UNIVERSITY OF UTAH

EMPLOYEE HEALTH CARE PLAN

UNIVERSITY HEALTH CARE PLUS NETWORK

BASIC, COMPREHENSIVE, AND ADVANTAGE PLAN OPTIONS

SUMMARY PLAN DESCRIPTION

Claims Administrator:

University Health Care Plus

127 South 500 East
Salt Lake City, Utah 84102

PO Box 45180
Salt Lake City, Utah 84145

Plan Administrator:

University of Utah
Benefits Department

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

HANDY PHONE NUMBERS AND OTHER INFORMATION

	Local	Toll-Free
Customer Service 7:00am to 6:00pm	(801) 587-6480 option 4	(888) 271-5870
Care Management Program	(801) 587-6480 option 2 http://uuhsc.utah.edu/uhealthplan	(800) 271-5870
University of Utah Benefits Department		
Phone	(801) 581-7447	
Fax	(801) 585-7375 www.hr.utah.edu/ben	
CVS Caremark	https://universityofutah.advancerx.com	(800) 966-5772
Employee Assistance Program (EAP)	(801) 587-9319	(800) 926-9619

Notice of Privacy Practices: University Health Care Plus has a Notice of Privacy Practices that is available by calling Customer Service or visiting the website listed above. The University's Notice of Privacy Practices is at the end of this SPD.

Effective July 1, 2008

HOW TO USE THIS SUMMARY PLAN DESCRIPTION

This document, together with the SUMMARY OF MEDICAL BENEFITS applicable to the plan option You have chosen, make up the University of Utah Employee Health Care Plan Summary Plan Description and describe the terms and benefits of coverage effective July 1, 2008, or the date after that on which Your coverage became effective. This Summary Plan Description replaces any plan 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 (including the appropriate SUMMARY OF MEDICAL BENEFITS) differ, the Plan Document will prevail.

While the SUMMARY OF MEDICAL BENEFITS is 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 MEDICAL BENEFITS, such as the percentages paid, Deductibles and Maximum Coinsurance amounts 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 University Health Care Plus. The term “Plan” refers to 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.

University Health Care Plus 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 Medical 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 THE PLAN

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

It is important for You to understand how the Plan works before You need health care services. Please read this material carefully. If You have any questions about benefits or procedures, please contact the Claims Administrator’s Customer Service Department (see the handy phone numbers page located at the front of this Summary Plan Description).

NETWORK PROVIDERS

The Plan will pay the Network Provider directly for Covered Services. Network Providers have agreed to accept Eligible Medical Expenses as full compensation for Covered Services. Your share of Eligible Medical Expenses is any amount You must pay due to Deductible, Copayment and/or Coinsurance. You may be required to pay Your share at the time You receive care or treatment from a Network Provider.

It is generally to Your financial advantage to use Network Providers. When a Network Provider is used, You are responsible to pay only Deductible, Copayment, and/or Coinsurance for Covered Services.

Refer to the CLAIMS ADMINISTRATION Section for additional information about Network Providers.

Out-of-Network Providers

Before the Plan will make payment for Covered Services provided by an Out-of-Network Provider, the Claims Administrator must receive all forms, information, statements, and certificates necessary or appropriate to process such claim. You will be responsible to ensure that the Out-of-Network Provider is paid in full. **Please note when Out-of-Network Providers are used, You are responsible not only for any Deductible and/or Coinsurance for Covered Services, but also for the difference between the Out-of-Network Provider's billed charges and Eligible Medical Expenses. The difference You pay will not count toward Your Maximum Coinsurance or Your Deductible.**

Refer to the CLAIMS ADMINISTRATION Section for additional information about Out-of-Network Providers.

Hospitals, Skilled Nursing Facilities And Other Facilities

Network Hospitals, Skilled Nursing Facilities and other facilities may follow the requirements of the Care Management Program. When You receive services from Network Hospitals, Skilled Nursing Facilities and other facilities, Your responsibility for payment will be the Deductible, Copayment and/or Coinsurance amounts shown in the SUMMARY OF MEDICAL BENEFITS.

When You receive services from Out-of-Network Hospitals, Skilled Nursing Facilities and other facilities, Your responsibility for payment will be the Deductible and/or Coinsurance amounts shown in the SUMMARY OF MEDICAL BENEFITS, plus the difference between the amount charged and Eligible Medical Expenses. The difference You pay will not count toward Your Maximum Coinsurance or Your Deductible. **It is always Your responsibility to ensure the Claims Administrator is notified of an admission to a Hospital, Skilled Nursing Facility or other facility.** Refer to the Care Management Program in the CLAIMS ADMINISTRATION Section for additional information about notification requirements.

Emergency Medical Conditions And Urgent Care

In the event of a medical emergency, You should seek emergency and urgent care at the nearest ***appropriate*** facility. The amount You pay will vary according to where You receive care for an Emergency Medical Condition or for urgent care. Costs are usually highest at a Hospital's emergency department, somewhat lower at an urgent care facility, and usually the lowest at a Physician's office. This general range of costs is reflected in Your Copayment and Coinsurance amounts.

Care Management Program

To help ensure appropriateness and cost-effectiveness of care, the Claims Administrator must be notified before You receive certain services. Failure to notify the Claims Administrator prior to receiving any of these specified services may result in no coverage. Refer to the Care Management Program in the CLAIMS ADMINISTRATION Section for additional information about notification requirements.

Benefits And Limitations

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

Health Care Policies

The Claims Administrator determines Medically Necessary care in accordance with approved policies, and all claims payments are subject to these policies. You are encouraged to call the Claims Administrator’s Customer Service Department for medical policy information prior to receiving services.

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SUMMARY OF PRESCRIPTION DRUG BENEFITS
EMPLOYEE HEALTH CARE PLAN

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

Contract Year Deductible – Prescription Drug Benefits Only

There is no Deductible amount applicable to Prescription Drug Benefits.

Contract Year Out-of-Pocket Maximum – Prescription Drug Benefits Only

Your specific Out-of-Pocket Maximum will vary depending on whether You purchase Your Prescription Drugs from a University Health Care Pharmacy or from a CVS Caremark Participating Pharmacy, and whether or not Your Prescription Drugs are generic/preferred or non-preferred (see "How the Plan Pays" below).

Coinsurance

Except as provided in Special Provisions below, You are responsible to pay the following Coinsurance amounts:

Retail Pharmacy

For Prescription Drugs purchased at University Health Care Pharmacies:

> 20% of negotiated Prescription Drug charge up to a 90-day supply

For Prescription Drugs purchased at any other CVS Caremark Participating Pharmacy:

> 25% of negotiated Prescription Drug charge for generic and name brand preferred Prescription Drugs up to a 90-day supply
>
> 35% of negotiated Prescription Drug charge for name brand non-preferred Prescription Drugs up to a 90-day supply

For diabetic supplies (syringes, lancets, alcohol swabs, and test strips) purchased at **any** Participating Pharmacy:

> 20% of negotiated charges

Non-covered Prescription Drugs purchased at Participating Pharmacies:

> 100% of discounted Prescription Drug charge

Prescription Mail Order Program

For Mail Order Prescription Drugs purchased through the University Health Care Mail Order Program:

> 20% of the negotiated Prescription Drug charge up to a 90-day supply

For Mail Order Prescription Drugs purchased through the CVS Caremark Mail Order Program (non-Utah residents ONLY):

> 25% of negotiated Prescription Drug charge for generic and name brand preferred Prescription Drugs for a 90-day supply
>
> 35% of negotiated Prescription Drug charge for name brand non-preferred Prescription Drugs for a 90-day supply

NOTE: The Prescription Mail Order Program is an exclusive contract with University Health Care. The Plan does not cover Prescriptions filled by other Mail Order programs (including, but not limited to, Foreign Pharmacies), except for Claimants residing outside the State of Utah. Non-Utah residents must use the CVS Caremark Mail Order Program.

How the Plan Pays:

The Prescription Drug Out-of-Pocket Maximum refers to the amount of claims paid by the Plan for covered retail and mail order Prescription Drugs combined. Once the amount of claims paid by the Plan has reached $4,000 for one individual, the Plan will pay 100% of that individual's negotiated Prescription Drug charges for the balance of that Contract Year. Once the amount of claims paid by the Plan has reached $12,000 for one Family, the Plan will pay 100% of the negotiated Prescription Drug charges for each individual in the Family for the balance of that Contract Year.

The Prescription Drug Coinsurance amounts do not apply toward any Deductible and/or medical Maximum Coinsurance amounts outlined in the SUMMARY OF MEDICAL BENEFITS Section.

Coordination of Benefits – Prescription Drug Benefits Only

Coordination of Prescription Drug Benefits to 100% of the negotiated charge is only available when both husband and wife work for the University and both carry health care coverage that covers the other and/or any dependent children. Coordination of Prescription Drug Benefits is not available for Claimants who have primary coverage provided by another employer's group insurance plan.

Special Provisions

The following are Special Provisions to Your Prescription Drug Benefit:

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

Additional information, including claim forms, may be obtained on the internet at: www.hr.utah.edu/ben/cob/.

SUMMARY OF BEHAVIORAL HEALTH BENEFITS
EMPLOYEE HEALTH CARE PLAN

Behavioral Health Benefits are provided by Blomquist Hale Consulting Employee Assistance Program (EAP) and the UNI BHN network. For maximum Behavioral Health benefits, and to avoid benefit reduction, please contact the EAP at (801) 587-9319, (801) 262-9619, or (800) 926-9619 before accessing care.

Contract Year Deductible

Services Coordinated Through The EAP:	**$0**
Services Not Coordinated Through The EAP:	
Inpatient Services per admission	**$200**
Chemical Dependency per Course of Treatment[1]	**$300**

Chemical Dependency Maximum

Services Coordinated Through The EAP:	
Per Claimant per Course of Treatment[1]	**$10,000**
Services Not Coordinated Through The EAP:	
Per Claimant per Course of Treatment[1]	**$3,500**

Contract Year Maximum Coinsurance

There is no Maximum Coinsurance amount applicable to Behavioral Health benefits.

Employee Assistance Program (EAP)

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

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

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

Mental Health Services

	When You Use EAP Referral	**When You Don't Use EAP Referral**
Inpatient: Limited to 30 days per Claimant per Contract Year	Upon referral from EAP, Plan pays 80% of EME and You pay 20% of EME.	After Deductible, Plan pays 50% of EME and You pay balance of billed charges.
Outpatient: Limited to 20 visits per Claimant per Contract Year	Upon referral from EAP, You pay $20 per visit. After Copayment, Plan pays 100% of EME.	Plan pays 50% of EME and You pay balance of billed charges.

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[1] Chemical Dependency Services are limited to 2 Courses of Treatment per Claimant per Lifetime. A Course of Treatment is defined as continuous treatment/services (without a break in participation of 90 days or more) to address a chemical dependency disorder that may involve several levels of treatment. The maximum amount the Plan will pay per Course of Treatment is $10,000 (includes benefit payments for both EAP-Referred and NonEAP-Referred providers/services).

Chemical Dependency Services*		
	When You Use EAP Referral	**When You Don't Use EAP Referral**
Inpatient Services	Upon referral from EAP, Plan pays 80% of EME and You pay 20% of EME.	After Deductible, Plan pays 50% of EME and You pay balance of billed charges.
Outpatient Services	Upon referral from EAP, Plan pays 80% of EME and You pay 20% of EME.	Plan pays 50% of EME and You pay balance of billed charges.
	Limited to $10,000 per Claimant per Course of Treatment	*Limited to $3,500 per Claimant per Course of Treatment*

*Chemical Dependency Services are limited to 2 Courses of Treatment per Claimant per Lifetime. A Course of Treatment is defined as continuous treatment/services (without a break in participation of 90 days or more) to address a chemical dependency disorder that may involve several levels of treatment. The maximum amount the Plan will pay per Course of Treatment is $10,000 (includes benefit payments for both EAP-Referred and NonEAP-Referred providers/services).

