, fraudulent statements, or material misrepresentations by You. The Plan will be entitled to recover the amount of such excess made by the reversal of payment from You and You agree to reimburse the Claims Administrator, on behalf of the Plan, on demand for any and all such amounts. You also agree to pay the Plan interest at 18% per annum until such debt is paid in full, which will begin accruing the date the demand for reimbursement is made. In the event the Plan uses 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. In the event You do not make payment to the Claims Administrator, the Plan may withhold future benefits to offset the amount owing. The Plan is responsible to see that proper adjustments between insurers and providers are made;
- from Providers, if payment was made to them. Recovery would be by reversal of payments and be limited to a period within 36 months of the overpayment, unless the overpayment is the result of fraudulent acts, fraudulent statements, or material misrepresentations by You (including failing to notify the Plan of an ineligible dependent), then amounts may be recovered from You. The Plan is responsible to see that proper adjustments between insurers and Providers are made;
- from the other Health and/or Dental Plan or an insurer; or

- from other organizations.

#### Information

You will promptly furnish or cause to be furnished to the Claims Administrator any information necessary or appropriate for administration of the provisions of this Coordination of Benefits provision. Receipt of such information by the Claims Administrator will be a condition precedent to the Claims Administrator's obligation to provide benefits under the Plan.

#### Payments

- In administering and accomplishing the provisions of this Coordination of Benefits provision, the Plan will have the absolute right to: 1) make and recover any payments to or from You, a Provider of Covered Services, and/or any Health and/or Dental Plan; and 2) to release any information which the Plan deems appropriate in connection therewith, as long as the release complies with the Privacy Notice provisions of the Plan.
- A payment made under another Health and/or Dental Plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the Health and/or Dental Plan which made that payment. That amount will then be treated as though it were a benefit paid under the Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

## APPEAL PROCESS

This section describes the Appeal Process in the event You or Your Representative have a complaint or grievance regarding a claim denial or other action by the Claims Administrator under this Plan and wish to have it reviewed. A request for Appeal must be submitted to the Claims Administrator within 180 days of the claim denial or other action giving rise to the complaint or grievance. Failure to Appeal within this time period will preclude all further rights to Appeal.

NOTE: In the event You or Your Representative reasonably believes that a utilization management decision denying preauthorization of a Pre-service 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, You or Your Representative may request an Expedited Appeal. Expedited review will also be granted to requests concerning admissions, continued stay, or other health care services for a Claimant who has received emergency care and has not been discharged from a facility. For procedures, see "Expedited Appeals" below.

## APPEALS

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### First Level - Complaint/Grievance/Reconsideration

You may initiate an Appeal through either a written or oral request. Written Appeal requests should be mailed to: Benefits Administration, Regence BlueCross BlueShield of Utah, PO Box 30270, Salt Lake City, Utah 84130-0270. Oral requests can be made by calling the Claims Administrator at (801) 333-2110 within the Salt Lake area or (866) 849-6956 outside the Salt Lake area. Within 5 working days or 7 calendar days, whichever is sooner, of the receipt of request for an Appeal, Benefits Administration will send an acknowledgement of the request for Appeal and information describing the entire Appeal Process and Your rights. "First Level - Complaint/Grievance/Reconsideration" is a review by a Benefits Administration Representative who was not involved in the initial decision. In the case of an Appeal involving a decision requiring medical judgment, the Benefits Administration Representative will consult with one of the Claims Administrator's Medical Directors prior to rendering a decision. For Appeals involving a Post-service investigational or experimental issue, a written notice of the decision will be sent within 20 working days (or 30 calendar days, if sooner) of the receipt of the "First Level - Complaint/Grievance/Reconsideration" and within 5 working days of the decision being made. For all other Post-service Appeals, a written notice of the decision will be sent within 30 days of receipt of the "First Level - Complaint/Grievance/Reconsideration" and within 5 working days of the decision being made. If Your Provider requests reconsideration of a denial of preauthorization, a peer-to-peer discussion with one of the Claims Administrator's Medical Directors will be arranged within 1 working day of the request. For Appeals involving a Pre-service preauthorization of a procedure including a Pre-service investigational procedure, a written notice of the decision will be sent within 14 days of receipt of the "First Level - Complaint/Grievance/Reconsideration" and within 5 working days of the decision being made.

### Second Level - Internal Appeal

If You disagree with the decision made in the "First Level - Complaint/Grievance/Reconsideration," You may request further Appeal to the "Second Level - Internal Appeal." The Appeal request must be made in writing or orally within 180 days after You receive notice of the decision at the "First Level - Complaint/Grievance/Reconsideration". Failure to request a "Second Level - Internal Appeal" within this

time period will preclude Your right to further internal Appeal of the decision. The written Appeal request, including any additional information or comments, must be made to the Appeal Coordinator, Regence BlueCross BlueShield of Utah, PO Box 30270, Salt Lake City, Utah 84130-0270. Oral requests can be made by calling the Claims Administrator at (801) 333-2110 within the Salt Lake area or (866) 849-6956 outside the Salt Lake area. Within 5 working days or 7 calendar days, whichever is sooner, of the receipt of the request for "Second Level - Internal Appeal," the Appeal Coordinator will send information describing the entire Appeal Process and Your rights. "Second Level - Internal Appeal" is a review by a Panel comprised of the Appeal Coordinator, one of the Claims Administrator's Medical Directors and another of the Claims Administrator's officers none of whom were 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 Appeals involving a Post-service investigational or experimental issue, a written notice of the decision will be sent within 20 working days (or 30 calendar days if sooner) of receipt of the "Second Level - Internal Appeal" and within 5 working days of the decision being made. For all other Post-service Appeals a written notice of the decision will be sent within 30 days of receipt of the "Second Level - Internal Appeal" and within 5 working days of the decision being made. For Appeals involving a Pre-service preauthorization of a procedure including a Pre-service investigational procedure, a written notice of the decision will be sent within 14 days of receipt of the "Second Level - Internal Appeal" and within 5 working days of the decision being made.

