
# Employee Health Care Plan

# Consumer Directed Health Plan Option and Dental Plan

Regence

# UNIVERSITY OF UTAH

# EMPLOYEE HEALTH CARE PLAN

# CONSUMER DIRECTED HEALTH PLAN OPTION AND DENTAL PLAN

# SUMMARY PLAN DESCRIPTION

GROUP NUMBER: 10002211

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|---|---|
| Regence BlueCross BlueShield<br>2890 East Cottonwood Parkway<br>Salt Lake City, UT 84121 | **regence.com** |
| Customer Service | (800) 262-9712<br>(TTY: 711) |
| Case Management | (866) 543-5765 |
| University of Utah Human Resources Department<br>250 East 200 South Suite 125<br>Salt Lake City, UT 84111 | benefits.utah.edu |
| UBenefits: | ubenefits.app.utah.edu |
| Phone | (801) 581-7447 |
| Regence<br>100 Southwest Market Street<br>P.O. Box 1271<br>Portland, OR 97207 | **regence.com** |
| Customer Service | (800) 262-9712 |
| Employee Assistance Program (EAP) | (801) 587-9319<br>(800) 926-9619 |

**Notice of Privacy Practices:** Regence BlueCross BlueShield of Utah has a Notice of Privacy Practices that is available by calling Customer Service or visiting the website listed above. The University's Notice of Privacy Practices is at the end of this SPD.

# Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

## What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

## You're protected from balance billing for:

### Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

### Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

**You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.**

**<u>When balance billing isn't allowed, you also have these protections:</u>**

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

**If you think you've been wrongly billed**, contact **www.cms.gov/nosurprises/consumers** or call the No Surprises Help Desk at 1-800-985-3059.

Visit **www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

# NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

**Regence:**
**Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:**

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

**Provides free language assistance services to people whose primary language is not English, which may include:**

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

**Customer Service**
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

**Medicare Customer Service**
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

**VSP Customer Service**
Phone: 1-844-299-3041
TTY: 1-800-428-4833

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

## Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

**توجه**: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)

# Introduction

This University of Utah Employee Health Care Plan Summary Plan Description (SPD) provides the written description of the terms and benefits of coverage available under the Plan. The administrative services contract between Your employer and Regence BlueCross BlueShield of Utah (called the "Agreement") contains all the terms of coverage. Your Plan Sponsor has a copy.

This SPD describes benefits effective **July 1, 2024**, or the date Your coverage became effective. This SPD replaces any plan description, SPD previously issued by the Plan Sponsor and makes it void. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your Provider before receiving care.

In this SPD, the term "Claims Administrator" refers to Regence BlueCross BlueShield of Utah (Regence BCBSU), and the term "Plan Sponsor" refers to Your employer. References to "You" and "Your" refer to both the Participant and enrolled Dependents. The term "Family" refers to the Plan Participant and all individuals enrolled as his/her eligible Dependents. The term "Plan" refers to this University of Utah Employee Health Care Plan. "Plan Sponsor" and "University" mean The University of Utah, whose employees may participate under this Plan. Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized.

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

The University reserves the right to amend or terminate this Plan in whole or in part, at any time, regardless of Your or Your enrolled Dependents' health or treatment status. You will be given a 60-day notice of any amendment or termination that reduces coverage during the Plan Year. Amendment or termination may result in modification or termination of Your coverage and/or the coverage of Your enrolled Dependents. Covered Services and Allowed Amounts incurred prior to the Plan's amendment or termination will be paid as provided under the terms of the Plan as it existed at the time they were incurred.

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

### CONTACT INFORMATION

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

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

Contact Customer Service:

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

**Case Management:** Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. For additional information refer to the Medical Benefits Section or call Case Management at 1 (866) 543-5765.

**BlueCard® Program:** This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence BlueCross BlueShield of Utah serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Call Customer Service to learn how to have access to care through the BlueCard Program.

# Using Your Summary Plan Description

The Plan has two separate medical plan options, Advantage ("Advantage Option") and Consumer Directed Health Plan ("CDHP Option") and one Dental Plan. Your selected plan option is described below in the Medical Benefits and Dental Benefits Sections.

If You do not have Your applicable SPD or are unsure of Your medical plan option, contact the Claims Administrator or the University Human Resources Department.

It is important for You to understand how the Plan works before You need services. Please read this material carefully. If You have any questions about benefits or procedures, please contact the Claims Administrator's Customer Service Department or check the Regence website.

## ACCESSING MEDICAL PROVIDERS

You are not restricted in Your choice of a Provider for care or treatment of an Illness or Injury. You control Your out-of-pocket expenses by choosing between "In-Network" and "Out-of-Network" Providers.

- **In-Network.** Choosing In-Network Providers saves You the most in Your out-of-pocket expenses. In-Network Providers will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network.** Choosing Out-of-Network Providers generally means Your out-of-pocket expenses will be higher than choosing an In-Network Provider. Also, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. This is referred to as balance billing. Refer to the "Notice: Your Rights and Protections Against Surprise Medical Bills" attached to this SPD for information regarding reimbursement and balance billing applicable to Out-of-Network Providers for certain services.

## ACCESSING DENTAL PROVIDERS

If you are enrolled in the Dental Plan, You are not restricted in Your choice of a Dentist for dental care or treatment. You control Your out-of-pocket expenses by choosing between an "In-Network Dentist " and "Out-of-Network Dentist."

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

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

## ADDITIONAL ADVANTAGES OF PARTICIPATION

The Claims Administrator provides access to discounts on select items and services, personalized health/dental care planning information, health/dental-related events and innovative health/dental decision tools, as well as a team dedicated to Your personal health/dental care needs. You also have access to the Claims Administrator's website and mobile application to help You navigate Your way through health/dental care decisions. For access to the mobile application, set up Your free account once and it is there whenever You wish to use it. **THESE SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS IN THE PLAN.** Additional information about some programs and services can be found in the Value-Added Services Appendix at the end of the SPD.

- **Go to regence.com** or use the Claims Administrator's mobile application. You can use the Claims Administrator's secure applications to:
    - view recent claims, benefits and coverage;

- find a contracting Provider, contracting dental provider or identify Participating Pharmacies;
- use tools to estimate upcoming health care costs and otherwise help You manage health care expenses;
- get suggestions to improve or maintain wellness and participate in self-guided motivational online wellness programs;
- learn about prescriptions for various Illnesses; and
- access information about Regence Advantages. Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services. The Claims Administrator has contracted with several program partners, listed on the secure applications, to offer discounts on their products and services, such as hearing care, health and wellness products and vision care.*

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by this Plan, that also may create savings or administrative fees for the Claims Administrator. **ANY SUCH DISCOUNTS OR COUPONS ARE COMPLEMENTS TO THE PLAN, BUT ARE NOT INSURANCE.**

# Table of Contents

# Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits, Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximum. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the Medical Benefits, Prescription Medications and Dental Benefits Sections to see what Your benefits are.

## MAXIMUM BENEFITS

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

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

## DEDUCTIBLES

The Deductible is the amount You must pay each Plan Year before the Plan will provide payments for Covered Services. Only Allowed Amounts for Covered Services are applied to satisfy the Deductible. There is a Single Coverage Deductible amount and a Family Coverage Deductible amount for In-Network benefits and also for Out-of-Network benefits. The Single Coverage Deductible is satisfied by a Claimant who is enrolled on Single Coverage.

The Family Coverage Deductible is satisfied when any combination of Family members' payments total the Family Coverage Deductible amount.

The High Deductible Health Plan may include "single" or "family" coverage.

Single Coverage means only one person has coverage. Examples include, but are not limited to:

- a Participant who is the only one in their Family who has coverage;
- spouses who both work for the Plan Sponsor and have each filled out an application and are Participants on separate coverages; or
- a Dependent who is continuing insurance coverage on their own.

Family Coverage means two or more members of the same Family have the same coverage.

The Plan does not pay for services applied toward the Deductible. Refer to the benefit sections to see what Covered Services are subject to the Deductible. A Claimant's Deductible amount paid toward the following Covered Services will apply toward the In-Network Deductible amount: adoption, ambulance services, blood bank, gene therapy travel expenses, emergency room services, fertility services and prescription medications. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not apply toward the Deductible. Further, reduction in Your cost-sharing for Prescription Medications resulting from the use of any discount or a drug manufacturer coupon may not apply toward the Deductible.

## COPAYMENTS

Copayments are a specific dollar amount that You pay directly to the Provider at the time You receive a specified service. Refer to the benefit sections to see what Covered Services are subject to a Copayment.

## COINSURANCE (PERCENTAGE YOU PAY)

Your Coinsurance is the percentage You pay when the Plan's payment is less than 100 percent. The Coinsurance varies, depending on the service or supply You received and who rendered it. Your Coinsurance applies once You have satisfied the Deductible and/or any applicable Copayment for Covered Services up to any Maximum Benefit. Your Coinsurance will be based upon the lesser of either

the billed charges or the Allowed Amount. The Plan does not reimburse Providers or Dentists for charges above the Allowed Amount.

## OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the most You could pay in a Plan Year for Covered Services. Your payments of any Deductible, Copayments and/or Coinsurance apply to the Out-of-Pocket Maximum, unless specified otherwise. There is a Single Coverage Out-of-Pocket Maximum amount and a Family Coverage Out-of-Pocket Maximum amount for In-Network benefits and also for Out-of-Network benefits. The Single Coverage Out-of-Pocket Maximum is satisfied by a Claimant who is enrolled on Single Coverage.

The Family Coverage Out-of-Pocket Maximum is satisfied when any combination of Family members' payments of their cost shares for Covered Services total the Family Coverage Out-of-Pocket Maximum.

A Claimant's payment of any Deductible, Copayment and/or Coinsurance for the following, which may be provided by an Out-of-Network provider, will apply toward the In-Network Out-of-Pocket Maximum amount: ambulance, blood bank, emergency room services and Prescription Medications. Any amounts You pay for non-Covered Services or amounts an Out-of-Network Provider may balance bill You in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. Further, any reduction in Your cost-sharing for Prescription Medications resulting from the use of any discount or a drug manufacturer coupon may not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum, benefits subject to the Out-of-Pocket Maximum will be paid by the Plan at 100 percent of the Allowed Amount for the remainder of the Plan Year.

## HOW PLAN YEAR BENEFITS RENEW

The Deductible, Out-of-Pocket Maximum and certain Maximum Benefits are calculated on a Plan Year basis. Each July 1, those Plan Year amounts begin again. Some benefits have a separate Maximum Benefit based upon a Claimant's Lifetime and do not renew every Plan Year.

# Summary of Medical Benefits

This section explains Your benefits and cost-sharing responsibilities for Covered Services. Referrals are not required before You can use any of the benefits of this coverage, including women's health care services. For Your ease in finding the information regarding medical benefits most important to You, these medical benefits have been listed alphabetically.

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care) and received from a Provider practicing within the scope of their license. All covered benefits are subject to the limitations, exclusions and provisions of this Plan. In some cases, the Plan may limit benefits or coverage to a less costly and Medically Necessary alternative item. A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service. See the Definitions Section for descriptions of Medically Necessary and the types of Providers who deliver Covered Services.

If benefits change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

Reimbursement may be available when You purchase new medical supplies, equipment and devices from a Provider or from an approved Commercial Seller. New medical supplies, equipment and devices purchased through an approved Commercial Seller are covered at the In-Network benefit level, with reimbursement based on the lesser of either the amount payable to an In-Network Provider for that item or the retail market value for that item. To learn more about how to access reimbursable new retail medical supplies, equipment and devices, visit the Claims Administrator's website or contact Customer Service.

NOTE: If You choose to access new medical supplies, equipment and devices through the Claims Administrator's website, the Claims Administrator may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are a complement to the Plan, but are not insurance.

### CASE MANAGEMENT

Case management is a program designed to provide early detection and intervention in cases of serious Illness or Injury that have the potential for continuing major or complex care. Case managers are experienced, licensed health care professionals. They will provide information, support and guidance and will work with Your Physicians or other health care professionals in supporting Your treatment plan and proposing alternative benefits.

### PREAUTHORIZATION

Some Covered Services may require preauthorization. Those services require contracted Providers to obtain preauthorization from the Claims Administrator before providing such services to You. You will not be penalized if the contracted Provider does not obtain preauthorization from the Claims Administrator in advance and the service is determined to be not covered.

Non-contracted Providers are not required to obtain preauthorization from the Claims Administrator prior to providing services. You may be responsible for the cost of services provided by a non-contracted Provider if those services are not Medically Necessary or a Covered Service. You may request that a non-contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to receiving those services.

A complete list of services and supplies that require preauthorization may be obtained by visiting the Claims Administrator's website at: **regence.com/web/regence_provider/pre-authorization** or by calling Customer Service.

Preauthorization requests should be faxed by Your Provider following the instructions on the Claims Administrator's website.

## PREVENTIVE VERSUS DIAGNOSTIC SERVICES

Covered Services may be either preventive or diagnostic. "Preventive" care is intended to prevent an Illness, Injury or to detect problems before symptoms are noticed. "Diagnostic" care treats, investigates or diagnoses a condition by evaluating new symptoms, following up on abnormal test results or monitoring existing problems.

Your Provider's classification of the service as either preventive or diagnostic and any other terms in this SPD will determine the benefit that applies. For example, colonoscopies and mammograms are covered in the Preventive Care and Immunizations benefit if Your Provider bills them as preventive and they fall within the recommendations identified in that benefit. Otherwise, colonoscopies and mammograms are covered the same as any other Illness or Injury. You may want to ask Your Provider why a Covered Service is ordered or requested.

## PLAN YEAR DEDUCTIBLES

### In-Network

**Single Coverage Deductible:** $1,600
**Family Coverage Deductible:** $3,200 (entire Deductible must be met before benefits begin.)

### Out-of-Network

**Single Coverage Deductible:** $3,200
**Family Coverage Deductible:** $6,400 (entire Deductible must be met before benefits begin.)

## PLAN YEAR OUT-OF-POCKET MAXIMUM

### In-Network

**Single Coverage:** $5,000
**Family Coverage:** $10,000

### Out-of-Network

**Single Coverage:** $10,000
**Family Coverage:** $20,000

The maximum In-Network Out-of-Pocket for any member on Family Coverage is not to exceed $5,000, including any In-Network Deductible. If a Claimant reaches this maximum amount prior to satisfying the In-Network Family Coverage Out-of-Pocket Maximum, including any In-Network Deductible, In-Network benefits will be paid at 100 percent of the Allowed Amount for that Claimant.

## COPAYMENTS AND COINSURANCE

Copayments and Coinsurance are listed in the tables for Covered Services for each applicable benefit.

## AMBULANCE SERVICES

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After In-Network Deductible, You pay 30% of the Allowed Amount. | **Payment:** After In-Network Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Ambulance services to the nearest facility equipped to provide treatment are covered when any other form of transportation would endanger Your health and the transportation is not for personal or convenience purposes. Covered Services include licensed ground and air ambulance (including fixed-wing and rotary wing) Providers. Prior authorization is required for elective fixed-wing air ambulance transport.

Non-emergency transportation by ambulance is also covered when any other form of transportation would endanger Your health and that transportation is Medically Necessary.

Claims for ambulance services must include the locations You were transported to and from. The claim should also show the date of service, the patient's name, the group's and Your identification numbers.

## APPLIED BEHAVIORAL ANALYSIS (ABA) THERAPY SERVICES

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

## APPROVED CLINICAL TRIALS

If an In-Network Provider is participating in an Approved Clinical Trial and will accept You as a trial participant, benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If an Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care. Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating are covered as specified in the Medical Benefits Section. Additional specified limits are as further defined.

### Definitions

The following definitions apply to this Approved Clinical Trials benefit:

Approved Clinical Trial means a phase I, phase II, phase III or phase IV clinical trial conducted in relation to prevention, detection or treatment of cancer or other Life-threatening Condition and that is a study or investigation:

- approved or funded by one or more of:
    - the National Institutes of Health (NIH), the CDC, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid or a cooperative group or center of any of those entities; or a cooperative group or center of the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
    - a qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or
    - the VA, DOD or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review.
- conducted under an investigational new drug application reviewed by the FDA or that is a drug trial exempt from having an investigational new drug application.

Life-threatening Condition means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Routine Patient Costs means items and services that typically are Covered Services for a Claimant not enrolled in a clinical trial, but do not include:

- an Investigational item, device or service that is the subject of the Approved Clinical Trial;
- items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Claimant; or
- a service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

## AUTISM SPECTRUM DISORDER SERVICES

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |
| **Limit:** 15 weeks per Claimant per Plan Year for social skills group therapy. | |

Covered services include diagnostic testing and social skills group therapy for autism spectrum disorder.