U BABY CARE® PROGRAM

The "U" Baby Care Program is a confidential maternity monitoring program administered by registered nurses dedicated to helping make every member's pregnancy a healthy experience. To encourage participation in this program, the Plan provides a $100 incentive to expectant mothers who call and participate in the program by the 13th week of pregnancy.

The expectant mother may be contacted by one of the "U" Baby Care® nurses to participate in the program, or she may call "U" Baby Care® at any time. A nurse will ask a series of confidential questions during a short telephone call to screen and evaluate the potential for high-risk pregnancy. For example, an expectant mother will be asked questions about her family and medical history, daily schedule, eating habits or other behaviors that may affect the outcome of her pregnancy. The nurse will also provide basic educational information that emphasizes the importance of proper medical care and physical health during pregnancy.

Each expectant mother will receive educational materials from nationally-recognized organizations. A specific nurse will be assigned to follow the expectant mother's progress throughout the pregnancy. The "U" Baby Care® nurse will also contact the expectant mother's physician to encourage communication and exchange of information.

An important feature of the program is that the information an expectant mother shares will not be given to the University, her family or anyone else who is not directly involved in her medical care. It is helpful for her to share as much information as possible with her assigned nurse. The more the nurse knows, the more the nurse will be able to tailor the monitoring program to meet the expectant mother's individual needs.

To participate in the "U" Baby Care® program or for 24-hour nurse access, please call (801) 587-6480 or (888) 271-5870 and select option 2.

BENEFITS

This Plan is a comprehensive indemnity medical benefit plan. Under a comprehensive indemnity plan, the Plan pays benefits at a percentage of the Eligible Medical Expenses for Covered Services after You meet any required Deductible.

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

MAXIMUM BENEFITS

The Plan pays a percentage of Eligible Medical Expenses after You pay any applicable Deductible amount, up to the Maximum Benefit amount shown in the SUMMARY OF MEDICAL BENEFITS for each Claimant. The Maximum Benefit amount includes amounts paid for benefits provided under all medical options of the University of Utah Employee Health Care Plan and the University of Utah ERIP and Retiree Health Care Plans and earlier Plans issued by the University. When a Claimant's benefits cumulatively total the Maximum Benefit amount, all coverage under the University of Utah Employee Health Care Plan will terminate with respect to that Claimant. In addition, benefits under the Plan may be limited to Maximum Benefits for specified Covered Services. For specified Covered Services, payments are made as indicated until the Maximum Benefit applicable to a specified Covered Service has been provided. Maximum Benefits for specified Covered Services apply toward the cumulative Maximum Benefit amount. Any benefits paid on Your behalf, or on behalf of Your Covered Dependents, under any previous University of Utah Health Plan shall be applied toward the Maximum Benefit amount of the University of Utah Employee Health Care Plan.

DEDUCTIBLES

The amount of any Deductible You are required to satisfy is shown in the SUMMARY OF MEDICAL BENEFITS.

The Plan will not begin to pay benefits for Your Covered Services in any Contract Year until any applicable Deductible amount is satisfied. Only the amount of Eligible Medical Expenses You pay will apply toward the Deductible. The Deductible applies separately to each Claimant. The Plan will begin payment for an individual Claimant once his/her Deductible has been met; however, if You are enrolled in family coverage, once 3 members of Your Family meet their individual Deductible, the Plan will consider all Deductibles met for each enrolled member in Your Family, no matter how many Enrolled Dependents are in Your Family.

MAXIMUM COINSURANCE

The Maximum Coinsurance amount for medical benefits is shown in the SUMMARY OF MEDICAL BENEFITS and applies separately to each Claimant. If You are enrolled in family coverage, once 3 members of Your Family meet their individual Maximum Coinsurance, the Plan will consider all Maximum Coinsurances for medical benefits met for each enrolled member in Your Family, no matter how many additional Enrolled Dependents are in Your Family.

When a Claimant has met the Maximum Coinsurance for the Contract Year, no further Coinsurance is charged for the remainder of the Contract Year for most types of Covered Services received by the Claimant. When Your Family has met the Maximum Coinsurance for the Contract Year, no further Coinsurance is charged for the remainder of the Contract Year for most types of Covered Services received by the Family. The types of Covered Services or Coinsurance amounts which do not apply toward the Maximum Coinsurance and which continue to be charged after the Maximum Coinsurance has been met are shown in the SUMMARY OF MEDICAL BENEFITS.

Copayments

Some of the Covered Services of the Plan may be subject to a Copayment (a fixed dollar amount) which must be paid to the Network Provider at the time a service or supply is received. Refer to the SUMMARY OF MEDICAL BENEFITS and SUMMARY OF BEHAVIORAL HEALTH BENEFITS to see if a particular service is subject to a Copayment.

Percentage Paid Under The Plan/Coinsurance

Once any applicable Deductible amount is satisfied, the Plan pays a percentage of the Eligible Medical Expenses for Covered Services You receive under the Plan, up to the maximum shown in the SUMMARY OF MEDICAL BENEFITS. See the DEFINITIONS Section for a detailed description of what is meant by Eligible Medical Expenses. When the payment is less than 100%, the remaining percentage is Your Coinsurance. The percentage paid by the Plan varies, depending on the medical plan option in which You are enrolled, the kind of service or supply, and who rendered it. Refer to the SUMMARY OF MEDICAL BENEFITS, SUMMARY OF PRESCRIPTION DRUG BENEFITS, and SUMMARY OF BEHAVIORAL HEALTH BENEFITS for a description of percentages paid, cost-sharing, and Maximum Coinsurance.

Charges in excess of Eligible Medical Expenses are not reimbursable under the Plan. However, Network Providers will not charge You for any balances beyond any Copayment, Deductible and/or Coinsurance amount for Covered Services. Out-of-Network Providers, however, may bill You for any balances over the Plan payment level in addition to any Deductible and/or Coinsurance amount.

Adoption Benefit

An Adoption Benefit in the amount of $2,500 will be available to Claimants (excluding dependent children) when all of the following conditions are met:

- The Claimant’s coverage under this Plan is in effect on the date a newborn child is placed for the purpose of adoption.
- A newborn child is placed for the purpose of adoption with the Claimant within 90 calendar days after the child's birth.
- The Claimant submits a written request for the Adoption Benefit along with proof of placement for adoption. Proof of placement will be a copy of the court order (or its equivalent) showing the date of placement for adoption. The written request must contain the child's name, date of birth and a statement regarding any other health coverage of the adoptive parent(s). The written request should be addressed to:

University Health Care Plus
PO Box 45180
Salt Lake City, Utah 84145

In the event of adoption of more than one newborn (for example, twins), the Adoption Benefit applies for each child adopted.

In the event the Claimant and/or the Claimant's spouse is covered by more than one health benefit plan, the Adoption Benefit will be pro-rated between or among the plans. In no event will the pro rata share paid by this Plan exceed $2,500 for each child adopted.

In the event the post-placement evaluation disapproves the adoption placement and a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety, the Claimant will be liable for re-payment of the Adoption Benefit. The full amount of such benefit must be refunded by the Claimant to the Claims Administrator within 30 calendar days after the date the child is removed from placement.

WOMEN'S HEALTH AND CANCER RIGHTS

If You are receiving benefits in connection with a mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, the Plan will provide coverage for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Reconstruction benefits are subject to the same provisions as any other benefit provided under this Plan (e.g., Deductibles, Coinsurance, and Maximum Coinsurance).

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

COVERED MEDICAL SERVICES

The following sections describe the Covered Services under all medical options of the Plan.

Except for any covered preventive care, the services and supplies You receive must be Medically Necessary for the treatment of an Illness or Injury in order to be considered a Covered Service. See the DEFINITIONS Section for a description of Medically Necessary.

AMBULANCE SERVICES

The Plan covers ambulance services to the nearest appropriate Hospital when any other form of transportation is inadvisable.

Specific Limitations and Exclusions

The Plan does not cover the following ambulance services:

- ambulance services when the patient could be safely transported by means other than ambulance, whether or not such other transportation is available; and
- air ambulance services when the patient could be safely transported by ground ambulance or by means other than ambulance.

BEHAVIORAL HEALTH SERVICES

Behavioral Health Services are administered through Blomquist Hale Consulting and UNI BHN. See the SUMMARY OF BEHAVIORAL HEALTH BENEFITS and COVERED BEHAVIORAL HEALTH BENEFITS Sections for information on Behavioral Health Services.

CHEMICAL DEPENDENCY

Chemical Dependency Services are administered through Blomquist Hale Consulting and UNI BHN. See the SUMMARY OF BEHAVIORAL HEALTH BENEFITS and COVERED BEHAVIORAL HEALTH BENEFITS Sections for information on Mental Health and Chemical Dependency Services.

DENTAL CARE

The Plan covers Dental Services required as a result of damage to or loss of sound natural teeth due to an Accidental Injury (other than from chewing). Payment for Dental Services will be determined by where the services are received (for example, a Provider's office or an emergency department).

DURABLE MEDICAL EQUIPMENT AND SUPPLIES, PROSTHETIC AND ORTHOTIC DEVICES

The Plan covers Durable Medical Equipment, supplies, prosthetic and orthotic devices when ordered by the attending Provider in connection with an Illness or Injury as follows:

Supplies

Medical and surgical supplies including colostomy bags, catheters, surgical dressings, and syringes/needles for injection of prescribed medication. Diabetic supplies, including but not limited to lancets, swabs, syringes (hypodermic needles), diabetic testing strips and insulin pump supplies including tubing, dressings, infusion reservoirs, and power kits (batteries).

Prosthetic Devices

Prosthetic devices including artificial limbs, artificial eyes, breast prostheses, and eyeglasses or contact lenses required as replacements of natural lenses surgically removed (cataract surgery). This includes the professional services for fitting, adjusting, and repairing prosthetic devices and replacements together with professional services related to replacement.

Orthotic Devices

Orthotic devices including braces, trusses, and other orthopedic appliances or apparatuses used to support, align, or correct deformities or to improve the function of moving parts of the body. This also includes the professional services for fitting, adjusting, and repairing prosthetic devices and replacements together with professional services related to replacement.

Durable Medical Equipment

Durable Medical Equipment means medical equipment that is all of the following:

- intended only for the patient's use and benefit in the care and treatment of an Illness or Injury;
- durable and usable over an extended period of time;
- used primarily and customarily for a medical purpose, rather than for convenience or comfort; and
- prescribed for the patient by the attending Physician or Practitioner.

Durable Medical Equipment includes crutches, wheelchairs, hospital-type beds, insulin pumps, and similar equipment.

Specific Limitations and Exclusions

The Plan does not cover the following Durable Medical Equipment, supplies, prosthetic or orthotic devices:

- devices to increase vertical dimensions or restore occlusion;
- corrective shoes unless they are an integral part of a lower body brace, foot orthotics (other than Medically Necessary foot orthotics immediately following foot surgery), arch supports, and special shoe accessories;
- wigs, hairpieces, cosmetics, and other items of a similar nature;
- replacements required as a result of loss, theft, negligence, or of willful damage and replacements when the device being replaced is one that would continue to meet the patient's basic medical needs;
- air conditioners, air filtration units, humidifiers, vaporizers, hydrotherapy devices, water spas, exercise equipment and machines, communication devices, heating pads, lamps or other devices containing

heating elements, contour chairs, vibrating chairs and beds, and other items which do not qualify as Durable Medical Equipment;

- modifications to vehicles or places of residence; and
- deluxe equipment when standard equipment is adequate to meet the patient's basic medical needs.