## OPTIONAL APPEALS

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

### Optional External Appeal (Medical Necessity Issues Only)

If You disagree with the decision made in the "Second Level - Internal Appeal" (or if You disagree with the decision made in a "First Level - Expedited Appeal" (described below), but preauthorization could no longer be reasonably believed to be clinically urgent (e.g., the service has been provided)), and the issue on Appeal is the Medical Necessity of services or services that are investigational or experimental in nature, You may request further Appeal to the "Optional External Appeal." The Appeal request must be made in writing or orally within 180 days after You receive notice of the decision at the "Second Level - Internal Appeal." Failure to request an "Optional External Appeal" within this time period will preclude the Claimant's right to further appeal of the decision through this optional level. The written Appeal request, including any additional information or comments must be made to the Appeal Coordinator, Regence BlueCross BlueShield of Utah, PO Box 30270, Salt Lake City, Utah 84130-0270. Oral requests can be made by calling the Claims Administrator at (801) 333-2110 within the Salt Lake area or (866) 849-6956 outside the Salt Lake area. "Optional External Appeal" will be coordinated by the Appeal Coordinator while the decision is made by an Independent Review Organization (IRO) at no cost to You. The IRO is an independent physician review organization that is unbiased, independent and not controlled by the Claims Administrator or the Plan. Within the IRO, there will be clinical expertise, use of evidence-based decision making, maintenance of confidentiality, and adequate administration and training capacity. Within 5 days of receipt of the request for a "Optional External Appeal," the Appeal Coordinator will determine if the Appeal concerns Medical Necessity and send information describing the

entire Appeal process and Your rights. If the Appeal Coordinator determines the Appeal concerns Medical Necessity, he or she will provide the IRO with the Appeal documentation within 3 working days and a written notice of the IRO's decision will be sent to You within 30 days of receipt of the request for "Optional External Appeal." Choosing the "Optional External Appeal" for the settlement of an Appeal as the final level will be binding in accordance with the IRO's decision and this section.

-OR-

#### Optional Arbitration

Voluntary arbitration is available as a level of Appeal for a dispute You have with the Plan. All other (non-optional) levels of this Appeal Process must be exhausted before arbitration is available. Choosing arbitration as the final level for the settlement of such disputes will be binding in accordance with the Arbitration provision of this section. The Appeal Coordinator can assist You with procedures for initiating and participating in an arbitration.

### EXPEDITED APPEALS

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#### First Level - Expedited Appeal

If You or Your Representative reasonably believes that a utilization management decision denying preauthorization of a Pre-service 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, You or Your Representative may request an Expedited Appeal. Expedited review also will be granted to requests concerning admissions, continued stay, or other health care services for a Claimant who has received emergency care and has not been discharged from a facility. The Appeal request must be made orally or in writing within 180 days after You receive notice of the initial written preauthorization denial, state the need for a decision on an expedited basis, and include documentation necessary for the Appeal decision. Oral requests can be made by calling the Claims Administrator at (801) 333-2110 within the Salt Lake area or (866) 849-6956 outside the Salt Lake area. The Appeal request, including any additional information or comments, must be made to the Appeal Coordinator, Regence BlueCross BlueShield of Utah, PO Box 30270, Salt Lake City, Utah 84130-0270. The "First Level - Expedited Appeal" is a review by a Panel comprised of the Appeal Coordinator, one of the Claims Administrator's Medical Directors and another of the Claims Administrator's officers none of whom were involved in, or subordinate to anyone involved in, the initial denial. You or Your Representative, on Your behalf, will be given the opportunity, within the constraints of the Expedited Appeals timeframe, to participate via telephone and/or provide written materials. A verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the request for "First Level - Expedited Appeal," and a written notice of the decision will be provided within 1 working day of providing the verbal notification.

### OPTIONAL EXPEDITED APPEALS

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

services or services are not investigational or experimental in nature, You may submit Your Appeal to "Optional Arbitration."

Optional Expedited Appeal (Medical Necessity Issues Only)

If You disagree with the decision made in the "First Level - Expedited Appeal" and You or Your Representative reasonably believe that preauthorization remains clinically urgent (Pre-service), and the issue on Appeal is the Medical Necessity of services or services that are investigational or experimental in nature You may request further Appeal to the "Optional Expedited Appeal." The Appeal request must be made verbally or in writing within 180 days after You receive either the verbal or written notice of the decision at the "First Level - Expedited Appeal." Failure to request an "Optional Expedited Appeal" within this time period will preclude the Claimant's right to further appeal of the decision through this optional level. If the request is received by the Claims Administrator orally, the Claims Administrator will send written confirmation to You verifying the oral notice within 24 hours after receiving the oral notice. Oral requests can be made by calling the Claims Administrator at (801) 333-2110 within the Salt Lake area or (866) 849-6956 outside the Salt Lake area. The Appeal request, including any additional information or comments must be made to the Appeal Coordinator, Regence BlueCross BlueShield of Utah, PO Box 30270, Salt Lake City, Utah 84130-0270. An "Optional Second Level - Expedited Appeal" will be coordinated by the Appeal Coordinator while the decision is made by an Independent Review Organization (IRO) at no cost to You. Within the IRO, there will be clinical expertise, use of evidence-based decision making, maintenance of confidentiality, and adequate administration and training capacity. Immediately upon receipt of the request for a "Optional Expedited Appeal," the Appeal Coordinator will determine if the Appeal concerns Medical Necessity and, if he or she determines that it does, provide the IRO with the Appeal documentation. A verbal notice of the decision will be provided by the IRO to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the request for "Optional Expedited Appeal," whichever is sooner, and a written notice will be provided by the IRO within 2 working days of providing the verbal notification. Choosing the "Optional External Appeal" as the final level for the settlement of an Appeal based on Medical Necessity will be binding in accordance with the IRO's decision and this section.