## BARIATRIC SERVICES

### Bariatric Office Visits

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

### Bariatric Surgery

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |
| **Limit:** one surgery per Claimant Lifetime (limit does not apply to covered complications) | |

Bariatric surgery to treat obesity is covered only after the Claims Administrator evaluates and approves that the surgery is meeting its published medical policy.

Coverage does not include treatment for complications, revisions and reversals of bariatric surgery, unless the previous bariatric surgery was approved by a United States medical insurance plan and the bariatric surgery was performed in the United States. If a covered complication, revision or reversal is received, the procedure will be covered the same as any other Illness or Injury.

## BLOOD BANK

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After In-Network Deductible, You pay 30% of the Allowed Amount. | **Payment:** After In-Network Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Services and supplies of a blood bank are covered, excluding storage costs.

## DENTAL HOSPITALIZATION

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

When necessary to safeguard Your health, hospitalization for Dental Services is covered. Covered Services include inpatient and outpatient services and supplies (including anesthesia) at an Ambulatory Surgical Center or Hospital.

## DETOXIFICATION

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

## DIABETIC EDUCATION

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Services and supplies for diabetic self-management training and education are covered, when requested by the attending physician, if provided by an accredited or certified program. Diabetic nutritional counseling and nutritional therapy services are covered in the Nutritional Counseling benefit.

## DIALYSIS

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Services and supplies for inpatient and outpatient dialysis are covered (including outpatient hemodialysis, peritoneal dialysis and hemofiltration).

## DURABLE MEDICAL EQUIPMENT

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

### Wigs

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the billed charges. |
| **Limit:** $500 per Claimant per five-year period for wigs (synthetic, human hair or blend) for hair loss due to chemotherapy or radiation treatment. | |

Durable Medical Equipment is covered, including, but not limited to, oxygen equipment, wheelchairs, wigs and supplies or equipment associated with diabetes.

Additionally, new Durable Medical Equipment is covered when obtained from an approved Commercial Seller. Benefits for eligible new Durable Medical Equipment will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible new Durable Medical Equipment, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit the Claims Administrator's website or contact Customer Service.

Generally, claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the location in which the equipment was received.

## EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After In-Network Deductible, You pay 30% of the Allowed Amount. |

Emergency room services and supplies are covered, including outpatient charges for patient observation, medical screening examinations and Medically Necessary detoxification services, which are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be preauthorized.

"Stabilization" means to provide Medically Necessary treatment:

- to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during or to result from, the transfer of the Claimant from a facility; and
- in the case of a covered Claimant, who is pregnant, to perform the delivery (including the placenta).

If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. Contact the Claims Administrator's Customer Service for further information and guidance.

## FERTILITY SERVICES

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |
| **Fertility Services Limit:** $13,000 per Claimant Lifetime<br><br>**Fertility Preservation Limit:** additional $7,500 per Claimant Lifetime; combined (fertility preservation and fertility services) for a total of $20,500 per Claimant Lifetime. Fertility preservation services are available to those Claimants that are receiving treatment that may affect future fertility.<br><br>The limit does not apply to services currently covered elsewhere in the Medical Benefits Section including, but not limited to, medical, surgical, laboratory, radiology and office visits. | |

Surgical and nonsurgical services (including medications received from a Provider to promote fertility) are covered. Medications to promote fertility received from a Pharmacy are covered in the Prescription Medications section and are combined with the fertility services limit described above.

Coverage also includes fertility preservation services for those Claimants age 11 through 44 when chemotherapy, radiation therapy, hormone therapy or surgery that would impact fertility is part of the treatment plan. Please contact Customer Service when services for fertility preservation are **not** received from a University of Utah Health Provider to receive the additional fertility preservation limit. Additionally, assisted reproductive procedures are covered, including:

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer; or
- any associated surgery, medications received from a Provider, testing or supplies.

Coverage does **not** include:

- uterine transplants.

## GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** Not covered. |

Gene therapies, adoptive cellular therapies as well as associated services and supplies are covered for Claimants who fulfill the Medical Necessity criteria.

To be covered, gene therapy and/or adoptive cellular therapy must be received from one of the Claims Administrator's Centers of Excellence (COE) facilities that is expressly identified as a COE for that therapy. However, if a COE has not been identified for a covered gene therapy and/or adoptive cellular therapy, that therapy must be received from an In-Network Provider to be covered at the COE benefit level. Receiving therapy from one of the Claims Administrator's COE facilities will save the most in Your out-of-pocket expenses. For a list of covered therapies or to identify a COE facility, contact the Claims Administrator's Customer Service, as the lists are subject to change.

### Travel Expenses

| |
|---|
| **Payment:** You pay 100% of all expenses. Your travel expenses may be reimbursed subject to Your In-Network Deductible and travel expense limit. |
| **Limit:** $7,500 per Claimant per course of treatment, including companion(s), for transportation and lodging expenses. Additional limitations included below. |

Transportation and lodging expenses are covered, subject to the following specified limits:

- based on the generally accepted course of treatment in the United States, the therapy would require an overnight stay of seven or more consecutive nights away from home and within reasonable proximity to the treatment area;
- if a COE has been identified for the specified covered therapy, covered treatment must be received from the COE;
- if a COE has not been identified for the specified covered therapy, covered treatment must be received from an In-Network Provider;
- coverage is for the Claimant and one companion (or two companions if the Claimant is under the age of 19);
- commercial lodging expenses are limited to the IRS medical expense allowances (currently $50 per night for the Claimant, not to exceed $100 per night for the Claimant and companion(s) combined); and
- covered transportation expenses to and from the treatment area include only:
    - commercial coach class airfare;
    - commercial coach class train fare; or
    - documented auto mileage (calculated per IRS medical expense allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of the treatment. The Plan will reimburse You for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact the Claims Administrator's Customer Service for further information and guidance.

Coverage does not include meals or expenses outside of transportation and lodging.

## GENETIC TESTING

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Medically Necessary genetic testing is covered.

## GROWTH HORMONE THERAPY

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Growth hormone therapy is covered when preauthorized.

## HEARING AIDS AND EVALUATIONS

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |
| **Limit:** one hearing aid per ear per Claimant every two Calendar Years | |

Hearing aids and any associated evaluations are covered for Claimants up to age 26 when necessary for treatment of hearing loss. Covered Services include the following:

- hearing aids (including evaluations);
- bone conduction sound processors (including examinations and fittings). Implantation and associated surgical services are covered in the Other Professional Services benefit;
- ear molds and replacement ear molds; and
- hearing aid checks and testing.

"Hearing aid" means any nondisposable, wearable instrument designed to aid or compensate for impaired human hearing and any necessary part or ear mold for the instrument.

Hearing aids that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Cochlear implants are covered the same as any other Illness or Injury.

Covered Services do **not** include:

- over-the-counter hearing aids;
- routine hearing examinations;
- hearing assistive technology systems; or
- the cost of batteries or cords.

## HEARING EXAMINATIONS

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |
| **Limit:** one routine hearing examination per Claimant per Plan Year | |

Routine hearing examinations that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

## HOME HEALTH CARE

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Home health care is covered when provided by a licensed agency or facility for home health care. Home health care includes all services for patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility.

Durable Medical Equipment associated with home health care services is covered in the Durable Medical Equipment benefit.

## HOSPICE CARE

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |
| **Limit:** 14 inpatient or outpatient respite care days per Claimant Lifetime | |

Hospice care is covered when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and their family during the final stages of Illness.

Respite care is also covered to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant. Respite days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered in the Durable Medical Equipment benefit.

## HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Services and supplies of a Hospital or an Ambulatory Surgical Center (including services of staff Providers) are covered for treatment of Illness or Injury. Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. Contact Customer Service for further information and guidance.

## INFUSION THERAPY

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Inpatient, outpatient and home therapy services, supplies (including infusion pumps) and medications for infusion therapy are covered. Covered Services also include parenteral and enteral therapy.

## MATERNITY CARE / ADOPTION BENEFIT

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy and related conditions are covered. There is no limit for the patient's length of inpatient stay. The attending Provider will determine an appropriate discharge time in consultation with the patient.

Certain services such as screening for gestational diabetes, breastfeeding support, supplies and counseling are covered in the Preventive Care and Immunizations benefit.

### Adoption Benefit

| |
|---|
| **Payment:** You pay 100% of billed charges. The Plan may reimburse You 70% of expenses up to the adoption limit, after the In-Network Deductible has been met. |
| **Adoption limit:** $4,000 per qualifying pregnancy, subject to the conditions below. |

An adoption benefit is available when a Participant meets all of the following conditions:

- Coverage is in effect on the date a newborn child is placed for the purpose of adoption.
- The newborn child is enrolled under this health plan.
- The newborn child is placed for the purpose of adoption with the Participant within 90 days after the child's birth and the date of placement is on or after the Participant's Effective Date.
- The Participant 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 (for example, a letter from the adoption agency) 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 will be addressed to:

  Regence BlueCross BlueShield of Utah
  P.O. Box 2998
  Tacoma, WA 98401-2998

In the event a Participant adopts more than one newborn from a single pregnancy (for example, twins), only a single $4,000 adoption benefit is available (subject to reduction for other coverage below).

Adoption coverage that is applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

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 Participant will be liable for repayment of the adoption benefit. The Participant will refund the full amount of such benefit to the Plan, upon request, within 30 days after the date the child is removed from placement.

### Termination of Pregnancy (Abortion)

In accordance with the Utah prohibition against public funding for abortions (U.C.A. 76-7-331, as amended) and provided that public funds are not used by the Plan to pay for the procedure, services and supplies in connection with the performance of any induced abortion, services are only covered for the following circumstances:

- in the professional judgment of the pregnant Claimant's attending physician, the abortion is necessary to save the pregnant Claimant's life.
- the pregnancy is the result of rape or incest reported to law enforcement agencies, unless the Claimant was unable to report the crime for physical reasons or fear of retaliation;

- in the professional judgment of the pregnant Claimant's attending physician, the abortion is necessary to prevent premature, irreparable, and grave damage to a major bodily function of the pregnant Claimant provided that a caesarian procedure or other medical procedure that could also save the life of the child is not a viable option; or
- the fetus is not viable, or the fetus has a defect that is uniformly diagnosable and uniformly lethal.

### Surrogacy

Maternity and related medical services received by You while Acting as a Surrogate are not Covered Services, up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, You Acting as a Surrogate. By incurring and making claim for such services, You agree to reimburse the Claims Administrator the lesser of the amount described in the preceding sentence and the amount the Plan has paid for those Covered Services (even if payment or compensation to You or any other person or entity occurs after the termination of Your coverage under this Plan).

You must notify the Claims Administrator within 30 days of entering into any agreement to Act as a Surrogate and agree to cooperate with the Plan as needed to ensure the Claims Administrator's ability to recover the costs of Covered Services received by You for which the Plan is entitled to reimbursement. To notify the Claims Administrator, or to request additional information on Your responsibilities related to these notification and cooperation requirements, contact Customer Service. Refer to the Subrogation and Right of Recovery Section for more information.

### Definitions

The following definition applies to this Maternity Care benefit:

Acting (or Act) as a Surrogate means You agree to become pregnant and to surrender, relinquish or otherwise give up any parental rights to the baby (or babies) produced by that pregnancy to another person or persons who intend to raise the baby (or babies), whether or not You receive payment, the agreement is written and/or the parties to the agreement meet their obligations.

## MEDICAL FOODS

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Medical foods for inborn errors of metabolism are covered including, but not limited to, formulas for Phenylketonuria (PKU). "Medical food" means a food which is formulated to be consumed or administered orally or enterally under the supervision of a Physician. Medical foods are intended for specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

## MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Mental Health and Substance Use Disorder Services are covered for treatment of Mental Health Conditions or Substance Use Disorders. Residential care days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

### Definitions

The following definitions apply to this Mental Health or Substance Use Disorder Services benefit:

Mental Health or Substance Use Disorder Services mean Medically Necessary outpatient services, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed

individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health Provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is Medically Necessary).

Mental Health Conditions mean mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association except as otherwise excluded. Mental disorders that accompany an excluded diagnosis are covered.

Residential Care means care in a facility setting that offers a defined course of therapeutic intervention and special programming in a controlled environment that also offers a degree of security, supervision and structure, and is licensed by the appropriate state and local authority to provide such services. Patients also must be medically monitored with 24-hour medical availability and 24-hour onsite clinician services. Residential Care does not include half-way houses, supervised living, group homes, wilderness courses or camps, Outward Bound, outdoor youth programs, outdoor behavioral programs, boarding houses, or settings that primarily either focus on building self-esteem or leadership skills or provide a supportive environment to address long-term social needs. However, services by Physicians or Practitioners in such settings may be covered if they are billed independently and would otherwise be a Covered Service.

Substance Use Disorders mean substance-related disorders included in the most recent edition of the DSM. Substance Use Disorder does not include addiction to or dependency on tobacco, tobacco products or foods.

## NEURODEVELOPMENTAL THERAPY

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |
| **limit:** $5,000 per Claimant per Plan Year for occupational therapy; $5,000 per Claimant per Plan Year for speech therapy; $5,000 per Claimant per Plan Year for physical therapy. | |

Neurodevelopmental therapy services by a Physician or Practitioner are covered. Covered Services must be to restore or improve function for a Claimant age 18 and under with a neurodevelopmental delay. "Neurodevelopmental delay" means a delay in normal development that is not related to any documented Illness or Injury. Covered Services include only physical therapy, occupational therapy, speech therapy and maintenance services, if significant deterioration of the Claimant's condition would result without the service.

Speech therapy services as a result of congenital anomaly for Claimants up to age 26 are included in the annual neurodevelopmental therapy maximum. You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

## NEWBORN CARE

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Services and supplies in connection with nursery care for the natural newborn or newly adoptive child are covered by the newborn's own coverage. The newborn child must be eligible and enrolled as explained in the Eligibility and Enrollment Section. There is no limit for the newborn's length of inpatient stay. "Newborn care" means the medical services provided to a newborn child following birth including Hospital nursery charges, the initial physical examination and a PKU test.

## NUTRITIONAL COUNSELING

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Services for nutritional counseling and nutritional therapy, such as diabetic counseling, discussions on eating habits, lifestyle choices and dietary interventions are covered for all conditions, including obesity.

## OFFICE OR URGENT CARE VISITS – ILLNESS OR INJURY

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Office (including home, Retail Clinic or Hospital outpatient department) and urgent care visits are covered for treatment of Illness or Injury. Coverage does not include other professional services performed in the office or urgent care that are specifically covered elsewhere in the Medical Benefits Section, including, but not limited to, separate facility fees or outpatient radiology and laboratory services billed in conjunction with the visit.

## ORTHOTIC DEVICES

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Braces, splints, orthopedic appliances and orthotic supplies (including foot orthotics when Medically Necessary immediately following foot surgery) or apparatuses are covered when used to support, align or correct deformities or to improve the function of moving parts of the body.

Additionally, certain orthotic devices that are new are covered when obtained from an approved Commercial Seller. Benefits for eligible new orthotic devices will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount payable to an In-Network Provider or the retail market value. To verify eligible new orthotic devices, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit the Claims Administrator's website or contact Customer Service.

The Plan may elect to provide benefits for a less costly alternative item. Off-the-shelf shoe inserts and orthopedic shoes are not covered.

## OTHER PROFESSIONAL SERVICES

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Services and supplies provided by a professional Provider are covered, subject to any specified limits as explained in the following paragraphs:

### Medical Services and Supplies

Professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider.

Services and supplies also include:

- treatment of a congenital anomaly for Claimants up to age 26;

- Virtual Care service facility fees;
- foot care associated with diabetes; and
- Medically Necessary foot care obtained from a professional Provider due to hazards of a systemic condition causing severe circulatory dysfunction or diminished sensation in the legs or feet.

Additionally, certain Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) that are new and obtained from an approved Commercial Seller. Benefits for eligible new supplies will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount payable to an In-Network Provider or the retail market value. To verify eligible new medical supplies, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit the Claims Administrator's website or contact Customer Service.

### Diagnostic Procedures
Services for diagnostic procedures including cardiovascular testing, pulmonary function studies, sleep studies, stress tests and neurology/neuromuscular procedures. CT Scans will be covered according to the guidelines used by CMS at the time of the procedure.

### Professional Inpatient
Professional inpatient visits for Illness or Injury. If pre-arranged procedures are performed by an In-Network Provider and You are admitted to an In-Network Hospital, the Plan will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by Out-of-Network Providers at the In-Network benefit level. Contact the Claims Administrator's Customer Service for further information and guidance.

### Radiology and Laboratory
Diagnostic services for treatment of Illness or Injury. This includes, but is not limited to, mammography services not covered in the Preventive Care and Immunizations benefit.

