
INTRODUCTION

We welcome you as a member of the Educators family and look forward to serving your insurance needs!

Your health and dental benefits, and the Plans' administrative procedures are described in this handbook. You are urged to read it carefully, share its contents with the members of your family, and keep it for future reference. If you have any questions or need further information, contact your employer or the Educators Customer Service Department.

This handbook is a summary only; it is not a contract. Refer to the Plan Documents for a more complete description of your coverage. The Plan Documents are available for your review from your employer during regular business hours.

Notwithstanding anything else in the Plans to the contrary, the items listed in the "Plan Exclusions" sections are not covered by the Plans.

Regardless of benefits specified, the Plans will reimburse or pay a claim only if the services rendered are determined to be medically necessary. Determination of medical necessity is made by Educators using its own set of criteria, or by an independent contractor appointed by Educators.

These are your plans. Anything you can do to contain costs will help provide additional benefits in the future. We recommend doing the following to assist in the reduction and control of costs:

- Question the need for medical services and physician visits.
- Reduce the length of hospital confinements where possible.
- Be sure all charges are for services actually provided.
- Ask about the price; charges should be competitive.

If you need more information on any of the plans or procedures, please call a Customer Service Representative between 8:00 a.m. and 5:00 p.m., Monday through Friday (MT):

(801) 262-7475 in Salt Lake City or
(800) 662-5851 elsewhere in the Continental U.S.A.

Claims Administrator

The Educators plans are administered by Educators Mutual Insurance Association of Utah.

TABLE OF CONTENTS

TABLE OF CONTENTS.....	i
SUMMARY OF BENEFITS	1
GENERAL PLAN INFORMATION	4
ELIGIBILITY AND PARTICIPATION	7
Eligibility	7
Changes in Covered Person Information	7
Enrollment.....	7
When Coverage Begins.....	7
Special Enrollment.....	8
Preexisting Condition Limitation.....	9
Waiver of Preexisting Condition Exclusion	10
Termination of Coverage	11
Family Medical Leave Act (FMLA).....	11
Military Leave.....	12
Qualified Medical Child Support Orders	12
Benefits for Employees Working Beyond Age 65	12
MEDICAL PLAN BENEFITS	13
Using the Care Plus Benefits	13
When Non-participating Provider Option Benefits Apply	14
Coinsurance Maximum.....	14
Lifetime Maximum Benefit	15
Benefit Accumulations.....	15
Care Plus Preauthorization Requirements	15
Preauthorization Review Process.....	16
Second Opinion.....	17
Inform Educators Care Plus of Changes	17
COVERED MEDICAL BENEFITS	18
Hospital/Facility Benefits	18
Emergency Room (ER) Service Benefit	18
Inpatient Rehabilitation Therapy Benefit.....	19
Accident and Life-threatening Condition Benefits.....	19
Physician and Professional Services	19
Preventive Care Services In-Network Benefits Only	21
Transplant Benefits	21
Medical Supplies and Equipment	22
Employee Assistance Program (EAP)	23
Mental Health and Drug/Alcohol Treatment	23
Other Limited Benefits	24
Important Health Care Messages from the Federal Government	25
Cost Reform Information.....	26
DENTAL BENEFITS.....	28

PRESCRIPTION DRUG PROGRAM	29
Copayment and Coinsurance	29
Covered Drugs	29
New Medications	29
How to Use the Prescription Card	30
Prescription Claims Review.....	30
HOME DELIVERY PHARMACY SERVICE PROGRAM.....	31
How to Use the Mail Service Program	31
PRESCRIPTION DRUG AND HOME DELIVERY PHARMACY SERVICE EXCLUSIONS	32
Pharmacy Items Excluded.....	32
MEDICAL PLAN EXCLUSIONS	34
PREMIER INDEMNITY PLAN	42
Summary of Benefits	42
COVERED DENTAL BENEFITS	43
Diagnostic/Preventive Benefits.....	43
Space Maintainers.....	43
Sealants	43
Basic Services	43
Major Services	43
Endodontic Services.....	43
Periodontic Services.....	43
Prosthodontic Services.....	43
Oral Surgery Services	44
Anesthesia Services	44
Orthodontic Services.....	44
Utah Valley University Employee Dental Plan Exclusions.....	45
CONTINUATION OF COVERAGE	48
COBRA Continuation of Coverage Requirements	48
Waiver of Premium.....	49
COORDINATION OF BENEFITS WITH OTHER GROUP PLANS	52
CLAIMS PROCEDURE.....	55
How to File a Claim	55
Requests for Additional Information	55
Exhaustion of Administrative Remedies	55
Claims Review Process.....	56
Subrogation and Reimbursement.....	57
DEFINITION OF TERMS	59

UTAH VALLEY UNIVERSITY
SELF-FUNDED EMPLOYEE MEDICAL BENEFIT PLAN
(CARE PLUS)

Administered by Educators Mutual Insurance Association of Utah

Administration..... 262-7476 • 1-800-662-5850

Customer Service..... 262-7475 • 1-800-662-5851

All services are subject to the Table of Allowances. The Covered Person is responsible for all fees in excess of the Table of Allowances when using a Provider that does not participant on the Care Plus or Beech Street panels. Non-participating Provider benefits apply to Beech Street Providers outside of Utah; however, the Covered Person is not responsible for fees in excess of the Table of Allowances.

Utah Valley University #128 800 West University Parkway, Orem, Utah 84058-5999 801-863-8389	Educators Care Plus	
Summary of Benefits July 1, 2008 - June 30, 2009	Participating Provider Option	Non-participating Provider Option
GENERAL INFORMATION	YOU PAY	
Lifetime Maximum Benefit	\$2,000,000	
Preexisting Condition Window Period	6 months prior	
Preexisting Condition Waiting Period	First 8 months of coverage / 18 months Late Enrollees	
Benefit Accumulator Year	Contract	
Dependent Age Limit	26	
Coinsurance Maximum (Per Person/Family Per Year - Separate from and not satisfied by the Prescription Drug Coinsurance Maximum). Services designated * do not accumulate toward the applicable Coinsurance Maximum.	\$1,500 / \$3,000	\$2,500 / \$5,000
Medical Deductible (Per Person/Family Per Year). Please note ♦.	None	*\$200 / *\$600
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits, limited to \$2,000 penalty per incident.
Non-Preauthorization Provider Sanction	50% Reduction in Payment	Not Applicable
Non-Precertification EAP Penalty	Not Applicable	
PRESCRIPTION DRUG BENEFITS	YOU PAY	
Prescription Drug Coinsurance Maximum (Per Person/Family Per Year - Separate from and not satisfied by the Medical Coinsurance Maximum). Services designated * do not accumulate toward the applicable Coinsurance Maximum.	\$1,100 / \$2,200	
Participating Pharmacy (30 day supply)	Generic \$4 / Preferred Brand - 30% / Non-Preferred Brand - 50%	
Significant Medication (during first 12 months after FDA approval)	*50%	
New Therapeutic Class of Medication (after a 6-month waiting period following FDA approval)	*50%	
Mail Order (90 day supply)	Generic \$4 / Preferred Brand - 30% / Non-Preferred Brand - 50%	
DENTAL BENEFITS	YOU PAY	
Impacted Teeth/Cysts/Tumors	Covered 100%	♦ 30%
HOSPITAL/FACILITY BENEFITS (Physician and Professional Services are not included in this section.)	YOU PAY	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	\$50 per person per Year then 10%	♦ 30%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	10%	♦ 30%
Skilled Nursing Facility (60 day per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	10%	♦ 30%
Medical/Surgical Care (Outpatient)	10%	♦ 30%
Emergency Room (ER)	\$150	♦ 30%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	10%	♦ 30%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	10%	♦ 30%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	10%	♦ 30%
Newborn	10%	♦ 30%
InstaCare Clinic	\$30	♦ 30%
REHABILITATION THERAPY BENEFIT	YOU PAY	
Inpatient – physical, speech, occupational, cardiac, or pulmonary	Covered 100%	♦ 30%
ACCIDENT AND LIFE THREATENING ILLNESS	YOU PAY	

Services designated **** do not accumulate toward your Coinsurance Maximum.

Services designated *♦ are subject to first dollar Deductible.

Utah Valley University #128 800 West University Parkway, Orem, Utah 84058-5999 801-863-8389		Educators Care Plus	
Summary of Benefits July 1, 2008 - June 30, 2009		Participating Provider Option	Non-participating Provider Option
Medical/Surgical – Physician/Facility/ER	Covered as any other condition		Covered as a Participating Benefit subject to the Table of Allowance
Ambulance Land/Air (Accident & Life-threatening)	20%		
Orthodontic Injury Treatment	Covered 100%		
Dental Injury Treatment	20%		
PHYSICIAN & PROFESSIONAL SERVICES	YOU PAY		
Physician Office Visits (primary care)	\$20		◆ 30%
Physician Office Visits (secondary care)	\$20		◆ 30%
Physician Office Visits (after hours)	\$30		◆ 30%
Physician Visits (Inpatient)	10%		◆ 30%
Physician Visits (Outpatient)	10%		◆ 30%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	10%		◆ 30%
Minor Diagnostic Test, X-ray, Lab (office)	Covered 100%		◆ 30%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	10%		◆ 30%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	10%		◆ 30%
Radiology/Pathology (office)	Covered 100%		◆ 30%
Radiology/Pathology (Inpatient)	10%		◆ 30%
Radiology/Pathology (Outpatient)	10%		◆ 30%
Injections (office)	Covered 100%		◆ 30%
Surgery (office)	Covered 100%		◆ 30%
Surgery (Inpatient)	10%		◆ 30%
Surgery (Outpatient)	10%		◆ 30%
Anesthesiology (office)	Covered 100%		◆ 30%
Anesthesiology (Inpatient)	10%		◆ 30%
Anesthesiology (Outpatient)	10%		◆ 30%
Routine Prenatal & Delivery (Dependent maternity included)	\$20 first visit only then Covered 100%		◆ 30%
Home Health Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	10%		◆ 30%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - \$5,000 per Year)	\$20		◆ 30%
Chiropractic Therapy (20 visits per person per Year)	\$20 (CHP)		◆ *50%
Allergy Testing	Covered 100%		◆ 30%
Allergy Treatment/Serum	\$80 per Year		Not Covered
PREVENTIVE SERVICES	YOU PAY		
Routine Physical Exam (1 visit per Year)	Covered 100%		Not Covered
Routine Gynecological Exam (1 visit per Year)	Covered 100%		Not Covered
Family History Exam (1 visit per Year)	Covered 100%		Not Covered
Routine Pap Smear & Mammogram (1 visit per Year)	Covered 100%		Not Covered
Routine Well-Baby Exams	Covered 100%		Not Covered
Covered Immunizations (excludes immunizations required exclusively for foreign travel)	Covered 100%		Not Covered
Routine Vision Exam (1 visit per Year)	\$20		Not Covered
Routine Hearing Exam (1 visit per Year)	\$20		Not Covered
TRANSPLANT BENEFIT	YOU PAY		
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition		Not Covered
MEDICAL SUPPLIES & EQUIPMENT	YOU PAY		
Medical Supplies	20%		◆ 30%
Medical Supplies (office)	Covered 100%		◆ 30%
Durable Medical Equipment	20%		◆ 30%
Orthotic Supplies	20%		Not Covered
Growth Hormone	20%		◆ 30%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT EAP (APS) 800-999-1077	YOU PAY		
Inpatient Facility Semi-private Room (21 days per Year)	*20%		◆ *50%
Inpatient Facility Ancillary (21 days per Year)	*20%		◆ *50%

Services designated "*" do not accumulate toward your Coinsurance Maximum.

Services designated "◆" are subject to first dollar Deductible.

Utah Valley University #128 800 West University Parkway, Orem, Utah 84058-5999 801-863-8389	Educators Care Plus	
Summary of Benefits July 1, 2008 - June 30, 2009	Participating Provider Option	Non-participating Provider Option
Inpatient Facility Physician Visits (21 visits per Year, 1 visit per day)	*20%	◆ *50%
Physician Office Visits (20 visits per Year, 1 visit per day)		
Psychologist / Clinical Social Worker / APRN	\$25	◆ *50%
Psychiatrist	\$50	◆ *50%
OTHER LIMITED BENEFITS	YOU PAY	
Adoption Indemnity Benefit	The Plan pays a maximum \$4,000 towards adoption expenses per child	
TMJ Syndrome diagnosis & non-surgical treatment (\$500 per lifetime)	*50%	Not Covered
Orthognathic/Mandibular Osteotomy	Not Covered	Not Covered
Total Parenteral Nutrition (TPN) (\$100,000 per lifetime)	10%	◆ *50%
Significant Medication (during first 12 months after FDA approval)	*50%	◆ *50%
New Therapeutic Class of Medication (after a 6-month waiting period following FDA approval)	*50%	◆ *50%
Primary Infertility (\$1,500 per Year, \$5,000 per lifetime)	*50%	Not Covered

PLEASE NOTE: This is a **summary only** and does not guarantee benefits. All benefits are subject to the terms, limitations, and exclusions set forth in the Plan.

GENERAL PLAN INFORMATION

UTAH VALLEY UNIVERSITY has adopted this Plan for the benefit of its eligible Employees and their eligible Dependents. This document provides a summary of the benefits provided under the Plan as of July 1, 2008. Please note that capitalized terms used in this document are defined either the first time they are used or in the "Definitions of Terms" section at the end of this document.

This summary is not meant to interpret, extend or change the provisions of the Plan in any way. Benefits under this Plan will be paid only if the Plan Sponsor decides, in its sole discretion, that Covered Persons are entitled to them. The provisions of the Plan may only be determined fully and completely from the actual Plan document, which is available from the Plan Sponsor. Prior to amendments, the Plan document is this Summary Plan Description. If any question should arise about benefits, or if there are any discrepancies between this summary and the Plan document, the language of the Plan document will control.

The Plan will pay benefits only for expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

PLAN NAME : THE UTAH VALLEY UNIVERSITY EMPLOYEE MEDICAL PLAN.

EMPLOYEE/PLAN SPONSOR INFORMATION

Utah Valley University
800 W. University Pkwy.
Orem, Utah 84058
Telephone: 801-863-8389
Fax: 801-863-5207
<http://www.uvu.edu/hrs/benefits>

EFFECTIVE DATE OF PLAN: July 1, 2008

PLAN YEAR: The 12 month period from July 1, to June 30

GROUP NUMBER: 128

TYPE OF PLAN

This Plan is commonly known as an employee medical benefits plan. The Plan has been adopted to provide participants certain benefits as described in this Summary Plan Description. The Plan Sponsor may purchase stop loss insurance coverage to provide coverage to the Plan Sponsor in the event claims exceed a certain level.

TYPE OF ADMINISTRATION

The Plan Sponsor is the Plan Administrator. The Plan Sponsor has entered into an agreement with Educators Mutual Insurance Association of Utah, as a third-party administrator (TPA), to assist the Plan Sponsor in the Plan's claims administration and certain other administrative matters. Educators Mutual Insurance Association of Utah does not insure any benefits under the Plan.

CLAIMS ADMINISTRATOR

Educators Mutual Insurance Association of Utah
852 East Arrowhead Lane
Murray, Utah 84107-5298
Telephone: (801) 262-7476
Fax: (801) 269-9734
Website: www.educatorsmutual.com

PLAN CONTRIBUTIONS AND FUNDING

All benefits under the Plan are self-insured by the Plan Sponsor. You and your employer share the cost of providing benefits. The cost of providing benefits are charged first to covered employee's contributions and then paid out of the general assets of the employer. The Plan Sponsor shall from time to time determine the amount of contributions payable by covered employees.