-OR-

Optional Expedited Arbitration

Voluntary arbitration is available as a level of Appeal for a dispute You have with the Plan. All other (non-optional) levels of this Appeal Process must be exhausted before arbitration is available. Choosing arbitration as the final level for the settlement of such disputes will be binding in accordance with the Arbitration provision of this section. The Appeal Coordinator can assist You with procedures for initiating and participating in an arbitration.

ARBITRATION (IF OPTED)

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In the event of any dispute or controversy concerning the construction, interpretation, performance or breach of the Plan arising between You, Your heir-at-law or Your Representative, and the Plan, whether involving a claim in tort, contract or otherwise, the same may be submitted, if opted by You as the final level of Appeal, to arbitration under the appropriate rules of the American Arbitration Association, a copy of which is available upon request from the Claims Administrator or the local office of the American Arbitration Association. All administrative remedies described in this Plan must be exhausted prior to the demand for arbitration. The costs of arbitration, including reasonable filing fees, administrative fees and arbitrator fees, will be borne by the Claims Administrator. Other expenses of arbitration (including but not limited to attorney fees, expenses of discovery, witnesses, stenographers, translators, and similar

expenses) will be borne by the party incurring those expenses. The parties agree that the arbitrator's award will be binding, may include attorney's fees if allowed by state law, and may be enforced in any court having jurisdiction thereof by filing a petition for enforcement of said award. Any arbitration will be conducted in Utah, as required by state law.

## DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

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Appeal means a written or oral request from You or, if authorized by You, Your Representative, to change a previous decision made by the Plan or the Claims Administrator concerning:

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

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision maker for Optional External Appeals and Optional Expedited External Appeals, through an independent contractor relationship with the Claims Administrator.

Medical Director means for purposes of the Appeal Process only, a physician employed by, or consulted by, the Claims Administrator. (The Medical Director shall 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 this Plan that is not considered Pre-service.

Pre-service means any claim for benefits under this Plan which the Claims Administrator must approve in advance, in whole or in part, in order for payment of the benefits to be made.

Representative means any representative authorized by You, as designated in writing by You or Your legal guardian on an executed Authorization Form. No Authorization Form is required from the parent(s) or legal guardian of a Claimant who is an unmarried and dependent child and is less than 13 years old. For Expedited Appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative, and no Authorization Form need be executed. Even if You have previously designated a person as Your Representative for a previous matter, an Authorization Form designating that person as Your Representative in a new matter will be required (but redesignation is not required for each Appeal level).

## WHO IS ELIGIBLE

This section contains the terms of eligibility under the Plan.

PLEASE NOTE: In the following sections starting with WHO IS ELIGIBLE through WHEN COVERAGE ENDS, the terms "You" and "Your" mean the Plan Participant only.

### EMPLOYEES

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You become eligible for coverage on the first day of the month following the date You are hired by the University in a benefit-eligible position, or on the first day of the month following the date You are transferred into a benefit-eligible position from an ineligible position. If Your date of hire/transfer is the first day of the month, You are eligible for coverage on that day.

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

### DEPENDENTS

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

- the person to whom You are legally married (spouse);
- Your (or Your spouse's) unmarried children by birth, placement for legal adoption or foster care, or legal (court-appointed) guardianship granting full guardianship rights, who are under age 26 and dependent on You for more than 50% of their support, as "support" is defined in the United States Internal Revenue Regulations (see NOTE below);
- a child who is under 18 years of age for whom the noncustodial parent is required by a court order or administrative order to provide health coverage, whether or not the custodial parent is a Plan Participant and whether or not the noncustodial parent, who is eligible for this coverage, has enrolled hereunder. If You are not already enrolled in coverage, upon receipt of a court order, You will automatically be enrolled in the same coverage as the child; and
- a child, as described in the third bullet above, who is any age and incapacitated from earning a living and without sufficient means for whom the noncustodial parent is required by a court order or administrative order to provide health coverage, whether or not the custodial parent is a Plan Participant and whether or not the noncustodial parent, who is eligible for this coverage, has enrolled hereunder. If You are not already enrolled in coverage, upon receipt of a court order, You will automatically be enrolled in the same coverage as the child.

NOTE: "Support" as used above includes food, shelter, clothing, medical and dental care, education, and the like. Generally, the amount of an item of support will be the amount of expense incurred by the one furnishing such item. If the item of support furnished an individual is in the form of property or lodging, it will be necessary to measure the amount of such item of support in terms of its fair market value. In computing the amount which is contributed for the support of an individual, there must be included any amount which is contributed by such individual for his own support, including income which is ordinarily excludable from gross income, such as benefits received under the Social Security Act. [Internal Revenue Regulation §1.152-1]

### Dependent Coverage Continuing Beyond Limiting Age

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

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

### RETIREES

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

### SURVIVING SPOUSE

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

## HOW TO ENROLL AND WHEN COVERAGE BEGINS

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

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

### WHEN YOU AND YOUR DEPENDENTS ARE INITIALLY ELIGIBLE

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Upon first becoming eligible for coverage at the University, You may enroll Yourself and Your Eligible Dependents by submitting Your completed enrollment forms to the University's Benefits Department within 3 months of Your date of hire or the date You transfer into a benefit-eligible position (if You transferred from an ineligible position). You must enroll in one of the University of Utah Employee Health Care Plan medical options to enroll in this Plan.

### NEWLY ELIGIBLE DEPENDENTS

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If You acquire a new dependent by marriage, birth or placement for adoption, You may enroll Yourself, the new dependent, and any other Eligible Dependents not already enrolled in the Employee Health Care Plan by completing and submitting to the University's Benefits Department a signed Health Care Coverage Change Form within 3 months of the date the dependent becomes eligible. If You are already enrolled in the Employee Health Care Plan, the new dependent and any other Eligible Dependents You wish to add will be added to Your existing medical and dental coverage. Upon acceptance of Your properly completed change form, coverage for Your dependent will be effective retroactive to the date the dependent gained eligibility or, at Your request, coverage may be effective on the date the University's Benefits Department accepts Your completed change form. If the change form is not submitted to the University's Benefits Department within 3 months of the date the dependent gains eligibility, You may add the dependent to Your coverage only during the Plan's future Open Enrollment Periods, if any.