Generally, claims for independent clinical laboratory services will be submitted to the Blue plan in the location in which the referring Provider is located.

### Surgical Services
Surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist. Covered Services include vasectomies.

### Therapeutic Injections
Therapeutic injections and related supplies, including clotting factor products, when given in a professional Provider's office.

A selected list of Self-Administrable Injectable Medications is covered in the Prescription Medications Section.

## PALLIATIVE CARE

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |
| **Limit:** 30 visits per Claimant per Plan Year | |

Palliative care is covered when a Provider has assessed that a Claimant is in need of palliative services for a serious Illness (including remission support), life-limiting Injury or end-of-life care. "Palliative care" means specialized services received from a Provider in a home setting for counseling and home health aide services for activities of daily living.

Palliative care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. All other Covered Services for a Claimant receiving palliative care remain covered the same as any other Illness or Injury.

## PREVENTIVE CARE AND IMMUNIZATIONS

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** No charge. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Preventive care and immunization services provided by a professional Provider, facility or Retail Clinic that are within age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA) or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), or as required by state or federal guidance for a specific time period as a result of a government declared disease outbreak, epidemic, or other public health emergency, are covered for the following:

- routine physical examinations, well-women's care, well-baby care and routine health screenings;
- routine nutritional counseling;
- routine vision examinations for children ages 3 and 4;
- Provider counseling and Prescription Medications prescribed for tobacco use cessation;
- immunizations for adults and children;
- breast pump (including its accompanying supplies) per pregnancy as follows:
    - one new non-Hospital grade breast pump at the In-Network benefit level when obtained from a Provider (including a Durable Medical Equipment supplier); or
    - a comparable new breast pump may be obtained from an approved Commercial Seller in lieu of a Provider. Benefits for a comparable new breast pump obtained from an approved Commercial Seller will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount payable to an In-Network Provider or the retail market value.
- United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods according to, and as recommended by HRSA, including, but not limited to:
    - condoms;
    - diaphragm with spermicide;
    - sponge with spermicide;
    - cervical cap with spermicide;
    - spermicide;
    - oral contraceptives (combined pill, mini pill and extended/continuous use pill);
    - contraceptive patch;
    - vaginal ring;
    - contraceptive shot/injection;
    - emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products);
    - intrauterine devices (both copper and those with progestin);
    - implantable contraceptive rod;
    - surgical implants; and
    - surgical sterilization procedures for women.

Prostate cancer screening is also covered when recommended by a Physician or Practitioner. Covered Services for prostate cancer screening include digital rectal examinations and prostate-specific antigen (PSA) tests.

NOTE: Certain preventive care and immunization services that do not meet these criteria may be covered in this Preventive Care and Immunizations benefit when received and billed as preventive. Covered Services that do not meet these criteria (for example, diagnostic colonoscopies or diagnostic

mammograms) will be covered the same as any other Illness or Injury. In the event HRSA, USPSTF or the CDC adopt a new or revised recommendation, the Plan has up to one year before coverage of the related services must be available and effective.

### Expanded Immunizations

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** No charge. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Some immunizations that do not meet age limits and frequency guidelines according to, and as recommended by, the USPSTF, HRSA or by the CDC are covered. Covered Services include immunizations for travel, occupation or residency in a foreign country. Contact Customer Service to verify what expanded immunizations are covered.

## PREVENTIVE CARE FOR SPECIFIED CHRONIC CONDITIONS

Services and supplies are covered when used to treat a Claimant diagnosed with the associated chronic condition and prescribed to prevent either exacerbation of the chronic condition or the development of a secondary condition. Covered Services as specified below are covered the same as any other condition, but are not subject to any applicable Deductible for In-Network services:

- blood pressure monitor with a diagnosis of hypertension;
- therapeutic continuous glucose monitor (device only), hemoglobin A1c testing and retinopathy screening with a diagnosis of diabetes;
- International Normalized Ratio (INR) testing with a diagnosis of liver disease and/or bleeding disorder;
- Low-Density Lipoprotein (LDL) testing with a diagnosis of heart disease; or
- peak flow meter with a diagnosis of asthma.

## PROSTHETIC DEVICES

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Prosthetic devices for functional reasons are covered to replace a missing body part, including artificial limbs, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered in the appropriate facility benefit. Additionally, the repair or replacement of a prosthetic device due to normal use or growth of a child is covered.

Covered prosthetic devices include penile prostheses to treat sexual impotence that is the result of a covered medical condition, complications of a covered surgery and other bodily injury. Coverage does not include penile implant/testicular prosthesis procedures and related supplies for psychological impotence.

## REHABILITATION SERVICES

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |
| **Inpatient limit:** 30 days per Claimant per Plan Year | |

Inpatient and outpatient rehabilitation services and accommodations are covered as appropriate and necessary to restore or improve lost function caused by Illness or Injury. "Rehabilitation services" mean physical, occupational and speech therapy services only.

Rehabilitation days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

## REPAIR OF TEETH

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Services and supplies for treatment required as a result of damage to or loss of sound natural teeth are covered when such damage or loss is due to an Injury.

## SKILLED NURSING FACILITY

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

Inpatient services and supplies of a Skilled Nursing Facility are covered for treatment of Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary.

## SPINAL MANIPULATIONS

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |
| **Limit:** 20 visits per Claimant per Plan Year (combined limit for spinal and osteopathic manipulations) | |

Spinal and osteopathic manipulations are covered. Massage therapy services are not covered. Visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Manipulations of extremities are covered in the Neurodevelopmental Therapy or Rehabilitation Services benefits.

## TRANSPLANTS

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** Not covered. |

Transplants are covered, including transplant-related services and supplies. Covered Services for a transplant recipient include the following:

- heart;
- lung;
- kidney;
- pancreas;
- liver;
- cornea;
- multivisceral;
- small bowel;

- islet cell; and
- hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors:

  - either autologous (self-donor);
  - allogeneic (related or unrelated donor);
  - syngeneic (identical twin donor); or
  - umbilical cord blood (only covered for certain conditions).

For a list of covered transplants, contact the Claims Administrator's Customer Service, as the list is subject to change. Gene and/or adoptive cellular therapies are covered in the Gene Therapy and Adoptive Cellular Therapy benefit.

NOTE: Coverage is only available for services, supplies or accommodations in connection with the following transplants when they are received at a University of Utah Health hospital:

- heart;
- heart/lung;
- heart/liver;
- heart/kidney;
- lung (single or double);
- liver;
- pancreas;
- kidney;
- kidney/liver; and
- kidney/pancreas.

Coverage may be available from other In-Network Providers in the following instances:

- Based on review by appropriate medical professionals at the University of Utah Health, it is determined the covered procedure cannot be performed at a University of Utah Health hospital. Medically Necessary Covered Services will be a benefit when performed at another, more appropriate facility; or
- The Claimant receiving transplant benefits has another insurance that is considered their Primary Plan and this Plan is the Secondary Plan.

### Donor Organ Benefits

Donor organ procurement costs are covered for a recipient. Procurement benefits are limited to:

- selection;
- removal of the organ;
- storage;
- transportation of the surgical harvesting team and the organ; and
- other such procurement costs.

## VIRTUAL CARE

Virtual care services are covered for the use of telehealth or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment or management of a covered medical condition. Some Providers may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share.

To learn more about how to access virtual care services or Providers that may offer lower-cost services, visit the Claims Administrator's website or contact Customer Service.

## Store and Forward Services

| Provider: | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

"Store and forward services" mean secure one-way electronic asynchronous (not live or real-time) electronic transmission (sending) of Your medical information to a Provider which may include some forms of secure HIPAA compliant texting, chatting or data sharing. For example, store and forward services include using a secure patient portal to send a picture of Your swollen ankle to Your Provider for review at a later time. Store and forward services that are not secure and HIPAA compliant are not covered, including, but not limited to:

- telephone;
- facsimile (fax);
- short message service (SMS) texting; or
- e-mail communication.

Your Provider is responsible for meeting applicable requirements and community standards of care.

## Telehealth

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |

"Telehealth" means Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform, including when You are in a Provider's office or healthcare facility. For example, telehealth includes a live video call from Your home to discuss a possible eye infection with Your Provider or using the equipment at Your local Provider's office to have a live video call with a cardiologist in a different city. Separate charges for facility fees are covered in the Other Professional Services benefit.

## VISION EXAMINATION

| Provider: In-Network | Provider: Out-of-Network |
|---|---|
| **Payment:** After Deductible, You pay 30% of the Allowed Amount. | **Payment:** After Deductible, You pay 30% of the Allowed Amount and the balance of billed charges. |
| **Limit:** one routine eye examination per Claimant per Plan Year | |

Covered Services do not include charges for contact lens fitting.

# Prescription Medications

This section explains Your benefits and cost-sharing responsibilities for Prescription Medications. If a medication or supply is covered by both this Prescription Medications benefit or any provision within the Medical Benefits section, benefits will be paid under this Prescription Medications benefit.

Prescription Medications listed on the Drug List are covered. Prescription Medications not on the Drug List may be covered as described in the Drug List Exception Process provision. To view the Drug List and find medications by tier, visit the Claims Administrator's website or contact Customer Service.

## COPAYMENTS AND/OR COINSURANCE

After You meet the In-Network Deductible, You are responsible for paying the following Copayment and/or Coinsurance amounts at the time of purchase, if the Pharmacy submits the claim electronically. Your Copayment and/or Coinsurance will be applied toward the In-Network Out-of-Pocket Maximum.

You are not responsible for any Copayment and/or Coinsurance when You fill prescriptions for medications intended to treat opioid overdose that are on the Opioid Rescue Medication Value List found on the Claims Administrator's website or by calling Customer Service. Additionally, You are not responsible for any Copayment and/or Coinsurance when You receive immunizations for travel, occupation or residency in a foreign country.

When You fill a prescription for Tier 2 insulin, Your cost-share will not exceed $28 per 30-day supply from a Pharmacy or $84 per 90-day supply from a Home Delivery Supplier, whether or not You have met any applicable Deductible.

### Prescription Medications from a Pharmacy (for Each 30-Day Supply)

| |
|---|
| • **Tier 1:** After In-Network Deductible, You pay 30% Coinsurance. |
| • **Tier 2:** After In-Network Deductible, You pay 30% Coinsurance. |
| • **Tier 3:** After In-Network Deductible, You pay 30% Coinsurance. |
| • **Compound Medication:** After In-Network Deductible, You pay 30% Coinsurance. |

### Prescription Medications from a Home Delivery Supplier (for Each 90-Day Supply)

| |
|---|
| • **Tier 1:** After In-Network Deductible, You pay 30% Coinsurance. |
| • **Tier 2:** After In-Network Deductible, You pay 30% Coinsurance. |
| • **Tier 3:** After In-Network Deductible, You pay 30% Coinsurance. |
| • **Compound Medication:** After In-Network Deductible, You pay 30% Coinsurance. |

### Prescription Specialty Medications (for Each 30-Day Supply)

| |
|---|
| • **Tier 4:** After In-Network Deductible, You pay 30% Coinsurance. |

## COVERED PRESCRIPTION MEDICATIONS

Prescription Medication benefits are available for the following:

- Prescription Medications;
- weight loss medications;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Injectable Medications) and teaching doses by which a Claimant is educated to self-inject;
- diabetic supplies, when obtained with a Prescription Order, including:
    - lancets;
    - test strips;
    - glucagon emergency kits; and

  - insulin syringes.

- therapeutic continuous glucose monitors and insulin pumps, and their supplies, that are on the Drug List may be purchased from a Pharmacy, when obtained with a Prescription Order; therapeutic continuous glucose monitors and insulin pumps, and their supplies, are also covered in the Medical Benefits Section;
- medications to promote fertility in combination with the fertility services benefit limit of $13,000 per Claimant Lifetime;
- Compound Medications;
- Specialty Medications (including, but not limited to, medications for multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders and hepatitis C);
- emergency contraceptive medications are covered at no charge to You for each Tier 1 and Tier 2 Medication;
- immunizations for travel, occupation or residency in a foreign country are covered at no charge to You; and
- certain Prescription Medications that are administered by Your Provider as determined by the Pharmacy and Therapeutics (P&T) Committee.

Additionally, the following preventive medications obtained from a Participating Pharmacy are covered at no charge to You, including, but not limited to:

- immunizations for adults and children according to, and as recommended by the CDC and/or USPSTF;
- certain preventive medications, according to, and as recommended by the USPSTF, that are on the Drug List and when obtained with a Prescription Order:

  - aspirin;
  - fluoride;
  - iron; and
  - medications for tobacco use cessation.

- FDA-approved prescription and over-the-counter contraception methods according to, and as recommended by the HRSA and when obtained with a Prescription Order:

  - condoms;
  - diaphragm with spermicide;
  - sponge with spermicide;
  - cervical cap with spermicide;
  - spermicide;
  - oral contraceptives (combined pill, mini pill and extended/continuous use pill);
  - contraceptive patch;
  - vaginal ring;
  - contraceptive shot/injection; and
  - emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products).

When preventive medications or immunizations are obtained from a Nonparticipating Pharmacy, You will be responsible for any Deductible, Copayment and/or Coinsurance listed above for Prescription Medications. If Your Provider believes that the Plan's covered preventive medications, including contraceptives, are medically inappropriate for You, You may request an equivalent preventive medication by contacting Customer Service. For additional information on covered Prescription Medications, visit the Claims Administrator's website or contact Customer Service.

## SPECIAL PROVISIONS FOR A CANCER DRUG TREATMENT REGIMEN

Prescription Medications used as part of a cancer drug treatment regimen for a cancer patient who is undergoing chemotherapy in an outpatient clinic setting, will be covered subject to the same benefits, limitations and exclusions of this Prescription Medications benefit, when dispensed through a professional Provider who meets the requirements set forth in Utah Code §58-17b-102(23)(a)(i) and (ii). "Cancer drug

treatment regimen" means a Prescription Medication used to treat cancer, manage its symptoms, or provide continuity of care for a cancer patient.

Prescription Medications eligible for dispensing through a professional Provider's office include a chemotherapy drug administered orally, rectally or by dermal methods and medication used to support cancer treatment (including to treat, alleviate or minimize physical and psychological symptoms of pain, to improve patient tolerance of cancer treatments, or prepare a patient for a subsequent course of therapy). Any Prescription Medication listed under federal law as a Schedule I, II, or III drug is not eligible for this special dispensing provision. Intravenous medications are otherwise covered under the applicable Medical Benefits Section(s). You can find a list of Prescription Medications eligible for dispensing through a professional Provider's office on the Claims Administrator's website.

## PRESCRIPTION MEDICATIONS CLAIMS AND ADMINISTRATION

### Preauthorization

Some Prescription Medications may require preauthorization before they are dispensed. The Claims Administrator notifies participating Providers, including Pharmacies, which Prescription Medications require preauthorization. Prescription Medications that require preauthorization must have medical information provided by the prescribing Provider to determine Medical Necessity. Prescribed Medications that require preauthorization will not be covered until they are preauthorized. For a list of medications that require preauthorization or if You have any questions, visit the Claims Administrator's website or contact Customer Service.

### Drug List Changes

Any removal of a Prescription Medication from the Drug List will be posted on the Claims Administrator's website 30 days prior to the effective date of that change unless the removal is done on an emergency basis or if an equivalent Generic Medication becomes available without prior notice. In the case of an emergency removal, the change will be posted as soon as possible.

If You are taking a Prescription Medication while it is removed from the Drug List and its removal was not due to the Prescription Medication being removed from the market, becoming available over-the-counter or issuance of a black box warning by the Federal Drug Administration, the Plan will continue to cover Your Prescription Medication for the time period required to use the Drug List exception process to request continuation of coverage for the removed Prescription Medication and receive a decision through that process, unless patient safety requires an expedited replacement.

### Drug List Exception Process

Non-Drug List medications are not covered by Your Prescription Medications benefit. However, a Prescription Medication not on the Drug List may be covered in certain circumstances.

"Non-Drug List" means those self-administered Prescription Medications not listed on the Drug List.

- To request coverage for a Prescription Medication not on the Drug List, You or Your Provider will need to request preauthorization so that the Claims Administrator can determine that a Prescription Medication not on the Drug List is Medically Necessary. Your Prescription Medication not on the Drug List may be considered Medically Necessary if medication policy criteria are met, if applicable, and:
- You are not able to tolerate a covered Prescription Medication(s) on the Drug List;
- Your Provider determines that the Prescription Medication(s) on the Drug List is not therapeutically effective for treating Your covered condition; or
- Your Provider determines that a dosage required for effective treatment of Your covered condition differs from the Prescription Medication on the Drug List dosage limitation.