PLAN ADMINISTRATOR

Utah Valley University
800 W. University Pkwy.
Orem, Utah 84058
Telephone: 801-863-8389
Fax: 801-863-5207

NAMED FIDUCIARY

Utah Valley University
800 W. University Pkwy.
Orem, Utah 84058
Telephone: 801-863-8389
Fax: 801-863-5207

AGENT FOR SERVICE OF LEGAL PROCESS

Utah Valley University
800 W. University Pkwy.
Orem, Utah 84058
Telephone: 801-863-8389
Fax: 801-863-5207
Executive Director of Human Resources

AMENDMENT OR TERMINATION

The Plan Sponsor intends this Plan to be permanent, but since future conditions affecting the Plan Sponsor cannot be anticipated or foreseen, the Plan Sponsor reserves the right to amend, modify, or terminate the Plan in any manner, at any time, regardless of the health or treatment status of Covered Persons, which may result in the termination or modification of their coverage. If the Plan is amended, modified, or terminated, Covered Persons' rights are limited to eligible expenses incurred prior to the Plan's amendment, modification, or termination, which will be paid as provided under the terms of the Plan prior to its termination or modification. The Plan Sponsor does not promise the continuation of any benefits nor does it promise any specific level of benefits at or during retirement.

The decision to terminate or amend the Plan may be due to changes in federal or state laws governing welfare benefits, the requirements of the IRS, or for any other reason. A Plan change

may transfer assets and liabilities to another plan or split the Plan into two or more parts. If the Employer does change or end the Plan, it may decide to set up a different plan providing similar or identical benefits.

The Table of Allowances may be updated as deemed necessary by the Claims Administrator. After the effective date of a change in the Table of Allowances, all benefits will be paid according to the new Table of Allowances.

Benefit changes to this Plan will apply to all Covered Persons on the date amended benefits become effective.

The terms of this Plan may not be amended by oral statements made by the Plan Sponsor, the Plan Administrator, the Claims Administrator, or any other person. In the event an oral statement conflicts with the written terms of this Plan, the Plan terms will control.

ELIGIBILITY AND PARTICIPATION

Eligibility

Employees and their Dependents are eligible for participation and coverage under this Plan if the Employee is a Full-time Benefits Eligible Employee of the Plan Sponsor. Dependents of the Employee eligible for coverage include unmarried Dependent children from birth to the 26th birthday and the Employee's Spouse. Unmarried children may include stepchildren, children legally placed for adoption, and legally adopted children. This does not include children that have been previously married and are now divorced. Coverage ends if the child is removed from placement prior to being legally adopted. Dependent children's coverage may be extended beyond the 26th birthday if the children are incapable of self-sustaining employment due to mental or physical disability, they rely on the Participant for over one-half of their support and maintenance (as described in Section 152 of the Internal Revenue Code), and are unmarried. The Participant must furnish written proof of disability and dependency to the Plan Sponsor and Claims Administrator within 31 days after the child reaches 26 years of age. The Plan Sponsor or Claims Administrator may require subsequent proof of disability and dependency after the child reaches age 26, but not more often than annually. (Please refer to *Dependent* in the "Definition of Terms" section for more information.)

Changes in Covered Person Information

Participants should notify the Plan Sponsor within 31 days whenever there is a change in a Covered Person's situation that may affect the Covered Person's enrollment eligibility or status.

Enrollment

To enroll, Employees must complete enrollment applications and file them with the Plan Sponsor within 31 days of their employment date, or during a subsequent Open Enrollment period. Generally, Participants are not entitled to change their coverage elections during the Plan Year, except as provided in the *Special Enrollment* section.

New Enrollees are subject to an eight-month Preexisting Condition Limitation, and Late Enrollees are subject to an 18-month Preexisting Condition Limitation (see *Preexisting Condition Limitation* section). The Preexisting Condition period may be reduced in whole or in part upon submission by the Covered Person of a certificate of Creditable Coverage from the Covered Person's former group or individual health plan. (See the *Waiver of Preexisting Condition Exclusion* section.)

When Coverage Begins

If Employees enroll within 31 days of their employment, and their first day of Active Work coincides with the first business day of the month, the Employees' coverage (and the coverage of their eligible Dependents, if such Dependents were also enrolled during such 31-day period) becomes effective the first day of the month in which they were Actively at Work.

If Employees enroll within 31 days of their employment, and their first day of Active Work is after the first business day of the month, the Employees' coverage (and the coverage of their eligible Dependents, if such Dependents were also enrolled during such 31-day period) becomes effective the first day of the following month.

If the Plan Sponsor imposes any waiting period prior to the start of coverage, such waiting period must run concurrently with the Preexisting Condition Limitation waiting period.

If Employees enroll during an Open Enrollment period, the Employees' coverage (and the coverage of their eligible Dependents, if such Dependents were also enrolled during such Open Enrollment period) becomes effective the first day of the following Plan Year.

If Employees enroll during a Special Enrollment period, the Employees' coverage (and the coverage of their eligible Dependents, if such Dependents were also enrolled during such Special Enrollment period) becomes effective as provided in the *Special Enrollment* section.

Special Enrollment

Special Enrollment Period When Other Coverage Terminates

If Employees declined participation for themselves and/or their eligible Dependents and, when enrollment was previously declined, the Employees and/or their eligible Dependents were covered under another group plan or had other insurance coverage, the Employees will have a Special Enrollment period if when the Employees declined enrollment for themselves and/or their eligible Dependents, the Employees and/or their eligible Dependents

1. Had COBRA continuation coverage under another plan and such continuation coverage has since been exhausted; or
2. If the other coverage was not under COBRA, either the other coverage has been terminated as a result of loss of eligibility of coverage or employer contributions towards such coverage have been terminated. (**Note:** Loss of eligibility of coverage includes a loss due to legal separation, divorce, death, termination of employment, reduction in hours worked, reaching the Lifetime Maximum Benefit, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or intentional misrepresentation.)

If Employees meet the above conditions, they may elect coverage for themselves and/or their eligible Dependents by making elections with the Plan Sponsor. To enroll, Employees must complete an enrollment application, supply proper documentation of prior coverage, and file it with the Plan Sponsor, within 31 days of such cessation. If the Employee makes a timely election, coverage will be effective as of the date such coverage ceased.

Special Enrollment Period for Acquisition of Dependent

Employees and/or new eligible Dependents may enroll for coverage (even if they previously declined coverage for themselves and/or their eligible Dependents) if the Employees acquire such new eligible Dependents due to marriage, birth, adoption, or placement for adoption. In addition, Employees may also enroll their Dependent Spouses if the Employees acquire new Dependents due to marriage, birth, adoption, or placement for adoption. To enroll during this Special Enrollment period, the Employee must enroll within 31 days of the event (e.g., marriage, birth, adoption, or placement for adoption). Coverage will be effective as follows:

1. In the case of marriage, the marriage date; or

-
2. In the case of an eligible Dependent's birth, the date of such birth; or
 3. In the case of adoption, or placement for adoption, the coverage of an adopted child of a Participant is provided from the moment of birth, if placement for adoption occurs within 30 days of the child's birth, or beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth.

Preexisting Condition Limitation

No benefit will be provided under this Plan for injury or Illness that was diagnosed or treated within six months before the Enrollment Date of coverage under this Plan, until the Covered Person has been covered by this Plan for eight months (or 18 months for Late Enrollees), unless such period is reduced in the *Waiver of Preexisting Condition Exclusion* section.

The Preexisting Condition Limitation Exclusion does not apply in the following cases:

- Pregnancy.
- Children who are covered under Creditable Coverage as of the last day of the 30-day period beginning on the date of birth, provided that this provision does not apply to a child after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.
- Adopted children who are adopted or placed for adoption before attaining 18 years of age covered under Creditable Coverage as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, provided that this provision does not apply to an adopted child after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

No benefit will be provided for the following injuries and Illnesses during the first eight months of coverage under this Plan, unless reduced by the *Waiver of Preexisting Condition Exclusion* provision of this Plan:

- Impacted teeth
- Tympanoplasty
- Tympanostomy
- Tonsillectomy
- Myringotomy
- Adenoidectomy
- Warts
- Moles
- Acne

-
- Lesions
 - Mouth and external cysts
 - Nasal septal repair
 - Elective sterilization

Waiver of Preexisting Condition Exclusion

The Preexisting Condition Limitation period explained above may be reduced for a Covered Person by the aggregate of the periods during which the Covered Person was covered under Creditable Coverage prior to enrollment in this Plan, except that a Covered Person is not entitled to a reduction of the Preexisting Condition Limitation period for a period of Creditable Coverage if, after such period and before the effective date of coverage under this Plan, the Covered Person experienced a break in coverage of 63 days or more, during all of which the individual was not covered under any Creditable Coverage. The Preexisting Condition Limitation period is the time Covered Persons must wait after enrolling in the Plan before they can be covered for a condition that was diagnosed or treated within six months prior to enrolling.

To obtain a reduction of the Preexisting Condition Limitation period, Covered Persons must provide certification that they have met the preexisting period through prior Creditable Coverage. Covered Persons must obtain this certification from their prior health plan or insurance carrier and present it to the Plan Sponsor before they can be credited with previous insurance coverage. The Plan Sponsor will assist Covered Persons in obtaining a certificate of Creditable Coverage from a prior plan or insurer. Covered Persons also have the right to demonstrate Creditable Coverage through documentation other than a certificate of Creditable Coverage, such as an Explanation of Benefits (EOB) or other correspondence from a plan or insurer indicating prior coverage or a health insurance card. Covered Persons must cooperate fully with the Plan to verify prior Creditable Coverage. Covered Persons who have questions regarding these rights should contact the Educators Enrollment Department or the San Francisco Department of Labor Office, San Francisco Regional Office, 71 Stevenson St., Ste. 915, P.O. Box 190250, San Francisco, CA., 94119-0250, or call (866) 444-3272.

Within a reasonable period following receipt of information regarding a Covered Person's prior Creditable Coverage, the Plan will do the following:

- Inform the Covered Person of its determination of Creditable Coverage and how it will be recognized towards any Preexisting Condition Limitation period;
- Notify the Covered Person in writing of its determination of any Preexisting Condition Limitation period;
- Explain the basis for the determination and the information on which the Plan relied in making the determination;
- Allow the Covered Person the opportunity to appeal the determination and submit additional evidence of Creditable Coverage. (See the *Claim Review Process* section.)

If the Plan subsequently determines that the Covered Person did not have the claimed Creditable Coverage, the Plan may modify its initial determination if notice of the reconsideration is provided in writing to the Covered Person and, until the final determination is made, the Plan acts in a manner consistent with the initial determination for purposes of approving access to medical services.

Termination of Coverage

Unless eligible for continuation coverage under COBRA a Covered Person's participation under the Plan ceases on the earliest of the following:

- For the Participant and covered Dependents, the 15th day of the calendar month coinciding with or following the Participant's termination of employment if such termination is on or before the 15th day of the month; or the last day of the calendar month coinciding with or following the Participant's termination of employment if such termination is after the 15th day of the month;
- For the Participant and covered Dependents, the last day of the month for which coverage has been paid, subject to a 31-day Grace Period, in the event any required Participant contributions are not made;
- For covered Dependents, other than the Participant's Spouse, the individual ceases to be an eligible Dependent when either of the following occurs:
 - a. The date the Dependent is married; or
 - b. The last day of the calendar month coinciding with the Dependent's 26th birthday.
- For covered Spouse, the date the divorce from the Participant is final;
- For the Participant and covered Dependents, the effective date of any election by the Participants to cease coverage for the Participants and/or their Dependents;
- For the Participant and covered Dependents, the date specified in any Plan amendment resulting in loss of eligibility;
- For the Participant and covered Dependents, the date this Plan is terminated; or
- For any Covered Person, the discovery of fraud or misrepresentation on the part of the Covered Person in either the enrollment process or in the use of services or facilities, including any misuse of a Plan ID card. (Note: If a Covered Person's coverage is terminated for cause, the termination of coverage will relate back to the effective date of coverage and the Plan Sponsor may recover any overpayments from the Covered Person such that the Plan Sponsor and the Covered Person are returned to the same financial position as if no coverage had ever been in force. Termination of a Participant's coverage for cause will also result in the termination of coverage of the Participant's covered Dependents.)

Family Medical Leave Act (FMLA)

A Participant who goes on a leave under the Family Medical Leave Act (FMLA) has the following rights during such leave:

-
- Participants may continue their coverage and the coverage of their covered Dependents during an FMLA leave provided they continue to pay any required Employee portion of the cost of coverage in accordance with the Plan Sponsor's FMLA leave policy. The Plan Sponsor will continue to make the same contributions toward that coverage that it would have made had the Participant not taken FMLA leave.
 - If the Employee portion of the cost of coverage is not paid, the Participant's and covered Dependents' coverage will be terminated 31 days after the due date of any required payment. Upon the Participant's return to work, the Participant's coverage and the coverage of any previously covered Dependents will be reinstated as long as the Participant returns to work before or immediately following the expiration of the FMLA leave. If Participants do not return to work before or immediately following the expiration of the FMLA leave, they will be treated as new Employees upon their return and will be entitled to elect coverage for themselves and their eligible Dependents in accordance with the rules applicable to new Employees.

Military Leave

Pursuant to the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), a Participant who is on military duty with a uniformed service has certain rights. If the period of duty is less than 31 days, coverage will be maintained if the Participant pays any required Participant contribution. If the period of duty is for more than 31 days, the Plan Sponsor must permit the Participant to continue coverage under rules similar to COBRA. The maximum coverage period is the lesser of 24 months or the period of duty. A Participant receiving coverage under USERRA shall be required to pay 102 percent of the applicable premium. No waiting period or Preexisting Condition Limitation exclusion can be imposed on returning Participants and their Dependents if the period or exclusion would have been satisfied had the Participants' coverage not terminated due to the duty leave.

Qualified Medical Child Support Orders

Upon receipt of a National Medical Support Notice requiring the Participant to provide coverage for a Dependent child, the Plan Sponsor will comply with all applicable requirements of the Notice and applicable law. If the Plan Sponsor determines that it is a legal, qualified order, and the Employee is not enrolled in the Plan, the Employee will be required to enroll along with the Dependent child, and the Plan Sponsor will also withhold from the Employee's pay the Employee's share of the cost for that coverage. The Employee may not drop coverage for the child unless written evidence has been submitted to the Plan Sponsor that the order is no longer valid. The Plan may make benefit payments for the child covered by the order directly to the custodial parent or legal guardian of such child.

Benefits for Employees Working Beyond Age 65

If a Participant becomes eligible for Medicare solely as a result of attaining age 65, the Participant will have the option of electing coverage under this Plan, in which case this Plan is primary and Medicare is secondary. Alternatively, Participants may elect to terminate coverage under this Plan and choose Medicare as their primary coverage. If Participants choose Medicare as their primary plan, they may not elect this Plan as their secondary plan. Any eligible Dependents will follow the Participant's election regarding Medicare participation.

Contact the Plan Sponsor or the Educators Enrollment Department for information.

MEDICAL PLAN BENEFITS

Using the Medical Benefits

Covered Persons should always carry their Medical Identification / Prescription Drug Cards so that Participating Providers can determine what the Covered Person is required to pay, how to bill the Plan, and when to preauthorize major services.