NOTE: Eligible Medical Expenses will be limited to the lesser of the purchase price or the rental cost of Durable Medical Equipment.

NOTE: When a custom or deluxe prosthetic device, orthotic device or piece of Durable Medical Equipment is prescribed for a condition for which a standard prosthetic device, orthotic device or piece of Durable Medical Equipment is Medically Necessary as determined by the Plan, the Eligible Medical Expenses for a standard prosthetic device, orthotic device or piece of Durable Medical Equipment will be allowed toward the cost of the custom or deluxe prosthetic device, orthotic device or piece of Durable Medical Equipment.

EMERGENCY DEPARTMENT

The Plan covers services in a Hospital's emergency department.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

EAP Services are administered through Blomquist Hale Consulting. See the SUMMARY OF BEHAVIORAL HEALTH BENEFITS and COVERED BEHAVIORAL HEALTH BENEFITS Sections for information on utilizing the EAP Benefit.

HEARING SERVICES

The Plan covers one routine hearing examination for each Claimant each Contract Year.

Specific Limitations and Exclusions

The Plan does not cover hearing aid devices designed to be worn in, on or by the external ear to enhance impaired human hearing, including the device's specialized parts, attachments and accessories.

HOME HEALTH CARE

Home health care includes all professional services, technical and ancillary medical services, health aide services, and medical supplies and equipment which would be covered if the patient were a bed-patient in a Hospital or Skilled Nursing Facility. The Plan covers services provided in the home by a licensed community Home Health Care Agency or an approved Hospital program for home health care when the patient is essentially homebound for medical reasons, is physically unable to obtain necessary medical care on an outpatient basis and has a condition which requires the services of a licensed health care Provider, and is under the care of a Physician as follows:

- professional skilled nursing services of a registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN);
- physical therapy, speech therapy, and occupational therapy (but not maintenance therapy) by a duly licensed therapist and one medical social service consultation;
- health aide services furnished to the patient while receiving skilled nursing services or therapy specified above;
- medical and surgical supplies which are customarily furnished by the Home Health Care Agency or program for its patients, including oxygen and its administration; and
- prescribed drugs furnished by the Home Health Care Agency or program. The administration of such drugs must require the professional skills of a nurse (RN, LPN or LVN) at the time the patient is receiving nursing services specified above and does not include prescribed drugs that can be self-administered or administered by a non-professional caretaker.

HOME INFUSION THERAPY SERVICES

The Plan covers home infusion therapy services provided in the home by a licensed Home Infusion Therapy Agency when the patient is under the care of a Physician and when the home infusion therapy regimen is Medically Necessary for treatment of an Illness or Injury as follows:

- professional skilled nursing services of a registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN) required for: 1) training the patient and/or alternative care giver; 2) the administration of therapy; and 3) monitoring the intravenous therapy regimen;
- medical and surgical supplies which are customarily furnished by the Home Infusion Therapy Agency for its patients and which are necessary to administer the home infusion therapy regimen;
- non-replaced blood, blood plasma, blood derivatives, and their administration; and
- prescribed drugs furnished by the Home Infusion Therapy Agency which are part of the home infusion therapy regimen. The administration of such drugs must require the professional skills of a nurse (RN, LPN or LVN) and does not include prescribed drugs that can be self-administered or administered by a non-professional caretaker.

HOSPICE CARE

Hospice care includes palliative care and treatment of a patient with a life expectancy of 6 months or less, where the unit of care is the entire family and the focus of the interdisciplinary team is the acknowledgement of death, dealing with it in both its physical and psychological aspects. When provided prior to the death of the patient and in place of all other benefits, the Plan covers services provided by a hospice or other facility under the direction of a hospice during a Hospice Benefit Period as follows:

- inpatient hospice care (i.e., respite care);
- Physician services;
- home health services;
- emotional support services;
- homemaker services; and
- prescription drugs and medications furnished by the hospice program. The administration of such drugs must require the professional skills of a nurse (RN, LPN or LVN) and does not include prescribed drugs that can be self-administered or administered by a non-professional caretaker; however, these may be covered under Your Prescription Drug Benefit.

NOTE: Hospice Benefit Period means a benefit period which begins on the date the attending Physician certifies in writing to the Claims Administrator that a Claimant is terminally ill and ends at the earlier of the death of the terminally ill Claimant or 6 months after the date of the attending Physician's certification; provided, however, that if the Claimant is living at the end of the 6 month period, a new 6 month period may begin when the attending Physician certifies in writing to the Claims Administrator that the Claimant is still terminally ill.

HOSPITAL INPATIENT CARE

Accommodations

The Plan covers the following accommodations (including bed, board and general nursing care) during an admission to a Hospital for acute care or intensive care:

- semi-private (or multi-bed unit) room; or
- private room accommodations, but only when a severe medical condition requires the patient be placed in a private room, or the Hospital furnishes private rooms as the principal room accommodations for its patients.

NOTE: The semi-private room rate will be allowed toward the private room rate when the patient receives private room accommodations for reasons other than those specified above.

- intensive care unit (including cardiac care unit), special nursing care and ICU equipment.

Services and Supplies

The Plan covers the following services and supplies as customarily furnished to patients by a Hospital:

- operating, recovery, and treatment rooms and delivery and labor rooms and their equipment;
- anesthesia materials and anesthesia administration by facility personnel;
- diagnostic and therapeutic radiological (x-ray), including radiation therapy, clinical pathology and laboratory, electrocardiograms, electroencephalograms, and other electronic diagnostic medical procedures required to diagnose an Illness, Injury, or other condition;
- drugs and medicines which have been approved for use in the United States by the United States Food and Drug Administration and intravenous injections and solutions;
- dressings, splints, casts, and other supplies for medical treatment provided by the facility from a central sterile supply department as well as devices or appliances surgically inserted into the body;
- oxygen and its administration and non-replaced blood, blood plasma, blood derivatives, and their administration and processing; and
- inhalation therapy.

Specific Limitations and Exclusions

The Plan does not cover the following in connection with Hospital inpatient care:

- inpatient comprehensive and/or multidisciplinary pain management programs; and
- vocational rehabilitation services, private duty nursing services, personal convenience or hygiene items, and late discharge billing for the convenience of the patient.

HOSPITAL OUTPATIENT AND AMBULATORY SERVICE FACILITY CARE

Services and Supplies

The Plan covers the following services and supplies as customarily furnished to patients by a Hospital or Ambulatory Service Facility:

- operating, recovery, and treatment rooms and delivery and labor rooms and their equipment;
- anesthesia materials and anesthesia administration by facility personnel;
- diagnostic and therapeutic radiological (x-ray), clinical pathology and laboratory, electrocardiograms, electroencephalograms, and other electronic diagnostic medical procedures required to diagnose an Illness, Injury, or other condition;
- dialysis treatment, respiration therapy, radiation and chemotherapy (subject to the specific limitations and exclusions stated in the TRANSPLANTS Section);
- drugs and medicines which have been approved for use in the United States by the United States Food and Drug Administration, including intravenous injections and solutions;
- dressings, splints, casts, and other supplies for medical treatment provided by the facility from a central sterile supply department as well as devices or appliances surgically inserted into the body;
- oxygen and its administration and non-replaced blood, blood plasma, blood derivatives, and their administration and processing;
- inhalation therapy; and
- coronary CT Angiography testing when Medically Necessary as determined by the Claims Administrator.

INPATIENT REHABILITATION SERVICES

The Plan covers inpatient rehabilitation services received in a Hospital, Skilled Nursing Facility or Rehabilitation Facility when part of an active rehabilitation program consisting of treatment directed toward the restoration of normal form and function after Injury or Illness. An acute condition must have stabilized to a level so that occupational therapy, physical therapy and/or speech therapy can be started with a realistically attainable goal for the patient.

Accommodations

The Plan covers the following accommodations (including bed, board and general nursing care) during an admission to a Hospital, Skilled Nursing Facility or Rehabilitation Facility for inpatient rehabilitation services:

- semi-private (or multi-bed unit) room.

Services and Supplies

In addition to the same services and supplies that would customarily be furnished to patients by a Hospital or Skilled Nursing Facility, the Plan also covers the following services when provided to the patient during an admission for inpatient rehabilitation:

- occupational therapy, which is treatment to restore or improve functions impaired by Illness or Injury and to improve a Claimant's ability to satisfactorily accomplish daily living tasks;
- physical therapy, which is remedial treatment of an Injury or Illness by means of therapeutic massage and exercise, heat, light, and sound waves, electrical stimulation, hydrotherapy and manual traction; and
- speech therapy, which is treatment for the correction of a speech, voice or language impairment resulting from an Illness or Injury.

Specific Limitations and Exclusions

The Plan does not cover the following in connection with inpatient rehabilitation services:

- vocational rehabilitation services, private duty nursing services, personal convenience or hygiene items, and late discharge billing for the convenience of the patient; and
- physical therapy, speech therapy and occupational therapy provided solely to maintain the Claimant's condition at the level to which it has been restored with no expectation of significant improvement.

MATERNITY CARE

The Plan covers maternity (pregnancy) care, childbirth and related conditions and/or complications for all Claimants the same as any Illness. Covered Services include Physician's obstetrical care and other Provider services and supplies related to pregnancy or any complications of pregnancy, including prenatal, delivery and postnatal care.

Maternity benefits for the mother and her newborn's length of inpatient stay will not be limited to less than 48 hours for a vaginal delivery and 96 hours for a cesarean section. However, the attending Physician, in consultation with the mother may decide on an early discharge. Such hospitalization does not need to follow the provisions of the Care Management Program.

MENTAL HEALTH SERVICES

Mental Health Services are administered through Blomquist Hale Consulting and UNI BHN. See the SUMMARY OF BEHAVIORAL HEALTH BENEFITS and COVERED BEHAVIORAL HEALTH BENEFITS Sections for information on Mental Health and Chemical Dependency Services.

OFFICE OR CLINIC CARE

The Plan covers professional services by a Physician or Practitioner which are generally recognized and accepted procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury as follows:

- direct physical or mental examination of the patient, patient's body or substance(s) from the body, and associated cognitive services for prescribing or administering treatment, but not counseling or patient education unless provided at no additional charge; and
- other Covered Services when received as appropriate in an office or clinic but which may be specified elsewhere, including but not limited to Medical Services, Surgical Services and Consultations listed under Professional Services.

OUTPATIENT PHYSIOTHERAPY SERVICES

The Plan covers physiotherapy services by a Physician or Practitioner for treatment of an Illness or Injury when received in an office, clinic or Hospital on an outpatient basis. Covered Services include only the following:

- physical therapy and occupational therapy when provided to restore or improve bodily function lost as a result of Illness or Injury; and
- chiropractic manipulative treatment (except for reduction of fractures and dislocations otherwise defined as surgical services).

Specific Limitations and Exclusions

The Plan does not cover the following rehabilitative services:

- physical therapy, occupational therapy and manual manipulation provided solely to maintain the Claimant's condition at the level to which it has been restored with no expectation of significant improvement.

PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are administered through CVS Caremark. Please see the SUMMARY OF PRESCRIPTION DRUG BENEFITS and COVERED PRESCRIPTION DRUG BENEFITS Sections for information on Prescription Drug Benefits.