The specific medication policy criteria to determine if a Prescription Medication not on the Drug List is Medically Necessary are available on the Claims Administrator's website. You or Your Provider may request preauthorization by calling Customer Service or by completing and submitting the form on the Claims Administrator's website.

Once preauthorization has been approved, the Prescription Medication not on the Drug List will be available for coverage at the Substituted Medication Copayment and/or Coinsurance level determined by Your Plan and will apply toward any Deductible or Out-of-Pocket Maximum.

### Your Responsibility for Cost Differences of Chosen Medications

You will be responsible for the applicable Copayment and/or Coinsurance for the Brand-Name Medication or Specialty Medication at the time of purchase. You will also be responsible for paying excess costs above Your applicable cost-share if either of the following occur:

- if You choose to fill a Prescription Order with a Brand-Name Medication and an equivalent Generic Medication is available, You will be responsible for paying the difference in cost; or
- if You choose to fill a Prescription Order with a Specialty Medication and a Specialty Biosimilar Medication is available, You will be responsible for paying the difference in cost.

The excess in cost does not apply toward any Out-of-Pocket Maximum. If the prescribing Provider specifies that the Brand-Name Medication or Specialty Medication must be dispensed, You will still be responsible for the excess in cost.

### Pharmacy Network Information

A nationwide network of Participating Pharmacies is available to You. You can find Participating Pharmacies on the Claims Administrator's website or by contacting Customer Service.

You must present Your identification card to identify Yourself as a Claimant of this Plan when obtaining Prescription Medications from a Pharmacy or Home Delivery Supplier. If You do not present Your identification card You may be charged more than the Covered Prescription Medication Expense.

### Claims Submitted Electronically

Participating Pharmacies will submit claims electronically. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, the Plan will pay the Nonparticipating Pharmacy directly. Nonparticipating Pharmacies, however, may charge amounts in excess of Covered Prescription Medication Expenses. If that happens, You will be responsible for the excess amounts, as well as any Deductible, Copayment and/or Coinsurance shown electronically to the Nonparticipating Pharmacy at the time of purchase.

### Claims Not Submitted Electronically

It is best to use a Participating Pharmacy so Your claims can be submitted electronically, and so You won't have to pay the difference between the Pharmacy's charges and the Covered Prescription Medication Expense in addition to Your Deductible, Copayment and/or Coinsurance.

However, when a claim is not submitted electronically, You must pay for the Prescription Medication in full at the time of purchase. For reimbursement, complete a Prescription Medication claim form and mail a copy of the form and the Prescription Medication receipt to the Claims Administrator. To find the Prescription Medication claim form visit the Claims Administrator's website or contact Customer Service.

The Plan will reimburse You directly based on the Covered Prescription Medication Expense, minus the applicable Deductible, Copayment and/or Coinsurance that would have been required had the medication been purchased from a Participating Pharmacy.

### Home Delivery

You can use home delivery services to purchase covered Prescription Medications. Home delivery coverage applies when Prescription Medications are purchased from a Home Delivery Supplier and the claim is submitted electronically. Not all Prescription Medications are available from Home Delivery Suppliers.

To buy Prescription Medications through the mail, send all of the following items to the Home Delivery Supplier at the address shown on the prescription home delivery form (which also includes refill instructions) available on the Claims Administrator's website or from Your Plan Sponsor:

- a completed prescription home delivery form;

- any Deductible, Copayment and/or Coinsurance; and
- the original Prescription Order.

### Prescription Medications Dispensed by Excluded Pharmacies

The Claims Administrator does not permit excluded Pharmacies to submit claims after the excluded Pharmacies have been added to the Office of the Inspector General (OIG) list. A Pharmacy may be excluded if it has been investigated by the OIG and appears on the OIG's exclusion list.

You will be notified if You are receiving medications from a Pharmacy that is later determined to be an excluded Pharmacy so that You may obtain future Prescription Medications from a non-excluded Pharmacy. Up to the time of notification, Your previously submitted claims will still be processed.

### Refills

Refills obtained from:

- a Pharmacy are covered when You have taken 75 percent of the previous prescription;
    - except as based upon state law, Schedule II or III controlled substance medications may be refilled only after You have taken 85 percent of the previous prescription.
- a Home Delivery Supplier are covered after You have taken all but 20 days of the previous Prescription Order.

However, if You:

- choose to refill Your Prescription Medications sooner, You will be responsible for the full cost of the Prescription Medication and those costs will not apply toward any Deductible and/or Out-of-Pocket Maximum.
- feel You need a refill sooner than allowed, a refill exception will be considered on a case-by-case basis. You may request an exception by calling Customer Service.

### Discounts or Manufacturer Coupons

Any reduction in Your cost-sharing resulting from the use of any discount or a drug manufacturer coupon may not apply toward the Deductible or Out-of-Pocket Maximum.

## LIMITATIONS

The following limitations apply to this Prescription Medications Section and certain preventive medications as specified in the Covered Prescription Medications Section:

### Prescription Medication Supply Limits

- **30-Day Supply Limit:**
    - **Specialty Medications –** the largest allowable quantity for a Specialty Medication purchased from a Specialty Pharmacy is a 30-day supply.
    - The first fill for Specialty Medications is allowed at a Pharmacy. Additional fills must be provided at a Specialty Pharmacy, however some Specialty Medications must have the first and subsequent fills at a Specialty Pharmacy. For more information on those medications, visit the Claims Administrator's website or contact Customer Service.
- **90-Day Supply Limit:**
    - **Pharmacy** – the largest allowable quantity of a Prescription Medication purchased from a Pharmacy is a 90-day supply. A Provider may prescribe or You may purchase, some medications in smaller quantities. The Copayment and/or Coinsurance is based on each 30-day supply.
    - **Home Delivery Supplier** – the largest allowable quantity of a Prescription Medication purchased from a Home Delivery Supplier is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
    - **Multiple-Month Supply** – the largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Pharmacy is a 90-day supply (even if the packaging includes a larger supply). The availability of that supply at a

given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The Copayment and/or Coinsurance is based on the Prescription Order up to a 34-day supply within that multiple-month supply.

- **Maximum Quantity Limit**
  - For certain Prescription Medications, the Claims Administrator establishes maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. The Claims Administrator uses information from the FDA and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service.
  - For certain Self-Administrable Cancer Chemotherapy Medications, due to safety factors and the Claimant's ability to tolerate these medications, the Prescription Medication may be reduced to an initial 14-day or 15-day supply before larger quantities are dispensed.
  - Any amount over the established maximum quantity is not covered, except if the Claims Administrator determines the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

## EXCLUSIONS

The following exclusions apply to this Prescription Medications Section and are not covered:

### Biological Sera, Blood or Blood Plasma

### Bulk Powders

Except as included on the Claims Administrator's Drug List and presented with a Prescription Order, bulk powders are not covered.

### Cosmetic Purposes

Prescription Medications used for Cosmetic purposes, including, but not limited to:

- removal, inhibition or stimulation of hair growth, except as related to a covered medical condition;
- anti-aging; or
- repair of sun-damaged skin.

### Devices or Appliances

Except as provided in the Medical Benefits Section, devices or appliances of any type, even if they require a Prescription Order are not covered.

### Diagnostic Agents

Except as provided in the Medical Benefits Section, diagnostic agents used to aid in diagnosis rather than treatment are not covered.

### Digital Therapeutics

Except as included on the Claims Administrator's Drug List and presented with a Prescription Order, digital therapeutics are not covered.

### Food Supplements, Special Formulas and Special Diets

Except as provided in the Medical Benefits Section, food supplements, special formulas and special diets are not covered.

### Foreign Prescription Medications

Except for the following, foreign Prescription Medications are not covered:

- Prescription Medications associated with an Emergency Medical Condition while You are traveling outside the United States; or
- Prescription Medications You purchase while residing outside the United States.

These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered in this section if obtained in the United States.

### General Anesthetics
Except as provided in the Medical Benefits Section, general anesthetics are not covered.

### Investigational/Experimental Medications

### Medical Foods
Except as provided in the Medical Benefits Section, medical foods are not covered.

### Medications that are Not Considered Self-Administrable
Except as provided in the Medical Benefits Section or as specifically indicated in this Prescription Medications Section, medications that are not considered self-administrable are not covered.

### Non-Medicinal Substances
Except for some cases where the following may be covered in the Medical Benefit Section, the following non-medicinal substances, regardless of intended use, are not covered:

- therapeutic devices or appliances, including hypodermic needles;
- syringes (except insulin syringes);
- support garments; and
- other non-medicinal substances.

### Nonprescription Medications
Except for the following, nonprescription medications that by law do not require a Prescription Order are not covered:

- medications included on the Claims Administrator's Drug List;
- medications approved by the FDA; or
- a Prescription Order by a Physician or Practitioner.

Nonprescription medications, include, but are not limited to:

- over-the-counter medications;
- vitamins;
- minerals;
- food supplements;
- homeopathic medicines;
- nutritional supplements; and
- any medications listed as over-the-counter in standard drug references, regardless of state law prescription requirements, such as pseudoephedrine and cough syrup products.

### Other Party Liability
Prescription Medications which an eligible person is entitled to receive without charge under any worker's compensation laws, or any municipal, state, or federal program are not covered.

### Over-the-Counter Medications

### Pigmenting/Depigmenting Agents
Except as required to treat photosensitive conditions, such as psoriasis, pigmenting/depigmenting agents are not covered.

### Prescription Medications Dispensed in a Facility
Prescription Medications dispensed to You while You are a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed by this benefit if obtained from a Pharmacy.

**Prescription Medications Dispensed in Connection with Participation in a Clinical Trial**

**Prescription Medications Found to be Less than Effective under Drug Efficacy Safety Implementation (DESI)**

**Prescription Medications Not Approved by the FDA**

**Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order**

**Prescription Medications Not on the Drug List**
Except as provided through the Drug List Exception Process provision, Prescription Medications that are not on the Drug List are not covered.

**Prescription Medications Not within a Provider's License**
Prescription Medications prescribed by Providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.

**Prescription Medications with No FDA Proven Therapeutic Indication**

**Prescription Medications with Therapeutic Alternatives**
Except for higher cost Prescription Medications that are Medically Necessary, Prescription Medications for which there are covered therapeutically equivalent (similar safety and efficacy) alternatives or over-the-counter (nonprescription) alternatives are not covered.

**Prescription Medications without Examination**
Except as provided in the Virtual Care benefit, whether the Prescription Order is provided by mail, telephone, internet or some other means, Prescription Medications without a recent and relevant in-person examination by a Provider, are not covered. Additionally, this exclusion does not apply to a Provider or Pharmacist who may prescribe an opioid antagonist to a Claimant who is at risk of experiencing an opiate-related overdose.

An examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

**Professional Charges for Administration of Any Medication**

**Refills**
Any Prescription Medication refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original Prescription Order are not covered.

**Repackaged Medications, Institutional Packs and Clinic Packs**

**DEFINITIONS**
The following definitions apply to this Prescription Medications Section:

Brand-Name Medication means a Prescription Medication that is marketed and sold by limited sources or is listed in widely accepted references as a Brand-Name Medication based on manufacturer and price.

Compound Medication means two or more medications that are mixed together by the Pharmacist. To be covered, Compound Medications must contain a Prescription Medication that has been approved by the FDA and may be subject to review for Medical Necessity.

Covered Prescription Medication Expense means the total payment a Participating Pharmacy or Home Delivery Supplier has contractually agreed to accept as full payment for a Prescription Medication. A Participating Pharmacy or Home Delivery Supplier may not charge You more than the Covered Prescription Medication Expense for a Prescription Medication.

Drug List means the Claims Administrator's list of selected Prescription Medications. The Claims Administrator established and routinely reviews and updates the Drug List. It is available on the Claims Administrator's website or by calling Customer Service. Medications are reviewed and selected for inclusion on the Claims Administrator's Drug List by an outside committee of Providers, including Physicians and Pharmacists.

Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references as a Generic Medication. "Equivalent" means the FDA ensures that the Generic Medication has the same active ingredients, meets the same manufacturing and testing standards, and is as safe and as effective as the Brand-Name Medication. Medications available only from one source (also referred to as "single source") are not considered Generic Medications. If listings in widely accepted references are conflicting or indefinite about whether a Prescription Medication is a generic or Brand-Name Medication, the Claims Administrator will decide.

Home Delivery Supplier means a home delivery Pharmacy with which the Claims Administrator has contracted for home delivery services.

Nonparticipating Pharmacy means a Pharmacy with which the Claims Administrator neither has a contract nor has contracted access to any network it belongs to.

Participating Pharmacy means either a Pharmacy with which the Claims Administrator has a contract or a Pharmacy that participates in a network for which the Claims Administrator has contracted to have access.

Pharmacist means an individual licensed to dispense Prescription Medications, counsel a patient about how the medication works any possible adverse effects and perform other duties as described in their state's Pharmacy practice act.

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed.

Pharmacy and Therapeutics (P&T) Committee means an officially chartered group of practicing Physicians and Pharmacists who review the medical and scientific literature regarding medication use. The P&T Committee also provides input and oversight of the development of the Claims Administrator's Drug List and medication policies. Additionally, the P&T Committee is free from conflict of interest of drug manufacturers and the majority of whom are also free from conflict of interest of Your coverage.

Prescription Medications and Prescribed Medications mean medications and biologicals that:

- relate directly to the treatment of an Illness or Injury;
- legally cannot be dispensed without a Prescription Order;
- by law must bear the legend, "Prescription Only"; or
- are specifically included on the Claims Administrator's Drug List.

Prescription Order means a written prescription, oral or electronic request for Prescription Medications issued by a Provider who is licensed to prescribe medications.

Self-Administrable Prescription Medications, Self-Administrable Medications, Self-Administrable Injectable Medication or Self-Administrable Cancer Chemotherapy Medication means a Prescription Medication labeled by the manufacturer as intended to be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician's office or clinic). Self-Administrable Cancer Chemotherapy Medications include oral Prescription Medications used to kill or slow the growth of cancerous cells. Information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that is considered a relevant and reliable indication of safety and acceptability is used to determine a Self-Administrable Medication. The Claims Administrator does not consider Your status, such as Your ability to administer the medication, when determining whether a medication is self-administrable.

Specialty Biosimilar Medication means an FDA-approved Prescription Medication that has a biological similarity to a Specialty Medication. The Specialty Biosimilar Medication is identical in function to the

comparable Specialty Medication and may be more cost efficient. Similar to the FDA's requirements for a generic equivalent, a Specialty Biosimilar Medication must meet the same manufacturing and testing standards, and must be as safe and effective as the comparable Specialty Medication.

Specialty Medications mean medications that may be used to treat complex conditions, including, but not limited to:

- multiple sclerosis;
- rheumatoid arthritis;
- cancer;
- clotting factor for hemophilia or similar clotting disorders; and
- hepatitis C.

Information from the manufacturer, scientific literature, practice standards, Medicare practices and other information that is considered relevant and reliable is used to determine a Specialty Medication. For a list of such medications, visit the Claims Administrator's website or contact Customer Service.

Specialty Pharmacy means a Pharmacy or designated Hemophilia Treatment Center (HTC) that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. To find a Specialty Pharmacy, visit the Claims Administrator's website or contact Customer Service.

Substituted Medication means a Generic Medication or a Brand-Name Medication not on the Drug List that is approved for coverage at the Tier 3 benefit level. Substituted Medication also means a Specialty Medication not on the Drug List that is approved for coverage at the Tier 4 benefit level.

Tier 1 means medications that provide the highest overall value. Mostly includes Generic Medications but may include some Brand-Name Medications.

Tier 2 means medications that provide moderate overall value. Usually includes Brand-Name Medications that are categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

Tier 3 means medications that provide lower overall value. Usually includes Brand-Name Medications that are categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

Tier 4 means Specialty Medications that provide moderate overall value.

# General Medical Exclusions

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

### EXCLUSION PERIOD FOR PREEXISTING CONDITIONS

This coverage does not have an exclusion period for Preexisting Conditions. A Preexisting Condition normally means a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within a specified period of time before the enrollment date.

### EXCLUSION EXAMPLES

The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered, including related secondary medical conditions and are not all inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications by infection from a Cosmetic procedure, except in cases of reconstructive surgery:
    - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
    - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- complications that result from an Illness or Injury resulting from active participation in illegal activities.

### SPECIFIC EXCLUSIONS

The following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**, are not covered. However, these exclusions will not apply with regard to a Covered Service for:

- an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law; or
- a preventive service as specified in the Preventive Care and Immunizations and/or the Prescription Medications Section.

### Activity Therapy

The following activity therapy services are not covered:

- creative arts;
- play;
- dance;
- aroma;
- music;
- equine or other animal-assisted;
- recreational or similar therapy; and
- sensory movement groups.