- Covered Persons generally should go to a participating Educators Care Plus primary care physician (PCP) first. Educators Care Plus PCPs are specialists in family practice, internal medicine, pediatrics, and obstetrics or gynecology. PCPs provide primary care and can help coordinate secondary Provider care. A directory of Participating Providers will be furnished free of charge as a separate document. The Covered Person may also obtain a copy of the directory of Participating Providers from the Plan Sponsor, on the Internet at the Claims Administrator's website: www.educatorsmutual.com, or by calling 801-262-7475. It is the responsibility of the Covered Persons to ensure their provider(s) are participating in the network.
- The Medical Plan provides the following levels of care:
 1. Covered Persons are eligible for Participating Provider Option benefits when receiving care from Participating Providers.
 2. Covered Persons may choose to receive care from Non-participating Providers. However, when a Covered Person receives care from a Non-participating Provider, benefits are determined based on the Non-participating Provider Option (see "Summary of Benefits" chart). These benefits are less than the corresponding benefits under the Participating Provider Option.

Although benefits under the Plan are generally greater for services provided by Participating Providers, the choice to use a Participating Provider or Non-participating Provider is entirely up to the Covered Person. Neither the Claims Administrator or the Plan Sponsor employ Participating Providers, and they are not agents or partners of the Claims Administrator or the Plan Sponsor. Providers participate in the network only as independent contractors. Participating Provider status is not an endorsement or representation by the Plan Sponsor or the Claims Administrator as to the qualifications (or quality of care) of any particular Provider.

- **Advantages of Using Participating Providers.** When Covered Persons elect to use Participating Providers, they enjoy the following advantages over Non-participating Providers:
 - The Provider bills the Plan for them;
 - The Provider accepts the Plan's Table of Allowance and agrees not to bill Covered Persons for excess charges for covered services; and
 - The Provider agrees to obtain Preauthorization from the Plan for Covered Persons for major services.
- Covered Persons should verify their Providers' panel status at the time of each visit by following these steps:

-
- Contact Providers to assure that they are Participating Providers of the network.
 - Contact the Claims Administrator's Customer Service Department.

The Table of Allowances is the schedule established by the Claims Administrator on behalf of the Plan Sponsor for payment of eligible charges. **All benefits outlined in this Plan are subject to the Table of Allowances. For example, if a Provider charges \$125 for a procedure for which the Table of Allowances permits \$100 payment, the Plan will pay the specified percentage of \$100, not \$125.**

When Non-participating Provider Option Benefits Apply

Participating Provider Option benefits are available when the care is provided through a Participating Provider. Non-participating Provider Option benefits offer Covered Persons the flexibility to use any Non-participating Provider or facility.

In cases where the Covered Person uses a participating facility but uses a non-participating physician, Participating Provider Option benefits will apply to services from the participating facility, while Non-participating Provider Option benefits, which may require more payment by the Covered Person, will apply to services rendered by the non-participating physician.

- **Using Non-participating Providers and Facilities.** When the Covered Person elects to use Non-participating Providers and facilities
 - The Covered Person must obtain Preauthorization from the Plan for major services. (Refer to the *Preauthorization Requirements* section.)
 - The benefits may be less, and in some cases, there may be no benefits available under the Non-participating Provider Option.
 - The Covered Person is responsible for any charges exceeding the Plan's Table of Allowance for covered services.

Note: Non-participating Provider benefits apply to Beech Street Providers outside of Utah; however, the Covered Person is not responsible for fees in excess of the Table of Allowances.

Even in the unlikely event that there is no Participating Provider available to perform the services needed, the Plan will not pay Participating Provider Option benefits to a Non-participating Provider. Non-participating Provider Option benefits will apply.

Coinsurance Maximum

The Coinsurance Maximum is designed to insure against financial hardship caused by unexpected expenses from catastrophic illness. When a Covered Person has satisfied any applicable Deductible and paid Eligible Expenses, including eligible Copayments, up to the Coinsurance Maximum, the Plan will pay remaining Eligible Expenses at 100% of the Table of Allowances.

When a Covered Person receives any service or treatment specified as a limited benefit, the Plan will pay for services only up to the specified amounts.

Any payment made by Covered Persons for amounts in excess of the specified percentage, day, or dollar limits, and expenses Covered Persons pay if they do not follow Preauthorization procedures, will not accumulate toward the annual Deductible or Coinsurance Maximum. The

Participating Provider and Non-participating Provider Options each have a separate Coinsurance Maximum.

Lifetime Maximum Benefit

All Eligible Expenses paid by the Plan or any combination of plans and policies sponsored by the Plan Sponsor accumulate toward a Lifetime Maximum Benefit of \$2,000,000 per person. Up to \$1,000 incurred toward the Lifetime Maximum Benefit will automatically be reinstated each year until the Lifetime Maximum Benefit has been exhausted.

There is one Lifetime Maximum Benefit shared by both the Participating Provider and Non-participating Provider Options.

Benefit Accumulations

All Deductibles, Coinsurance Maximums, benefit limits, etc., except for the Lifetime Maximum Benefit, accumulate on a Plan Year basis, beginning July 1 and ending June 30.

Preauthorization Requirements

“Preauthorization” is the procedure for confirming, prior to the rendering of care, the medical necessity and appropriateness of the proposed treatment, and whether (and if so, to what extent) such treatment is a covered benefit for the Covered Person. Whether Preauthorization is required, and if so, how and when it must be obtained, depends on the kind of treatment and whether the Provider is a Participating Provider or a Non-participating Provider.

- **The following kinds of treatments require Preauthorization:**
 - Hospitalizations and Inpatient facility admissions, including skilled nursing facilities
 - Surgeries, in a Hospital or ambulatory surgical facility (This does not apply to diagnostic endoscopy procedures.)
 - Home Health services, including home I.V. services
 - Dental services, including orthodontics, when dental injury occurs as a result of an Accident
 - Hernia-related procedures
 - Day Treatment programs for mental health or substance abuse
 - Durable Medical Equipment and Prostheses costing more than \$300 (see *Medical Supplies and Equipment*)

- **If the Covered Person uses a Participating Provider** for any of the above treatments or procedures, **the Provider** (not the Covered Person) is responsible for Preauthorization. **The Covered Person is advised to verify with the physician that Preauthorization procedures have been followed.**

- **If the Covered Person uses a Non-participating Provider** for any of the above treatments or procedures, **the Covered Person (even in an emergency) is responsible for obtaining Preauthorization, and benefits may be denied or reduced if the Covered Person fails to timely obtain Preauthorization,** as follows:
 - To obtain Preauthorization for Durable Medical Equipment or Prostheses submit, to the Claims Administrator, a written request accompanied by a letter of Medical Necessity.

-
- To obtain Preauthorization for all other services, call 1-801-270-3037 or (toll free) 1-888-223-6866.
 - For services or treatments that require Inpatient hospitalization, other than emergencies, the Covered Person must obtain Preauthorization at least 48 hours prior to receiving the services or treatments.
 - **For emergency hospitalizations, the Covered Person must give notice of the hospitalization within 48 hours of the admission**, or as soon as reasonably possible, by calling one of the phone numbers listed above. An appropriate length of hospitalization will then be determined.
 - If a Covered Person responsible for obtaining Preauthorization fails to do so in the required time, the Claims Administrator will review the treatment and apply the following penalties:
 - If the treatment is deemed not Medically Necessary, benefits will be denied.
 - If the treatment is deemed Medically Necessary, benefits will be reduced by 50% to a maximum of \$2,000 (per admission for Inpatient hospitalization, or per service or procedure, for the others listed above).
 - Any amount paid out-of-pocket for failing to follow Preauthorization requirements is not applied toward the Coinsurance Maximum.
 - **Mental Health and Drug/Alcohol Treatment Preauthorization.** All Inpatient services and those received from a day treatment facility, must be preauthorized before hospitalization or facility admissions, by calling 1-801-270-3037 or (toll free) 1-888-223-6866. If Preauthorization is not obtained, benefits will be denied.

Preauthorization Review Process

The Covered Person may request a review of any determination of Medical Necessity adverse to the Covered Person, by contacting the Plan's Utilization Review at 1-801-270-3037 or toll free 1-888-223-6866 within 60 days after the Covered Person receives notice of the adverse decision. The Plan's Utilization Review will inform the Covered Person, in writing, of its decision. If the previous decision stands, the Covered Person will be given a specific reason for the decision.

If Covered Persons disagree with the finding of the Plan's Utilization Review, they may request a second review. This request must be made within 30 days of the date of the letter indicating the decision on the first level appeal. The participants in the second appeal review will not include anyone involved in the first level appeal. The Plan's Utilization Review will inform the Covered Person of its decision, and if adverse to the Covered Person, the basis of its decision.

If, after exhaustion of the Preauthorization Review Process provided in this Plan, the Covered Person still disputes the results of the same, the subject dispute shall be submitted for resolution through binding arbitration. The procedure for arbitration shall be as provided in the *Arbitration* provision of this Plan.

No action at law or in equity may be brought against the Plan Sponsor or the Claims Administrator, and no arbitration request may be made until the Covered Person has exhausted the Preauthorization Review Process, as provided in this Plan.

The Covered Person may request a review of any adverse determination based on Plan benefits or eligibility by following the Claims Review Process provided in this Plan.

Second Opinion

In order to determine whether any proposed or continuing care, diagnosis, treatment, service, surgical procedure, diagnostic or medical procedure, drug therapy, blood transfusion, or other covered service (collectively the “Recommended Care”) is Medically Necessary, the Plan may, at any time, require at its own expense a Covered Person to obtain a second (and third, if necessary) opinion from a Participating Provider, selected by the Plan, regarding such recommended care.

Inform the Claims Administrator of Changes

The Participant may call the Claims Administrator’s Enrollment Department or submit an Enrollment Application to notify the Plan of a change in address or telephone number. The Participant must use the Enrollment Application to make other changes, such as changes to name and/or marital status, as well as to add or delete family members to the Plan. Enrollment Applications are submitted to the Plan Sponsor. (See the *Eligibility and Participation* section for guidelines on adding new Dependents.) The Plan Sponsor will forward copies of all Enrollment Applications to the Claims Administrator.

COVERED MEDICAL BENEFITS

ALL OF THE FOLLOWING OUTLINED BENEFITS ARE FOR THE PARTICIPATING PROVIDER OPTION. IF NON-PARTICIPATING PROVIDERS ARE USED, BENEFITS WILL BE REDUCED TO THE AMOUNT SHOWN UNDER THE NON-PARTICIPATING PROVIDER OPTION COLUMN OF THE SUMMARY OF BENEFITS.

Hospital/Facility Benefits

This section provides a general summary of Hospital and Facility Benefits available under the Participating Provider Option. For details as to specific coverages, see the “Summary of Benefits” chart. This section does not apply to Physician and Professional Services, which are addressed separately in this Plan and in the “Summary of Benefits” chart.

Hospitalizations and Inpatient surgeries require Preauthorization. **The Covered Person is advised to verify with the physician that Preauthorization procedures have been followed.**

The Plan provides benefits for the following:

- Semi-private room and Intensive care charges.
- Hospital ancillary charges, including operating room, dressings and supplies, and Hospital Outpatient Services rendered in connection with surgery for which the operating room and other Hospital facilities are needed. Hospital ancillary charges include, but are not limited to, the following:
 - Drugs
 - Operating room
 - Medical Supplies
 - X-ray and laboratory expenses
 - Electrocardiograms
 - Chemotherapy or radiation therapy
 - Inhalation therapy
 - Intravenous therapy
- Skilled nursing facility services, up to a maximum of 60 days per year. Admission to a skilled nursing facility must occur within five days of a discharge from a Hospital Confinement.
- Outpatient surgery facility expenses. Some procedures require Preauthorization. Please refer to the list of procedures under the *Preauthorization Requirement* section of this contract.
- Major Diagnostic Testing.

Emergency Room (ER) Service Benefit

The Plan provides benefits for the following:

- Medically Necessary ER services are covered according to the “Summary of Benefits” chart.
- Although payment of the ER Copayment/Coinsurance amount is not required before service may be provided in the ER, it is the Covered Person’s responsibility to pay the ER

Copayment/Coinsurance listed on the “Summary of Benefits” chart directly to the providing facility.

- The ER Copayment/Coinsurance covers the facility charges only. The Covered Person may have additional physician and professional charges according to the “Summary of Benefits” chart.

If the Covered Person is admitted directly to the Hospital as an Inpatient because of the condition for which ER services were sought, then the ER Copayment/Coinsurance will be waived. The usual Copayment/Coinsurance amounts normally applied to such a hospitalization will be required.

Inpatient Rehabilitation Therapy Benefit

The Plan provides benefits for all services and treatments in connection with Inpatient rehabilitation therapy (limited to physical, speech, occupational, cardiac, and pulmonary).

Accident and Life-threatening Condition Benefits

The Plan provides benefits for the following:

- Expenses for Accidental Injuries. Accidental benefits apply when treatment commences within 48 hours of the Accidental Injury and is completed within 12 months, unless a delay in treatment is Medically Necessary. If a delay in treatment is necessary, the Covered Person must receive prior approval from the Plan.
- Expenses for Life-threatening Conditions.
- Services provided by a licensed ambulance service for necessary transportation to and from a Hospital, doctor’s office, clinic, or other medical institution when the Covered Person’s condition is deemed to be a Life-threatening Condition.
- Orthodontic treatment necessary due to an Accident. Accidental Injury benefits apply when treatment commences within 48 hours of the Accidental Injury and is completed within 12 months. If a delay in treatment is necessary, the Covered Person must receive prior approval from the Plan.

Physician and Professional Services

The Plan provides benefits for the following:

- Physician office visits and after-hours physician office visits.
- Inpatient Hospital physician visits.
- Routine prenatal physician visits and delivery expenses. This includes Dependent maternity. A Covered Person may choose to deliver on an outpatient basis. The length of a Hospital stay after a delivery is based on Medical Necessity.
- Surgical and anesthetic procedures including the following:
 - Multiple or bilateral surgical procedures.

-
- Surgical procedures rendered during Inpatient hospitalization, as an outpatient, or in a physician's office.
 - Treatment of fractures or dislocations and orthopedic casting.
 - Operative and major diagnostic endoscopic procedures.
 - Therapeutic surgical injections and aspirations, biopsies, and destruction of lesions by chemical, mechanical, or electrical means.
 - Operative and curative procedures rendered by a podiatrist for the treatment of diseases of the feet.
 - Surgical and anesthetic benefits cover expenses incurred for medical treatment rendered on the date of any surgical procedure or during a reasonable convalescent period following any surgery.
 - Physiological conditions resulting from corrective procedures that are not directly related to a previous Reconstructive, Cosmetic, or Plastic Surgery; for example, anesthetic complications, myocardial infarction, venous thrombosis, or anaphylactic reaction.

Incidental surgical procedures or incidental scar excisions are excluded from coverage.

- Benefits for the primary surgeon performing a surgical procedure. Pre-operative and post-operative services within the global period of the surgical procedure are included in the allowable surgeon's fee.
- Benefits for an assistant surgeon, only when Medically Necessary.
- Benefits for a co-surgeon in the absence of an assistant surgeon, in cases where two surgeons are involved in the same procedure, and if both sets of operative notes indicate the use of co-surgeons.
- Expenses for an anesthesiologist.
- Preadmission testing.
- Laboratory and X-ray charges.
- Home Health/Skilled Nursing Care, including charges of a qualified licensed practitioner for approved private duty nursing. Certain Injectables are covered only under the Prescription Card. See the "Prescription Drug Program" for details.
- Rehabilitation therapy (limited to physical, speech, occupational, cardiac, and pulmonary) must be given to improve the physical capabilities of a Covered Person in an attempt to restore the individual to a previous level of good health. (Outpatient benefits limited to a maximum of \$5,000 per person per Plan Year.)
- Chiropractic adjustments of the vertebral column and its immediate articulations, up to a maximum of 20 visits per person per Plan Year, subject to the Claim Administrator's criteria. **Participating Provider Option benefits are available when using a Chiropractic Health Plan (CHP) Provider.**
- Allergy testing.

-
- Allergy serum.
 - Chemotherapeutic medications.