PREVENTIVE CARE SERVICES

Professional Exams

Regardless of Medical Necessity, the Plan covers professional exams by a Physician to assess the Claimant's state of health, including routine diagnostic tests and immunizations in connection with the exam as follows:

- 1 professional exam each year; and
- 1 professional gynecological exam each year for female Claimants.

Immunizations

The Plan covers routine and adult immunizations as follows:

- routine immunizations for childhood diseases for a Claimant through age 17.
- the following adult immunizations subject to documentation that the stated criteria are met:
  - influenza;
  - pneumovax for a Claimant with chronic Illness and a Claimant over age 65;
  - hepatitis B for a Claimant at high risk for exposure;
  - hepatitis A for a Claimant who has been exposed to hepatitis A, as well as a Claimant traveling to countries with high or intermediate endemicity of infection; a Claimant who works with HAV-infected

primates or with HAV in research laboratory settings; a Claimant with chronic liver disease; a Claimant with clotting factor disorders; or a Claimant who engages in homosexual activities;
  - meningococcal vaccine;
  - lyme disease immunization;
  - rubella for a Claimant with low antibody titer;
  - diphtheria every 10 years;
  - tetanus toxoid or tetanus-diptheria-pertussis every 10 years;
  - varicella if test results are negative for varicella;
  - measles and mumps for a Claimant who has not been previously immunized;
  - HPV vaccine for female Claimants ages 9 to 26 years; and
  - Zostavax vaccine for Claimants age 60 or older.

Screening Procedures

The Plan covers screening procedures when appropriate for a Claimant as follows:

- 1 pap smear each year;
- 1 prostate specific antigen (PSA) test each year for a Claimant age 40 or older;
- mammography screening in accordance with the following:
  - 1 mammography screening each year for a Claimant age 25 through age 39, with documentation that there is an inherited predisposition for cancer of the breast; and
  - 1 mammography screening each year for a Claimant age 40 or older.
- annual test of the stool for occult blood for a Claimant age 40 or older;
- 1 bone density scan every 2 years for a Claimant age 40 or older;
- 1 sigmoidoscopy every 3 years for a Claimant age 40 or older; and
- 1 total colon examination by colonoscopy every 10 years for a Claimant age 50 or older.

Specific Limitations and Exclusions

The Plan does not cover the following preventive care services:

- "wellness" educational materials such as books, pamphlets, audiotapes and video-tapes;
- mental examinations and psychological tests; and
- examinations, x-rays and laboratory procedures in the absence of presenting signs and symptoms, except preventive care services specified above.

PROFESSIONAL SERVICES

Payment for some professional services may be included with the benefit for the facility services, as applicable.

Anesthesia Services

The Plan covers the administration of anesthetics to achieve general or regional, but not local, anesthesia and related resuscitative procedures. Local anesthesia is the administration of an anesthetic agent to achieve muscular relaxation and/or loss of sensation in a narrowly confined area of treatment while allowing the patient to remain conscious.

Consultations

The Plan covers the services of a Provider whose opinion or advice is requested by the attending Provider for further evaluation of an Illness or Injury.

Diabetic Education

The Plan covers services for diabetic self-management training and education, including nutritional therapy, when requested by the attending Physician. Services must be provided by an accredited or certified program.

Family Planning

The Plan covers basic evaluative services for family planning, birth control devices, injectable contraceptives and sterilization procedures.

Medical Services

The Plan covers professional services by a Physician or Practitioner which are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury as follows:

- direct physical or mental examination of the patient, patient's body or substance(s) from the body, and associated cognitive services for prescribing or administering treatment, but not counseling or patient education unless provided at no additional charge;
- diagnostic services which are radiology, ultrasound, nuclear medicine, laboratory, pathology, and electronic diagnostic medical procedures;
- non-replaced blood, blood plasma, blood derivatives, and their administration;
- dialysis treatment, respiration therapy, radiation and chemotherapy (subject to the specific limitations and exclusions stated in the TRANSPLANTS Section); and
- intrauterine devices (IUDs) and diaphragms.

Surgical Assistants

The Plan covers the services of an assistant surgeon when performed in connection with a surgical procedure which is a Covered Service.

Surgical Services

The Plan covers surgical services which are generally recognized and accepted procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury as follows:

- cutting or laser operative procedures;
- suturing of wounds and debridement of wounds, burns, or infections;
- reduction of fractures or dislocations and orthopedic casting;
- endoscopic examination of internal organs of the body;
- use of a needle or cannula for biopsy, aspiration, or injection of a tendon sheath, joint, major body cavity, or blood vessel (vein or artery), but not routine venipuncture (drawing blood for laboratory tests is a medical service);
- intraarterial, intravenous, or intracardiac catheterization;
- electrical, chemical, or mechanical destruction of tissue;
- orthognathic surgery for skeletal deformities not correctable by orthodontic means; and
- oral surgery, but not dental (teeth and gums) surgery.

Specific Limitations and Exclusions

The Plan does not cover the following professional services:

- services of an assistant surgeon when the Hospital provides or makes available qualified staff personnel (including Physicians in training status) as surgical assistants; services of more than one assistant surgeon at one operative procedure; and services of an assistant surgeon when the complexity of the surgery does not warrant the services of an assistant;

- acupuncture, hypnosis, and administration of anesthesia by the primary or the assistant surgeon other than dental general anesthesia by a dentist or oral surgeon;
- treatment of Morbid Obesity, including bariatric surgical procedures, services or related expenses not specifically approved by the Claims Administrator;
- surgical correction of vision; and
- reversal of voluntary surgical sterilization or subsequent re-sterilization.

Skilled Nursing Facility (SNF) Care

Accommodations

The Plan covers the following accommodations (including bed, board and general nursing care) during an admission to a Skilled Nursing Facility for extended care:

- semi-private (or multi-bed unit) room.

Services and Supplies

The Plan covers the following services and supplies as customarily furnished to patients by a Skilled Nursing Facility:

- drugs and medicines which have been approved for use in the United States by the United States Food and Drug Administration, including intravenous injections and solutions;
- dressings, splints, casts, and other supplies for medical treatment provided by the facility from a central sterile supply department;
- oxygen and its administration; and
- inhalation therapy.

Specific Limitations and Exclusions

The Plan does not cover the following in connection with Skilled Nursing Facility care:

- vocational rehabilitation services, private duty nursing services, personal convenience or hygiene items, and late discharge billing for the convenience of the patient.

Speech Therapy Services

The Plan covers speech therapy as follows:

All Claimants

The Plan covers Speech Therapy services when provided to restore or improve speech function lost as a result of an Illness or Injury, or when part of an approved treatment plan following the insertion of a cochlear implant.

Claimants Through Age 12

Additionally, the Plan covers speech therapy services for Claimants through age 12 when provided to restore or improve speech function resulting from congenital anomalies or a medical condition.

Specific Limitations and Exclusions

The Plan does not cover assistance in learning a new language, voice training, or therapy to reduce an accent. The Plan does not cover speech therapy provided solely to maintain the Claimant's condition at the level to which it has been restored with no expectation of significant improvement.

Transplants

The Plan covers the following transplant procedures when Medically Necessary and **only** when the provisions of the Care Management Program have been followed before services are received (the prenotification provision of the Care Management Program does not apply to kidney and cornea transplants).

Solid Organ and Bone Marrow Transplants

Certain restrictions apply to heart; heart/lung; lung (single or double); liver; and pancreas transplants, please see the specific exclusions and limitations in this section for details.

Covered Solid Organ Transplants

The Plan covers only the following solid organ transplants:

- kidney
- cornea
- small bowel
- heart
- heart/lung
- lung (single or double)
- liver
- pancreas

Services and Supplies

The Plan covers services and supplies directly related to covered solid organ transplants as follows:

- Organ Procurement Expenses which means those diagnostic or medical services to evaluate, select, store, identify or test an organ or tissue. It also means the donor's surgical and Hospital services directly related to the removal of an organ or tissue. Organ Procurement Expenses also include those expenses incurred by recipients in the medical process to locate a compatible donor. Transportation of the donor or for the donated organ or tissue is not an Organ Procurement Expense;
- pre-operative, post-operative and follow-up care; and
- medications to inhibit rejection of the transplant.

Covered Bone Marrow Transplants for Treatment of Non-Malignant Diseases

The Plan covers only bone marrow transplants for treatment of non-malignant diseases in which native bone marrow is insufficient to provide essential blood elements.

Services and Supplies

The Plan covers services and supplies directly related to covered bone marrow transplants for treatment of non-malignant diseases as follows:

- bone marrow or peripheral stem cell identification, donation and storage expenses;
- pre-transplant chemotherapy and/or radiation treatment;
- allogeneic bone marrow or peripheral stem cell transplant;
- post-transplant outpatient care directly related to the transplant; and
- re-transplantation.

Specific Limitations and Exclusions

The Plan does not cover the following in connection with solid organ and bone marrow transplant services:

- services, supplies or accommodations in connection with heart; heart/lung; lung (single or double); liver; and pancreas transplants not received at the University of Utah Hospitals provided, however, if based on review by appropriate medical professionals at the University of Utah Hospitals, it is determined the covered procedure cannot be performed at the University of Utah Hospitals, medically necessary Covered Services will be a benefit when performed at another, more appropriate facility. However, pre-admission certification must be completed and one of the Claims Administrator’s case managers will be assigned to assist in the coordination of the transplant authorization process;

- services, supplies or accommodations in connection with artificial heart, artificial pancreas, or artificial liver implants; and any other organ or artificial organ which may become available for transplant or implant after the Effective Date of the Plan. This exclusion does not apply to left ventricular assist devices (LVADs); and
- services, supplies or accommodations in connection with a transplant which is not listed as a Covered Service, including but not limited to: 1) any bone marrow transplant in the treatment of diseases or conditions resulting from infection from a human T-cell leukemia virus (e.g., AIDS); 2) any intestine transplant; 3) any transplant of a non-human organ or non-human bone marrow; 4) any bone marrow transplant in the treatment of brain cancer; and 5) implantation of any artificial organ, regardless of whether implantation is a temporary measure while awaiting an available human organ.

Myeloablative Therapy (MAT) with Hematopoietic Stem Cell Support (HSCS) for Malignancies Services (MAT/HSCS Transplant Services)

Certain restrictions apply to MAT/HSCS transplant services, please see the specific exclusions and limitations in this section for details.

Definitions Specific to MAT/HSCS Services

In addition to the definitions in the DEFINITIONS Section, the following are definitions that apply to MAT/HSCS transplant services:

- Allogeneic Hematopoietic Stem Cell Support is the harvesting of bone marrow stem cells and/or peripheral stem cells from a healthy donor for infusion into a patient whose bone marrow is compromised.
- Autologous Hematopoietic Stem Cell Support is an infusion of primitive cells capable of replication and differentiation into mature blood cells. They are harvested from the Claimant's blood stream or bone marrow prior to the administration of the Myeloablative Therapy.
- Colony Stimulating Factor is a substance that increases the reproduction, differentiation and maturation of blood cellular components.
- Myeloablative Therapy is a course of therapy which is expected to destroy the bone marrow.

Patient Selection Criteria

Before the Plan will cover MAT/HSCS transplant services, it must be shown that a Claimant's proposed treatment meets the criteria for health and age standards as determined by the Plan, in addition to the following criteria:

- the probability of achieving a durable complete remission is greater with MAT than with standard dose therapies, considering the Claimant's disease characteristics and treatment history;
- the Claimant does not have central nervous system metastases from a solid tumor; and
- the Claimant does not have a concurrent condition which would seriously jeopardize the achievement of a durable complete remission with MAT.