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

### SPECIAL ENROLLMENT

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There are certain situations when You may enroll Yourself and/or Your Eligible Dependents in the University of Utah Employee Health Care Plan if You failed to do so when first eligible and not be considered a Late Enrollee. If You are already enrolled in the Employee Health Care Plan, any Eligible Dependents You wish to add will be added to Your existing medical and dental coverage. The Special Enrollment Period lasts for 3 months beginning with the day of the triggering event, except the Special Enrollment Period following exhaustion of a lifetime maximum on total benefits does not end until 30 days after the first claim is denied on the basis of lifetime maximum exhaustion. In each situation, You must complete a Health Care Coverage Change Form and submit it to the University's Benefits Department prior to the expiration of the Special Enrollment Period. If You do not submit Your request timely, You may

only enroll You and/or Your Eligible Dependents during the Plan's subsequent Open Enrollment Periods, if any. In these situations, the rules regarding how to apply and when coverage begins are the same as those described earlier. For example:

- If You and/or Your Eligible Dependents lose coverage under another group or individual health benefit plan due to:
  - the exhaustion of federal COBRA or any state continuation coverage;
  - the loss of eligibility due to legal separation, divorce, death, termination of employment or reduction in hours; significant reduction in or termination of the employer contributions; a significant change in coverage; a significant increase in Your cost of the other coverage; exhaustion of lifetime maximum on total benefits; or
  - involuntary loss of coverage under Medicaid, Medicare, CHAMPUS/Tricare, Indian Health Service, or a publicly sponsored or subsidized health plan.

then You and/or Your Eligible Dependents become eligible for coverage under the University of Utah Employee Health Care Plan on the date the other coverage ends. Note that loss of eligibility does not include a voluntary termination of coverage, a loss because premiums were not paid in time, or termination of coverage because of fraud.

- If You declined coverage when You were first eligible and You subsequently marry, You become eligible for coverage under the University of Utah Employee Health Care Plan on behalf of Yourself, Your spouse, and any Eligible Dependent children on the date of marriage.
- If You declined coverage when You were first eligible (or You declined coverage for Your spouse when he or she was first eligible) and You subsequently acquire a new dependent child by birth, adoption, or placement for adoption or foster care, You become eligible for coverage under the University of Utah Employee Health Care Plan along with Your eligible spouse and Eligible Dependent children including the newly acquired child on the date of the birth, adoption, or placement.

## LATE ENROLLMENT/OPEN ENROLLMENT PERIOD

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

## ENROLLMENT BY OTHERS

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

## NOTICE OF STATUS CHANGE

In the event You acquire a dependent or a dependent loses eligibility under the Plan, You must give the Plan written notice within three (3) months after such date. If a dependent loses eligibility under the

Plan, You must give the Plan written notice within **60 days** after such date in order for the dependent to be eligible for continuation of coverage under COBRA.

## LEAVES OF ABSENCE

### FAMILY AND MEDICAL LEAVE ACT LEAVE OF ABSENCE

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

- You and Your Enrolled Dependents will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period as provided under the FMLA for one of the following:
  - in order to care for Your newly born child;
  - the placement of a child with You for adoption or foster care;
  - in order to care for Your spouse, child, or parent, if such spouse, child, or parent has a serious health condition (as defined by the FMLA); or
  - You suffer a serious health condition (as defined by the FMLA).

Persons entitled to coverage under this paragraph will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this paragraph. Entitlement to FMLA leave does not constitute a Qualifying Event for the purposes of COBRA continuation. However, a person not returning to active employment following FMLA leave may be entitled to COBRA continuation coverage, the duration of which will be calculated from the date the person fails to return from the FMLA leave.

- You must continue to make timely payment of Your monthly contribution through the University. The provisions described here will not be available if this Plan terminates.
- If You and/or Your Enrolled Dependents elect not to remain enrolled during the leave, You (and/or Your Enrolled Dependents) will be eligible to be reenrolled under the Plan on the date You return from the FMLA leave if You request reenrollment upon Your return to work. If You return during the same Contract Year, You must be reenrolled in the same medical and dental options You had on the day coverage was terminated.

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

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

## MEDICAL LEAVE OF ABSENCE

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

- You are totally disabled as defined by the University's Long Term Disability Plan or the Social Security Administration; and
- You were employed by the University in a benefit-eligible position and were enrolled in the Plan on the day immediately preceding the date You became totally disabled.

If You remain totally disabled and are eligible and enrolled in the Plan at the end of the 30-month period and You worked for the University in a benefit-eligible position for:

- 5 or more consecutive years immediately prior to Your date of disability (including any periods of FMLA leave), then You and Your Enrolled Dependents may enroll in the University of Utah Retiree Health Care Plan or elect to continue coverage for a limited time through COBRA; or
- less than 5 consecutive years immediately prior to Your date of disability (including any periods of FMLA leave), then You and Your Enrolled Dependents may be eligible for continuation coverage for a limited time through COBRA.

If You are eligible and enroll in the Retiree Health Care Plan, dental coverage for You and Your Enrolled Dependents will terminate on the first to occur of the following events: (a) the date You are no longer totally disabled; (b) for Your Enrolled Dependent children, the date each child loses eligibility under the Plan's then current definition of an Eligible Dependent child; (c) 18 months from the date You enroll in the Retiree Health Care Plan; or (d) the date You and/or Your Enrolled Dependent(s) become ineligible for or terminate coverage under the Plan.

## PERSONAL LEAVE OF ABSENCE

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

## MILITARY LEAVE OF ABSENCE

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

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

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

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

## WHEN COVERAGE ENDS

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

### PLAN TERMINATION

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If the Plan is terminated by the University, coverage for You and Your Enrolled Dependents will end on the date the Plan is terminated.

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

### WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

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

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

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

#### Nonpayment Of Required Contribution

If You fail to make the required contribution in a timely manner, Your coverage will end for You and all Enrolled Dependents on the date You fail to make such a required contribution.