Preventive Care Services In-Network Benefits Only

Please check the summary page for coverage levels and copays. The Plan provides benefits for the following In-Network services:

- One Routine Physical Examination per person per Plan Year, including appropriate routine health screenings, testing, and counseling concerning the person's specific prevention needs based upon age, gender, and risk factors.
- One routine gynecological examination per person per Plan Year, including consultation for contraceptive devices/prescriptions.
- One Family History Examination per person per Plan Year.
- One routine pap smear per person per Plan Year.
- One routine mammogram per person per Plan Year.
- One routine hearing exam per person per Plan Year.
- One routine vision exam per person per Plan Year.
- Routine well-baby care.

The Plan pays benefits for all immunizations except those received exclusively for foreign travel.

The Plan pays for Vitamin B12 injections. Up to three injections will be covered when administered in the physician's office. After the third injection, Vitamin B12 will only be covered under the Prescription Card. See the "Prescription Drug Program" section of the Plan. The only exception to this provision is for the treatment of pernicious anemia or pregnancy, in which case, the Plan will continue to cover injections administered in the physician's office.

Transplant Benefits

The Plan will provide benefits for expenses incurred in connection with liver, bone marrow, heart, pancreas, cornea, lung, and kidney Transplants, including presurgery testing, medical expenses incurred by the donor and/or recipient directly as a result of the Transplant process, the cost of transporting the donated organ, and prescribed medications to inhibit rejection of the Transplant ("Transplant Benefits"). Transplants must be preauthorized in order for Transplant Benefits to apply. Covered services shall include only those services or supplies provided in connection with a heart, pancreas, cornea, lung, liver, kidney, or bone marrow Transplant that are within the scope of the Transplant Benefits, and shall expressly exclude all other services or supplies provided in connection with an organ Transplant. Non-covered Transplant services or supplies include, but are not limited to, the following:

-
- Any bone marrow Transplant in the treatment of disease or conditions resulting from infection from a human T-cell lymphotropic virus or HIV (e.g. AIDS).
 - Any intestine Transplant.
 - Any Transplant of a non-human organ or non-human bone marrow.
 - Any bone marrow Transplant in the treatment of breast cancer, brain cancer, myeloma, or germ cell tumors.
 - Any services or supplies in connection with the implantation of any artificial organ or device, regardless of whether implantation is a temporary measure while awaiting an available human organ.

Medical Supplies and Equipment

The Plan provides benefits for the following:

- Medical supplies including, but not limited to, ileostomy supplies, I.V. therapy, oxygen, and surgical dressings. (The prescription drug card covers insulin syringes, lancets, test strips, and alcohol swabs.)
- Durable Medical Equipment. Rental of Durable Medical Equipment (not to exceed purchase price) when Medically Necessary for therapeutic use, unless the purchase of an item of Durable Medical Equipment will be less expensive than rental or if such equipment is not available for rental. In most cases, the Plan will make payment on the standard model of Durable Medical Equipment. If additional items of comfort or convenience are desired, it will be the Covered Person's responsibility to pay for them. **For maximum benefits to be paid, Durable Medical Equipment costing more than \$300 must be preauthorized by submitting a written request, accompanied by a letter of medical necessity, to the Claims Administrator, including a description of the Medical Necessity and the expected length of time that the equipment will be required.**
- Prostheses. Expenses in connection with a Prosthesis will be covered no more than once every five years, except replacement will be covered if the replacement is Medically Necessary due to normal physical growth of the Covered Person.
- Orthotic devices of the feet.
- Growth hormones.
- Pacemakers. Expenses in connection with a pacemaker will be covered no more than once every five years.
- Cochlear implants. Expenses in connection with the initial surgery and device will be covered as any other condition. Expenses in connection with a Medically Necessary replacement will be covered only when the existing device cannot be repaired, or when the replacement is required because a change in the Covered Person's condition makes the existing device non-functional and improvement is expected with the replacement unit. Batteries are not covered.

Employee Assistance Program (EAP)

The EAP is offered through APS Healthcare, an independent company. Coverage provided through the EAP is not subject to, or part of, the Mental Health benefits otherwise available under the Plan.

An EAP is designed to offer counseling to address such typical problem areas as abuse, aging, alcohol/drugs, depression, family, grief, managing stress, marriage, parenting, relationships, workplace, and financial and legal services. The EAP program provides a limited number of counseling sessions available at no cost to Employees and their families in a safe and private atmosphere.

The following services are provided through the EAP:

- 5 visits per incident
- 24-hour crisis services (800)-833-3031
- Referral services (community programs or services)
- Financial and legal services
- Unlimited access to interactive web-based management and resource solutions at www.APSHelpLink.com. Company access code: UVU.

The decision to use the EAP benefit is voluntary and confidential. To schedule an appointment with the EAP, call (800) 999-1077. Many problems can be addressed directly with the EAP professional, but some may require a referral to other mental health Providers. The Covered Person should verify the referred Provider's panel status by contacting Educators' customer service department.

Mental Health and Drug/Alcohol Treatment

Mental Health and Drug/Alcohol Treatment will be considered for payment only when provided by a person licensed to provide individual psychotherapy, including a psychiatrist, licensed clinical psychologist, licensed social worker, and/or advanced practice registered nurse. The Plan provides benefits for the following:

- Inpatient Mental Health and Drug/Alcohol Treatment, limited to a maximum of 21 days per person per Plan Year. Requires Preauthorization. The Covered Person's payments **do not** accumulate toward the Coinsurance Maximum.
- One Inpatient physician visit per day for Mental Health and Drug/Alcohol Treatment, up to 21 days, limited to one visit per day. Requires Preauthorization. The Covered Person's payments **do not** accumulate toward the Coinsurance Maximum.
- Outpatient Mental Health and Drug/Alcohol Treatment visits, up to 20 visits per person per Plan Year, limited to one visit per day. The Covered Person's payments **do not** accumulate toward the Coinsurance Maximum.

Some eligible Mental Health and Drug/Alcohol Treatment services may be provided by a day treatment facility. These services require Preauthorization. Some services provided by day treatment facilities are not covered including but not limited to, convenience items, biofeedback, education, and family therapy. All limits and exclusions of the Plan apply.

Treatment or services related to mental health or emotional conditions including, but not limited to, a diagnosis of manic depression, manic depressive psychosis, or bipolar affective disorder, are included in the Mental Health and Drug/Alcohol Treatment and are subject to those benefit maximums. All limits and exclusions of the Plan apply.

Other Limited Benefits

The following benefits are limited and are available only if specific medical criteria are met. The portion a Covered Person pays for these benefits *does not* apply toward the Coinsurance Maximum. The Plan provides limited benefits for the following:

- Diagnosis and treatment of temporomandibular joint dysfunction (TMJ), limited to a maximum lifetime payment of \$500 per person.
- Total parenteral nutrition (TPN) for both Inpatient and outpatient treatment, limited to a maximum lifetime limit of \$100,000 per person.
- New Medications. The Claims Administrator will review all new medications within 90 days of FDA approval. Based on this review, new medications will be placed into one of the following categories. This includes any eligible medication prescribed by a physician or given in any setting.
 - **Significant Medication that may have life-saving or –extending potential (including, but not limited to, chemotherapy, transplant, and cardiac medications).** A Significant Medication will be covered immediately upon completion of the Claims Administrator’s review and placement in the Significant Medication category, and the Covered Person will have a 50% Coinsurance. Twelve months after FDA approval, eligible Significant Medications will be covered as any other medication.
 - **New Therapeutic Class of Medication that treats an Illness, disease, condition, and/or symptom that was not treated with medication before the new medication was approved by the FDA, but that does not fall within the Significant Medication definition.** A medication that qualifies as a New Therapeutic Class of Medication will be covered six months after FDA approval, and the Covered Person will have a 50% Coinsurance. Twelve months after FDA approval, eligible medications in this class will be covered as any other medication.
 - **A new medication that is in an existing therapeutic class or has similar indications or uses as a currently available FDA-approved medication.** Twelve months after FDA approval, eligible medications in this class will be covered as any other medication.
- Treatment of Primary Infertility limited to \$1,500 per person per year, and \$5,000 per person per lifetime.
- An Indemnity Benefit for Adoption in the amount of \$4,000 shall be available to the Covered Person when all of the following conditions are met:
 - The Covered Person’s Plan provides maternity benefits for the Covered Person or the Covered Person’s Spouse and coverage is in effect on the date a newborn child is placed for the purpose of adoption.

-
- A newborn child is placed for the purpose of adoption with the Covered Person within (one) year after the child's birth and the date of placement is on or after the Covered Person's effective date.
 - The Covered Person submits a written request for the Indemnity Benefit for Adoption along with proof of placement of adoption. Proof of placement shall be a copy of the court order (or its equivalent) showing the date of placement for adoption. The written request must contain the child's name, date of birth, and a statement regarding any other health coverage of the adoptive parent(s). The written request shall be addressed to the Claims Administrator at the following address:

Educators Mutual Insurance Association of Utah
852 East Arrowhead Lane
Murray, UT 84107-5298

- In the event of adoption of more than one newborn child (for example, twins), the Indemnity Benefit for Adoption applies for each child adopted.
- In the event the Covered Person and/or the Covered Person's Spouse is covered by more than one health benefit plan, the Indemnity Benefit for Adoption shall be prorated between or among the plans so that the full amount provided by both or all of the plans does not exceed \$4,000.
- In the event the Plan excludes care and treatment of pregnancy, the Indemnity Benefit for Adoption is not available to that Covered Person or that Covered Person's Spouse.
- 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 Covered Person shall be liable for repayment of the Indemnity Benefit for Adoption. The full amount of such benefit shall be refunded by the Covered Person to the Claims Administrator within 30 days after that date the child is removed from placement.

Important Health Care Messages from the Federal Government

Newborns' and Mothers' Health Protection

The Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for a mother or newborn child for less than 48 hours following a normal vaginal delivery, or for less than 96 hours following a cesarean section or require that a Provider obtain authorization from the Claims Administrator for prescribing a length of stay not in excess of the above periods. The mother or the newborn child's attending Provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Women's Cancer Rights

The Plan provides medical and surgical benefits for mastectomies and will comply with the requirements of the Women's Health and Cancer Rights Act of 1998, including coverage for the following:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and Reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and coverage for complications, including lymphedemas.

Cost Reform Information

Medical cost reform is a high priority for the Plan Sponsor who is eager to help Covered Persons become better-informed health care consumers which, in turn, will provide for more efficient use of the medical benefits under this Plan. The following information is presented in an effort to assist Covered Persons in making better-informed decisions.

- **Admission the Day of Surgery (Same-day Surgery)**

Many surgeries can be performed on the same day of admission to the Hospital. This means the necessary testing and preliminary operative workup should take place before admission on either an outpatient basis or on the day of surgery.

- **Home Health/Skilled Nursing Care and I.V. Therapy**

As part of the Plan Sponsor's commitment to medical cost reform, they will arrange for Home Health/Skilled Nursing Care and I.V. therapy if Covered Persons choose to leave the Hospital earlier than the days allowed for their particular illnesses. Please contact the Claims Administrator for more information on this program or to make arrangements for Home Health Care. Any reduction in the length of stay must have the full knowledge and consent of the physician.

- **Office Surgery**

Many procedures may be performed in a physician's office rather than a Hospital. Covered Persons should ask their physicians if the proposed surgery is suitable to be performed as an office surgery.

- **Outpatient Procedures**

Due to advances in medical technology and patient care, it is now possible to have surgery and return home the same day. This type of surgery, known by various terms such as "one-day surgery," "ambulatory surgery," "same-day surgery," and "outpatient surgery," can be performed in a special facility at a Hospital or in a licensed independent Surgical Center.

There are many advantages to outpatient surgery. The first obvious advantage is in the area of cost. There is also the advantage of reduced emotional stress, especially with children. There is also less time spent away from home, thus avoiding needless interruptions in the Covered Person's routine and family activities.

- **Second Opinions**

There are instances when it may be advisable to obtain a second opinion for surgery. If Covered Persons have questions regarding second opinion, they should contact the Claims Administrator's Customer Service Department for assistance. If the Plan requests a second opinion, the charge will be paid in full by the Plan.

- **Hospital Bill Audits**

The purpose of the Hospital bill audit is to protect the Covered Person and the Plan from billing errors and unnecessary services. Through these Hospital bill audits, the Plan can help assure that the level of care and the services received are compatible with the amount billed. Hospital Confinements in which the Hospital charges are over the threshold amount will be evaluated to determine if an audit is necessary. In addition, Hospital bills of less than the threshold amount will be prescreened for billing irregularities and audited when appropriate.

- **Billing Accuracy**

In most cases, Covered Persons know better than anyone the medical care that they have received. By reviewing Provider billings for accuracy, the Covered Person can make certain that there are no duplicate or incorrect charges. The Covered Person should report any possible discrepancies to the Claims Administrator's Customer Service Department.

- **Claims Edit System**

The American Medical Association publishes standards for the coding of medical procedures. Health care Providers are expected to bill for services based on these guidelines, but errors occasionally occur. The Claims Administrator uses a claims edit system that is programmed to help identify inappropriate billing codes or coding combinations. Any charges that are denied as a result of this claims edit system are identified as such on the Covered Person's Explanation of Benefits. These amounts represent Provider adjustments and are not the patient's responsibility. Covered Persons should contact the Claims Administrator if they believe that they are being billed for claims edit system denials.

DENTAL BENEFITS

The Plan provides benefits for the following:

- Operative and curative procedures rendered by an oral surgeon for the treatment of injuries and disease of the jaw including, but not limited to, cysts and tumors.
- Surgical removal of impacted teeth, including exam and x-rays.
- Dental anesthesia for covered oral surgery.

Eligible treatment or services related to oral surgery will be processed using American Dental Association procedure codes, subject to the Plan's Table of Allowances. All limits and exclusions of the Plan apply.

No benefit will be provided for impacted teeth or oral cysts during the first eight months of coverage under this Plan, unless reduced by the *Waiver of Preexisting Condition Exclusion* provision of this Plan.

PRESCRIPTION DRUG PROGRAM

The prescription drug program is separate from the medical plans outlined in this document. Coinsurance and Copayments for prescriptions do not apply toward the medical plan Deductible or Coinsurance Maximum.

Copayment and Coinsurance

Copayments and Coinsurances are listed in the “Summary of Benefits” chart. The Participating Pharmacy line indicates the amount Covered Persons must pay if they purchase prescriptions at a participating pharmacy.

Covered Drugs

This program provides benefits for medications that require a prescription under state or federal law unless listed under the “Prescription Drug and Home Delivery Pharmacy Service Exclusions” section. This program reviews prescribing, dispensing, and consumption patterns for potential abuse. The program may also involve the review of claims for drug interactions, drug conflicts, duplicate therapies, overutilization, and/or clinically appropriate maximum daily dose limits.

Covered Persons receive up to a 30-day supply per Copayment.

This program covers the following diabetic supplies only if purchased at a participating pharmacy (see the *Participating Pharmacy* list): insulin syringes, lancets, test strips, and alcohol swabs.

New Medications

The Claims Administrator will review all new medications within 90 days of FDA approval. Based on this review, new medications will be placed into one of the following categories. This includes any eligible medication prescribed by a physician or given in any setting.

- **Significant Medication that may have life-saving or –extending potential (including, but not limited to, chemotherapy, transplant, and cardiac medications).** A Significant Medication will be covered immediately upon completion of the Claims Administrator’s review and placement in the Significant Medication category, and the Covered Person will have a 50% Coinsurance and will not accumulate toward the prescription drug coinsurance maximum. Twelve months after FDA approval, eligible Significant Medications will be covered as any other medication.
- **New Therapeutic Class of Medication that treats an Illness, disease, condition, and/or symptom that was not treated with medication before the new medication was approved by the FDA, but that does not fall within the Significant Medication definition.** A medication that qualifies as a New Therapeutic Class of Medication will be covered six months after FDA approval, and the Covered Person will have a 50% Coinsurance and will not accumulate toward the prescription drug coinsurance maximum. Twelve months after FDA approval, eligible medications in this class will be covered as any other medication.