Covered Diseases

The Plan covers MAT/HSCS transplant and/or autologous peripheral stem cell transplant services only for treatment of the following diseases:

- lymphoma
- Hodgkin's disease
- neuroblastoma
- acute leukemia
  - lymphocytic
  - myelogenous

- germ cell tumors
- Ewing's sarcoma, recurrent or refractory
- medulloblastoma, recurrent or refractory
- Wilm's tumor, high risk or recurrent
- primitive neuroectodermal tumor
- multiple myeloma

The Plan covers Allogeneic MAT/HSCS transplant only for the treatment of the following conditions:

- aplastic anemia
- acute leukemia
  - Lymphocytic
  - Myelogenous
- severe combined immunodeficiency (not AIDS)
- infantile malignant osteopetrosis
  - Albers - Schonberg syndrome
  - marble bone disease
- chronic myelogenous leukemia
- lymphoma
- Wiskott-Aldrich Syndrome
- Neuroblastoma
- homozygous beta-thalassemia (thalassemia major)
- Hodgkin's disease
- myelodysplastic syndrome
- mucopolysaccharidoses
- mucolipidoses
- myeloproliferative disorders
- sickle cell anemia
- Kostmann's syndrome
- leucocyte adhesion deficiencies
- x-linked lymphoproliferative syndrome
- Wilm's tumor, high risk or recurrent
- breast cancer
- Ewing's sarcoma, recurrent or refractory
- other transplants determined by the Plan to be a covered transplant since the Summary Plan Description was issued.

Services and Supplies

The Plan covers services and supplies directly related to covered MAT/HSCS transplant services as follows:

- allogeneic bone marrow and/or peripheral stem cell transplant/rescue which is the harvesting of bone marrow stem cells and/or peripheral stem cells from a healthy donor for infusion into a patient whose bone marrow is compromised
- Autologous Hematopoietic Stem Cell Support including collection, processing and storage;

- high dose chemotherapy which is the administration of cytotoxic agents at doses several times greater than the standard therapeutic dose and may include whole body or localized radiotherapy
- Myeloablative Therapy
- Colony-Stimulating Factor
- post-transplant care for 60 calendar days, including immunosuppressive drugs

Specific Limitations and Exclusions

The Plan does not cover the following in connection with MAT/HSCS transplant services:

- services, supplies or accommodations in connection with the use of MAT/HSCS not received at the University of Utah Hospitals provided, Covered Services will be a benefit at another, more appropriate facility when it is determined by appropriate medical professionals at the University of Utah Hospitals that the covered procedure cannot be performed at the University of Utah Hospitals. However, pre-admission certification must be completed and one of the Claims Administrator's case managers will be assigned to assist in the coordination of the authorization process;
- services, supplies or accommodations related to any evaluation, treatment or therapy involving the use of MAT/HSCS which are not specifically identified as Covered Services, including but not limited to services, supplies or accommodations related to non-human bone marrow; and
- services, supplies or accommodations related to any evaluation, treatment or therapy involving the use of MAT/HSCS in the treatment of diseases not specifically listed as Covered Diseases or which do not meet the criteria set forth for Covered Diseases, including but not limited to: 1) the treatment of diseases or conditions resulting from infection from a human T-cell leukemia virus or HIV (e.g., AIDS); 2) chronic lymphotic leukemia/small lymphocytic lymphoma; 3) primary intrinsic tumors of the brain in adults; 4) epithelial ovarian cancer; 5) lung cancer, small cell or non-small cell; 6) mesothelioma; 7) malignant melanoma; 8) tumors of the gastrointestinal tract, including those of the colon, rectum, pancreas, stomach, esophagus, gall bladder, and bile duct; 9) renal cell carcinoma, and carcinomata of the cervix, uterus, fallopian tubes, and prostate gland; 10) nasopharyngeal tumors, paranasal sinus neuroendocrine tumors, and tumors of unspecified histology; 11) soft tissue sarcomas or osteogenic sarcomas, unless specifically provided in the Plan; 12) thyroid tumors; 13) tumors of the thymus; 14) undifferentiated tumors; and 15) tumors of unknown primary origin.

VISION SERVICES

The Plan covers one routine vision examination for each Claimant each Contract Year.

Specific Limitations and Exclusions

The Plan does not cover the following vision services:

- the fitting, purchase, or replacement of eyeglasses
- contact lenses, including contact lens checks, except for the first intraocular lenses following cataract surgery
- visual therapy, training, and eye exercises
- vision orthoptics
- vitamin therapy for vision
- fundus photography
- surgical procedures to correct refractive errors/astigmatism. Additionally, reversals or revisions of surgical procedures which alter the refractive character of the eye are excluded.

COVERED PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are administered through CVS Caremark, not through University Health Care Plus. Please contact CVS Caremark at (800) 966-5772 for information on Prescription Drug Benefits.

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

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

COVERED PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are available for the following:

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

LIMITATIONS AND EXCLUSIONS

The following limitations and exclusions apply to Prescription Drug Benefits:

A Non-Legend Patent or Proprietary Medicine

Anabolic Steroids

Charges for the Administration or Injection of Any Drug

Cosmetic Hair Growth and Removal Products

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

Food Supplements, Special Formulas, and Special Diets

Immunization Agents, Biological Sera, Blood, or Blood Plasma

Impotence Medication

In excess of 6 doses in a 25 day period.

Infertility Medications

Investigational or Experimental Drugs

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

<u>Mail Order Prescription Drugs from a Non-University Health Care Pharmacy</u>

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

<u>Medication Not Requiring a Prescription Order, Other than Insulin</u>

<u>Medication Taken or Administered While a Patient</u>

Medication which is taken by or administered to an individual, in whole or in part, while he or she is a patient in a doctor's office, hospital, rest home, sanatorium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals. (In some cases, this medication is covered under the Medical Benefits portion of the Plan.)

<u>Non-Medicinal Substances and Over-the-Counter Medication</u>

Therapeutic devices or appliances, including hypodermic needles, syringes (excluding insulin syringes), support garments, and other non-medicinal substances, regardless of intended use; and any over-the-counter medication, vitamin and/or mineral, or item(s) purchased at a pharmacy other than Prescription Drugs whether or not there is a Prescription Order for the item(s). (In some cases, items may be covered under the Medical Benefits portion of the Plan.)

<u>Other Party Liability</u>

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

<u>Pigmenting/Depigmenting Agents</u>

Except as required to treat photosensitive conditions, such as psoriasis.

<u>Prescription Drugs for a Non-FDA Approved Purpose or Dosage</u>

Any Prescription Drug prescribed for use other than its FDA-approved purpose or in a dosage other than the standard dosage for an FDA-approved purpose.

<u>Prescription Drugs In Excess of a 90 Day Supply</u>

<u>Refills</u>

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

DEFINITIONS

In addition to the definitions in the DEFINITIONS Section of this Summary Plan Description, the following definitions apply to this COVERED PRESCRIPTION DRUG BENEFITS Section:

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

<u>Nonparticipating Pharmacy</u> means a pharmacy which has no network agreement with CVS Caremark.

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

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

<u>Prescription Order</u> means a written or oral order for a Prescription Drug issued by a Physician or Practitioner within the scope of his or her professional license.

COVERED BEHAVIORAL HEALTH BENEFITS

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

EMPLOYEE ASSISTANCE PROGRAM (EAP)

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

The EAP provides the following services:

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

MENTAL HEALTH SERVICES AND CHEMICAL DEPENDENCY SERVICES

Inpatient and Outpatient benefits are subject to the dollar and visit limits and the Lifetime Maximums listed in the SUMMARY OF BEHAVIORAL HEALTH BENEFITS Section.

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

LIMITATIONS AND EXCLUSIONS

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

Care or treatment of the following **conditions**:

- ADD/ADHD, except for the purpose of assessment and medication management
- adjustment disorder
- autism
- conduct disorders
- enuresis and encopresis
- gambling addiction
- grief
- kleptomania

- learning disabilities
- mental or emotional conditions without manifest psychiatric disorder
- mental retardation
- non-specific conditions
- oppositional disorders
- paraphilias
- personality disorders
- psychosexual disorders
- pyromania
- tourette's

The following **costs and services**:

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

Costs for Discontinuing Treatment

Costs incurred for discontinuing treatment or program against medical advice.

Services Not Coordinated Through The EAP:

Any Behavioral Health Service NOT coordinated through the EAP will be covered as a Without EAP Referral benefit, regardless of whether or not the Provider/Hospital has an existing contract with the UNI BHN network.

APPEALS PROCESS – BEHAVIORAL HEALTH BENEFITS ONLY

First Level - Complaint/Grievance/Reconsideration

You may initiate an Appeal through either a written or oral request. Written Appeal requests should be mailed to: UNI BHN, 501 Chipeta Way, Salt Lake City, Utah 84108. Oral requests can be made by calling the EAP at (801) 587-9319 within the Salt Lake area or (800) 926-9619 outside the Salt Lake area. "First Level - Complaint/Grievance/Reconsideration" is a review by the Director of Clinical Services. A written notice of the decision will be sent within 30 calendar days of receipt of the "First Level - Complaint/Grievance/Reconsideration" and within 5 business days of the decision being made. If Your Provider requests reconsideration of a denial of preauthorization, a peer-to-peer discussion with the Director of Clinical Services will be arranged within 1 working day of the request.

Second Level - Committee Appeal

If You disagree with the decision made in the "First Level - Complaint/Grievance/Reconsideration," You may request further Appeal to the "Second Level - Committee Appeal." The Appeal request must be made in writing or orally within 180 calendar days after You receive notice of the decision at the "First Level - Complaint/Grievance/Reconsideration". Failure to request a "Second Level - Committee Appeal" within this time period will preclude Your right to further Committee Appeal of the decision. The written Appeal request, including any additional information or comments, must be made to the Director of Clinical Services, UNI BHN, 501 Chipeta Way, Salt Lake City, Utah 84108. "Second Level - Committee Appeal" is a review by the Clinical Management Committee, which is comprised of the Director of Clinical Services, the Medical Director and at least one other member of the Claims Administrator's officers. You or Your Representative, on Your behalf, will be given a reasonable opportunity to personally appear or participate via telephone, video conference, or other technology, and/or to provide written materials. A written notice of the decision will be sent within 30 calendar days of receipt of the "Second Level - Committee Appeal" and within 5 business days of the decision being made.

OPTIONAL APPEALS – BEHAVIORAL HEALTH BENEFITS ONLY

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

Optional External Appeal (Medical Necessity Issues Only)

If You disagree with the decision made in the "Second Level - Committee Appeal", and the issue on Appeal is the Medical Necessity of services or services that are investigational or experimental in nature, You may request further Appeal to the "Optional External Appeal." The Appeal request must be made in writing or orally within 180 calendar days after You receive notice of the decision at the "Second Level - Committee Appeal." Failure to request an "Optional External Appeal" within this time period will preclude the Claimant's right to further appeal of the decision through this optional level. The written Appeal request, including any additional information or comments must be made to the Director of Clinical Services, UNI BHN, 501 Chipeta Way, Salt Lake City, Utah 84108. "Optional External Appeal" will be coordinated by the Director of Clinical Services while the decision is made by an Independent Review Organization (IRO) at no cost to You. The IRO is an independent physician review organization that is unbiased, independent and not controlled by the Claims Administrator or the Plan. Within the IRO, there will be clinical expertise, use of evidence-based decision making, maintenance of confidentiality, and adequate administration and training capacity. Within 5 calendar days of receipt of the request for a

"Optional External Appeal," the Director of Clinical Services will determine if the Appeal concerns Medical Necessity. If the Director of Clinical Services determines the Appeal concerns Medical Necessity, he or she will provide the IRO with the Appeal documentation within 3 business days and a written notice of the IRO's decision will be sent to You within 30 calendar days of receipt of the request for "Optional External Appeal." Choosing the "Optional External Appeal" for the settlement of an Appeal as the final level will be binding in accordance with the IRO's decision and this section.