### Adventure, Outdoor, or Wilderness Interventions and Camps

Outward Bound, outdoor youth or outdoor behavioral programs, or courses or camps that primarily utilize an outdoor or similar non-traditional setting to provide services that are primarily supportive in nature and rendered by individuals who are not Providers, are not covered, including, but not limited to, interventions or camps focused on:

- building self-esteem or leadership skills;
- losing weight;

- managing diabetes;
- contending with cancer or a terminal diagnosis; or
- living with, controlling or overcoming:

    - blindness;
    - deafness/hardness of hearing;
    - a Mental Health Condition; or
    - a Substance Use Disorder.

Services by Physicians or Practitioners in adventure, outdoor or wilderness settings may be covered if they are billed independently and would otherwise be a Covered Service by the Plan.

### Alternative Care
Alternative care, including, but not limited to, the following is not covered:

- acupuncture and acupressure; and
- massage or massage therapy.

### Assisted Reproductive Technologies
Except as provided in the Fertility Services benefit, assisted reproductive technologies, regardless of underlying condition or circumstance, are not covered, including, but not limited to:

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer;
- other artificial means of conception; or
- any associated surgery, medications, testing or supplies

### Certain Therapy, Counseling and Training
The following therapies, counseling and training services are not covered:

- educational;
- vocational;
- social;
- image;
- self-esteem;
- milieu or marathon group therapy;
- premarital or marital counseling;
- employee assistance program services; and
- job skills or sensitivity training.

### Conditions Caused by Active Participation in a War
The treatment of any condition caused by or arising out of a Claimant's active participation in a war.

### Conditions Incurred in or Aggravated During Performances in the Uniformed Services
The treatment of any Claimant's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

### Cosmetic/Reconstructive Services and Supplies
Except for treatment of the following, Cosmetic and/or reconstructive services and supplies are not covered:

- a congenital anomaly for Claimants up to age 26;
- to restore a physical bodily function lost as a result of Illness or Injury; or

- related to breast reconstruction following a Medically Necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice.

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

### Counseling
Charges for counseling a Claimant, including the following are not covered:

- occupational, or religious counseling; and
- counseling with a patient's family, friend(s), employer, school counselor, or school teacher.

### Counseling in the Absence of Illness
Except as required by law, counseling in the absence of Illness is not covered.

### Custodial Care
Except as provided in the Palliative Care benefit, non-skilled care and helping with activities of daily living is not covered.

### Dental Services
Except as provided in the Repair of Teeth benefit, Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues are not covered, including treatment that restores the function of teeth.

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

### Family Counseling
Except when provided as part of the treatment for a child or adolescent with a covered diagnosis, family counseling is not covered.

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

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

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

Additionally, except as listed below, government facilities or government facilities outside the service area are not covered:

- facilities contracting with the local Blue Cross and/or Blue Shield plan; or
- as required by law for emergency services.

### Hearing Aids and Other Devices
Except for cochlear implants or as provided in the Hearing Aids and Evaluations benefit,, hearing aids (externally worn or surgically implanted) or other hearing devices are not covered.

### Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses are not covered, including, but not limited to:

- treatment of painful physical conditions;
- mental health conditions;
- substance use disorders; or
- for anesthesia purposes.

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

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

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

### Illegal Services, Substances and Supplies
Services, substances and supplies that are illegal as defined by state or federal law.

### Individualized Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids and supports as provided in an IEP developed and adopted pursuant to the Individuals with Disabilities Education Act.

### Infertility
Except as provided in the Fertility Services benefit or to the extent Covered Services are required to diagnose such condition, treatment of infertility or uterine transplants is not covered.

### Investigational Services
Except as provided in the Approved Clinical Trials benefit, Investigational services are not covered, including, but not limited to:

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

### Liposuction for the Treatment of Lipedema

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

- automobile medical;
- personal injury protection (PIP);
- automobile no-fault;
- underinsured or uninsured motorist coverage;
- homeowner's coverage;
- commercial premises coverage;
- excess coverage; or
- similar contract or insurance.

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

### Non-Direct Patient Care
Except as provided in the Virtual Care benefit, non-direct patient care services are not covered, including, but not limited to:

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

### Non-Therapeutic Continuous Glucose Monitors

### Obesity or Weight Reduction/Control
Except as provided in the Nutritional Counseling or Bariatric Services benefits or as required by law, services or supplies that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered, including, but not limited to:

- medical treatment;
- medications;
- surgical treatment (including treatment of complications, revisions and reversals); or
- programs.

### Orthognathic Surgery
Except for treatment of the following, orthognathic surgery is not covered:

- orthognathic surgery due to an Injury;
- temporomandibular joint disorder;
- sleep apnea (specifically, telegnathic surgery);
- developmental anomalies; or
- congenital anomaly for Claimants up to age 26.

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

"Telegnathic surgery" means skeletal (maxillary, mandibular and hyoid) advancement to anatomically enlarge and physiologically stabilize the pharyngeal airway to treat obstructive sleep apnea.

### Over-the-Counter Contraceptives
Except as provided in the Prescription Medications Section or as required by law, over-the-counter contraceptive supplies are not covered.

### Personal Items
Items that are primarily for comfort, convenience, Cosmetics, contentment, hygiene, environmental control, education or general physical fitness are not covered, including, but not limited to:

- telephones;
- televisions;
- air conditioners, air filters or humidifiers;
- whirlpools;
- heat lamps;
- light boxes;

- weightlifting equipment; and
- therapy or service animals, including the cost of training and maintenance.

### Physical Exercise Programs and Equipment
Physical exercise programs or equipment are not covered (even if recommended or prescribed by Your Provider), including, but not limited to:

- hot tubs; or
- membership fees to spas, health clubs or other such facilities.

### Private-Duty Nursing
Private-duty nursing, including ongoing shift care in the home.

### Reversals of Sterilizations
Services and supplies related to reversals of sterilization.

### Routine Foot Care

### Self-Help, Self-Care, Training or Instructional Programs
Except as provided in the Diabetic Education and Nutritional Counseling benefits or for services provided without a separate charge in connection with Covered Services that train or educate a Claimant, self-help, non-medical self-care and training or instructional programs are not covered, including, but not limited to:

- childbirth-related classes including infant care;
- instructional programs that:
  - teach a person how to use Durable Medical Equipment;
  - teach a person how to care for a family member; and
  - provide a supportive environment focusing on the Claimant's long-term social needs when rendered by individuals who are not Providers.

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

"Immediate family" means:

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

### Services and Supplies That Are Not Medically Necessary
Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

### Services Required by an Employer or for Administrative or Qualification Purposes
Physical or mental examinations and associated services (laboratory or similar tests) required by an employer or primarily for administrative or qualification purposes are not covered.

Administrative or qualification purposes, include, but are not limited to:

- admission to or remaining in:
  - school;
  - a camp;
  - a sports team;
  - the military; or
  - any other institution.
- athletic training evaluation;

- legal proceedings (establishing paternity or custody);
- qualification for:
    - employment or return to work;
    - marriage;
    - insurance;
    - occupational injury benefits;
    - licensure; or
    - certification.
- travel, immigration or emigration.

### Sexual Dysfunction
Except as provided in the Prosthetic Devices Benefit, treatment, services and supplies are not covered for or in connection with sexual dysfunction regardless of cause.

### Surrogacy
Maternity and related medical services received by You Acting as a Surrogate are not Covered Services up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, Your Acting as a Surrogate. "Maternity and related medical services" include otherwise Covered Services for conception, prenatal, maternity, delivery and postpartum care. Refer to the Maternity Care Benefit and/or Subrogation and Right of Recovery Sections for more information.

### Termination of Pregnancy (Abortion)
Except as provided in the Maternity Care Benefit, services or supplies related to the termination of a pregnancy (abortion) are not covered.

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

### Travel and Transportation Expenses
Except as provided in the Ambulance benefit or as otherwise provided in the Medical Benefits Section, travel and transportation expenses are not covered.

### Vision Care
Except as provided in the Medical Benefits Section, vision care services are not covered, including, but not limited to:

- vision hardware;
- visual therapy;
- training and eye exercises;
- vision orthoptics;
- surgical procedures to correct refractive errors/astigmatism; and
- reversals or revisions of surgical procedures which alter the refractive character of the eye.

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

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

# Summary of Dental Benefits

This section explains Your benefits and cost-sharing responsibilities for Covered Services. All benefits are listed alphabetically.

**MAXIMUM BENEFITS**

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

**Per Claimant:** $2,000 per Plan Year

NOTE: After the maximum benefit has been reached, additional Dental Services may be covered for a Claimant, in the same Plan Year, due to chemotherapy or radiation treatment. Contact Customer Service for further information and guidance.

**Orthodontic Dental Services:**

**Per Claimant:** $2,500 per Lifetime

**BASIC DENTAL SERVICES**

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

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

- Adjustment and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within one year of insertion.
- Complex oral surgery procedures including:
  - surgical extractions of teeth;
  - impactions;
  - alveoloplasty; and
  - residual root removal.
- Emergency treatment for pain relief.
- Endodontic services consisting of:
  - apicoectomy;
  - debridement;
  - direct pulp capping;
  - pulpal therapy;
  - pulpotomy; and
  - root canal treatment.
- Fillings consisting of composite and amalgam restorations.
- General dental anesthesia or intravenous sedation administered for:
  - extractions of partially or completely bony impacted teeth; or
  - to safeguard the Claimant's health (for example, a child under seven years of age or a physically or developmentally disabled individual).
- Periodontal services consisting of:
  - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery);
  - debridement limited to once per Claimant in a three-year period;
  - gingivectomy and gingivoplasty;
  - periodontal maintenance limited to two* per Claimant per Plan Year (however, in any Plan Year a Claimant will be entitled to no more than two* cleanings whether periodontal maintenance or standard cleaning).

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

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

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

- scaling and root planing limited to once per Claimant per quadrant per Plan Year.

- Repair of dentures and bridges, limited to every 5 years per tooth (must have a lapse of at least 6 months from the date of service); and
- Uncomplicated oral surgery procedures including removal of teeth, incision and drainage.

## MAJOR DENTAL SERVICES

| Provider: In-Network Dentist | Provider: Out-of-Network Dentist |
|---|---|
| **Payment:** You pay 50% of the Allowed Amount. | **Payment:** You pay 50% of the Allowed Amount and You pay the balance of billed charges. |

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

- Bridges (fixed partial dentures), limited to every five years per tooth.
- Crowns, crown build-ups, inlays and onlays (for gold inlays, onlays and crowns, payment is limited to the amount that would have been paid for plastic inlays, onlays and crowns unless special need is demonstrated for use of gold), except that benefits will not be provided for any of the following:

  - any crown, inlay or onlay replacement made fewer than five years after placement per tooth (or subsequent replacement) whether or not originally covered in this SPD; and
  - additional procedures to construct a new crown under an existing partial denture framework.

- Dental implant crown and abutment related procedures.
- Dentures, full and partial, including:

  - denture rebase; and
  - denture relines.

- Denture benefits will **not** be provided for:

  - any denture replacement made fewer than five years after denture placement (or subsequent replacement) whether or not originally covered in this SPD.
  - interim partial or complete dentures; or
  - pediatric dentures.

- Endosteal implants;
- Recement crown, inlay or onlay;
- Repair of crowns is limited to every five years per tooth;
- Repair of implant supported prosthesis or abutment;
- Veneers, when Dentally Appropriate; and
- Vestibuloplasty.

## ORTHODONTIC DENTAL SERVICES

| Provider: All Dentists |
|---|
| **Payment:** You pay 50% of the Allowed Amount and You pay the balance of billed charges. |
| **Limit:** $2,500 per Claimant Lifetime |

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

- The initial and subsequent installations of orthodontic appliances and all non-surgical orthodontic treatments concerned with the reduction or elimination of an existing malocclusion, subject to the submission of a treatment plan (submitted by the attending Provider). The treatment plan should include all of the following information:

  - a diagnosis indicating an abnormal occlusion that can be corrected by orthodontic treatment;
  - the estimated length of required treatment;
  - the initial banding fee; and
  - the total orthodontic treatment charge.

- If treatment stops before the end of the prescribed treatment period, benefits will end on the last day of the month during which the treatment was discontinued.

## PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

| Provider: In-Network Dentist | Provider: Out-of-Network Dentist |
|---|---|
| **Payment:** No charge. | **Payment:** No charge up to the Allowed Amount and You pay the balance of billed charges. |

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

- The following services are limited to two per Claimant per Plan Year:

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

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

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

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

- The following services are limited to one per Claimant in a three-year period:

  - complete intra-oral mouth x-rays; and
  - panoramic mouth x-rays.

- Bitewing x-ray sets;
- Problem-focused oral examinations.
- Sealants, limited to once per tooth and:

  - to deciduous teeth only on the chewing surface of the first and second molars; and
  - permanent teeth only on the chewing surface, excluding wisdom teeth.

- Space maintainers for Claimants under 13 years of age.

# General Dental Exclusions

The following are limitations and exclusions from coverage, other exclusions may apply as described elsewhere in this SPD.

## LIMITATIONS

### Optional Techniques

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

### Transfer of Care

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

## SPECIFIC EXCLUSIONS

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

### Aesthetic Dental Procedures

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

### Antimicrobial Agents

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

### Appliances and Restorations for Malalignment of The Teeth

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

### Charges that Exceed the Allowed Amount

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

### Collection of Cultures and Specimens

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

- saliva; or
- tissue of the oral cavity.

### Conditions Caused by Active Participation in a War

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

### Conditions Incurred in or Aggravated During Performances in the Uniformed Services

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

### Connector Bar or Stress Breaker

A device attached to a prosthesis or coping which serves to stabilize and anchor prosthesis.

### Cosmetic/Reconstructive Services and Supplies

Except for Dentally Appropriate treatment of the following, Cosmetic and/or reconstructive services and supplies are not covered:

- a congenital anomaly; or

- to restore a physical bodily function lost as a result of Illness or Injury.

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

### Court-Ordered or Court-Related Services/Services in Connection with Legal Proceedings
Services, supplies, examinations, reports, or appearances in connection with legal proceedings or court ordered or court-related services.

### Dentist Practicing Beyond Scope of License
Services rendered by a Dentist practicing beyond the scope of their license.

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

### Diagnostic Casts or Study Models
Services and supplies provided in connection with diagnostic casts or study models including taking the impression and pouring the study models.

### Duplicate X-Rays

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

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

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

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

### Fractures of the Mandible (Jaw)
Except for surgical correction required as the result of an Injury or as provided in the Medical Benefits Section, services and supplies provided in connection with the treatment of simple or compound fractures of the mandible are not covered.

### Gold-Foil Restorations

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

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

## Home Visits

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

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

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

## Implants
Except as provided in the Major Dental Services benefit, implants and any associated services and supplies are not covered (whether or not the implant itself was covered), including, but not limited to:

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

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

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

## Medications and Supplies
Charges in connection with medications and supplies are not covered, including, but not limited to:

- take-home drugs;
- pre-medications; and
- therapeutic drug injections.

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

- automobile medical;
- personal injury protection (PIP);
- automobile no-fault coverage;
- underinsured or uninsured motorist coverage;
- homeowner's coverage;
- commercial premises coverage;
- excess coverage; or
- similar contract or insurance.

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

## Nitrous Oxide

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

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

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

- occlusal analysis and adjustments; and
- occlusal guards.

### Oral Hygiene Instructions

### Oral Surgery
Except as provided in the Medical Benefits Section, oral surgery treating any fractured jaw and orthognathic surgery are not covered. "Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

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

### Photographic Images

### Pin Retention in Addition to Restoration
Small metal rod used to aid in support of a restoration.

### Precision Attachments
Device to stabilize or retain a prosthesis when seated in mouth.

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

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

### Provisional Splinting
Interim or temporary stabilization of loose/mobile teeth.

### Pulp Vitality Tests

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

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

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

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

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

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

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

"Immediate family" means:

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

### Services Performed in a Laboratory

### Surgical Procedures
Services and supplies provided in connection with the following surgical procedures are not covered:

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

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

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

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

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

### Travel and Transportation Expenses

### Veneers
Thin laminated restoration that covers the facial surface and/or the incisal edge of a tooth, and/or may extend between the adjoining surfaces of adjacent teeth are not covered, except for Dentally Appropriate veneers.

### Work-Related Conditions

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

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

# Claims Administration

This section explains administration of benefits and claims, including situations that may arise when Your health care expenses are the responsibility of a source other than the Plan. Payment of benefits will be made in accordance with the terms and conditions of this SPD.