-
- **A new medication that is in an existing therapeutic class or has similar indications or uses as a currently available FDA-approved medication.** Twelve months after FDA approval, eligible medications in this class will be covered as any other medication.

How to Use the Prescription Card

1. Use participating pharmacies. You may obtain a list of participating pharmacies by calling the telephone number on the back of the ID card.
2. Present the ID card whenever purchasing eligible prescription drugs.
3. Pay the applicable Copayment at the time of purchase. (Some maintenance drugs may be available through the mail-order program. See “Home Delivery Pharmacy Service Program” section.)
4. If Covered Persons have prescriptions filled at non-participating pharmacies, they will pay the pharmacy’s full regular price.
5. Some prescriptions may require a Preauthorization for purchase through this program. For additional information, the Covered Person should contact the prescription drug program customer service telephone number printed on the back of the ID card.
6. Eligible self-administered Injectables are covered under the prescription drug program. Some may be subject to days-supply limits and/or Preauthorization. For additional information, the Covered Person should contact the prescription drug program customer service telephone number printed on the back of the ID card.

Note: The prescription card will include only the name of the primary Participant. Dependents eligible for coverage are recorded on a computerized program provided to the pharmacist. When this Plan is secondary, Dependent coverage is only available by filing a direct reimbursement claim with this program. The Covered Person should contact the prescription drug program customer service department for details on how to submit prescriptions when this Plan is secondary.

Prescription Claims Review

If the Claims Administrator denies payment of prescription claims which Covered Persons believe are properly compensable under the applicable terms of the Plan, they shall follow the steps outlined in the “Claims Review Process” section.

HOME DELIVERY PHARMACY SERVICE PROGRAM

Covered Persons may be able to save money by purchasing their maintenance prescriptions through the home delivery pharmacy service (mail order) program.

The home delivery pharmacy service program is separate from the medical plans outlined in this document. Coinsurance and Copayments for prescriptions do not apply toward the medical plan Deductible or Coinsurance Maximum.

How to Use the Mail Service Program

1. *New prescriptions:* Ask the physician for a sample medication. If medication is required immediately, but will be taken on an on-going basis, ask the doctor to write two prescriptions: the first, up to a 30-day supply, to be filled at a retail pharmacy; the second, up to a 90-day supply, to be filled through the home delivery pharmacy service program. Send the second prescription along with the order form and the appropriate Copayment to the participating home delivery pharmacy service Provider.
2. *Prescriptions currently being taken:* Obtain a new, written prescription, for up to a 90-day supply (plus refills if applicable), from the physician. (In most cases, one can be obtained by calling the physician's office.) Send the new prescription along with the order form and the appropriate Copayment to the home delivery pharmacy service Provider.
3. Important: Sign the order, indicating that the prescribed drugs are for the Covered Person or covered family members. Unsigned orders will be returned unfilled.
4. The participating home delivery pharmacy service will process the order and return it via U.S. Mail or UPS, along with instructions for future refills. Allow up to 14 days for delivery from the time the Covered Person mails the prescription.
5. *Refills:* With the original prescription medication, the Covered Person will receive a notice showing the number of times it may be refilled. Simply mail this refill notice with the Copayment for each prescription in the order envelope provided. Refills should be ordered at least two weeks before they are needed.
6. Some prescriptions may require a Preauthorization for purchase through the home delivery pharmacy service. For additional information, the Covered Person should contact the prescription drug program customer service telephone number printed on the back of the ID card.
7. Eligible self-administered Injectables are covered under the home delivery pharmacy service program. Some may be subject to days-supply limits and/or Preauthorization. For additional information, the Covered Person should contact the prescription drug program customer service telephone number printed on the back of the ID card.

Note: The prescription card will include only the name of the primary Participant. Dependents eligible for coverage are recorded on a computerized program provided to the pharmacist. When this Plan is secondary, Dependent coverage is only available by filing a direct reimbursement claim with this program. The Covered Person should contact the prescription drug program customer service department for details on how to submit prescriptions when this Plan is secondary.

PRESCRIPTION DRUG AND HOME DELIVERY PHARMACY SERVICE EXCLUSIONS

Pharmacy Items Excluded

The following items are excluded under the prescription drug and home delivery pharmacy service (mail order) programs, regardless of medical necessity or prescription by a licensed prescriber:

1. Medication received by a Covered Person before coverage under the Plan is effective or after coverage under the Plan ends.
2. Medication that is not Medically Necessary.
3. Specialty drugs related to a Preexisting Condition for the period described in the *Preexisting Condition Limitation* section, except as described in the *Waiver of Preexisting Condition Exclusion* section, which can be found in the plan section of this policy.
4. Fertility medication (Primary or Secondary Infertility).
5. Anorexiant.
6. Chemotherapeutic medications, administered by IV or injections.
7. Hemophiliac medications.
8. Medication which is to be taken by, or administered to, individuals, in whole or in part, while they are patients in licensed Hospitals, rest homes, sanitariums, Extended Care Facilities, skilled nursing facilities, convalescent Hospitals, nursing homes, or similar institutions which operate on their premises, or allow to be operated on their premises, facilities for dispensing pharmaceuticals.
9. Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
10. Any drug exceeding the number of days supply or doses eligible in the policy.
11. Charges for the administration of any drug.
12. Any drugs used for weight loss, smoking cessation, progesterone suppositories, and related services, or complications thereof.
13. Any drug that does not require a prescription except insulin.
14. Any over-the-counter drugs even if prescribed by a physician including, but not limited to, supplements and nutritional substitutes, enteral feedings, amino acids, electrolyte supplements, herbs, and related services.
15. Any drug provided under another provision of the policy; e.g., Inpatient Hospital use.

-
16. Any drug purchased for Cosmetic purposes, or complications thereof.
 17. Any item specifically limited or excluded in the medical exclusions. (See “Medical Plan Exclusions” section.)
 18. Any drug for erectile dysfunction.
 19. Any drug when it has been determined by the clinical consultants of the Claims Administrator that there is over-utilization of drugs or evidence of drug abuse.
 20. Experimental drugs or any drug labeled “Caution, limited by Federal Law to Investigational Use” or dispensed by the government. Twelve months must have passed after FDA approval before the Plan will consider coverage, unless the Claims Administrator determines that the drug is a Significant Medication or a New Therapeutic Class of Medication. (See the *New Medications* section of the “Prescription Drug Program.”)
 21. Preventive medications including equipment and application of medications, including but not limited to, fluoride, vitamins, minerals, and homeopathic medicine. This exclusion does not include prenatal vitamins prescribed by a physician during pregnancy. This exclusion does not include self-injectable Vitamin B12 injections.
 22. Unit dose packaging of prescription drug products, including but not limited to, Factor VIII.
 23. Non-self-administered Injectables.
 24. Expenses in connection with the Morning after pill (Levonorgestrel), and the abortion pill (RU486 or Mifeprex).

MEDICAL PLAN EXCLUSIONS

Notwithstanding anything else in the Plan to the contrary, the items listed below are not covered by the Plan.

The Plan does not pay for the following:

1. Services received by a Covered Person before coverage under the Plan became effective or after coverage under the Plan has terminated.
2. Services not specified as covered. There is no presumption of coverage.
3. Charges in excess of the Summary of Benefits, the Table of Allowances, or other Plan provisions.
4. Any Copayments or Deductibles incurred under this policy, except as they are applied to the Coinsurance Maximum where applicable.
5. Care, treatment, medication, supplies, or services rendered for any Preexisting Condition if treatment is rendered before the Covered Person has been enrolled under this Plan for at least eight months (or 18 months for Late Enrollees), unless reduced by the Waiver of Preexisting Condition Exclusion provision of this Plan.
6. Care, treatment, medication, supplies, or services rendered during the first eight months of coverage under this Plan, unless reduced by the Waiver of Preexisting Condition Exclusion provision of this Plan, for the following: impacted teeth, tympanoplasty, tympanostomy, tonsillectomy, myringotomy, adenoidectomy, warts, moles, acne, lesions, mouth and external cysts, nasal septal repair, or elective sterilization.
7. Illness or injury caused by the negligent or wrongful act of another, or for which the Covered Person is covered by any workers' compensation or similar law; except that the Plan may advance benefits to or on behalf of the Covered Person in such situations, subject to the Plan's right of Subrogation and reimbursement set forth herein.
8. Illness or injury that a Covered Person incurred either (1) while in the service of an employer that was obligated by law to provide workers' compensation insurance that would have covered such Illness or injury, or, (2) while in the service of an employer that had elected to exclude workers' compensation coverage for such Covered Person, except that the Plan may elect to advance benefits to or on behalf of the Covered Person in either situation, subject to the Plan's right to Subrogation and reimbursement set forth herein.
9. Illness or injury for which the Covered Person is covered by other responsible insurance including, but not limited to, coverage under a government sponsored health plan, except as otherwise provided herein.
10. Except as otherwise provided by law, charges for Hospital Confinement, services, supplies, or treatment the Covered Person is not legally required to pay.

-
11. Coverage for Illness or injury as a result of war or any act of war, whether declared or undeclared, or caused while performing service in the armed forces of any country.
 12. Charges for care, treatment, or surgical procedures which are not Medically Necessary.
 13. Care, treatment, or services provided when there are no symptoms of Illness or injury, or when there is or has been no diagnosis of Illness or injury.
 14. Care, treatment, or surgical procedures incurred primarily for convenience, contentment, or other non-therapeutic purposes.
 15. Expenses related to immunizations required exclusively for foreign travel.
 16. Expenses for personal hygiene, convenience, wellness, or preventive care including, but not limited to, buildings, motor vehicles, air conditioners, whirlpool baths, exercise equipment, or other multi-purpose equipment or facilities, related appurtenances, controls, accessories, or modifications thereof.
 17. Convenience items in or out of the Hospital such as guest trays, cots, telephone calls, and other services.
 18. Expenses for preparing medical reports, itemized bills, or claim forms.
 19. Expenses for shipping, handling, postage, sales tax, interest, finance charges, and other administrative charges.
 20. Transportation expenses including, but not limited to, mileage reimbursement, airfare, meals, accommodations, and car rental.
 21. Ancillary charges made by a medical institution, Hospital, clinic, hospice, nursing home, or similar facility to hold or reserve a room during any temporary leave of absence of the Covered Person, or in anticipation of a Hospital stay.
 22. Any care, treatment, or expenses for Cosmetic procedures or complications thereof, including Reconstructive or corrective procedures done primarily for Cosmetic purposes. A care, treatment, or procedure is considered Cosmetic when it is primarily intended to improve appearance or correct a deformity without restoring physical bodily function. Psychological factors such as, but not limited to, poor self-image or difficult peer or social relations are not relevant and do not justify a Cosmetic procedure as being Medically Necessary. The reversal of a non-covered Cosmetic procedure is not covered. This exclusion does not apply to Reconstructive Surgery performed as a result of a mastectomy, or treatment of physical complications at any stage of the mastectomy, including lymphedemas.
 23. Care, treatment, services, or surgical procedures rendered for abdominoplasties, diastasis recti abdominous, protruding ears, breast enlargement, or gynecomastia, or for complications thereof.

-
24. Care, treatment, services, or surgical procedures rendered for reduction mammoplasty, unless the patient meets the Claims Administrator's criteria, a copy of which will be provided upon request.
 25. Care, treatment, services, or surgical procedures rendered for blepharoplasty.
 26. Health services and associated expenses for the surgical treatment and non-surgical medical treatment of obesity (whether morbid obesity or not) including, but not limited to, weight loss programs, or for complications thereof.
 27. Expenses in connection with gastric banding, gastric stapling, or digestive bypass, or for complications thereof.
 28. Educational or behavioral modification services or counseling including, but not limited to, biofeedback, weight control clinics, stop-smoking clinics, training for care of diabetes, cholesterol counseling, exercise programs, or other types of physical fitness training.
 29. Confinement, education, or training in a nursing home, rest home, or similar establishment, including an institution that is primarily a school or other institution for training, except an Extended Care Facility as provided in this Plan.
 30. Expenses in connection with Custodial Care.
 31. Charges in connection with institutional care, including residential treatment or programs, which as determined by the Plan, is for the primary purpose of controlling or changing the environment for the individual.
 32. Charges for cognitive therapy.
 33. Care or treatment of learning disability, mental retardation, or chronic organic brain syndrome, except services required to diagnose any of the above.
 34. Treatment or services for marriage counseling and any counseling or psychotherapy for relief of family or marital discord, divorce, preparation for marriage, encounter groups, parental counseling, treatment for situational disturbances such as financial or environmental problems, or other types of everyday stresses and strains.
 35. Expenses for treatment of personality disorders, behavior disorders, or chronic situational reactions; phobias, occupational, religious, or other social maladjustment; or non-specific conditions such as acts of impulse including, but not limited to, gambling, pyromania, and kleptomania.
 36. Care, treatment, procedures, or services for transsexualism, gender dysphoria, sexual reassignment, psychosexual identity disorder, or psychosexual dysfunction. This exclusion does not apply to the initial assessment and diagnosis of the condition.
 37. Charges for individual or group psychotherapy in excess of one visit per day.

-
38. Any loss caused or contributed to by the Covered Person committing, or attempting to commit, an Act of Aggression, or an illegal act, unless the patient meets the Claims Administrator's criteria, a copy of which will be provided upon request.
 39. Care, treatment, or services for any Illness or injury resulting from, or caused by, intoxication or the use of any drug unless such drug is administered or prescribed by a physician and taken in the manner prescribed and unless the patient meets the Claims Administrator's criteria, a copy of which will be provided upon request.
 40. Care, treatment, or services, including Custodial Care, for substance abuse or the aftereffects of substance abuse including, but not limited to, alcoholism, narcotism, or use of hallucinogenic drugs or similar substances, except as specifically provided under Mental Health and Drug/Alcohol treatment.
 41. Infertility services including, but not limited to, the following:
 - Artificial insemination, sperm washing, sperm banking, and/or storage.
 - Donor costs.
 - Experimental or Investigative treatment.
 - Gamete intrafallopian transfer ("GIFT").
 - Hamster egg penetration tests.
 - In-vitro fertilization (IVF).
 - Medications for Infertility and ultrasounds associated with Infertility medications therapy.
 - Non-participating Provider or facility services for Infertility.
 - Zygote intrafallopian transfer ("ZIFT").
 - Surrogate mothers.
 - Secondary Infertility.
 - Expenses in connection with retrieval or collection of semen and/or ovum.
 42. The Adoption Indemnity Benefit (see Other Limited Benefit section) in connection with the adoption of any child over (one) year of age.
 43. Expenses for removal of a contraceptive intrauterine device (IUD) if removed less than five years after insertion, unless the removal is due to complications of the device.
 44. Expenses for removal of a contraceptive implant (such as Progestogen Implant), if removed before 80% of the expected life, unless the removal is due to complications of the device.
 45. The reversal of a surgically performed sterilization, subsequent sterilization, or ovulation-inducing drugs or injections.
 46. Expenses in connection with abortion, except as follows:
 - Where documented by medical evidence that the life of the mother would be endangered if the fetus were carried to term.
 - Where the pregnancy is the result of incest or rape.