#### Termination By University

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

#### If You Die

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

If Your surviving spouse and/or Your Enrolled Dependent child(ren) enroll in the Retiree Health Care Plan, their coverage will terminate on the date they become eligible for another group plan (e.g., through employment, marriage, etc.), on the date each child loses eligibility under the Plan's then current definition of an Eligible Dependent child, or 18 months from the date they enroll in the Retiree Health Care Plan.

If Your surviving spouse or Eligible Dependent children enroll in the Plan and later terminate participation in the Plan, they will not be eligible to reenroll in the future.

## DEPENDENTS ARE NO LONGER ELIGIBLE

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If Your dependents are no longer eligible as explained in the following paragraphs, their eligibility for coverage will end at 12:01 a.m., Mountain Time, on the date of the event that makes them ineligible. However, it may be possible for Your ineligible dependents to continue coverage under the Plan according to the COBRA continuation of coverage provisions of this Summary Plan Description. **You or the dependent must notify the University's Benefits Department of the ineligibility within 60 days of the event in order to be eligible for COBRA continuation of coverage** (see the COBRA Section for additional information).

### Divorce Or Annulment

Eligibility ends for Your enrolled spouse and the spouse's children (unless such children remain eligible by virtue of their continuing relationship to You) on the date the divorce or annulment is final. You or Your former spouse must notify the University's Benefits Department of the former spouse's ineligibility under the Plan. In the event the Plan is notified within 60 days of the date of divorce or annulment, Your former spouse may continue coverage under the Plan according to the COBRA continuation of coverage provisions of this Summary Plan Description (continuation of dental coverage is not available without continuation of medical coverage).

### Loss Of Dependent Status

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

You or Your dependent must notify the University's Benefits Department of an Enrolled Dependent's ineligibility under the Plan. In the event You provide written notification to the Plan within **60 calendar days** of the date the dependent becomes ineligible under the Plan, the dependent may continue coverage under the Plan according to the COBRA continuation of coverage provisions of this Summary Plan Description (continuation of dental coverage is not available without continuation of medical coverage).

## FRAUDULENT USE OF BENEFITS

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If You or Your Enrolled Dependents engage in an act or practice that constitutes fraud in connection with coverage under this Plan or make an intentional misrepresentation of fact in connection with coverage, coverage under the Plan may be terminated. In addition, any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be subject to corrective action up to and including termination of employment with the University, and may be guilty of a criminal act punishable under law and subject to civil penalties.

## CERTIFICATES OF CREDITABLE COVERAGE

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Requests for and inquiries about required certifications of coverage relating to period(s) of coverage under the Plan should be directed to the Plan or to the Claims Administrator at (801) 333-2110 or (866) 849-6956, PO Box 30270, Salt Lake City, Utah 84130-0270.

## COBRA CONTINUATION OF COVERAGE

This COBRA CONTINUATION OF COVERAGE Section applies only when the University is subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA. Under certain circumstances called Qualifying Events, Claimants may have the right to continue coverage beyond the time coverage would ordinarily have ended. The following rights and obligations regarding continuation of coverage are governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. In the event of any conflict between this continuation of coverage provision and COBRA, the minimum requirements of COBRA will govern. This provision will automatically cease to be effective when federal law requiring continuation of eligibility for coverage no longer applies to the University. This section does not provide a full description of COBRA. For more complete information, contact the University's Benefits Department.

Continuation of dental coverage under this Plan is only available through COBRA if You elect continuation of coverage in one of the Employee Health Care Plan medical options.

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

### QUALIFYING EVENTS

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Qualifying Events are certain events defined by COBRA regulations that cause an individual to lose health care coverage. Qualifying Events that trigger Your right to COBRA coverage are:

- voluntary or involuntary termination of the Plan Participant's employment for reasons other than gross misconduct;
- reduced hours of work for the Plan Participant, resulting in ineligibility for coverage;
- divorce or legal separation of the Plan Participant;
- death of the Plan Participant;
- loss of status as an "Eligible Dependent child" under Plan rules;
- the Plan Participant becomes entitled to Medicare, resulting in ineligibility for coverage; or
- the employer files a Chapter 11 bankruptcy (only applicable to retired employees and their dependents covered under the Retiree Health Care Plan).

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

### WHEN AND HOW YOU MUST GIVE NOTICE

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You, Your spouse, or dependent child must notify the University's Benefits Department of a **divorce or legal separation**, or a **child losing dependent status** within **60 days** of the event. (The Plan is required to provide notice to You and/or Your Enrolled Dependents of the right to elect COBRA coverage due to any of the other Qualifying Events.) To provide this notice, You may complete the Health Care Coverage Change Form available on the internet at [www.hr.utah.edu/ben/forms](http://www.hr.utah.edu/ben/forms) or in the University's Benefits Department. Alternatively, Your spouse or dependent child may give written notice of the Qualifying Event to the University's Benefits Department at 420 Wakara Way, Suite 105, Salt Lake City, Utah 84108. The written notice must provide the individual's name and current mailing address, the specific Qualifying Event and the date of the Qualifying Event. If written notice is not provided to the

Benefits Department within **60 days** after the date of the Qualifying Event, all rights of that individual to elect COBRA coverage will be lost.

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

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

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

## QUALIFIED BENEFICIARIES

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Each individual who was covered under the Plan on the day before the Qualifying Event is a "Qualified Beneficiary" and has independent rights to purchase COBRA coverage. An exception to this rule applies if coverage is reduced or eliminated in anticipation of a Qualifying Event. Qualified Beneficiaries include the covered employee, employee's spouse, and dependent child or children.

## INDIVIDUAL ELECTION RIGHTS

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

## LENGTH OF COBRA COVERAGE

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The length of COBRA coverage offered depends on Your Qualifying Event. If the Qualifying Event is termination of employment or a reduction of work hours, Qualified Beneficiaries are given the opportunity to continue COBRA coverage for 18 months. If the Qualifying Event is death of the covered employee, divorce or legal separation, or loss of dependent status, COBRA coverage is available for 36 months. If a Qualified Beneficiary is determined to have been disabled on the date of the Qualifying Event or during the first 60 days of COBRA coverage, additional coverage may be available (see Social Security Disability below).