## SUBMISSION OF CLAIMS AND REIMBURSEMENT

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

### In-Network Provider Claims and Reimbursement

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

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

### Out-of-Network Provider Claims and Reimbursement

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

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

If the treatment is for an Injury, include a statement explaining the date, time, place and circumstances of the Injury when You send the Claims Administrator the claim.

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

**NOTE: Refer to the "Notice: Your Rights and Protections Against Surprise Medical Bills" attached to this SPD for information regarding reimbursement and balance billing applicable to Out-of-Network Providers for certain services.**

### Timely Filing of Claims

Written proof of loss (submission of a claim) must be received within one year after the date of service. Claims that are not filed in a timely manner will be denied, unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. Benefits or coverage will not be invalidated nor reduced if it can be shown that it was not reasonably possible to file the claim and that the claim was submitted as soon as reasonably possible. You may Appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner. If You were covered

by more than one health plan on the date of service, see the text of Primary Health Plan Benefits in the Coordination of Benefits provision for an exception to this timely filing rule.

### Claim Determinations

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

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

## CONTINUITY OF CARE

You may qualify to receive 90 days of continued coverage (or 90 days from the date You are no longer a continuing care patient, whichever is earlier) at the In-Network benefit level, if Your Provider was a contracted In-Network Provider, but is no longer contracted (this provision does not apply if the contract with the Provider was terminated due to a failure to meet quality standards or for fraud).

To qualify for continued coverage, You must be:

- undergoing a course of treatment for a certain serious and complex condition from the Provider;
- undergoing a course of institutional or inpatient care from the Provider;
- scheduled to undergo non-elective surgery from the Provider (including postoperative care following surgery);
- pregnant and undergoing a course of treatment for pregnancy from the Provider; or
- determined to be terminally ill and receiving treatment for such Illness from the Provider.

The Claims Administrator will notify You of Your right to receive continued care from the Provider or You may contact the Claims Administrator with a need for continued care. Coverage under this Continuity of Care provision will be subject to the benefits of this Plan and provided on the same terms and conditions as any other In-Network Provider. Your Provider must accept the Allowed Amount and cannot bill You for any amount beyond any Deductible, Copayment and/or Coinsurance. Contact the Claims Administrator's Customer Service for further information and guidance.

## OUT-OF-AREA SERVICES

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever You access health care services outside the geographic area the Claims Administrator serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When Your network is ValueCare: When You receive care outside the Claims Administrator's service area, You may receive it from one of three kinds of Providers. Providers that contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue") as a preferred Provider are paid at the In-Network Provider level and will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. Providers that contract with the Host Blue as a participating Provider are paid at the Out-of-Network Provider level and may not bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Some Providers ("Out-of-Network Providers") don't contract with the Host Blue. The SPD further explains below how the Plan pays these different kinds of Providers.

When Your network is Participating: When You receive care outside the Claims Administrator's service area, You will receive it from one of two kinds of Providers. Most Providers ("In-Network Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Out-of-Network Providers") don't contract with the Host Blue. The SPD further explains below how the Plan pays these different kinds of Providers.

### BlueCard Program

In the BlueCard Program, when You access Covered Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for doing what the Claims Administrator agreed to in the Agreement. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever You receive Covered Services outside the Claims Administrator's service area and the claim is processed through the BlueCard Program, the amount You pay for Covered Services is calculated based on the lower of:

- the billed covered charges for Your Covered Services; or
- the negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your health care Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price the Claims Administrator has used for Your claim because they will not be applied after a claim has already been paid.

### Value-Based Programs

If You receive Covered Services from a Value-Based Program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordination Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

The following definitions apply:

- Value-Based Program: An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.
- Provider Incentive: An additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.
- Care Coordination Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination in a Value-Based Program.

### Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal law or state law may require a surcharge, tax or other fee that applies to insured accounts. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

### Out-of-Network Providers Outside the Claims Administrator's Service Area

- **Your Liability Calculation**. When Covered Services are provided outside of the Claims Administrator's service area, by Out-of-Network Providers, the amount You pay for such services will normally be based on either the Host Blue's Out-of-Network Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the Out-of-Network Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for Out-of-Network emergency services.
- **Exceptions.** In certain situations, the Claims Administrator may use other payment methods, such as billed covered charges, the payment the Claims Administrator would make if the health care services had been obtained within the Claims Administrator's service area, or a special negotiated

payment to determine the amount the Claims Administrator will pay for services provided by Out-of-Network Providers. In these situations, You may be liable for the difference between the amount that the Out-of-Network Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

## BLUE CROSS BLUE SHIELD GLOBAL® CORE

If You are outside the United States (hereinafter "BlueCard service area"), You may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when You receive care from Providers outside the BlueCard service area, You will typically have to pay the Providers and submit the claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, You should call the service center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

- **Inpatient Services**
  In most cases, if You contact the service center for assistance, Hospitals will not require You to pay for covered inpatient services, except for Your applicable Deductible, Coinsurance, etc. In such cases, the Hospital will submit Your claims to the service center to begin claims processing. However, if You paid in full at the time of services, You must submit a claim to receive reimbursement for Covered Services.

- **Outpatient Services**
  Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require You to pay in full at the time of services. You must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**
  When You pay for Covered Services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from the service center or online at **www.bcbsglobalcore.com**. If You need assistance with Your claim submission, You should call the service center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week.

## CLAIMS RECOVERY

If the Plan pays a benefit to which You or Your beneficiaries were not entitled, or if the Plan pays a person who is not eligible for benefits at all, the Plan has the right to recover the payment from the person the Plan paid or anyone else who benefited from it, including a provider of services. The Plan's right to recovery includes the right to deduct the mistakenly paid amount from future benefits the Plan would provide the Participant or any of their Dependents under this Plan.

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

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

## SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former Claimants who incur claims and are or have been covered by the Plan. No adult Claimant hereunder, may assign any rights that they may have to recover expenses from any tortfeasor or other person or entity to any minor child or children of said adult Claimant without the prior express written consent of the Plan. These provisions will apply to all claims

arising from Your Illness, Injury or condition, including, but not limited to, wrongful death, survival or survivorship claims brought on Your, Your estate's or Your heirs' behalf, regardless of whether medical expenses were or could be claimed. "You" or "Your" includes anyone on whose behalf the Plan pays benefits.

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

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

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

### Subrogation

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

### Reimbursement

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

### Constructive Trust

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

### Lien Rights

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

### Assignment

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

### First-Priority Claim

By accepting benefits from the Plan, You acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before You receive any recovery for Your damages. The Plan shall

be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make You whole or to compensate You in part or in whole for the damages sustained. The Plan is not required to participate in or pay Your court costs or attorney fees to any attorney You hire to pursue Your damage claim.

### Applicability to All Settlements and Judgments

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

### Cooperation

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

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

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

### Workers' Compensation

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

### Future Related Expenses

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

### Interpretation

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

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

## COORDINATION OF BENEFITS
If You are covered by any other Plan (as defined below), the benefits in this SPD and those of the Other Plan will be coordinated in accordance with the provisions of this section. Coordination of Prescription Medications Benefit is not available if You participate in the CDHP Option.

### Coordination of Benefits with a High Deductible Health Plan – CDHP Option
Laws strictly limit the types of other coverages that a health savings account (HSA) participant may carry in addition to their qualified high deductible health Plan. The benefits of maintaining an HSA are jeopardized if impermissible types of other coverages are maintained. Benefits will be coordinated according to this Coordination of Benefits provision, regardless of whether other coverage is permissible per HSA law or not. It is Your responsibility to ensure that You do not maintain other coverage that might jeopardize any HSA tax benefit that You plan to claim.

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

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

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

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

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

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

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

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

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

Other Plan does not include:

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

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

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

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

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

### Order of Benefit Determination

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

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

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

- When Your parents are married or living together (whether or not they have ever been married), the Plan of the parent whose Birthday falls earlier in the Year is the Primary Plan. If both parents have the same Birthday, the Plan that has covered a parent longer is the Primary Plan.
- When Your parents are divorced or separated or are not living together (if they have never been married) and a court decree states that one of Your parents is responsible for Your health care expenses or health care coverage, the Plan of that parent is primary to the Plan of Your other parent. If the parent with that responsibility has no health care coverage for Your health care expenses, but that parent's spouse does, the Plan of the spouse shall be primary to the Plan of Your other parent.
- If a court decree states that both parents are responsible for Your health care expenses or health care coverage, or if a court decree states that the parents have joint custody of You, without specifying that one of the parents is responsible for Your health care expenses or health care coverage, the provisions of the first bullet above (based on parental Birthdays) shall determine the order of benefits.
- If there is no court decree allocating responsibility for Your health care expenses or health care coverage, the order of benefits is as follows:
    - The Plan of Your Custodial Parent shall be primary to the Plan of Your Custodial Parent's spouse.
    - The Plan of Your Custodial Parent's spouse shall be primary to the Plan of Your noncustodial parent.
    - Then the Plan of Your noncustodial parent shall be primary to the Plan of Your noncustodial parent's spouse.

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

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

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

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

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

Your length of time covered by a Plan is measured from Your first date of coverage with that Plan. If that date is not readily available for a group Plan, the date You first became a member of the group will be

used as the date from which to determine the length of time coverage with the present Plan has been in force.

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

### Primary Health Plan Benefits

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

### Secondary Health Plan Benefits

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

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

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

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

**Coordination of Benefits with Medicare:** If You are eligible for Medicare, Your Medicare coverage will pay as the Secondary Plan and this Plan will pay benefits as the Primary Plan.

### Right to Receive and Release Needed Information

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

### Right of Recovery

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

- From You, if payment was made to You. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentations. This Plan will be entitled to recover the amount of such excess by the reversal of payment from You and You agree to reimburse this Plan on demand for any and all such amounts. If a third-party collection agency or attorney is used to collect the overpayment, You agree to pay collection fees incurred, including, but not limited to, any court costs and attorney fees. If You do not pay, future benefits may be withheld to offset the amount

owing to it. The Claims Administrator is responsible for making proper adjustments between insurers and Providers.

- From Providers, if payment was made to them. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentation(s). The Claims Administrator is responsible for making proper adjustments between insurers and Providers.
- From the Other Plan or an insurer.
- From other organizations.

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

# Appeal Process

If You or Your Representative wish to seek review of a claim denial or other dispute that is identified below, You may appeal. There are two levels of appeal, as well as additional voluntary appeal levels that You may pursue. Certain situations requiring a faster decision may qualify for an expedited appeal as described below.

NOTE: For all appeals, written materials provided in support of the appeal that include others' medical or health records and other personal health information should not be submitted.

Each level of appeal, except voluntary external review, must be pursued within 180 days of Your receipt of the Claims Administrator's determination (or, in the case of the first level, within 180 days of Your receipt of the Claims Administrator's original adverse decision that You are appealing). You will be given a reasonable opportunity to provide written materials. If You don't appeal within this time period, You will not be able to continue to pursue the appeal process and may jeopardize Your ability to pursue the matter in any forum. When an appeal request is received, the Claims Administrator will send You a written acknowledgement.

### INTERNAL APPEAL – FIRST LEVEL

First-level appeals are reviewed by an employee(s) of the Claims Administrator who was not involved in the initial decision that You are Appealing. In Appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's staff of health care professionals.

### INTERNAL APPEAL – SECOND LEVEL

Second-level appeals are reviewed by an employee(s) of the Claims Administrator who was not involved in, or subordinate to anyone involved in, the initial or the first-level decision.

### What You May Appeal – Internal Appeal

You may appeal an Adverse Benefit Determination.

### INTERNAL EXPEDITED APPEAL

If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision from the regular appeal process, You or Your treating Provider may specifically request an expedited appeal within 180 days of Your receipt of the Claims Administrator's Adverse Benefit Determination.

The internal expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. Internal expedited appeals are reviewed by an employee(s) of the Claims Administrator who was not involved in, or subordinate to anyone involved in, the initial decision that You are Appealing. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the expedited appeal time frame) to provide written materials, including written testimony on Your behalf.

### What You May Appeal – Internal Expedited Appeal

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

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

## FILING AN INTERNAL APPEAL

Appeals can be initiated through either written or verbal request using any of the following methods:

| Method of Request | Contact Information |
|---|---|
| Secure Online Account | Sign-in to Your account at **regence.com**, navigate to appeals and complete an appeal request |
| Phone | Call the Customer Service phone number on Your identification card |
| Fax | 1 (877) 663-7526 |
| Mail | Attn: ASO Appeals and Grievances<br>Regence BlueCross BlueShield of Utah<br>P.O. Box 1106<br>Lewiston, ID 83501 |

## INTERNAL APPEAL DETERMINATION TIMING

The Claims Administrator will send its decision on Your internal appeal as follows:

| Type of Appeal | How and When to Expect a Response |
|---|---|
| Post-Service appeal | In writing, within 30 days of the Claims Administrator's receipt of the appeal. |
| Pre-Service appeal for preauthorization | In writing, within 15 days of the Claims Administrator's receipt of the appeal. |
| Expedited appeal | By phone, fax or e-mail within 72 hours of the Claims Administrator's receipt of the appeal, followed by written notice within 3 working days. |

## VOLUNTARY EXTERNAL APPEAL

The Claims Administrator coordinates voluntary external Appeals, but the decision is made by the external review entity at no cost to You. The Claims Administrator will provide the external review entity with the Appeal documentation. The external review entity will make their decision and provide You with written determination within 45 days of receipt of the request.

A voluntary Appeal to an external review entity is available for issues involving medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a Covered Service; or the determination that a treatment is Investigational), but only after You have exhausted all of the applicable non-voluntary levels of Appeal, or if the Claims Administrator has failed to adhere to all claims and internal Appeal requirements. Voluntary external appeals must be requested within four months of Your receipt of the notice of the prior adverse decision.

The voluntary external Appeal to an external review entity is optional and You should know that other forums may be used as the final level of Appeal to resolve a dispute You have under the Plan. The Claims Administrator will coordinate review by the external review entity. You may choose from the following two external review entities:

### University of Utah Medically Appropriate Review Committee

A committee consisting of physicians employed by University of Utah Health, one member of Human Resources who is not involved in any employment decision, and a legal advisor from the University's Office of General Counsel. The committee will not include Your health care Provider. Information provided to the committee will be de-identified by the HR member. You may also choose to appeal the decision of this committee to the Independent Review Organization described below. You are not required to appeal to the University of Utah Medically Appropriate Review Committee prior to requesting a review by the Independent Review Organization following a second-level determination.

### Independent Review Organization (IRO)
An IRO which is independent from Your health care Provider and the Claims Administrator. This level of appeal is also available to You if you choose to have your appeal reviewed by the University of Utah Medically Appropriate Review Committee and wish to appeal their decision. The decision of the IRO is final and binding and may not be appealed further, except to the extent other remedies are available under State and Federal law.

## VOLUNTARY EXTERNAL EXPEDITED APPEAL – IRO
If You disagree with the decision made in the internal expedited appeal and You or Your Representative reasonably believes that preauthorization remains clinically urgent (Pre-Service or concurrent), You may request a voluntary external expedited appeal to an IRO. The criteria for a voluntary external expedited appeal to an IRO are the same as described above for a voluntary external appeal.

The Claims Administrator coordinates voluntary external expedited appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the appeal documentation. Choosing the voluntary external expedited appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision and this section.

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

### What You May Appeal – Voluntary External Expedited Appeal
A voluntary external expedited appeal is available for the same reasons as described above for an internal expedited appeal.

## FILING AN EXTERNAL APPEAL
You may file an external appeal using the same options as described above for filing an internal appeal.

## EXTERNAL APPEAL DETERMINATION TIMING
The Claims Administrator will send its decision on Your external appeal as follows:

| Type of Appeal | How and When to Expect a Response |
|---|---|
| External appeal | In writing, within 45 days of the Claims Administrator's receipt of the appeal. |
| External expedited appeal | By phone, fax or e-mail within 72 hours of the Claims Administrator's receipt of the appeal, followed by a written notice which will be mailed to You within 48 hours of the notice provided by phone, fax or e-mail. |

## DEFINITIONS
The following definitions apply to this Appeal Process Section:

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including when based on a determination of a Participant's or Beneficiary's eligibility to participate in a Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or Investigational, or not Medically Necessary or appropriate. A denial or rescission of coverage is subject to review of Adverse Benefit Determination, whether or not the rescission has an adverse effect on any particular benefit at the time.

Independent Review Organization (IRO) is an independent physician review organization that acts as the decision-maker for voluntary external appeals and voluntary external expedited appeals and that is not controlled by the Claims Administrator.

Post-Service means a request to change an Adverse Benefit Determination for care or services that have been received, or any claim for benefits that is not considered Pre-Service.