-
47. Care, treatment, or surgical procedures for erectile dysfunction.
 48. Care, treatment, or devices to aid in female sexual arousal disorder including, but not limited to, Eros Clitoral Therapy Device.
 49. Expenses in connection with a penile prosthesis.
 50. All organ Transplant services when rendered by Non-participating Providers.
 51. Services for cross matching and/or harvesting organs from live or deceased donors for all non-covered Transplant/Implant services and whenever the organ recipient is not a Covered Person.
 52. Repair or replacement of any otherwise covered Implant when rendered by Non-participating Providers.
 53. Any bone marrow Transplant in the treatment or care of any disease or condition resulting from infection from a human T-cell lymphotropic virus or HIV and central nervous system metastases or myeloma.
 54. Expenses for and in connection with implantable electrical, pneumatic, mechanical, or semi-mechanical devices or prostheses including, but not limited to, neurostimulators of any kind and for any purpose, artificial hearts, LVAD, LVAS, ventricular-assist devices, and deep brain stimulators (DBS). This exclusion does not apply to heart pacemakers or implantable defibrillators.
 55. Duplication, replacement, upgrade, improvement, alteration, or repair of existing Durable Medical Equipment, except this exclusion does not apply to the replacement of Durable Medical Equipment other than Durable Medical Equipment that the Claims Administrator has previously paid for under *Medical Supplies and Equipment*. This includes parts, such as but not limited to, batteries. Replacement of existing Durable Medical Equipment will only be covered if the replacement is Medically Necessary due to normal physical growth of the Covered Person. Expenses related to modifications and/or improvements to home, van, or other vehicle, regardless of medical necessity are excluded.
 56. Care, treatment, or surgical procedures in connection with hearing aids or the fitting of hearing aids or appliances. This exclusion does not apply to cochlear implantation.
 57. Eyeglasses, contact lenses, or the fitting of eyeglasses or contact lenses, with the exception of one lens per operated eye following eye surgery; for example, an external contact lens or surgically implanted intraocular lens.
 58. Radial keratotomy or lamellar keratectomy, or other eye surgery performed primarily to correct refractive errors.
 59. Dental, mouth, and jaw services including, but not limited to, all care, treatment, therapy, surgery, or diagnostic procedures for the following, unless otherwise indicated in the “Summary of Benefits” chart:

-
- Appliances, bite guards, space maintainers, splints
 - Bone resection, bone screws, Implants
 - Crowns or caps, dentures, permanent bridgework
 - Endodontics, nerves within the teeth
 - Full mouth rehabilitation therapy
 - Injection of joints
 - Maxillary and or mandibular osteotomy
 - Orthodontic treatment
 - Orthognathic procedures, upper/lower jaw augmentation or reduction procedures, including problems due to development or altering of vertical dimensions
 - Periodontics, gums alveolar processes
 - Prosthodontic treatment
 - Restorations, including restoration of occlusion
 - Teeth, including nursing bottle syndrome, caries, etc.
 - X-rays
60. Dental anesthesia. This exclusion does not apply to covered oral surgery, or when treatment is for a Covered Person who is four years old or younger.
61. Services, supplies, or accommodations provided in connection with the following:
- Routine cutting, removal, or other treatment of corns, calluses, or toenails unless deemed Medically Necessary due to infection or a metabolic disease such as diabetes mellitus or a peripheral vascular disease such as arteriosclerosis.
 - Orthopedic shoes that are not attached to a brace.
62. Expenses in connection with speech therapy, unless required as a result of speech defects as a result of Illness or Accident.
63. Expenses for whole blood, or blood derivatives.
64. Care, treatment, or services involving acupuncture, acupressure, or hypnosis.
65. Care, treatment, surgical procedures or supplies, or any appliances, aids, devices, or drugs that are illegal, Experimental, or Investigative as defined in the Plan, or for complications thereof. Twelve months must have passed after FDA approval before the Plan will consider coverage, unless the Claims Administrator determined that a drug is a Significant Medication or a New Therapeutic Class of Medication. (See the *New Medications* section of the “Covered Medical Benefits” and “Prescription Drug Program.”)
66. Care, treatment, or services including, but not limited to, testing associated with autogenous urine immunization, sublingual provocation, leukocytotoxicity, and subcutaneous provocation and neutralizing.
67. Expenses in connection with herbal, holistic, or homeopathic treatment, or for complications thereof.

-
68. Genetic counseling and testing except prenatal amniocentesis or chorionic villi sampling for high risk pregnancy.
69. Expenses related to a sleep laboratory or facility, except services related to sleep apnea, unless otherwise indicated. This includes, but is not limited to, insomnia.
70. Expenses for any of the following:
- Ambulance services when the individual could be safely transported by means other than ambulance.
 - Air ambulance services when the Covered Person could be safely transported by ground ambulance or by means other than ambulance.
 - Ambulance services beyond transportation to the nearest facility expected to have appropriate services for the treatment of the injury or illness involved.
 - Ambulance services for conditions, other than injuries received in an Accident, not deemed Life-threatening.
71. Special duty nursing services, including the following:
- That ordinarily would be provided by the Hospital staff or its Intensive Care unit. (The Hospital benefit pays for general nursing service by Hospital staff.)
 - Requested by, or for the convenience of, the Covered Person or the Covered Person's family or consisting primarily of bathing, feeding, exercising, house keeping, moving the Covered Person, giving medication, or acting as a companion or sitter, or when otherwise deemed not to be Medically Necessary.
 - Rendered by a private duty nurse, who is an immediate family member (e.g. Spouse, parent).
 - Home Health aides or services.
72. Charges for physician calls in excess of one per physician per day.
73. Expenses for appointments scheduled but not kept.
74. Expenses for telephone consultations.
75. Care, treatment, or services rendered by any Provider who is an immediate family member (e.g. Spouse, parent).
76. Services performed by a Provider that is not covered by the Plan including, but not limited to, the following:
- Acupuncturist
 - Registered dietician
 - Doctor of education
 - Clergy
 - Home Health/nurse aid
 - Hygienist
 - Hypnotist

-
- Medical assistant
 - Massage therapist
 - Naturopath
 - Physician's assistant/doctor's assistant (This exclusion does not apply for surgical assistant services.)
 - Practical nurse/vocational nurse (This exclusion does not apply for surgical assistant services.)
 - Personal fitness trainer/coach
77. All self-administered Injectables. (Refer to "Prescription Drug Program.") This exclusion does not apply to the following:
- Neupogen (Filgrastim)
 - Epogen, Procrit (Epoetin Alfa)
 - Lupron, Lupron Depot, Lupron Depot-3 month, Lupron Depot-4 month, Lupron Depot-Ped, Lupron Depot-Gyn, Oaklide (Leuprolide Acetate)
 - Neulasta (Pegfilgrastim)
 - Neumega (Oprelvekin)
 - Leukine, Prokine (Saragramostim)
78. All medications that are excluded under the "Prescription Drug Program" are also excluded under Medical. This exclusion does not apply to the following (under Medical plan):
- Chemotherapeutic medications.
 - Hemophiliac medications.
 - Otherwise covered medication which is to be taken by, or administered to, individuals, in whole or in part, while they are a patients in licensed Hospitals, rest homes, sanitariums, Extended Care Facilities, skilled nursing facilities, convalescent Hospitals, nursing homes, or similar institutions which operates on their premises, or allow to be operated on their premises, facilities for dispensing pharmaceuticals.
 - Any otherwise covered drug provided under another provision of the policy; e.g. Inpatient Hospital use.
 - Unit dose packaging of prescription drug products, including but not limited to, Factor VIII.
 - Medically Necessary enteral feeding when administered via nasogastric, gastrotomy, or jejunostomy tube.
79. All services, equipment, and supplies provided or ordered to treat complications of a non-covered illness, injury, condition, situation, procedure, or treatment.

Utah Valley University
 800 W. University Pkwy.
 Orem, Utah 84058
 (801) 863-5207

Plan Sponsor:

Plan:

Administered By:

Utah Valley University – Plan #128

Utah Valley University Employee Dental Plan

Educators Mutual Insurance Association of Utah

Summary of Benefits	PREMIER INDEMNITY PLAN	
	In-Network	Out-of-Network
Type 1 - Preventive Oral Exams, Cleanings, X-rays, Fluoride	100%	100%
Type 2 - Basic Fillings, Oral Surgery	80%	80%
Type 3 - Major Crowns, Bridges, Prosthodontics	60%	60%
Type 4 - Orthodontics Dependent Children up to age 26	50%	50%
Adults	50%	50%
Orthodontic Discount (All Members)	25% Discount	No Discount
Endodontics	Type 2 – Basic	Type 2 – Basic
Periodontics	Type 2 – Basic	Type 2 – Basic
Sealants	Type 2 – Basic	Type 2 – Basic
Space Maintainers	Type 2 – Basic	Type 2 – Basic
Specialists	Paid same as General Dentists	Paid same as General Dentists
Waiting periods		
Type 2 – Basic	None	
Type 3 – Major		
Type 4 – Orthodontics	12 Month Late Entrant Waiting Period	
Deductible		
Per Person	\$0.00	\$0.00
Family Max	\$0.00	\$0.00
Deductible Applies To	N/A	N/A
Annual Maximum Per Person	\$1,500.00	
Orthodontic Lifetime Maximum	\$1,500.00	
Reimbursement Schedule	Premier Fee Schedule	R & C
Provisions / Limitations / Exclusions		
Exams (including Periodontal), Cleanings and Fluoride	2 per Contract Year	
Fluoride	Up to age 16	
Sealants	Up to age 16	
Space Maintainers	Up to age 16	
Bitewing X-Rays	Up to 4, twice per Contract Year	
Periapical X-Rays	6 per Contract Year	
Panoramic X-Ray	1 every 3 years	
Impacted Teeth	Covered in Type 2 – Basic	
Anesthesia – (Age 8 and over for the extraction of impacted teeth only)	Covered in Type 3 – Major	
Anesthesia – (For children age 7 and under, once per Contract Year)	Covered in Type 3 – Major	
Implants – Limited to \$225.00	Covered in Type 3 – Major	
Crowns, Pontics, Abutments, Onlays and Dentures	1 every 5 years per tooth	
Fillings on the same surface	1 every 18 months	
R & C (Reasonable and Customary Charge of most dentists in the same geographic area)		

Benefits illustrated are in summary only. Refer to your Dental handbook for a complete description of benefits, limitations and Exclusions. All services are subject to Educators Table of Allowances. When using a Non-participating Provider, the Covered Person is responsible for all fees in excess of the Table of Allowances.

COVERED DENTAL BENEFITS

Diagnostic/Preventive Benefits

- Oral examinations two times per Contract Year.
- X-rays are covered as follows:
 - Full mouth – once every three years
 - Supplementary bitewings – up to four procedures, twice per Contract Year
 - Supplementary periapical – six procedures per Contract Year
- Cleaning and scaling teeth (prophylaxis) two times per Contract Year.
- Application of fluoride in conjunction with cleaning two times per Contract Year, limited to Dependent children up to the 16th birthday.

Space Maintainers

- Space maintainers used to maintain the present position of a tooth following an extraction for Dependent children up to the 16th birthday.

Sealants

- Sealants for Dependent children up to the 16th birthday.

Basic Services

- Restoration of decayed teeth with amalgam, synthetics, or plastic, up to one restoration per surface. Repairs to restorations are allowed only once every 18 months, regardless of the reason. Tooth preparation, temporary restorations, cement bases, impressions, and local anesthesia are all considered part of the restoration and are covered only when included in the charge for the entire process.

Major Services

- Gold onlays and crowns are covered if teeth cannot be restored with amalgam, synthetic, porcelain, or plastic. Benefits are payable once every five years for the same tooth.

Endodontic Services

- Endodontic treatment, including root canal therapy. One pulp cap per tooth is allowed. Bases are not covered.

Periodontic Services

- Periodontic services are limited to one perio maintenance (two per Contract Year in lieu of preventive cleaning); root scaling and planing (once per quadrant of mouth in any 24 month period); gingivectomy, gingival curettage; osseous surgery including flap entry and closure; pedicle or free soft tissue grafts; full mouth debridement (one every five years).

Prosthodontic Services

- Initial installation of a removable or fixed partial or complete denture once every five years. Fixed bridges for patients under age 16 are covered up to the amount allowed for a removable partial denture.
- One laboratory relines is covered following the initial installation of a denture and once every three years thereafter. Office relines are not a covered benefit.

-
- An implant in lieu of a crown or bridge is covered, limited to \$225. All services and products related to the implant (including, but not limited to, the anchor, the post, and the artificial tooth) apply toward the implant limit.
 - Replacement of missing teeth with complete or partial dentures, fixed bridges, or implants is covered. Services to replace teeth that are missing prior to the effective date of coverage are not eligible for a period of five years from effective date of continuous coverage with the Plan. However, the Claims Administrator may review the abutment teeth for eligibility of prosthetic benefits on their own merit.
 - Replacement of a denture or implant that is no longer serviceable is covered once every five years.

Oral Surgery Services

- Extractions and other oral surgery involving procedures for simple and complicated extractions of impacted or erupted teeth, including frenectomy, alveolectomy, removal of palatal and mandibular tori, and crown exposure. Post-operative care and removal of sutures are considered part of the surgical procedure and are covered only when included in the charge for the entire surgical procedure.

Anesthesia Services

- General anesthesia, including intravenous sedation, is limited to age seven and under, once per Contract Year. General anesthesia for the extraction of impacted teeth for individuals age eight and over is covered to the Table of Allowances, based on necessity, not for anxiety management.

Orthodontic Services

Orthodontic services are covered for functionally related problems, not for Cosmetic purposes, for eligible unmarried Dependent children up to the 26th birthday, the eligible Employee, and Spouse.

- Initial diagnostic records (study models, facial photographs, etc.) are covered only if eligible orthodontic treatment is rendered.
- Orthodontic treatment, including diagnostic procedures, X-rays, and appliance therapy.

UTAH VALLEY UNIVERSITY EMPLOYEE DENTAL PLAN EXCLUSIONS

Notwithstanding anything else in the Plan to the contrary, the items listed below are not covered by the Plan.

The Utah Valley University Employee Dental Plan does not pay for any of the following:

1. Services received by a Covered Person before coverage under the Plan became effective or after coverage under the Plan has terminated.
2. Expenses for preparing dental reports, itemized bills, or claim forms.
3. Illness or injury caused by the negligent or wrongful act of another, or for which the Covered Person is covered by any workers' compensation or similar law; except that the Plan may advance benefits to or on behalf of the Covered Person in such situations, subject to the Plan's right of Subrogation and reimbursement set forth herein.
4. Illness or injury that a Covered Person incurred either (1) while in the service of an employer that was obligated by law to provide workers' compensation insurance that would have covered such illness or injury, or, (2) while in the service of an employer that had elected to exclude workers' compensation coverage for such Covered Person, except that Plan may elect to advance benefits to or on behalf of the Covered Person in either situation, subject to the Plan's rights of Subrogation and reimbursement set forth herein.
5. Illness or injury for which the Covered Person is covered by other responsible insurance including, but not limited to, coverage under a government sponsored health plan, except as otherwise provided herein, or as otherwise provided by law.
6. Charges for services related to Cosmetic surgery or dentistry for solely Cosmetic reasons including, but not limited to, bonding and veneers.
7. Any procedure started prior to the date the patient became covered for such services under this policy.
8. Medical care, confinement, treatment, services, use of facilities, or supplies for which charges are made by a facility, including freestanding nursing home, rest home, or similar establishment.
9. Plaque control programs, oral hygiene instruction, and dietary instruction.
10. Myofunctional therapy.
11. Lab costs for an oral tissue biopsy.
12. Treatment to correct problems with the way teeth meet or to adjust bite (alter vertical dimensions or restore or equilibrate occlusion) except as covered under orthodontia.