## SOCIAL SECURITY DISABILITY

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If Your Qualifying Event is termination of employment or reduction in hours and You are determined by the Social Security Administration to have been disabled on the date of the Qualifying Event or during the first 60 days of COBRA coverage, You and/or Your enrolled dependents may obtain an extension of coverage from 18 months to 29 months. It is Your responsibility to obtain the disability determination from the Social Security Administration and to provide a copy of the determination to the University's

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

## SECOND QUALIFYING EVENT

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Qualified Beneficiaries, other than the employee, who enrolled in COBRA coverage as a result of the employee's termination of employment or reduction of work hours, who experience another Qualifying Event (divorce, legal separation, death of the covered employee, Medicare entitlement, or loss of dependent status), may extend COBRA coverage beyond 18 months (or 29 months if there has been a disability extension) to 36 months. You must provide a written notice to the University's Benefits Department within 60 days of the second Qualifying Event and during the original 18-month COBRA coverage period (or 29-month period if there has been a disability extension), in order to extend COBRA coverage to 36 months. The written notice must be sent to the University's Benefits Department and provide the individual's name and current mailing address, the specific Qualifying Event and the date the event occurred. **COBRA coverage will never extend beyond 36 months of the date of the original Qualifying Event.**

## WHEN YOU ACQUIRE A NEW DEPENDENT CHILD WHILE ON COBRA

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A child who is born to or placed for adoption with You while You are enrolled in COBRA coverage can be added to Your COBRA coverage upon proper written notification to the University's Benefits Department (Health Care Coverage Change Form or written notice) of the birth or placement. Notification must be received within 3 months of the date of birth or placement (if notification is not received within **3 months** of the date of birth or placement, You will not be able to add the child to Your coverage until the next Open Enrollment period). The child will not have an independent right to purchase COBRA coverage. The child's COBRA coverage will terminate when Your COBRA coverage terminates, unless You terminate his/her coverage voluntarily at an earlier date.

## IF YOU ARE RETIRED AND THE UNIVERSITY FILES CHAPTER 11 BANKRUPTCY

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

## IF YOU BECOME ENTITLED TO MEDICARE BEFORE ELECTING COBRA

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If You become entitled to Medicare before electing COBRA in connection with a termination of employment or reduction in hours Qualifying Event, You may maintain both Medicare and up to 18

months of COBRA coverage and Your Enrolled Dependents will be allowed to continue their COBRA coverage until the later of:

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

## ELECTING COVERAGE

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Qualified Beneficiaries have **60 days** from the date of the Qualifying Event or if later, from the date of the notice offering COBRA, to elect COBRA coverage. (You are not eligible to elect COBRA coverage and this paragraph does not apply to You if You, Your spouse, or dependent child failed to notify the University's Benefits Department of a divorce or legal separation, or a child losing dependent status within **60 days** of the event, as required by COBRA.) If neither You nor Your spouse or dependent child(ren) elect COBRA continuation coverage during the applicable election period, Your health care coverage will end according to the terms of the Plan. The Plan will not pay claims for services provided on and after the date coverage ends and You and Your dependents will have no right to elect COBRA coverage at a later date.

## COBRA PREMIUM PAYMENTS

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If You elect COBRA coverage, You will be responsible to pay the full cost of coverage plus a 2% administration fee. The COBRA premiums, including this fee, will be listed on the "Notice of Right to Elect Continuation Coverage (COBRA)" that will be sent to You by the University. Coupons will be provided for premium payments; however, in the event You do not receive coupons, You are responsible for remitting payments timely to avoid termination of coverage.

## INITIAL PAYMENT

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Payment must be received by the University's Benefits Department within **45 days** of the date You elect COBRA coverage. Your first premium payment will include premiums due retroactive to the date You lost coverage as a result of Your Qualifying Event. If Your first payment is not received timely, COBRA coverage will not be effective and You will lose all rights to COBRA coverage.

## SUBSEQUENT PAYMENTS

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Payment for each subsequent period is **due on the first day of each month**. You will have a 30-day grace period from the premium due date to make subsequent payments. If the COBRA premiums are not paid within the grace period, Your COBRA coverage will terminate as of the end of the last period for which payment was received and You will lose all further rights to continue COBRA coverage.

## TRADE ADJUSTMENT ASSISTANCE (TAA)

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If You are a TAA-eligible individual and do not elect continuation coverage during the 60-day COBRA election period that was a direct consequence of the TAA-related loss of coverage, You may elect continuation coverage during a **second** 60-day election period that begins on the first day of the month in which You are determined to be eligible. Provided such election is made not later than 6 months after the date of the TAA-related loss of coverage. Continuation coverage elected during the second election period will begin with the first day of the second election period, and not on the date on which coverage originally lapsed. The time period between the original loss of coverage and the start of the second election period cannot be counted for the purposes of determining whether You had a 63-day break in

coverage, which affects pre-existing condition exclusions under HIPAA. In addition, TAA eligible persons could be eligible for a tax credit.

## CHANGES IN COBRA COVERAGE

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

## FLEXIBLE SPENDING ACCOUNTS

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If You participated in the University's Flexible Benefit Plan at the time of Your Qualifying Event and have a positive fund balance in Your flexible spending account, You may be allowed to continue participation in the Flexible Benefit Plan through the end of the plan year in which the Qualifying Event occurred. If You fail to make payment, Your participation in the Flexible Benefit Plan will terminate and expenses incurred after the termination date will not be eligible for reimbursement.

## FINANCIAL AID

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Some states offer financial aid to help certain individuals pay for COBRA coverage. Contact Your appropriate state agency regarding availability and eligibility requirements.