-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 Director of Clinical Services can assist You with procedures for initiating and participating in an arbitration.

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.

WAITING PERIOD FOR PREEXISTING CONDITIONS

The Plan has a waiting period for Preexisting Conditions. A Preexisting Condition is defined as a physical or mental condition, except for pregnancy, whether diagnosed or misdiagnosed, which within the six-month period before Your Enrollment Date (defined below):

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

Enrollment Date means:

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

Pregnancy is not considered a Preexisting Condition. In addition, the Plan will not impose the waiting period for a Preexisting Condition of a newborn child, an adopted child, or a child placed with You for adoption if You complete the paperwork necessary to add the child to Your coverage within 3 months of the birth, adoption or placement, respectively.

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

Waiting Period Time Limit

The waiting period will end 6 months following Your Enrollment Date, unless You enrolled as a Late Enrollee in which case the waiting period will end 18 months following Your Effective Date of coverage under this Plan.

Creditable Coverage

The Plan will reduce the duration of the Preexisting Condition waiting period by the amount of Your combined periods of Creditable Coverage if You have been covered by Qualifying Coverage, provided there is no break in coverage greater than 63 calendar days, immediately preceding Your Enrollment Date (as defined above). Coverage may be concurrent.

Qualifying Coverage means any of the following: group coverage (including self-funded plans not qualified for regulatory exception, FEHBP, and Peace Corps); individual coverage (including student health plans); S-CHIP; Medicaid; Medicare; CHAMPUS/Tricare; Indian Health Service or tribal organization coverage; state high risk pool coverage; and public health plans (including foreign government and US government plans).

Qualifying Coverage is determined separately for each Claimant.

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

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

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

EXCLUSIONS

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

Alternative Care

The following types of alternative care:

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

Appliances Or Restorations Necessary To Increase Vertical Dimension Or Restore Occlusion

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.

Behavioral Health Services

Behavioral Health Services are administered through Blomquist Hale Consulting and UNI BHN. See the COVERED BEHAVIORAL HEALTH SERVICES Section for the specific limitations and exclusions of Behavioral Health benefits.

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.

Birth Control/Infertility

Services and supplies in connection with the following:

- non-prescription contraceptives;
- reversal of voluntary surgically performed sterilization or subsequent re-sterilization;
- artificial insemination or in vitro fertilization;
- infertility, except to the extent Covered Services are required to diagnose such condition; and
- fertility drugs and medications.

Charges That Exceed Eligible Medical Expenses

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

Cosmetic/Reconstructive Services And Supplies

Cosmetic services and supplies, except in the case of surgery and other care or procedures:

- performed to restore a physical bodily function; or
- required as a result of an Accidental Injury, Illness, or therapeutic intervention and services are rendered or planned (as specifically documented in the Claimant's medical record) within 12 months of the cause or onset of the Injury, Illness or therapeutic intervention (generally performed to restore function, but may also be done to restore a normal appearance).

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

Counseling

Charges for counseling a Claimant, including the following:

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

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

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.

Custodial, Domiciliary and Convalescent Care and Residential Treatment

Custodial Care, domiciliary care, convalescent care (other than extended care), rest cures, and services provided for or in connection with institutional care which is for the primary purpose of controlling or changing the Claimant's environment. Also excluded is residential treatment, regardless of the condition or diagnosis for which the Claimant is admitted and regardless of the program or treatment being received.

Custodial Care means care that mainly provides room and board (meals), or if it is for a physically or mentally disabled person who is not receiving care specifically to reduce the disability so that the person can live outside a medical care facility or nursing home. No matter where the person lives, care is considered Custodial Care if it is non-skilled nursing care, training in personal hygiene, other forms of self-care, supervisory care by a Provider, or care provided by a health care facility licensed by the State of Utah as an assisted living facility, hospice, residential health care facility, or small health care facility, or that is similarly licensed by the state in which it is located. Custodial Care does not mean outpatient palliative and supportive care provided by a hospice program to a Claimant who is terminally ill with a life expectancy of not more than 6 months and is in lieu of institutional or inpatient Hospital care.

Dental Services

Dental Services, unless the Plan specifically covers them.

Expenses Incurred Before Coverage Begins Or After Coverage Ends

Services and supplies incurred whether before enrollment under the Plan or after termination or ineligibility 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 scientific evaluation has not been completed, effectiveness has not been established, or the procedure or treatment has not been accepted and generally used for a period of five years unless approved sooner by the Plan’s medical policy committee. Benefits shall be provided for experimental treatments or procedures related to the diagnosis and treatment of high-risk osteogenic sarcoma.

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.

Food Supplements, Special Formulas, and Special Diets

Food supplements, special formulas and special diets, except as required for inborn metabolic errors including neocate formula and other specifically formulated foods as the Claims Administrator determines Medically Necessary.

Foot Care

Foot care, including but not limited to:

- treatment of corns and calluses
- trimming of nails, except when Medically Necessary for diabetic patients (the Plan does cover surgery for ingrown toenails)
- foot impression casting including x-rays
- nonsurgical treatment of bunions, flat feet, fallen arches, weak feet, chronic foot strain, or other symptomatic complaints of the foot
- arch supports
- special shoe accessories
- foot orthotics other than Medically Necessary foot orthotics immediately following foot surgery

Gastric Procedures

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

Genetic Services

Services and supplies for or in connection with nucleic acid level genetic studies or for genetic alteration. This exclusion does not apply to a Claimant’s genetic tests when all of the following conditions are met: 1) there is a reasonable expectation based on family history, pedigree analysis, risk factors, and/or symptomatology that a genetically inherited condition exists; 2) the test can be adequately interpreted and is subject to peer review; 3) the result will aid in the diagnosis or influence the medical or surgical management of the Claimant or family members at risk; 4) the Claimant has received pre-test genetic counseling from a qualified professional; and 5) the Claimant has not already had the specific test performed during his/her lifetime.

Growth Hormone

Growth hormone therapy once bone growth is complete.

Hearing Treatment

Programs or treatment for hearing loss, including but not limited to hearing aids (internal or external); implantable hearing aids and the surgery and services necessary to implant them.

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.

Obesity Or Weight Reduction/Control

Medical or surgical treatment (including reversals), programs, or supplies that are intended to result in weight reduction, regardless of diagnosis or psychological conditions, except certain surgical procedures for the treatment of Morbid Obesity.

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; 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. For example, the Plan does not cover telephones, television, and guest meals while in a facility if they are charged separately from the cost of the room.

Personality Disorder, Learning Disability, etc.

Care or treatment of chronic organic brain syndrome, personality disorder, learning disability, or mental retardation, except to the extent Covered Services are required to diagnose such conditions.

Physical Exercise Programs And Equipment

Physical exercise programs or equipment, including hot tubs, or membership fees at spas, health clubs, or other such facilities whether or not the program, equipment, or membership is recommended by the Claimant's Provider.

Pregnancy Termination (Abortion)

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

Preparation Of Forms/Missed Appointments

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

Prescription Drugs And Other Medications

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

Private Duty Nursing

Private duty nursing or hourly nursing services, including ongoing hourly shift care in the home.

Psychoanalysis/Psychotherapy

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

Riot, Rebellion, War And Illegal Acts

Services and supplies for treatment of an Illness or Injury caused by a Claimant's **voluntary 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.

Routine Physical Examinations, Tests, Screening Procedures, And Immunizations

Except as specifically described as a benefit under the Plan, routine physical examinations, including tests, screening procedures, and immunizations when the Claimant has no symptoms of Illness or Injury

(for example, cancer screening tests and general health screening tests). The Plan will, however, cover tetanus or rabies vaccinations administered in connection with an Accidental Injury.

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

Self-help, non-medical self-care, training, educational, or instructional programs. Unless specifically described as a benefit, this includes diet and weight monitoring services, instruction programs including those to learn how to self-administer prescriptions or nutrition, and programs that explain how to use Durable Medical Equipment or how to care for a person in the family. 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 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 By A School Or Halfway House

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

Services And Supplies 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 And Supplies That Are Not Medically Necessary

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

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).

Sexual Counseling, Treatment, Or Surgery

Counseling, treatment (including drugs, except as provided under Prescription Drug Benefits), or surgery for sexual dysfunction, including but not limited to transsexualism, psychosexual identity disorder, psychosexual disorder or gender dysphoria.

Tobacco Addiction Treatment

Treatment of tobacco addiction, including supplies for addiction to tobacco, tobacco products, or nicotine substitutes.

Travel And Transportation Expenses

Travel and transportation expenses other than covered Ambulance Services provided in the Plan.

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

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

Vision Care

Services and supplies related to vision care, unless specifically described as a benefit under the Plan, including but not limited to:

- the fitting, provision, or replacement of eyeglasses
- contact lenses, including contact lens checks, except for the first intraocular lenses following cataract surgery
- visual therapy, training, and eye exercises
- vision orthoptics
- vitamin therapy for vision
- fundus photography
- surgical procedures to correct refractive errors/astigmatism. Additionally, reversals or revisions of surgical procedures which alter the refractive character of the eye are excluded.

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

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 health care expenses are the responsibility of a source other than the Plan.

CASE MANAGEMENT PROGRAM

The Plan uses a program called Case Management to help ensure the services that You receive are Medically Necessary, appropriate and consistent with current medical practice. (It is important to note that Medical Necessity does not make a service that is a specific exclusion of the Plan a Covered Service.) The Claims Administrator has four methods of reviewing the health care You receive. Case Management consists of the following:

Prenotification

The Plan reviews certain services before they are received. Because many types of treatment may be available for certain conditions, the prenotification process helps Your Physician work together with You, other Providers, and the Claims Administrator to determine the treatment that best meets Your medical needs. The Claims Administrator looks for these things: 1) the benefit to You; 2) whether the service meets accepted medical guidelines, using the latest scientific information and recommendations; 3) whether the requested service is consistent with benefits under the Plan; and 4) whether the level of care and length of stay meet the Plan's guidelines.

Concurrent Review

The Plan monitors and reviews certain services while they are being received. The Claims Administrator does this to see if they meet the Plan's medical guidelines. The Claims Administrator can also help You and Your Provider plan for anticipated needs, such as physical therapy after You leave the Hospital, and help coordinate these services.

Post Service Review

The Claims Administrator reviews some services already received to ensure they meet the Plan's criteria and that they were appropriate for Your condition. This also helps the Claims Administrator monitor how care is being delivered by Providers in the community.

Case Management

The Claims Administrator can help You coordinate medical needs for complex and catastrophic Illnesses or Injuries as well as certain chronic Illnesses. Case management is designed to provide early detection, intervention and assistance in cases of serious or long-term Illness or Injury that have the potential for major continuing expense so that the appropriate level of care and treatment settings can be coordinated and a plan of care developed. The Plan may assess treatment methods and propose possible alternative health care to help promote positive treatment outcomes and maximize use of Your benefits under the Plan.

University Health Care Plus Providers have agreed to participate in the Case Management Program and are responsible to notify University Health Care Plus before You receive any of the following services:

- home health care and home infusion therapy;
- transplants, including the use of Myeloablative Therapy with Hematopoietic Stem Cell Support; and
- all inpatient admissions, including admissions to a Skilled Nursing Facility or Rehabilitation Facility, except as follows:
  - when Your admission cannot be scheduled in advance (an emergency admission), the Claims Administrator must be notified of the admission on the next business day or no later than the next business day following stabilization of the patient;
  - notification is not required for any maternity (delivery) admission having a duration of 48 hours or less following vaginal delivery or of 96 hours or less following cesarean delivery. An admission having a longer duration requires notification of the continued stay; and
  - when the Plan is the Secondary Health Plan.