-
13. Care, treatment, operations, supplies, appliances, aids, devices, or drugs that are not FDA approved.
 14. Any loss caused, or contributed to, by the Covered Person committing, or attempting to commit, an Act of Aggression or an illegal act. This exclusion does not apply to benefits for victims of domestic violence or for Covered Persons with mental health conditions.
 15. Care, treatment, operations, or supplies that are illegal, Experimental, Investigational, or for research purposes by the United States medical profession that are not recognized or proven to be effective for treatment of illness or injury in accordance with generally accepted dental/medical practices.
 16. Expenses in connection with transportation or mileage reimbursement.
 17. Expenses including, but not limited to, air fare, meals, accommodations, and car rental.
 18. Medications labeled “Caution, Limited by Federal Law to Investigational Use” or experimental drugs. Twelve months must have passed after FDA approval, before the Plan will consider coverage.
 19. Services that are not Medically Necessary or Cosmetic services including veneers, special techniques, precious metals used for removable appliances other than orthodontics, precision attachments for partial dentures or bridges, and personal characterization.
 20. Any procedure or appliance to correct or treat temporomandibular joint dysfunction (TMJ).
 21. Transplants, reimplantations, Cosmetic implants and associated appliances or services rendered in conjunction with Cosmetic implants; for example, crowns or bridges.
 22. Hospital services.
 23. Habit-breaking devices or appliances to correct thumb sucking, tongue thrusting, etc.
 24. Temporary restorations, appliances, or procedures of any nature, except that temporary restorations are covered when included in the charge for the restoration process.
 25. Replacement of lost, stolen, or damaged dentures, except once every five years.
 26. Procedures, appliances, or restorations, other than those for replacement of structure loss from caries, that are necessary to alter, restore, or maintain occlusion by any of the following: realignment of teeth, periodontal splinting, gnathological recordings, equilibration, treatment of disturbances of the temporomandibular joint (TMJ), orthognathic procedures.
 27. Hypnosis and related analgesia.
 28. Restorative dental services in connection with an overdenture.

-
29. Expenses for services required due to complications associated with, or due to, non-covered services, and where applicable, reversal of non-covered services.
 30. Services rendered by anyone other than a licensed DENTIST and when necessary and customary, as determined by the standards of generally accepted dental practice.
 31. Services for injury resulting from war or any act of war, whether declared or undeclared.
 32. Care, treatment, or services the Covered Person is not, in the absence of this policy, legally obligated to pay, except as otherwise provided by law.
 33. Care, treatment, or services rendered by any PROVIDER who is an immediate family member (e.g. Spouse, parent).
 34. Benefits for services or treatments covered under any medical plan.
 35. Expenses for appointments scheduled but not kept, or for telephone consultations.
 36. Expenses for shipping, handling, postage, sales tax, interest, or finance charges.
 37. Charges for completion or submission of insurance forms.
 38. Prescription drugs and over-the-counter medication.
 39. Charges for care, treatment, or surgical procedures that are unnecessary or in excess of the Summary of Benefits or the Table of Allowance.
 40. The application of a dental sealant on any tooth that has been previously treated with a temporary or permanent restoration.
 41. The application of dental sealants on all Anterior teeth whether Deciduous or permanent teeth.
 42. Chemotherapeutic injections.
 43. All other services not specified as covered benefits or not specifically included in the contract with the Employer.

CONTINUATION OF COVERAGE

COBRA Continuation of Coverage Requirements

Under the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), a Covered Person who could otherwise lose coverage as a result of a “qualifying event” is entitled to elect to purchase medical continuation under the Plan. The coverage will be identical to the coverage provided to Covered Persons to whom a qualifying event has not occurred.

- **Qualifying Event.** A “qualifying event” is any of the following:
 - For an Employee, termination of employment (other than for gross misconduct) or reduction of hours worked so as to render the Employee ineligible for coverage;
 - For a Spouse and eligible Dependents, death of the Employee;
 - For a Spouse, divorce or legal separation;
 - For a Spouse and eligible Dependents, loss of coverage due to the Employee becoming eligible for Medicare;
 - For a Dependent child, ceasing to qualify as a Dependent under the Plan;
 - For retirees and their Dependents, employer bankruptcy under Chapter 11.

- **Notification of the Claims Administrator by Employee or Dependent.** The Employee or Dependent has the responsibility for notifying the Claims Administrator in writing of a divorce, legal separation, or a child losing Dependent status under the Plan, within 60 days of the later of the date of the event or the date coverage under the Plan would be lost.

- **Notice of Continuation Rights.** When the Claims Administrator is notified of a qualifying event, it will advise the Covered Person of the right to continue medical coverage. Continued coverage is not automatic. Covered Persons must elect to continue coverage within 60 days of the latest of the following:
 - The qualifying event;
 - The date the Covered Person is advised by the Plan Administrator of the right to continued coverage.

Notice of the right to continued coverage to a Spouse of a covered Employee will be deemed notice to any Dependent child residing with that Spouse.

- **Payment of Premium for Continuation Coverage.** The Covered Person is required to pay a premium for the continued coverage and has the option to make these payments in monthly installments. A Covered Person will be charged the full cost of coverage under the Plan, plus an administration charge that is two percent of the group rate.

COBRA coverage will be paid for on a monthly basis. The first payment must be made within 45 days after the date coverage is elected. The first payment will include the cost of coverage retroactive to the date coverage would otherwise terminate. Failure to pay this initial premium will result in cancellation of all coverage(s), ***without prior notice***.

Subsequent premiums must be paid by the first of each month. Failure to pay this premium within 31 days of the premium due date for any month will result in

cancellation of all coverage(s), *without prior notice*. Any claims received for services rendered during the 31-day Grace Period will be held for processing until premium payment is received.

- **Period of Continuation Coverage.** If elected, the maximum period for continued coverage for a “qualifying event” involving termination of employment or reduced working hours is 18 months. For all other “qualifying events,” the maximum period is 36 months. Other events will cause coverage to end sooner and this will occur on the earliest of any of the following:
 - The date the Plan Sponsor ceases to provide any group health plan to any Employee;
 - The date the Covered Person fails to make any required premium payment; or
 - The date the Covered Person becomes either of the following:
 - A covered Employee under any other group health plan that does not contain any exclusion or limitation with respect to any Preexisting Condition the Covered Person has, or
 - Entitled to Medicare.

- **Extension of Coverage for Disabled Individuals.** If a Covered Person is disabled according to Social Security any time within the first 60 days of COBRA coverage (or a qualifying new child is so disabled within 60 days of the birth, adoption, or placement for adoption), the Covered Person may extend the 18 months COBRA coverage period to 29 months from the termination date or reduction in hours date. This extension may apply independently to each qualified Covered Person regardless of whether the disabled individual is covered under a COBRA election.

To qualify for this extension, the Plan Sponsor must be notified within 60 days of the date Social Security makes a disability determination, but before the end of the initial 18 month COBRA coverage period. If Social Security makes a determination of disability prior to the date employment ends, the Covered Person must notify the Plan Sponsor within 60 days of the date the Employee’s employment ends. The Plan Sponsor must be notified within 30 days of the date Social Security determines that the Covered Person is no longer disabled.

The cost of coverage during the 19th through 29th month extension period will be 150 percent of the group plan rate for each month provided at least one Covered Person is disabled.

COBRA coverage will end the earliest of the following:

- The first day of the month that is more than 30 days after Social Security determines that the Covered Person is no longer disabled; or
- The dates otherwise specified for terminating COBRA coverage.

Waiver of Premium

If Participants become disabled while covered under this Plan, and would otherwise lose coverage, they may apply for either COBRA continuation coverage or for continuation of medical coverage for the Participant and eligible Dependents under the Plan Sponsor’s base plan without payment of the Employee portion of the cost of coverage (Waiver of Premium). The waiver of premium benefit will begin after a continuous five month waiting period has elapsed.

Election of waiver of premium benefits will be considered a waiver of COBRA rights.

In order to establish eligibility for the waiver of premium, Participants are encouraged to supply, within 90 days of the onset of disability or their last Active Work days, evidence that the disability began while they were insured under this Plan. Evidence of disability must be submitted within 12 months of the onset of disability. However, failure to provide evidence of disability within this time period does not invalidate the claim if the Participant shows that it was not reasonably possible to provide evidence of disability within the prescribed time and that notice was given as soon as reasonably possible. The Participant must also pay the required Employee portion of the cost of coverage during the waiting period unless other arrangements have been made by the Plan Sponsor.

During the continuance of coverage under the provisions of this Plan, the Plan Sponsor and the Claims Administrator will require, at least annually, evidence of the existence and continuation of Total Disability and may require an examination of the disabled Participant. If an exam is required by the Plan Sponsor or the Claims Administrator, the Plan Sponsor will be responsible for charges incurred to establish eligibility for continuation of waiver of premium.

If the Participant ceases to be Totally Disabled and is then eligible for coverage under the provisions of this Plan, the coverage will be continued only if the Employee's portion of the cost of coverage payments are resumed.

If the Participant ceases to be Totally Disabled but is not then eligible for coverage under this Plan, the coverage will automatically cease the last day of the month in which eligibility ended. Regardless of disability, the coverage will automatically cease if the Participant fails to furnish evidence of the continuance of disability within 31 days of the Claims Administrator's request for such evidence.

Waiver of premium benefits may continue for a maximum of 24 months, or until age 65, whichever comes first.

A Covered Person's participation under the Plan ceases on the earliest of the following:

- For covered Dependents, other than the Participant's Spouse, the individual ceases to be an eligible Dependent when either of the following occurs:
 - a. The date the Dependent is married; or
 - b. The last day of the calendar month coinciding with the Dependent's 26th birthday.
- For covered Spouse, the date the divorce from the Participant is final;
- For the Participant and covered Dependents, the effective date of any election by the Participant to cease coverage for the Participant and/or their Dependents;
- For the Participant and covered Dependents, the date specified in any Plan amendment resulting in loss of eligibility;
- For the Participant and covered Dependents, the date this Plan is terminated; or
- For any Covered Person, the discovery of fraud or misrepresentation on the part of the Covered Person in either the enrollment process or in the use of services or facilities,

including any misuse of a Plan ID card. (Note: If a Covered Person's coverage is terminated for cause, the termination of coverage will relate back to the effective date of coverage and the Plan Sponsor may recover any overpayments from the Covered Person such that the Plan Sponsor and the Covered Person are returned to the same financial position as if no coverage had ever been in force. Termination of a Participant's coverage for cause will also result in the termination of coverage of the Participant's covered Dependents.)

COORDINATION OF BENEFITS WITH OTHER GROUP PLANS

When a Covered Person is covered by this Plan and another COB Plan, one plan is designated as the primary plan. The primary plan pays first and ignores benefits payable under the other plan. The secondary plan reduces its benefits by those payable under the primary plan.

Any COB Plan that does not contain a coordination of benefits provision will be considered primary.

If a person is covered by two COB Plans that both have a coordination of benefits provision, the order of payment will be as follows:

- A COB Plan that covers a person as an employee (including early retirees, if applicable) will be primary over a COB Plan that covers the same person as a Dependent, retiree, or laid-off individual.
- A COB Plan covering a person as a Dependent child of non-divorced or non-separated parents will be primary according to which parent has the earlier birthday (month and day) in the year. If both parents have the same birthday, the COB Plan covering the child for the longer period of time will be primary.
- If the other COB Plan does not have the ‘birthday’ rule, but instead has a rule based upon the gender of the parent, and if, as a result, the coordinating plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
- When the parents are legally separated or divorced, and if there are two or more COB Plans covering a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 1. First, the COB Plan of the parent with custody of the child;
 2. Then, the COB Plan of the Spouse of the parent with custody of the child; and
 3. Finally, the COB Plan of the parent not having custody of the child.

If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that COB Plan are determined first. The COB Plan of the other parent shall be the secondary COB Plan. This paragraph does not apply with respect to any claim determination period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules outlined in the second bullet above will apply.

- If the preceding rules do not establish an order of benefit determination, the benefits of a COB Plan that has covered the person for the longer period of time will be primary over a COB Plan that has covered the person for a shorter period of time.

To determine the length of time a person has been covered under a COB Plan, two COB Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

The start of a new COB Plan does not include any of the following:

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

The claimant's length of time covered under a COB Plan is measured from the claimant's first date of coverage under that COB Plan. If that date is not readily available, the date the claimant first became a Participant or Covered Person of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present COB Plan has been in force.

When the Plan is primary, the benefits of another COB Plan will not be considered for the purpose of determining the benefits under this Plan. However, the sum of the benefits from this Plan and benefits from all other COB Plans may not exceed the lesser of this Plan's Eligible Expenses or the submitted charges. Benefits from other COB Plans include benefits that would be paid had a claim been submitted.

The primary COB Plan must pay or provide its benefits as if the secondary COB Plan or plans did not exist. A COB Plan that does not include a coordination of benefits provision may not take the benefits of another COB Plan into account when it determines its benefits.

This COB Plan will coordinate its benefits with a COB Plan that states it is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this rule on the following basis:

- If this Plan is the primary plan, the Plan will pay or provide its benefits on a primary basis;
- If this Plan is the secondary plan, the Plan will pay or provide its benefits first, but the amount of the benefits payable will be determined as if it were the secondary plan. Such payment shall be the limit of the Plan's liability, and if the other COB Plan does not provide the information needed by the Plan Administrator to determine its benefits within a reasonable time after it is requested to do so, the Plan will assume that the benefits of the other Plan are identical to this Plan, and will pay its benefits accordingly. However, the Plan will adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the other COB Plan.

Whenever payments that should have been made under this Plan have been made under any other COB Plan, the Plan Sponsor or the Claims Administrator may, at its own discretion, pay any amounts to the organization that has made excess payments to satisfy the intent of this provision. Amounts paid will be regarded as benefit payment, and the Plan Sponsor and the Claims Administrator will be fully discharged from liability under this Plan to the extent of the payment.

If any payment under this Plan exceeds the maximum amount necessary to satisfy this provision, the Plan Sponsor and the Claims Administrator may recover the excess amount from one or more of the following:

- Any person to, or for whom, such payments were made.
- Any other insurance companies.
- Any other organization.

If attempts to recover such overpayments are exhausted, the Covered Person is ultimately responsible for reimbursement to the Plan. In order to avoid overpayments, it is important for the Covered Person to take responsibility in reporting to the Claims Administrator any changes in the status of other insurance coverage.

Failure to report additional insurance coverage may result in a delay of claims payment.

For prompt reimbursement after the payment from the primary insurance carrier, a copy of the itemized billing and a copy of the explanation of benefits provided by the primary insurance carrier must be included.

The amount of medical benefits paid by group, group-type, and individual automobile “no-fault” medical payment contracts are not payable under this Plan. However, when all available no-fault auto medical insurance benefits have been paid, this Plan will pay according to its normal schedule of benefits. If Covered Persons do not have proper no-fault insurance and are involved in Accidents, no benefits will be paid under this Plan until the minimum no-fault auto medical benefits have been paid by the Covered Person, their Dependents, or a third party.

Certain facts may be needed in order to apply COB rules. These facts may be obtained from, or provided to, any other organization or person, subject to applicable privacy laws. Each person claiming benefits under this Plan will be required to give the Plan Sponsor and the Claims Administrator any facts needed to pay a claim.

CLAIMS PROCEDURE

Except as otherwise provided in this Plan or by Utah law, no benefits provided under this Plan shall be paid to, or on behalf of, a Covered Person unless the Covered Person, or an authorized representative, has first submitted a written claim for benefits to the Claims Administrator, on behalf of Plan Sponsor. Claims may be submitted at any time within 12 months of the date the expenses are incurred. If, however, the Covered Person shows that it was not reasonably possible to submit the claim within that time period, then a claim may be submitted as soon as reasonably possible. The Plan may deny an untimely claim.