## WHEN COBRA CONTINUATION COVERAGE ENDS

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COBRA continuation under the Plan will end for You and/or Your Enrolled Dependents if any of the following occurs:

- The required premium payments are not paid within the timeframe allowed;
- You notify the COBRA administrator that You wish to cancel Your coverage;
- The applicable period of COBRA coverage ends;
- You become entitled to Medicare benefits;
- The date You reach the Lifetime Maximum Benefit under the Plan;
- The University terminates its group health plan(s);
- You have extended COBRA coverage due to Social Security disability and a final determination is made that You are no longer disabled, coverage for all Claimants who had qualified for the disability extension will end as of the later of:
  - the last day of 18 months of continuation coverage, or
  - the first day of the month that is more than 30 days following the date of the final determination of the nondisability;
- After the date of Your COBRA election, You become covered under another group health plan that does not contain any exclusion or limitation for any of Your pre-existing conditions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the extent to which health plans may impose pre-existing condition limitations. If You become covered by another group health plan with a pre-existing condition limitation that affects You, Your COBRA coverage can continue. If the other plan's pre-existing condition rule does not apply to You by reason of HIPAA's restrictions on pre-existing conditions clauses, You are no longer eligible to continue COBRA coverage; or

- An event occurs that permits termination of coverage under the University health plan for an individual covered other than pursuant to COBRA (e.g., submitting fraudulent claims).

## GENERAL PROVISIONS

This section explains various general provisions regarding Your benefits under the Plan.

### WHEN BENEFITS ARE AVAILABLE

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In order for dental expenses to be covered under the Plan, they must be incurred when coverage is in effect. Coverage is in effect when:

- the person is eligible to be covered according to the eligibility provisions of the Plan;
- the person has applied for coverage and has been accepted by the Plan; and
- the person has paid their portion (if any) of the cost of coverage.

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

### NOTICES

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Any notice to Claimants or to the University required in the Plan will be deemed to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Plan Participant or to the Plan will be addressed to the Plan Participant or to the Plan at the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address form (COA) for a Plan Participant, the Claims Administrator will update their records accordingly. Additionally, the Claims Administrator may forward any notice for a Plan Participant to the Plan Administrator if the Plan fails to provide the Claims Administrator a valid mailing address or the Plan fails to update the Plan Participant's address with a mailing address the Claims Administrator can use to send the Plan Participant his or her mail. Any notice to the Claims Administrator required in the Plan may be given by mail addressed to: Regence BlueCross BlueShield of Utah at PO Box 30270, Salt Lake City, Utah 84130-0270; provided, however that any notice to the Claims Administrator will not be deemed to have been given to and received by the Claims Administrator until physically received by the Claims Administrator.

### MODIFICATION REQUIRED BY CHANGE IN LAW

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In the event of a change in federal law that results in a material change in the obligation of either party, the Claims Administrator will contact the University prior to the time such law becomes effective for approval. The Claims Administrator must incorporate the change in law by amendment to the Plan Document, submitted to the University for approval prior to any change in administration by the Claims Administrator. Upon signed approval of the amendment to the Plan Document, the Claims Administrator may incorporate the change in law effective the date assigned by the University.

### CHOICE OF FORUM

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Any legal action arising out of this Plan must be filed in either state or federal court in the state of Utah.

## GOVERNING LAW

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The Plan 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. Where the law or judicial interpretation of the law changes over time, the administration of benefits for otherwise identical claims may differ, unless such change is expressly made retroactive. Where not directly in conflict with the laws of the United States of America or the State of Utah, the Plan will be interpreted in accordance with the Claims Administrator's rules and regulations in effect at the time of interpretation.

## SUMMARY PLAN DESCRIPTION TITLES AND HEADINGS ARE FOR CONVENIENCE

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Section titles and headings throughout the Summary Plan Description are only for convenience and are not intended to be part of the provision that they introduce.

## RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

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

## NO WAIVER

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

## REPRESENTATIONS ARE NOT WARRANTIES

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In the absence of fraud, all statements You make in an application will be deemed 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 has been furnished to You.

## LEGAL OR ARBITRATION PROCEEDINGS

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In case of any dispute under the Plan which becomes the subject of any arbitration or legal proceeding, You, on behalf of Yourself and Your heirs and Representatives, do hereby expressly waive the privileges and benefits of all and any laws and rules which are now in force or hereafter enacted or promulgated in

regard to disqualifying any doctor, nurse, hospital official or employee, or any other person or organization providing medical services, supplies, or accommodations from testifying concerning any information obtained by such person or organization in a professional capacity, or other capacity which makes such information or knowledge privileged; and You, on behalf of Yourself and Your heirs and Representatives, do hereby expressly authorize and request such doctor, nurse, hospital official or employee, or other person or organization to make full disclosure in the arbitration or legal proceeding concerning the Claims Administrator's liability for such benefits.

## DEFINITIONS

The following definitions of important terms used in this Summary Plan Description will be capitalized throughout the Summary Plan Description. Other terms are defined and capitalized where they are first used in the text of the Summary Plan Description. The same term used in the Summary Plan Description but which is not capitalized does not have the same meaning as defined here or when first used in the Summary Plan Description:

Calendar Year means the period from January 1 through December 31 of the same year.

Claimant means a Plan Participant or an Enrolled Dependent.

Coinsurance means an amount, expressed as a percentage, that You must pay for Covered Services.

Contract Year means the period of twelve consecutive months beginning on the Plan Effective Date and at each Renewal Date thereafter. For the University of Utah, this twelve month period is the period of July 1 through June 30 of the following year; however, the first Contract Year commences on the Claimant's Effective Date.

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

Deductible means the amount of Eligible Dental Expenses that You must pay each Contract Year before the Plan will provide payments for Covered Services.

Dentist means an individual who is licensed to practice dentistry.

Effective Date means the date specified by Plan Administrator or its designee, following the Claims Administrator's acceptance of the application for coverage, as the date coverage begins for the Plan Participant or Enrolled Dependent.

Eligible Dental Expenses means the amount Participating Dentists have agreed to accept as full payment for Covered Services, as determined by the Claims Administrator. Charges in excess of Eligible Dental Expenses are not deemed reasonable charges and are not reimbursable under the Plan. For questions regarding the basis for determination Eligible Dental Expenses, please contact the Claims Administrator.