It should be noted that although You notify the Claims Administrator of the intent to receive a service, it does not guarantee that the Plan will cover the service. In the event the Plan determines that the service is not covered, the Plan will not provide any benefit for the service, regardless of whether notification was received.

The Claims Administrator also encourages You to contact them when receiving the following services:

- high risk maternity care;
- cosmetic and reconstructive procedures; and
- high cost Durable Medical Equipment, including prosthetics and orthotics.

The special telephone numbers to use for Case Management are:

Within the Salt Lake area: (801) 587-6480 Outside of the Salt Lake area: (888) 271-5870

Regular business hours are from 8:00a.m. to 5:00p.m., Mountain Time, Monday through Friday, except holidays. Voice messaging service is available during non-business hours, including weekends and holidays.

HEALTH PLAN IDENTIFICATION CARD

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

It is important to keep Your Health Plan Identification Card with You at all times. Be sure to present it to Your Provider before receiving care and to Your Pharmacy before purchasing Your Prescription Drugs.

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

SUBMISSION OF CLAIMS AND REIMBURSEMENT

The Plan has the sole right to decide whether to pay You, the Provider, or You and the Provider 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 Appeal Process when You can demonstrate that the claim could not have been filed timely.

Network Provider Claims

When obtaining Covered Services from a Network Provider, Your Health Plan Identification Card must be presented and You must furnish any additional information requested. The Network Provider will furnish to the Claims Administrator the necessary forms and information to process Your claim.

Network Provider Reimbursement

The Plan will pay the Network Provider directly for Covered Services as follows:

- Network Physicians, Network Practitioners and other professionals who are Network Providers have agreed to accept Eligible Medical Expenses as full compensation for Covered Services. Your share of Eligible Medical Expenses is any amount You must pay due to Deductible, Copayment and/or Coinsurance. A Network Provider may require You to pay Your share at the time You receive care or treatment;
- Network Hospitals, Network Skilled Nursing Facilities and other facilities that are Network Providers have agreed to accept Eligible Medical Expenses as full compensation for Covered Services. Eligible Medical Expenses can be greater than or less than the facility's actual charges for Covered Services. Your obligation for payment to a Network Provider is the Deductible, Copayment and/or Coinsurance as provided in the SUMMARY OF MEDICAL BENEFITS. Your Coinsurance will be calculated as a percentage of the lower of: 1) the facility's actual charges; or 2) Eligible Medical Expenses. A Network Provider 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 Network Providers. When a Network Provider is used, You are responsible to pay only Your Deductible, Copayment and/or Coinsurance for Covered Services.

Out-of-Network Provider Claims

Before You will be entitled to payments under the Plan for Covered Services provided by an Out-of-Network Provider, 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 medical 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 Out-of-Network Provider itemizing the diagnosis, the accommodations, services and supplies 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.

Out-of-Network Physicians, Out-of-Network Practitioners and other professionals who are Out-of-Network Providers have not agreed to accept Eligible Medical Expenses as full compensation for Covered Services. Thus, You are responsible for paying any difference between the amount billed by the Out-of-Network Provider and Eligible Medical Expenses in addition to any amount You must pay due to Deductible and/or Coinsurance;

Out-of-Network Hospitals, Out-of-Network Skilled Nursing Facilities and other facilities that are Out-of-Network Providers have not agreed to accept payment in accordance with contractual payment schedules. Thus, You are responsible for paying any difference between the amount billed by the Out-of-Network Provider and the amount the Plan determines to be reasonable charges in addition to any amount You must pay due to Deductible and/or Coinsurance.

NOTE: When Out-of-Network Providers are used, You are responsible not only for Deductible and/or Coinsurance for Covered Services, but also for the difference between the Out-of-Network Provider's billed charges and Eligible Medical Expenses, except as specified in the SUMMARY OF MEDICAL BENEFITS Section.

Nothing contained in the Plan will be construed to restrict You in exercising full freedom of choice in the selection of a Hospital, Skilled Nursing Facility or other Provider for care or treatment of an Illness or Injury.

<u>Claims Procedures</u>

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.

MULTIPLAN PPO PROGRAM

Outside the Wasatch Front Area, University Health Care Plus has an arrangement through the MultiPlan PPO Program to provide Covered Services to You in accordance with the provisions of the Plan. When You obtain Covered Services outside the Wasatch Front Area from a MultiPlan PPO Provider, the Plan will provide benefits at the same level as for University Health Care Plus Providers in the University Health Care Plus Area. Payments will be made directly to the MultiPlan PPO Provider. The amount You pay for Covered Services is usually calculated from the lower of: 1) the Provider's billed charges for the Covered Services; or 2) the negotiated contract price. However, the amount You pay is considered a final price.

NOTE: It is generally to Your financial advantage to use MultiPlan PPO Providers outside the Wasatch Front Area. When a MultiPlan PPO Provider is used, You are responsible to pay only Copayment and/or Coinsurance for Covered Services.

NOTE: Outside the Wasatch Front Area, call (800) 464-0292 for assistance in locating a Provider who participates in the MultiPlan PPO Program.

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 University Health Care Plus or the Plan. You may not assign, transfer, or delegate any right of representation or collection other than to legal counsel directly authorized by You on a case-by-case basis.

CLAIMS RECOVERY

If 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 Claims Administrator, on behalf of 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 Claims Administrator 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, or to take legal or corrective action in cases of fraud. Refer to the Other Party Liability provision in the CLAIMS ADMINISTRATION Section for additional information.

Right To Receive And Release Necessary Information And Medical Records

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

If this Health Care Plan 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

In all cases, You have the exclusive right to choose a health care provider. The Plan is not responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since the Plan does not provide any health care services, the Plan cannot be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither employees nor agents of University Health Care Plus.

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 Plan's control.

Other Party Liability

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 will not reduce its reimbursement or subrogation right due to Your not being made whole. 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

In the event You are covered under one or more Health Plans (as defined below), the benefits of the Health 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 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 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 Plan means the Health Plan that must determine its benefits for a person's health care first. There may be more than one Primary Health Plan. A Health Plan is a Primary Health Plan in either of the following conditions:

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

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

Allowable Expenses means the amount on which a Health Plan would base its benefit payment for Covered Services in the absence of any other coverage. When a Health 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 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 Plan which covers the person as a dependent;
- When this and another Health 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 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 Plan which covered the parent longer are determined before those of the Health Plan which covered the other parent for a shorter period of time.
- When this and another Health Plan cover the same child as a dependent of parents who are separated, divorced, or not living together:
  - The benefits of the Health 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 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 Plan which covers the child as a dependent of the parent without custody, then the benefits of the Health 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 Plan of that parent has actual knowledge of those terms, the benefits of that Health Plan will be determined before the benefits of any other Health 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 Plan will be determined before the benefits of any other Health 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 Plan which covers a person as an active employee, member or subscriber are determined before those of a Health Plan which covers that person as an inactive employee, member or subscriber. If the other Health Plan does not have this rule, and if, as a result, the Health 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 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 Plan which has covered the person for the longer period of time will be determined before the benefits of the Health Plan which has covered the person for a shorter period of time.

Primary Health Plan Benefits

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

Secondary Health Plan Benefits

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

- When either this Health Plan or the Primary Health Plan has contracted for discounted provider fees, the Plan will limit payment to any Copayment, Coinsurance and/or Deductible owed by You after payment by the Primary Health Plan.
- If none of the Health Plans has contracted for discounted provider fees, the Plan will reduce benefits so that the total benefits paid or provided by all Health Plans for a Covered Service are not more than the highest Allowable Expense of any of the Health Plans for that service.

If this Health Plan is the Secondary Health 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 Plan and apply that payable amount to unpaid covered charges owed by You after the Primary Health Plan's payment, including any Deductibles, Coinsurance, and Copayments You owe after the Primary Health Plan's payment. Deductibles, Coinsurance, and Copayments under this Health Plan will be used in the calculation of the benefits that the Plan would pay if this was the Primary Health Plan, but shall not be applied to the unpaid covered charges owed by You after the Primary Health 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 Plan is the Secondary Health Plan according to the Order of Benefit Determination (see above) and another Health Plan claims to be "always secondary" or uses order of benefit determination rules inconsistent with those above, this Health Plan shall pay its benefits first, but the amount paid shall be calculated as if this Health Plan is a Secondary Health Plan. If the other Health 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 Plan's and pay Secondary Health Plan Benefits accordingly, subject to adjustment upon receipt of the information requested from the other Health 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 the 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.

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 dependent's 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.

<u>No Expansion Of Benefits</u>

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.

<u>Recovery Of Overpayment</u>

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 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 Plan or an insurer; or
- from other organizations.

<u>Information</u>

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.

<u>Payments</u>

- 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 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 Plan may include an amount which should have been paid under this Health Plan. If it does, the Plan may pay that amount to the Health 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. See the COVERED BEHAVIORAL HEALTH BENEFITS Section for the appeal process for Behavioral Health Benefit claims. A request for Appeal must be submitted to the Claims Administrator within 180 calendar 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.

APPEALS

You, Your legally authorized representative, or Your provider may file Your appeal. If You need help filing Your appeal, call us at (801) 587-6480, or (888) 271-5870 and press option 1. Si necesita esta carta en Espanol, por favor llamenos al (801) 587-6480 o (888) 271-5870 opcion 1.

We will accept appeals by mail or fax. To file an appeal:

1. Complete the appeal request form located on our website at http://uuhsc.utah.edu/uhealthplan/.
2. Mail or fax Your appeal request form and any requested documentation to
   Appeals Committee Chairperson
   P.O. Box 45180
   Salt Lake City, UT 84145
   Fax: (801) 587-6433
3. Clinical Appeals (i.e., appeals for pre-service denials) must be received within 30 calendar days from the date on the Notice of Action letter.
4. Non-clinical appeals (i.e. appeals after the service has taken place) must be received within 365 calendars from the date on the Explanation of Benefits or Notice of Action letter.
5. If You would like to appear in person, please notify us in Your written appeal.
6. A decision will be made within 30 calendar days of receipt of Your completed written appeal. Once a decision has been reached, You will receive an Appeal Resolution Letter within 14 calendar days.
7. If You or Your provider believes Your life or immediate health may be in danger, You may request an expedited appeal by calling Case Management at 801-587-6480, option 2. If we agree the decision needs to be made quickly, we will make a decision in 3 business days. Otherwise You will be notified in writing within 14 calendar days.
8. If You are appealing because a service is not a covered benefit, and You would like Your provider to appeal for You, he or she must have Your consent.

ARBITRATION (IF OPTED)

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

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 OTHER CONTINUATION OPTIONS, the terms "You" and "Your" mean the Plan Participant only.

EMPLOYEES

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

- Faculty members who have an appointment for nine (9) months or longer at 50% FTE (full-time equivalent) or greater.
- Staff employees who are employed in a position expected to last nine (9) months or longer at 50% FTE or greater.

Employees who have qualified under one of the first two categories and are currently on an approved Phased Retirement Agreement.