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

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

# Eligibility and Enrollment

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 employed in a Tenure-line (Tenured or Tenure-track) position(s) at 50% FTE or greater, or at 37.5% or greater pursuant to a nine-month employment contract which is to be paid out over a twelve-month period. Faculty members employed in a faculty position(s) other than a Tenure-line category (for example, in a Career-line, Adjunct, or Visiting Faculty category position) who have an appointment for nine months or longer at 50% FTE (full-time equivalent) or greater. The FTE of a faculty member with an appointment with the Veterans Administration Hospital and/or Shriner's Hospital is combined for all appointments to determine eligibility.
- Staff employees who are employed in a position expected to last nine 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.
- Employees who are employed at less than 50% FTE and hold a J-1 visa;
- Employees who are employed in a position that is not otherwise eligible for coverage under this Plan; however, they have the option to enroll in health coverage pursuant to Federal or State law, including the Affordable Care Act.

### Non-University Employees and Groups

You are eligible to enroll in this Plan if you are a member or employee of one of the following groups as identified in the list below:

- Post-doctoral trainees being paid through a grant and working at the University with other University employees.
- Members of the Utah State Board of Regents throughout their period of appointment.
- Employees for whom the University processes payroll and provides access to employee benefits: Utah Humanities Council, Huntsman Cancer Foundation, Huntsman Mental Health Foundation, Office of the Commissioner of Higher Education, and Utah System of Higher Education, who are employed in positions expected to last nine months or longer at 50% FTE or greater.

### Dependents

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

- The person to whom You are legally married (spouse);
- Your domestic partner, provided that:
  - both You and Your domestic partner are age 18 or older;
  - You and Your domestic partner reside together in a permanent residence and have done so for at least 6 months and will remain members of the same household for the period of coverage.
  - You and Your domestic partner share a committed relationship and intend to continue that relationship indefinitely;
  - You and Your domestic partner are emotionally committed to one another and jointly responsible for the common welfare and financial obligations of the household or one is chiefly dependent upon the other for financial assistance;
  - neither You nor Your domestic partner are legally married to anyone else or the domestic partner of anyone else;

  - You and Your domestic partner are not related in any way that would prohibit legal marriage in Your state of residence; and
  - As part of the enrollment process, You have certified that all the above information is true and correct.

- Your (or Your spouse's or Your domestic partner's) children by birth, placement for legal adoption or foster care, or legal (court-appointed) guardianship granting full guardianship rights, who are under age 26;
- Your (or Your spouse's or Your domestic partner's) child, who is age 26 or older, unmarried and who is a Disabled Dependent due to a Physical Impairment or a Mental Impairment (terms defined below) that began before the child's 26th birthday (You must complete and submit Regence's affidavit of Dependent eligibility form, with written evidence of the child's impairment, within 90 days (this changes to 30 days effective 4/1/2025) of the later of the child's 26th birthday or Your Effective Date);
- a child who is under 18 years of age for whom the noncustodial parent is required by a court order or administrative order to provide health coverage, whether or not the custodial parent is a Plan Participant and whether or not the noncustodial parent, who is eligible for this coverage, has enrolled hereunder. If You are not already enrolled in coverage, upon receipt of a court order, You will automatically be enrolled in the same coverage as the child; and
- a child, as described in the third bullet above, who is any age and incapacitated from earning a living and without sufficient means for whom the noncustodial parent is required by a court order or administrative order to provide health coverage, whether or not the custodial parent is a Plan Participant and whether or not the noncustodial parent, who is eligible for this coverage, has enrolled hereunder. If You are not already enrolled in coverage, upon receipt of a court order, You will automatically be enrolled in the same coverage as the child.

### Dependent Coverage Continuing Beyond Limiting Age

- You may continue coverage for Your (or Your spouse's or Your domestic partner's), unmarried, child at age 26 (or enroll such child if You are a new hire to the University) if the child is a Disabled Dependent (defined below). To do so, You must provide to the University's Human Resources Department a written request along with proof that the Dependent meets the Plan's definition of Disabled Dependent, as follows:
  - within 90 days (this changes to 30 days effective 4/1/2025) after the Dependent reaches age 26, within 90 days (this changes to 30 days effective 4/1/2025) of Your hire into a benefit-eligible position with the University, or within 90 days (this changes to 30 days effective 4/1/2025) of the date the Dependent loses other coverage; and
  - at reasonable times thereafter as the Claims Administrator may consider necessary, but not more often than annually.

- You may continue coverage for Your (or Your spouse's or Your domestic partner's) unmarried, child at age 26 if the child is currently enrolled in the Plan as Your eligible Dependent and is currently enrolled as a full-time student; and qualifies as Your Qualifying Relative as defined in the United States Internal Revenue Code (the child must meet all dependency tests as set forth by the United States Internal Revenue Code regarding taxability of employer-provided health coverage). To do so, You must provide to the University's Human Resources Department a written request to continue coverage along with certification of the Dependent's full-time student status, as follows:
  - within 90 days (this changes to 30 days effective 4/1/2025) 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 Human Resources Department any information necessary or appropriate to determine the validity of a Dependent's status. Receipt of such information by the University's Human Resources 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 Human Resources Department when the Dependent is no longer eligible under these exceptions.

### Retirees
If You are an eligible retiree, You may enroll in a Retiree Health Care Plan offered through the University or continue coverage for a limited period of time under COBRA.

## DEFINITIONS
The following definitions apply to this Eligibility and Enrollment Section:

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

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

Mental Impairment means a mental or psychological disorder such as:

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

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

- neurological;
- musculoskeletal;
- special sense organs;
- respiratory organs;
- speech organs;
- cardiovascular;
- reproductive;
- digestive;
- genito-urinary;
- hemic and lymphatic;
- skin; or
- endocrine.

# 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 Human Resources Department.

## WHEN YOU AND YOUR DEPENDENTS ARE INITIALLY ELIGIBLE

You become eligible for coverage on (a) the date You are hired by the University into a benefit-eligible position, (b) the date You are transferred into a benefit-eligible position from an ineligible position, or (c) the date of Your appointment or hire into one of the specified Non-University Employee or Groups categories. To enroll Yourself and Your eligible Dependents You must submit Your complete enrollment within 90 days (this changes to 30 days effective 4/1/2025) of Your date of hire, the date You transfer into a benefit-eligible position (if You transferred from an ineligible position), or the date You are appointed in one of the specified Non-University Employee groups.

## NEWLY ELIGIBLE DEPENDENTS

If You acquire a new Dependent by marriage, birth, or newly qualifying as a domestic partnership, You may enroll Yourself, the newly eligible Dependent, and any other eligible Dependents not already enrolled by completing the required enrollment within 90 days (this changes to 30 days effective 4/1/2025) of the Dependent becoming eligible. Upon acceptance of Your properly completed enrollment form, coverage for Your Dependent(s) will be effective retroactive to the date the Dependent gained eligibility or, at Your request, coverage may be effective on the date You completed the required enrollment. If the change form is not submitted to the University's Benefits Department within 90 days (this changes to 30 days effective 4/1/2025) 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.

If You acquire a new Dependent by placement for adoption, coverage for the newly eligible Dependent will be based on the following:

- if the baby is legally placed with You for adoption within 30 days of the date of birth, coverage will be effective the date the baby was born; or
- if the baby is legally placed with You for adoption 31 days or after the date of birth, coverage will begin the date stated in the legal placement order signed by the judge.

**NOTE:** When the addition of a new 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 contact the University Human Resources Department, 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 90 days (this changes to 30 days effective 4/1/2025) beginning with the day of the triggering event; except the Special Enrollment period following exhaustion of any lifetime maximum on total benefits under a plan other than a plan sponsored by the University, which ends 30 days following the date the first claim is denied on the basis of lifetime maximum exhaustion. In each situation, You must complete the requested enrollment change within the Special Enrollment period. If You do not submit Your request within the Special Enrollment period, You may only enroll You and/or Your eligible Dependents during the Plan's subsequent Open Enrollment Periods, if any. In these situations, the rules regarding how to apply and when coverage begins are the same as those described earlier:

- If You and/or Your eligible Dependents lose coverage under another group or individual health benefit plan due to:
  - the exhaustion of federal COBRA or any state continuation coverage;

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

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

- If You declined coverage for Yourself and/or Your eligible Dependents when You were first eligible and You and/or one of Your eligible Dependents loses eligibility for coverage under Medicaid or CHIP, or becomes eligible for premium assistance from Medicaid or CHIP, You become eligible for coverage under this Plan on behalf of Yourself and Your eligible Dependents on the date of change in eligibility.
- If You declined coverage for Yourself and/or Your eligible Dependents when You were first eligible and You subsequently marry or qualify as a domestic partnership, You become eligible for coverage under this Plan on behalf of Yourself, Your spouse or domestic partner, and any Eligible children and/or Your eligible Dependents on the date of marriage or the date You and Your domestic partner qualify as a domestic partnership.
- If You declined coverage for Yourself and/or Your eligible Dependents when You were first eligible (or You declined coverage for Your spouse or domestic partner when they were first eligible) and You subsequently acquire a new child by birth, adoption, placement for legal adoption, or placement for legal guardianship or foster care (if the order requires health coverage for the child), You become eligible for coverage under this Plan along with Your eligible spouse or domestic partner and Eligible children on behalf of Yourself and/or Your eligible Dependents, including the newly acquired child on the date of the birth, adoption, or placement.

## LATE ENROLLMENT/OPEN ENROLLMENT PERIOD

If You wish to enroll and/or add Your eligible Dependents under the Plan but did not enroll when first eligible or during 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 Plan 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 Plan 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 enter the change election within 90 days (this changes to 30 days effective 4/1/2025) after such date. In order for an individual who loses eligibility for coverage under the Plan to be eligible for continuation of coverage under COBRA, You must notify the Human Resources Department or otherwise give the Plan written notice within **60 calendar days** after such date in order for the Dependent to be eligible for continuation of coverage under COBRA.

# When Coverage Ends

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

### PLAN TERMINATION OR AMENDMENT

If the Plan is terminated by the University, coverage for You and Your enrolled Dependents will end on the date the Plan is terminated. If the terms of eligibility are amended and You are in a class no longer eligible to participate in the Plan, coverage for You and Your enrolled Dependents will end on the date the terms of eligibility are amended.

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

### WHEN YOU MAY ELECT TO CANCEL COVERAGE

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

If You and/or Your enrolled Dependent(s) obtain other similar coverage during the Plan Year (including enrolling in Medicare), You may elect to cancel coverage for such covered individual(s). In order to drop coverage during the Plan Year, You must complete the enrollment change within 90 days (this changes to 30 days effective 4/1/2025) from the date You and/or Your enrolled Dependent(s) gain other similar coverage. Coverage will be dropped on the date the enrollment change is completed (no refund of premiums will be provided).

If You and/or Your enrolled Dependent(s) obtain other coverage through the Health Insurance Marketplace, You may elect to cancel coverage for such covered individual(s). In order to drop coverage during the Plan Year, You must complete the enrollment change within 90 days (this changes to 30 days effective 4/1/2025) from the effective date of coverage through the Health Insurance Marketplace for You and/or Your enrolled Dependent(s). Coverage will be dropped on the date the enrollment change is completed.

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 the enrollment change within 90 days (this changes to 30 days effective 4/1/2025) from the date of the significant increase in Your cost of coverage. Coverage will be dropped on the date the enrollment change is completed.

### WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your enrolled Dependents' 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 in this SPD.

#### Termination of Your Employment or Appointment, Change to an Ineligible Employment Status or End of Eligibility Under Law

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

### Nonpayment of Required Contribution
If You fail to make the required contribution in a timely manner, Your coverage will end for You and all enrolled Dependents on the date You fail to make such a required contribution and You and Your enrolled Dependents will not be eligible for continuation of coverage under COBRA.

### 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.

## 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 Section in this SPD. You must make the enrollment change within 90 days (this changes to 30 days effective 4/1/2025) of the date of the event. Any change to Your coverage level (for example, two-party to single coverage), will be effective on the date You submit Your completed enrollment change. **You or the Dependent must notify the University's Human Resources 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. Complete the enrollment change within 90 days (this changes to 30 days effective 4/1/2025) of the date of the event. You or Your former spouse must notify the University's Human Resources 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 Section of this SPD.

### Termination of Domestic Partnership
In the event Your domestic partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet the requirements outlined in the definition of an eligible Dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing dependent relationship with You) on the date of termination of the domestic partnership. Complete the enrollment change within 90 days (this changes to 30 days effective 4/1/2025) of the date of the event. You or Your former domestic partner must notify the University's Human Resources Department of the domestic partner's (and domestic partner's children's) ineligibility under the Plan. In the event the Plan is notified within 60 calendar days of the date of the partnership termination, Your domestic partner (and domestic partner's children) may continue coverage under the Plan for a limited period of time according to the COBRA Continuation of Coverage Section of this SPD.

### Child's Loss of Dependent Status
- Eligibility ends on the first day of the month following the child's 26th birthday (or on the date the child is no longer a full-time student or a Disabled Dependent as defined in the Eligibility and Enrollment Section, if over age 26).
- Eligibility ends on the date the child is removed from placement due to disruption of placement prior to legal adoption and the child is removed from placement.
- Eligibility ends on the date the child is no longer an eligible Dependent for any other cause (except by reason of Your death).

You or Your Dependent must notify the University's Human Resources 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 Section of this SPD.

### Death of the Participant

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 continue coverage for a limited period of time under COBRA or enroll in a University Retiree Health Care Plan, if available. If You die while in the line-of-duty as a public safety officer for the University (as outlined in Utah Code 53-17-201), coverage for Your enrolled Dependents (spouse and/or children) who were covered under the Plan immediately preceding Your death may continue until Your surviving spouse (if applicable) becomes eligible for Medicare, and the first day of the month following the date Your child turns age 26.

### 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 material fact in connection with coverage, coverage under the Plan may be terminated and continuation of coverage under COBRA may not be available. Claims associated with care obtained under fraudulent circumstances (for example, misrepresentation of patient identity, condition, or symptoms) may be denied or, if paid, refund of payment may be pursued from the provider, recipient, or any individual benefiting from the payment. In addition, any person who knowingly files, or causes to be filed, a statement of claim containing or premised upon 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 lawn and subject to civil penalties.

# Leaves of Absence

### FAMILY AND MEDICAL LEAVE ACT LEAVE OF ABSENCE

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

- You and Your enrolled Dependents will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period as provided under the FMLA or up to 26 total weeks if You are approved for Servicemember Family Leave under the FMLA.
- Persons entitled to coverage under this paragraph will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this paragraph. Entitlement to FMLA leave does not constitute a Qualifying Event for the purposes of COBRA continuation. However, a person not returning to active employment following FMLA leave may be entitled to COBRA continuation coverage, the duration of which will be calculated from the date the person fails to return from the FMLA leave.
- You must make timely payment of Your monthly contribution through the University. The provisions described here will not be available if this Plan terminates.
- If Your FMLA leave is unpaid and You and/or Your enrolled Dependents elect not to remain enrolled during the leave, You and/or Your enrolled Dependents will be eligible to be reenrolled under the Plan on the date You return from the FMLA leave if You request reenrollment upon Your return to work. If You return during the same Plan 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 (as defined by the University's Long Term Disability Plan), You may continue coverage through the University by making required contributions. For the first six months, You may continue Your current coverage in this Plan. After six months, if You remain totally disabled and are eligible and enrolled in this Plan, You may enroll in the University's ERIP Health Care Plan for up to 30 months from Your initial date of disability. If You or Your enrolled Dependents are eligible for Medicare, You will need to enroll in Medicare at that time.

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

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

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

## PERSONAL LEAVE OF ABSENCE

You may continue coverage under the Plan during an approved personal leave of absence by making required contributions through the University's Human Resources 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 Human Resources 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.

# 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.

The right to COBRA coverage was created by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage may become available to you and your family members when you would otherwise lose your health care coverage.

This section contains important information about your right to continue your health care coverage in the Plan.

There may be other coverage options for you and your family including a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) or coverage through the Health Insurance Marketplace.

## QUALIFYING EVENTS

"Qualifying Events" are certain events 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 covered employee's employment for reasons other than "gross misconduct";
- Reduced hours of work for the covered employee, resulting in ineligibility for health coverage;
- Divorce or legal separation of the covered employee;
- Death of the covered employee;
- Loss of status as an "eligible Dependent child" under plan rules;
- The covered employee 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 a retiree medical program).

Your Qualifying Event 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 Human Resource Management within 60 days of one of the following events:

- Divorce or legal separation
- Child losing Dependent status
- You experience a Second Qualifying Event
- Disability determination by the Social Security Administration (see Social Security Disability for details)

To provide this notice, you may complete the Health Care Coverage Change Form available on the internet at www.hr.utah.edu/forms/index.php or in University Human Resource Management. Alternatively, your spouse or Dependent child may give written notice of the Qualifying Event to Human Resources at the address listed at the end of this section. 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 Human Resources within 60 days after the date of the Qualifying Event, all rights of that individual to elect COBRA coverage will be lost. 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.