Enrolled Dependent means a Plan Participant's Eligible Dependent who is listed on the Plan Participant's application for coverage or on subsequent change forms who have been accepted for coverage under this Plan.

Family means a Plan Participant and his or her Enrolled Dependents.

Health Plan Identification Card means the identification card issued to You by the Claims Administrator, which includes information regarding Your dental benefits.

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

Injury means physical damage to the body inflicted by a foreign object, force, temperature, or corrosive chemical.

Lifetime means the period of time a Claimant is covered under the Plan or an earlier Plan previously issued to the Plan Administrator.

Maximum Benefit means that when payments total the specified amount or when benefits have been provided for a specified number of days, visits, or services, no more payments will be made by the Plan. When the Maximum Benefit is for a specified time period such as a Contract Year, no more payments will be made during the remainder of the specified time period.

Nonparticipating Dentist means a Dentist who does not have an effective participating contract with the Claims Administrator to provide services and supplies to Claimants.

Participating Dentist means a Dentist who has an effective participating contract with the Claims Administrator to provide services and supplies to Claimants in accordance with the provisions of the Plan.

Plan Participant means an employee of the Plan who is eligible under the terms of the Plan, whose application is accepted by the Plan, and who is enrolled under this Plan.

Summary Plan Description is the description of the benefits of the Plan. The Summary Plan Description is part of the Plan Document.

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

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

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

- **Treatment** – The Plan may use and disclose Your PHI for the Plan’s treatment activities, if any, or for the treatment activities of a health care provider. For example, if Your health care provider refers You to a specialist for treatment, the Plan can disclose Your PHI so the specialist can become familiar with those records.
- **Payment** – The Plan may use and disclose Your PHI for payment activities, including but not limited to determining Your eligibility for coverage; obtaining reimbursement for benefits paid while You were ineligible; determining whether particular expenses are covered under the Plan; coordinating benefits (e.g., collection from another plan); and sharing information with third parties who assist the Plan with treatment, payment, and health care operations (such third parties must follow our privacy practices). For example, the Plan may communicate with insurance companies to help You resolve problems relating to payment of claims.
- **Plan Operations** – The Plan may use and disclose Your PHI for internal operations, including providing customer service to You; conducting quality assessment and improvement activities; conducting fraud and abuse detection; reviewing claims for medical necessity; confirming compliance with applicable laws; administering business planning and development; underwriting and rate setting; administration of reinsurance and excess or stop loss insurance and coordination with those insurers; conducting or arranging medical review, legal services, and auditing functions; directing activities to improve health or reduce costs; providing care coordination and education about alternative treatments; and informing You of health services and products that may benefit You. For example, the Plan may use Your PHI to audit claim processing accuracy.
- **Business Associates** – The Plan may disclose Your PHI to third parties (“Business Associates”) who perform certain activities for the Plan. The Plan requires those Business Associates receiving PHI to agree to restrictions on the use and disclosure of Your PHI equivalent to those that apply to the Plan.
- **Family Members and Others Involved in Your Care** – The Plan may disclose Your PHI to Your family member, relative, or close friend, or any other person You identify for purposes of assisting in Your care or payment for Your care. For example, if Your spouse calls the University Benefits Department to get information about the processing of a claim for Your care, they may talk with Your spouse to assist You in resolving a problem. If You do not want the Plan to discuss Your PHI with Your family members or others involved in Your care, please contact the University Benefits Department.
- **Research** – The Plan may use and disclose Your PHI for research projects, such as studying the effectiveness of a treatment You received, if an Institutional Review Board approves a waiver of

authorization for disclosure. These research projects must go through a special process that protects the confidentiality of Your medical information.

- **As Required by Law** – Federal, state or local laws sometimes require the Plan to disclose PHI. For example, the Plan may be required to release information for a worker's compensation claim.
- **Law Enforcement** – The Plan may disclose PHI to law enforcement officials as required by law or in compliance with a search warrant, subpoena, or court order. The Plan may also disclose PHI to law enforcement officials in certain circumstances, including, but not limited to the following: to help in locating or identifying a person; to prosecute a violent crime; to report a death that may have resulted from criminal conduct; to report criminal conduct at the offices of the Plan; and to give certain information in domestic violence cases. For example, the Plan may disclose Your PHI to a third party if ordered to do so by a court of law or if the Plan receives a subpoena or search warrant.
- **Public Health Activities or Public Safety** – The Plan may use and disclose certain PHI for public health purposes such as preventing or lessening a serious and/or imminent threat to an individual or the public.
- **Military, Veteran, National Security and Other Governmental Purposes** – If You are a member of the armed forces, the Plan may release Your PHI as required by military command authorities or to the Department of Veterans Affairs. The Plan may also disclose PHI to federal officials for intelligence and national security purposes, or for Presidential Protective Services.
- **Health Oversight Activities** – The Plan may disclose PHI to a government agency that oversees the Plan or their personnel, such as the United States Department of Labor, to ensure compliance with state and federal laws.
- **Complaint Resolution** – The Plan may disclose PHI to the UUHSC Privacy Office if You contact that office or file a complaint with that office regarding Your PHI, Your rights, and/or the Plan's obligations under its Notice of Privacy Practices.

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

- (a) Not use or further disclose the information other than as permitted or required to perform the Plan Administration Functions listed above or as required by law;
- (b) Require that any agents to whom it provides Your PHI agree to the same restrictions and conditions that apply to the University/Plan Sponsor with respect to such information;
- (c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the University/Plan Sponsor.
- (d) Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware.
- (e) Make Your PHI available to You in accordance with 45 CFR §164.524.
- (f) Make Your PHI available for amendment and incorporate any amendments to Your PHI in accordance with 45 CFR §164.526.
- (g) Make available information required to provide an accounting of disclosures.
- (h) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for the purpose of determining compliance by the Plan with applicable laws and regulations.

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

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

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

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