DEPENDENTS

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

- the person to whom You are legally married (spouse);
- Your (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 a Disabled Dependent (defined below). To do so, You must provide to the University's Benefits Department a written request to continue coverage along with proof that the dependent meets the Plan's definition of Disabled Dependent, as follows:
  - within 3 months after the dependent reaches age 26; and
  - at reasonable times thereafter as the Claims Administrator may consider necessary, but not more often than annually.
- You may continue coverage for Your (or Your spouse's) unmarried, dependent 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. You are an eligible retiree if You:

- (a) are age 60 or older; (b) have 30 or more years of service with the University; or (c) have 20 or more years of service with the University, working in a position that qualifies for participation in the Public Safety Retirement Systems Plan through Utah Retirement Systems; and
- were enrolled in this Plan on the day immediately preceding Your retirement; and
- commence full retirement after completing 5 years of continuous benefit-eligible service for the University immediately prior to retirement.

If You are an eligible retiree, and elect to enroll in the University of Utah Retiree Health Care Plan, You may also enroll Your Eligible Dependents.

DEFINITIONS SPECIFIC TO THE WHO IS ELIGIBLE SECTION

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

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

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

HOW TO ENROLL AND WHEN COVERAGE BEGINS

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

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

WHEN YOU AND YOUR DEPENDENTS ARE INITIALLY ELIGIBLE

You become eligible for coverage on the first day of the month following the date You are hired by the University in a benefit-eligible position, or on the first day of the month following the date You are transferred into a benefit-eligible position from an ineligible position. If Your date of hire/transfer is the first day of the month, You are eligible for coverage on that day. Upon first becoming eligible for coverage at the University, You may enroll Yourself and Your Eligible Dependents by submitting Your completed enrollment form to the University's Benefits Department within 3 months of Your date of hire or the date You transfer into a benefit-eligible position (if You transferred from an ineligible position).

NEWLY ELIGIBLE DEPENDENTS

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

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

SPECIAL ENROLLMENT

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

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

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

- If You declined coverage when You were first eligible and You subsequently marry, You become eligible for coverage under this Plan on behalf of Yourself, Your spouse, and any Eligible 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, placement for legal adoption, or placement for legal guardianship or foster care (if the order requires health coverage for the child), You become eligible for coverage under this Plan along with Your eligible spouse and Eligible Dependent children including the newly acquired child on date of the birth, adoption, or placement.

Late Enrollment/Open Enrollment Period

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

Transfer During Annual Open Enrollment Period

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

Enrollment By Others

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

Notice Of Status Change

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

LEAVES OF ABSENCE

Family And Medical Leave Act Leave of Absence

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

- You and Your Enrolled Dependents will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period as provided under the FMLA or up to 26 total weeks if You are approved for Servicemember Family Leave under the FMLA.

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

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

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

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

MEDICAL LEAVE OF ABSENCE

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

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

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

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

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

Personal Leave of Absence

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

Military Leave of Absence

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

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

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

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

WHEN COVERAGE ENDS

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

Plan Termination

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.

When You May Elect to Cancel Coverage

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

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

Enrolled Dependent(s) gain other similar coverage. Coverage will be dropped on the date the form is received in the Benefits Department.

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

What Happens When You Are No Longer Eligible

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

Termination Of Your Employment Or 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 and You and Your Enrolled Dependents will not be eligible for conversion of coverage in connection with such a termination.

Termination By University

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

If You Die

If You die, Your Enrolled Dependents may remain enrolled in the Plan at no cost for 6 months from the date of Your death. Thereafter, they may enroll in 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.) or on the date each child loses eligibility under the Plan's then current definition of an Eligible Dependent child. If Your surviving spouse or Eligible Dependent children enroll in the Retiree Health Care Plan and later terminate participation in the Plan, they will not be eligible to reenroll in the future.

What Happens When Your Enrolled Dependents Are No Longer Eligible

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

Divorce Or Annulment

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

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.

Fraudulent Use Of Benefits

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

Certificates Of Creditable Coverage

Requests for and inquiries about required 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) 587-6480 or (888) 271-5870, PO Box 45180, Salt Lake City, Utah 84145.

COBRA CONTINUATION OF COVERAGE

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

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

QUALIFYING EVENTS

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

- voluntary or involuntary termination of the Plan Participant's employment for reasons other than gross misconduct;
- 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

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 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

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

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

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

If Your Qualifying Event is termination of employment or reduction in hours and You or one of Your Enrolled Dependents is determined by the Social Security Administration to have been disabled on the date of the Qualifying Event or during the first 60 days of COBRA coverage, You and/or Your enrolled dependents may obtain an extension of coverage from 18 months to 29 months. It is Your responsibility to obtain the disability determination from the Social Security Administration and to provide a copy of the determination to the University's Benefits Department within **60 days** after the date of the determination. The Social Security Administration determination must occur and You must notify the University's Benefits Department before the end of the original 18-month period. ***If You do not notify the University's Benefits Department and provide the determination within these time frames, You will not be eligible for the 11-month extension of COBRA coverage.*** If coverage is extended for an additional 11 months due to Social Security disability, Your COBRA premiums will be adjusted to 150% of the full cost during the extended 11-month coverage period. It is also Your responsibility to provide a written notice to the University's Benefits Department within **30 days** if a final determination is made that You are no longer disabled.

Second Qualifying Event

Qualified 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

A child who is born to or placed for adoption with You while You are enrolled in COBRA coverage can be added to Your COBRA coverage upon proper written notification to the University's Benefits Department (Health Care Coverage Change Form or written notice) of the birth or placement. Notification must be received within **3 months** of the date of birth or placement (if notification is not received within 3 months of the date of birth or placement, You will not be able to add the child to Your coverage until the next

Open Enrollment period). The child will be a Qualified Beneficiary with an individual right to continue COBRA coverage through Your maximum COBRA period, unless You cancel his/her coverage or one of the events permitting extension or termination occurs.

If You Are Retired And The University Files Chapter 11 Bankruptcy

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

If You Become Entitled To Medicare Before Electing COBRA

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

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

Electing Coverage

Qualified 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. If Claimants do not elect COBRA continuation coverage, they may be eligible for an individual conversion-type plan.

COBRA Premium Payments

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

Initial Payment

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

Subsequent Payments

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

Trade Adjustment Assistance (TAA)

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

Changes in COBRA Coverage

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

Flexible Spending Accounts

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

Financial Aid

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

When COBRA Continuation Coverage Ends

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

- The required premium payments are not paid within the timeframe allowed;
- You notify the COBRA administrator that You wish to cancel Your coverage;
- The applicable period of COBRA coverage ends;
- You become entitled to Medicare benefits;
- The 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).

Conversion Or Transfer To An Individual Policy

At the end of Your applicable maximum COBRA period, You may be allowed to convert Your coverage to an individual insurance policy. See the OTHER CONTINUATION OPTIONS Section for details.

Questions, Notices, And Address Change

This section does not fully describe COBRA coverage. For additional information about Your rights and obligations under the Plan and under federal law, contact the University's Benefits Department.

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

If You divorce or legally separate or lose eligibility as a dependent child under the University Health Care Plan, You must provide the required written notice to the University's Benefits Department within 60 days.

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

OTHER CONTINUATION OPTIONS

Conversion

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

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

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

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

Transfer Of Coverage

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

GENERAL PROVISIONS

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

When Benefits Are Available

In order for health 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

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 University Health Care Plus records. If University Health Care Plus receives a United States Postal Service change of address form (COA) for a Plan Participant, University Health Care Plus will update its records accordingly. Additionally, University Health Care Plus may forward any notice for a Plan Participant to the Plan Administrator if the Plan fails to provide University Health Care Plus a valid mailing address or the Plan fails to update the Plan Participant's address with a mailing address University Health Care Plus can use to send the Plan Participant his or her mail. Any notice to University Health Care Plus required in the Plan may be given by mail addressed to: University Health Care Plus at PO Box 45180, Salt Lake City, Utah 84145; provided, however that any notice to University Health Care Plus will not be deemed to have been given to and received by University Health Care Plus until physically received by University Health Care Plus.

Funding the Plan and Payment of Benefits

Funding is derived first, from the contributions made by the covered employees and then from the general assets of the University. The level of any employee contributions will be set by the University. The employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the employee or withheld from the employee’s pay through payroll deduction. All

Plan benefits are paid directly from the general assets of the University. The University may purchase excess risk insurance coverage which is intended to reimburse the University for certain losses it may have incurred and paid under the Plan. Such excess risk insurance and coverage, if any, is not an asset of the Plan.

Modification Required By Change In Law

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

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

Governing Law

The Plan will be governed by and construed in accordance with the laws of the United States of America and by 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 Plan's rules and regulations in effect at the time of interpretation.

Summary Plan Description Titles And Headings Are For Convenience

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.

No Waiver

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

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

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 Plan'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:

Accidental Injury means an Injury sustained by a Claimant which is the direct result of an accident, independent of Illness or any other cause. Accidental Injury does not mean bodily injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

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

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.

Copayment means the fixed amount that You must pay each time You receive a specified service.

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

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

Dental Services means services or supplies provided to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues or structures, including but not limited to services or supplies rendered:

- to repair defects which have developed because of tooth loss;
- to restore the ability to chew; or
- to control bruxism.

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

Eligible Medical Expenses means:

- with respect to Network Hospitals, Network Skilled Nursing Facilities, and other facilities that are Network Providers, the amount as provided in the applicable contractual payment schedule;
- with respect to Physicians, Practitioners and other professional Providers, the amount Network Physicians/Practitioners have agreed to accept as full payment for Covered Services as determined by the Claims Administrator; and
- with respect to all other Providers, reasonable charges for Covered Services as determined by the Claims Administrator.

Charges in excess of Eligible Medical Expenses are not deemed reasonable charges and are not reimbursable under the Plan. For questions regarding the basis for determination of the Claims Administrator's Eligible Medical Expenses, please contact the Claims Administrator.

Emergency Medical Condition means a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency department would result in:

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

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.

Home Health Care Agency means an agency that is duly licensed by the state in which it is located to provide home health care.

Home Infusion Therapy Agency means an agency that is duly licensed by the state in which it is located to provide home infusion therapy services.

Hospital means a facility that is licensed by the State of Utah as a general acute or specialty hospital or is similarly licensed by the state in which the Hospital is located. A Hospital provides continuous 24-hour nursing services by registered nurses. A Hospital has an attending medical staff consisting of one or more Physicians. Hospital does not include the following:

- residential treatment facilities
- health resorts or spas
- nursing homes
- Christian Science sanatoria
- institutions for exceptional children
- institutions which are primarily places for care of convalescents
- institutions which are primarily places for treatment of pulmonary tuberculosis
- clinics
- Provider offices
- Skilled Nursing Facilities
- Rehabilitation Facilities
- private homes
- halfway houses
- Ambulatory Service Facilities

Illness means a congenital malformation which causes functional impairment; a condition, disease, ailment, or bodily disorder, other than an Injury; and pregnancy. Illness does not include any state of mental health or mental disorder.

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

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

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.

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, disease, or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for the patient's Illness, Injury, or disease; and
- not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative service or sequence of services, or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, or disease.

For the purpose of this definition, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors.

Morbid Obesity means a diagnosed condition in which a Claimant's Body Mass Index ("BMI") which is weight in kilograms divided by height in meters squared is greater than or equal to 40.

Network Provider means a Provider who has an effective contract with University Health Care Plus (or a Provider outside the Wasatch front who or which has a contract with MultiPlan) to provide services and supplies to Claimants in accordance with the provisions of the Plan.

Out-of-Network Provider means a Provider who does not have an effective contract with University Health Care Plus to provide services and supplies to Claimants.

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

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

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

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

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

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

Summary Plan Description, including the SUMMARY OF MEDICAL BENEFITS for the medical option in which You are enrolled, 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 University Health Care Plus 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 Associate Vice President for Human Resources;
- University of Utah Benefits Department personnel; and
- UUHSC Privacy Office.

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