## QUALIFIED BENEFICIARIES

Each individual who was covered under the Plan on the day before the Qualifying Event is a "Qualified Beneficiary" and has an independent right to purchase COBRA coverage. An exception to this rule applies if coverage is reduced or eliminated in anticipation of a Qualifying Event. COBRA coverage may

still be available to a spouse or Dependent child who has been dropped from coverage in anticipation of divorce or legal separation. In this case, COBRA coverage will be effective upon the date of divorce or separation, not the date that coverage was terminated, and will only be available provided that, but for the lost coverage, the spouse or Dependent child would otherwise have been eligible. Qualified Beneficiary includes 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. The Plan Administrator may terminate your COBRA coverage retroactively if you are determined to have been ineligible for coverage.

## 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 may continue COBRA coverage for 18 months. If the Qualifying Event is death of the covered employee, divorce or legal separation, or loss of Dependent status, COBRA coverage is available for 36 months. If a Qualified Dependent is determined to have been disabled on the date of the Qualifying Event or during the first 60 days of COBRA coverage, additional coverage may be available (see Social Security Disability below).

## SOCIAL SECURITY DISABILITY

If your Qualifying Event is termination of employment or reduction in hours and you are determined by the Social Security Administration to have been disabled on the date of the Qualifying Event or during the first 60 days of COBRA coverage, you and/or your enrolled Dependents may obtain an extension of coverage from 18 months to 29 months. It is your responsibility to obtain the disability determination from the Social Security Administration and to provide a copy of the determination to the University Human Resource Management within 60 days of the date the determination is made and before the end of the original 18-month COBRA period. If you do not notify Human Resources 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 Human Resource Management within 30 days if a final determination is made that you are no longer disabled.

## 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 if you, your spouse, or Dependent child failed to notify the University Human Resource Management of a divorce, legal separation or a child losing Dependent status within 60 days of the event.) If neither you nor your spouse or Dependent child(ren) elect COBRA 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, your spouse and your Dependents will have no right to elect COBRA coverage at a later date.

## COBRA PREMIUM PAYMENTS

If you elect COBRA coverage, you will be responsible to pay the full cost of coverage plus a 2% administration fee. The COBRA premiums, including this fee, will be listed on your "Notice of Right to Elect Continuation Coverage (COBRA)." 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 Human Resource Management within 45 days of the date you elect COBRA coverage. Your first premium payment will include premiums due retroactive to the date you lost coverage as a result of your Qualifying Event. If your first payment is not received timely, COBRA coverage will not be effective and you will lose all rights to COBRA coverage.

## SUBSEQUENT PAYMENTS

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

## 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 Human Resource Management within 60 days of the second Qualifying Event and during the original 18-month COBRA coverage period (or 29-month period if there has been a disability extension) in order to extend COBRA coverage to 36 months. The written notice must 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.

## CHANGES IN COBRA COVERAGE

You will have the same rights to enroll Dependents and change elections with respect to the University Health Care Plan as active employees of the University. Changes to coverage may be made during the University's Open Enrollment period each year.

## NEWBORNS AND ADOPTEES

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

## FLEXIBLE SPENDING ACCOUNTS

If you were enrolled in a Health Flexible Spending Account at the time of your Qualifying Event and would like to retain access to any fund balance in your account, please contact University Human Resource Management to obtain additional information. 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.

## TERMINATION OF COBRA COVERAGE

Your COBRA coverage 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 (under Part A, Part B, or both);
- 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 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 impose any pre-existing condition exclusion for a pre-existing condition of the qualified Dependent (note: there are limitations on plans' imposing a pre-existing condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act); or
- An event occurs that permits termination of coverage under the University Health Care Plan for an individual covered other than pursuant to COBRA (for example, submitting fraudulent claims).

## QUESTIONS, NOTICES AND ADDRESS CHANGE

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

The University's COBRA Administrator is Sandy Robison, 250 East 200 South, Suite 125, Salt Lake City, UT 84111, telephone (801) 581-7447 (the contact person may change from time to time).

**If You divorce or legally separate, no longer qualify as a domestic partnership, or lose eligibility as a child under the Plan, You must provide the required written notice to University Human Resource Management within 60 days.**

In order to protect Your Family's rights, You should keep the University Human Resource Management informed of any change in address for You, Your spouse, domestic partner or enrolled children. If You have any questions or need additional information, please contact the University Human Resource Management.

# Notices

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

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

**THIS NOTICE IS EFFECTIVE SEPTEMBER 20, 2013**

**YOUR RIGHTS**

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

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

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

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

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

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

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

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

### File a complaint if you feel your rights are violated

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

## YOUR CHOICES

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

  *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

## OUR USES AND DISCLOSURES

### How do we typically use or share your health information?

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

### Help manage the health care treatment you receive

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

### Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This federal rule does not apply to long term care plans.

  Example: We use health information about enrolled employees in the aggregate to develop better services for health plan members.

### Pay for your health services

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

### Administer your plan

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

## HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

### Help with public health and safety issues
We can share health information about you for certain situations such as:

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

### Do research
We can use or share your information for health research.

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

### Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

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

### Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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

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

## CHANGES TO THE TERMS OF THIS NOTICE
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

## CONTACT US
If you are concerned that your privacy rights may have been violated, or disagree with a decision that we made about access to your health information, contact:

**University of Utah Human Resources Department**
Attention: Director of Benefits
250 East 200 South, Suite 125
Salt Lake City, UT 84111

(801) 581-7447
Fax: (801) 585-7375

**University of Utah Information Security and Privacy Office**
515 East 100 South, Suite 650
Salt Lake City, UT 84102
(801) 581-2121
Fax: (801) 587-9443
Email: privacy@utah.edu
http://privacy.utah.edu/

# General Provisions and Legal Notices

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

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

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

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

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

### NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT – STATEMENT OF RIGHTS
Under federal law, group health plans and health insurance issuers offering group health insurance coverage may not 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 delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending Provider, after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, the Plan or issuer may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan or issuer may not, under federal law, require that a Physician or other health care provider obtain preauthorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain preauthorization. Contact the Claims Administrator's Customer Service for additional information on preauthorization.

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

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

## NOTICES

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

## PLAN SPONSOR IS AGENT

The Plan Sponsor is Your agent for all purposes under the Plan and not the Claims Administrator's agent. You are entitled to health care benefits pursuant to the Agreement between the Claims Administrator and the Plan Sponsor. In the Agreement, the Plan Sponsor agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in this SPD. You, through the enrollment form signed by the Participant, and as Dependent of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this SPD.

## RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

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

## REPRESENTATIONS ARE NOT WARRANTIES

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

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

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

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

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

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

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

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

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

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

## TAX TREATMENT

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

## CLAIMS ADMINISTRATOR IS NOT RESPONSIBLE FOR HSA FINANCIAL OR TAX ARRANGEMENTS – CDHP OPTION

You are solely responsible to ensure that this plan qualifies, and continues to qualify, for use with any HSA that You choose to establish and maintain. The Claims Administrator does not assume any liability associated with Your contribution to an HSA during any period that this high deductible health Plan does not qualify for use with an HSA. An HSA is a tax-exempt account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible but in order to qualify for and make contributions to an HSA, You must be enrolled in a qualified high deductible health Plan (and not be enrolled in other coverage). Note that the tax references contained in this SPD relate to federal income tax only. The tax treatment of HSA contributions and distributions per Your state's income tax laws may differ from the federal tax treatment and differs from state to state.

The Claims Administrator does not provide tax advice and assumes no responsibility for reimbursement from the custodial financial institution for any HSA with which this high deductible health Plan is used. Consult with Your financial or tax advisor for tax advice or for more information about Your eligibility for an HSA.

## WHEN BENEFITS ARE AVAILABLE

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

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

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

## 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 (subject to the same provisions as any other benefit) 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.

# Definitions

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

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.

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

Allowed Amount means:

- For In-Network Providers and In-Network Dentists, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Providers who are not accessed through the BlueCard Program, the amount the Claims Administrator has determined to be eligible charges or have negotiated for Covered Services. The Allowed Amount may consider factors such as amounts allowed for similar services by In-Network Providers, amounts allowed by other plans or programs or billed charges, as determined by the Claims Administrator and/or as otherwise required by law.
- For Out-of-Network Providers accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to the Claims Administrator as the amount on which it would base a payment to that Provider. In exceptional circumstances, such as if the Host Blue does not identify an amount on which it would base payment, the Claims Administrator may substitute another payment basis.
- For Out-of-Network Dentists, the amount the Claims Administrator has determined to be reasonable charges for Covered Services. The Allowed Amount may be based upon billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

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

Ambulatory Surgical Center means a facility or that portion of a facility licensed by the state in which it is located, that operates exclusively to provide surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission. An Ambulatory Surgical Center must be a freestanding facility, meaning that it exists independently or is physically separated from another health care facility by fire walls and doors and is administered by separate staff with separate records.

Claimant means a Participant or an enrolled Dependent.

Commercial Seller includes, but is not limited to, retailers, wholesalers or commercial vendors that are not Providers, who are approved to provide new medical supplies, equipment and devices in accordance with the provisions of this coverage.

Cosmetic means services or supplies (including medications) that are provided primarily to improve or change appearance to normal structures of the body.

Covered Service for your medical benefits means a service, supply, treatment or accommodation that is listed in the benefit sections in this SPD.

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

Custodial Care means care for watching and protecting a patient, rather than being a Health Intervention. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily to separate the patient from others or prevent self-harm.

Dependent means a Participant's eligible Dependent who meets the eligibility requirements in the Who Is Eligible Section is listed on the Participant's completed enrollment form and who is enrolled under the Plan.

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

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

A dental service may be Dentally Appropriate yet not be a Covered Service.

Dental Services mean services or supplies (including medications) that are provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

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

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Claimant's home.

Effective Date means the date, following the Claims Administrator's receipt of the enrollment form, as the date coverage begins for You and/or Your Dependents.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency room to result in any one of the following:

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

Family means a Participant and any Dependents.

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

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

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

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

Hospital means a facility that is licensed as a general acute or specialty Hospital 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. A Hospital per this definition is not, other than incidentally, a place for rest, a nursing home or a facility for convalescence.

Illness means a:

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

Illness does not include any state of mental health or mental disorder (which is otherwise defined).

Injury means physical damage to the body caused by:

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

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

In-Network means:

- When Your network is ValueCare:
    - A Provider that has an effective participating contract with the Claims Administrator that designates the Provider as in Your network, to provide services and supplies to Claimants in accordance with the provisions of this coverage. Your network is preferred; or
    - A Provider that has an effective participating contract with one of the Claims Administrator's Affiliates (designated as a preferred Provider in the "In-Network"), to provide services and supplies to Claimants in accordance with the provisions of this coverage.
- When Your network is Participating:
    - A Provider that has an effective participating contract with the Claims Administrator that designates the Provider as in Your network, to provide services and supplies to Claimants in accordance with the provisions of this coverage. Your network is participating; or
    - A Provider that has an effective participating contract with one of the Claims Administrator's Affiliates (designated as a participating Provider in the "In-Network"), to provide services and supplies to Claimants in accordance with the provisions of this coverage.

If the Claims Administrator or one of its Affiliates has more than one Provider network from which the Plan Sponsor may choose for benefits under the Plan, then the Providers contracted with the network selected by the Plan Sponsor will be considered the only In-Network Providers for purpose of payment of benefits. For In-Network Provider reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

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

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

- If a medication or device, the Health Intervention must have final approval from the FDA as being safe and effective for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the medication may be provided when so used.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Illness or Injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

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

Medically Necessary or Medical Necessity means health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an Illness or Injury or its symptoms in a manner that is:

- in accordance with generally accepted standards of medical practice in the United States;
- clinically appropriate in terms of type, frequency, extent, site, and duration;
- 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; and
- covered under the Plan.

When a medical question-of-fact exists, Medical Necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and that is known to be effective. For Health Interventions not yet in widespread use, the effectiveness shall be based on Scientific Evidence. For established Health Interventions, the effectiveness shall be based on first Scientific Evidence; then professional standards; and then expert opinion.

A HEALTH INTERVENTION MAY BE MEDICALLY INDICATED OR OTHERWISE BE MEDICALLY NECESSARY, YET NOT BE A COVERED SERVICE UNDER THE PLAN.

Out-of-Network means a Provider or Dentist that is not In-Network. For Out-of-Network services, You may be billed for balances over the Plan's payment level in addition to any Deductible, Copayment and/or Coinsurance amount for Covered Services provided inside or outside the area that the Claims Administrator or one of its Affiliates serves.

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

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

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

Plan Year means the period from July 1 through June 30 of the following year; however, the first Plan Year begins on the Claimant's Effective Date.

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include, but are not limited to:

- 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;
- a Skilled Nursing Facility;
- an Ambulatory Surgical Center;
- a Physician;
- a Practitioner; or
- other individual or organization which is duly licensed to provide medical or surgical services.

Regence refers to Regence BlueCross BlueShield of Utah.

Retail Clinic means a walk-in health clinic located within a retail operation and providing, on an ambulatory basis, preventive and primary care services. A Retail Clinic does not include:

- an office or independent clinic outside a retail operation;
- an Ambulatory Surgical Center;
- an urgent care center or facility;
- a Hospital;
- a Pharmacy;
- a rehabilitation facility; or
- a Skilled Nursing Facility.

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

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

Summary Plan Description (SPD) is a summary of the benefits provided by the group health plan. A group health plan with different benefit plan options may describe them in one SPD or in separate SPDs for each alternative benefit plan option.

# Appendix: Value-Added Services

This Plan includes access to the value-added services detailed in this Appendix. Services may be provided through third-party program partners who are solely responsible for their services. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS OF THIS SPD.**

For additional information regarding any of these value-added services, visit the Claims Administrator's website or contact Customer Service. Contact information for value-added services for specific program partners is also included below, if applicable.

### DIABETES MANAGEMENT

If You are identified to participate, the Diabetes Management program is an online program that has extensive support tools such as glucose tracking, live coaching and mental and emotional care to help You improve health and manage diabetes. To better track blood sugar levels and provide more focused support, You will be provided a cellular-enabled glucose monitor.

### INFUSION SITE OF CARE

If You receive certain infused or injectable drugs, You may be notified about an opportunity to receive Your care at an alternative location. Alternative locations such as standalone infusion sites, doctor's offices and home infusion can offer more comfort, convenience, and reduced costs compared to most Hospital settings. You may contact the Claims Administrator for a list of drugs included in the Infusion Site of Care program or for help finding an alternative location.

### REGENCE EMPOWER

Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. It may include the following:

- earning up to $25 in gift cards for completion of well-being activities such as an online health risk assessment;
- incentives to reward participation in healthy activities; and
- online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals.

# General Plan Information

### EMPLOYER
The University's legal name and federal Employer Identification Number (EIN) are:

University of Utah

EIN # 87-6000525

### PLAN NAME
The name of the Plan is The University of Utah Employee Health Care Plan.

### PLAN YEAR
The Plan year is the twelve month period beginning July 1 and ending on June 30.

### TYPE OF PLAN
The Plan is commonly known as an employee welfare benefit plan. The Plan has been adopted to provide You certain benefits as described in this document.

### PLAN FUNDING
Funding is derived first from the contributions made by the covered employees and then from general assets of The University. The level of Your contributions will be set by The University. Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received.

### PLAN SPONSOR
The University of Utah
250 East 200 South, Suite 125
Salt Lake City, UT 84111
(801) 585-9144

### LEGAL PROCESS
Address where a processor may serve legal process:

Office of the Attorney General
Utah State Capitol Complex
350 North State Street, Suite 230
Salt Lake City, UT 84114-2320

### CLAIMS ADMINISTRATOR
The University has contracted with a Claims Administrator to assist The University with claims adjudication. The Claims Administrator's name, address and telephone number are:

Regence BlueCross BlueShield
2890 East Cottonwood Parkway
Salt Lake City, UT 84121
Customer Service (800) 262-9712
Case Management (866) 543-5765

### PLAN SPONSOR'S RIGHT TO TERMINATE
The University reserves the right to amend or terminate this Plan in whole or in part, at any time, regardless of Your or Your enrolled Dependent's health or treatment status. Amendment or termination may result in modification or termination of Your coverage and/or the coverage of Your enrolled Dependents. Covered Services and Allowed Amount incurred prior to the Plan's amendment or termination will be paid as provided under the terms of the Plan as it existed at the time they were incurred.

## PLAN SPONSOR'S RIGHT TO INTERPRET THE PLAN

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

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

**regence.com**

Regence