How to File a Claim

Submit properly completed and coded Provider bills (e.g., HCFA 1500) to the Claims Administrator at the following address:

Educators Mutual Insurance Association of Utah
852 East Arrowhead Lane
Murray, Utah 84107-5298

If the claim form is not properly completed, it cannot be processed, and it will be returned.

Requests for Additional Information

There are times when claims submitted in the Covered Person's behalf may not contain sufficient information for the Claims Administrator to process them correctly. In those situations, the Claims Administrator will request additional information from the Covered Person or the Provider. The Claims Administrator is likely to request information directly from the Covered Person for the following reasons:

- To obtain details of an Accident.
- To determine if a condition is preexisting.
- To expedite coordination of benefits.
- To conduct an audit.

Covered Persons can expedite the processing of their claims by providing the requested information as quickly as possible, and in as much detail as possible.

Exhaustion of Administrative Remedies

No action at law or in equity may be brought against the Plan Sponsor, the Claims Administrator, or the Plan Administrator, and no arbitration request may be made, until the Covered Person has exhausted the Claims Review Process, as provided in this Plan. Covered Persons shall not assign, and have no power to assign, their rights to appeal adverse claims decisions through the Claims Review Process to any agent, assignee, attorney, or authorized representative, except where the Covered Persons, by reason of mental, physical, or legal incapacity, are unable to pursue their own appeals. Any attempted assignment inconsistent with the foregoing shall be void.

Claims Review Process

For and on behalf of Plan Sponsor, the Claims Administrator will administer the following claim appeal process:

1. If a claim is denied, in whole or in part, a written notice (the “Denial Notice”) will be sent to the Covered Person which sets forth the following:
 - The specific reasons the claim was denied.
 - Specific references to the pertinent plan provision on which the denial is based.
 - A description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed.
 - An explanation of the Plan’s claims review procedure.
2. The Covered Person may appeal an adverse claim decision, in whole or part, by sending a written notice to the Claim Administrator’s Claim Review Committee (the “CRC”), which will review the initial adverse claim decision on behalf of the Plan Sponsor. This written appeal notice (the “Initial Appeal Notice”) must be received by the CRC within 180 calendar days from the date of the Denial Notice. The Initial Appeal Notice must include all pertinent information regarding the claim and must explain the reasons why the Covered Person believes the claim should have been granted, in whole or part. The CRC will then review the initial adverse claim decision on behalf of the Plan Sponsor and shall inform the Covered Person in writing of its decision within 30 days of such decision. The Plan Sponsor will indemnify and hold the CRC harmless with respect to any such decision on appeal, except for intentional acts of the CRC which are clearly made in willful disregard of the rights of the Covered Person. A denial of a claim based on a reasonable interpretation of the provisions of the Plan shall not be considered to be an intentional act which is in willful disregard of the rights of a Covered Person.
3. If the Covered Person does not agree with the findings of the CRC, the Covered Person may further appeal any adverse claim decision, by sending a second written notice (the “Second Appeal Notice”) to the Claims Administrator. The Second Appeal Notice must be received within 180 calendar days after the date of the Initial Appeal CRC decision. The Second Appeal Notice should include all pertinent information regarding the claim and explain the reasons the Covered Person believes the claim should have been granted, in whole or part. The Plan Sponsor will then review the initial adverse claim decision and also the findings and decision of the CRC. The Plan Sponsor’s review and subsequent decision on such second appeal shall be based upon the provisions of the Plan documents in which the Covered Person was enrolled on the date of service of the claim(s) which is (are) subject to such second appeal. The Plan Sponsor will inform the Covered Person in writing of its decision on such second appeal within thirty days of such decision.
4. Any matter in dispute between the Covered Person and the Plan following the exhaustion of the claims appeal process described above is subject to compulsory arbitration. If the Covered Person does not agree with the findings of the Plan Sponsor and desires further review, the matter must be submitted to binding arbitration. The Covered Person must submit a written demand for arbitration within 30 days after the Covered Person receives notice of the adverse findings of the Plan Sponsor on the second appeal. Such binding arbitration will be required instead of litigation and will be conducted according to the

Utah Arbitration Act and the rules of the American Arbitration Association. The arbitration decision shall be binding upon the Covered Person, the Plan, and the Plan Sponsor. Venue for any court action to enforce an arbitration award or otherwise related to any claim for benefits shall be exclusively in Salt Lake County, State of Utah. Both parties will bear their own costs and attorney's fees in any arbitration or court action. The arbitration award shall not include attorney's fees.

5. The Plan Sponsor shall have the exclusive right to interpret the terms of the Plan. The decision about whether to pay any claim of the Covered Person, in whole or in part, is within the sole discretion of the Plan Sponsor and such decisions shall be final and conclusive.
6. Covered Persons shall have the burden of persuasion. They will have the right to examine all evidence presented to the CRC and to the Plan Sponsor and to question witnesses. It shall be in the discretion of the Plan Sponsor to decide whether to have a hearing on the appeal of the Covered Person. If a hearing is held, it shall be brief and informal, and shall not be conducted according to technical judicial rules of evidence. Rather, any relevant information may be submitted if, in the discretion of the Plan Sponsor, it is evidence upon which responsible persons generally rely. No attorneys or other representatives of the Covered Person may appear or submit information during either the first or second level of appeal. Attorneys or other representatives for the Covered Person may participate in the binding arbitration described above.

Subrogation and Reimbursement

When the Plan Sponsor has advanced payment of benefits to or on behalf of a Covered Person for any bodily injury actionable at law or for which the Covered Person may obtain a recovery from a third party, the Plan acquires both a right of Subrogation against the third party and a right of reimbursement against the Covered Person. In such situations, the Covered Person has the following obligations:

- The Covered Person must reimburse the Plan, up to the amount of such benefits advanced or paid by the Plan, out of any recovery obtained by the Covered Person from the third party (or such party's liability insurance) by judgment, settlement, or otherwise, whether or not the Covered Person is or has been made whole. The Plan is entitled to the first dollar of any recovery by the Covered Person and each dollar thereafter up to the amount of benefits advanced or paid by the Plan for the injuries to the Covered Person that were caused by the third party.
- The Covered Person cannot limit or avoid such reimbursement obligation to the Plan by any agreement with the third party or any assignment or designation of such proceeds.
- The Covered Person must not release or discharge any claims that the Covered Person may have against any potentially responsible parties without written permission from the Plan.
- The Covered Person must fully cooperate with the Plan Sponsor and the Claims Administrator (including, but not limited to, executing all required instruments and papers), if the Plan chooses to pursue its own right of Subrogation against the third party; the Plan's right of Subrogation is limited to the amount of benefits advanced or paid by the Plan to or on behalf of the Covered Person as a result of the fault of the third party, and the Plan's right

to recover such benefits from the third party does not depend upon whether the Covered Person is made whole by any recovery.

DEFINITION OF TERMS

Accident or **Accidental Injury**, for which benefits are provided, means Accidental bodily Injury sustained by the Covered Person which is the direct result of an Accident, independent of disease or bodily infirmity or any other cause.

Act of Aggression means any physical contact initiated by the Covered Person that a reasonable person would perceive to be a threat of bodily harm.

Actively at Work or **Active Work** means being in attendance at the customary place of employment, performing the duties of employment on a Full-time Basis, and devoting full efforts and energies in the employment.

Adult, for purposes of immunizations, means an individual who has reached their 19th birthdays.

Allowable Expenses, when used in conjunction with coordination of benefits, means the amount on which the Plan would base its benefit payment for covered services in the absence of any other coverage. The difference in cost between a private Hospital room and a semi-private Hospital room is not considered an Allowable Expense under this definition, unless the Covered Person's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice.

Allowable Fee means the schedule for payment of Eligible Expenses established by the Claims Administrator, on behalf of the Plan Sponsor.

Ancillary Expenses, when used in conjunction with Hospital expenses, means services and supplies in excess of daily room and board charges.

Anterior means the teeth and tissues located towards the front of the mouth; maxillary and mandibular incisors and canines.

Calendar Year means the 12-month period beginning January 1 and ending December 31.

Claims Administrator is Educators Mutual Insurance Association of Utah.

COB Plan means a form of coverage with which coordination of benefits is allowed. These COB Plans include the following:

- Individual, group, or health maintenance organization (HMO) insurance coverage providing Hospital expense or medical surgical expense benefits, except those included in the following paragraph.
- Another group plan covering a Covered Person.
- Group, group-type, and individual automobile “no-fault” medical and underinsured motorist payment contracts.
- Another self-funded employee welfare benefit plan.
- Medicare or other governmental programs, except those included in the following paragraph and any coverage required or provided by any statute.

The term COB Plan does not include any of the following:

-
- Hospital indemnity policies.
 - Disability income protection.
 - Accident-only policies.
 - Specified disease or specified Accident policies.
 - Nursing home or long-term care policies.
 - Any state plan under Medicaid.
 - Any law or plan when, by state or federal law, its benefits are in excess of those of any private insurance or other non-governmental plan.
 - Medicare supplement policies.

The term COB Plan is construed separately with respect to each plan, contract, or other arrangement for benefits or services. The term COB Plan may also mean a portion of a plan, contract, or other arrangement which is subject to a coordination of benefits provision, as separate from the portion which is not subject to such a provision.

Coinsurance means the percentage of eligible charges payable by a Covered Person directly to a Provider for covered services. Coinsurance percentages are specified on the “Summary of Benefits” chart.

Coinsurance Maximum is designed to insure against financial hardship caused by unexpected expenses from catastrophic illness. The Coinsurance Maximum amount is specified on the “Summary of Benefits” chart. When the Covered Person has satisfied any applicable Deductible and paid Eligible Expenses, including Copayments, up to the Coinsurance Maximum, the Claims Administrator, on behalf of Plan Sponsor, will pay remaining Eligible Expenses at 100% of the Table of Allowances, up to the per person Lifetime Maximum Benefit, for the remainder of that Plan Year. The Participating Provider and Non-participating Provider Options each have a separate Coinsurance Maximum.

Confinement or **Confine** means an uninterrupted stay following formal admission to a Hospital, skilled nursing facility, or Inpatient rehabilitation facility.

Copayment or **Copay** means, other than Coinsurance, a fixed dollar amount that a Covered Person is responsible to pay directly to a Provider. Copayment amounts are specified on the “Summary of Benefits” chart.

Covered Person means an Employee or Dependent who enrolled with the Plan to receive covered services and who is recognized by the Plan as a Covered Person. Employees/retirees of the Plan Sponsor who are eligible to become Covered Persons can choose to enroll Dependents who satisfy the Plan’s Dependent eligibility requirements. In situations requiring consent, payment, or some other action, references to “Covered Person” include the parent or guardian of a minor or disabled Covered Person on behalf of that Covered Person.

Creditable Coverage, as defined by HIPAA legislation, means coverage under a group health plan, individual insurance, Medicare, Medicaid, S-CHIP, military-service-related coverage (TRICARE), a medical program of the Indian Health Service or of a tribal organization, or a State health benefits risk pool. Creditable Coverage does not include limited-scope dental or vision policies that are issued under a separate policy, or Accident only, disability income,

liability, supplement to liability, Workers' Compensation, automobile medical, or credit-only coverage, or coverage for on-site medical clinics.

Custodial Care means maintenance of a Covered Person beyond the acute phase of Illness or injury. Custodial Care may include rooms, meals, bed, or skilled medical care in a Hospital, facility, or at home. Care is considered custodial when its primary purpose is to meet personal needs. Custodial Care may include, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, eating, taking medication, or bowel or bladder care.

Deciduous means having the property of falling off or shedding; a name used for the primary teeth.

Deductible means the amount paid by a Covered Person for Eligible Expenses from the Covered Person's own money before any benefits will be paid under this Plan. Deductibles are not considered a Coinsurance Maximum expense.

Dentist means a duly licensed Dentist legally entitled to practice dentistry at the time, and in the place, services are performed.

Dependent means the Participant's children (including stepchildren and legally adopted children) to their 26th birthday, who are not married and are chiefly dependent on the Participant for support and maintenance. A child is considered a Dependent beyond the 26th birthday if the child is incapable of self-sustaining employment due to a mental or physical disability and is chiefly dependent on the Participant for support and maintenance. The Participant must furnish proof of disability and dependency to the Claims Administrator, on behalf of the Plan Sponsor, within 31 days after the child reaches 26 years of age. The Claims Administrator may require subsequent proof of disability and dependency after the child reaches age 26, but not more often than annually. Dependent also refers to any of the Participant's natural children, children legally placed for adoption, or adopted children for whom a court order or administrative order has dictated that the Participant provide coverage. Dependent also refers to the Participant's Spouse. Dependent does not include an unborn fetus.

Durable Medical Equipment means a device that meets all of the following conditions:

- Can withstand repeated use.
- Is primarily and customarily used to serve a medical purpose rather than for convenience and/or comfort.
- Generally is not useful to a person in the absence of Illness or injury.
- Is appropriate for use in the home.
- Is Medically Necessary.

Durable Medical Equipment includes braces, crutches, and rental of special medical equipment such as a wheelchair, Hospital-type bed, or oxygen equipment. Regardless of Medical Necessity, any home, van, or other vehicle modifications, and/or improvements are not covered benefits.

Educators means Educators Mutual Insurance Association of Utah.

Elective Surgery means a non-emergency surgery that can be scheduled at least 48 hours after diagnosis.

Eligible Expenses means those charges incurred by the Covered Person for Illness or injury that meet all of the following conditions:

- Are necessary for care and treatment and are recommended by a Provider while under the Provider's continuous care and regular attendance.
- Do not exceed the Plan's Summary of Benefits or Table of Allowances for the services performed or materials furnished.
- Are not excluded from coverage by the terms of this Plan.
- Are incurred during the time the Covered Person is covered by this Plan.

Emergency Care means health care services that are provided for a condition of recent onset and sufficient severity including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that their condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in any of the following conditions:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Employee means a salaried Employee or an elected or appointed officer of the Plan Sponsor. Employees must be legally entitled to work in the United States.

Enrollment Date means the first day of coverage or if there is a waiting period before coverage takes effect, the first day of the waiting period.

Exclusion means any charge that is not eligible for payment under this Plan.

Experimental or Investigative means a drug, device, medical treatment, or procedure that meets any of the following conditions:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- If the drug, device, medical treatment, or procedure (or the patient informed consent document utilized with the drug, device, treatment, or procedure) was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- If Reliable Evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going research, Experimental study, or Investigational arm of an on-going phase III clinical trial, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
- If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are

necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Extended Care Facility means an institution, or distinct part thereof, licensed according to state law and operating within the scope of its license.

Family History Examination means any examination or procedure recommended by a physician due to a family history of illness or disease and billed with a family history diagnosis code.

Former Employee means an Employee who has retired or terminated employment and who is eligible for continuation of coverage.

Full-time Basis or ***Full-time Benefits Eligible*** means a salaried Employee who works 75% or more full-time equivalent (FTE) hours annually, as defined by the Plan Sponsor.

Full-time Benefits Eligible Employee, for purposes of this Plan, a Full-time Benefits Eligible Employee shall not include any individual who is classified as a leased employee or independent contractor by the Plan Sponsor, even if such individual is subsequently determined to be, or to have been, a common law Employee of the Plan Sponsor.

Grace Period means the period that shall be granted for the payment of any policy charge, during which time the policy shall continue in force; however, any claims received for services rendered during the Grace Period will be held for processing until policy charges are paid in full. In no event shall the Grace Period extend beyond the date the policy terminates.

Home Health/Skilled Nursing Care means medical care and treatment rendered to a sick or injured Covered Person in the Covered Person's home, when the Covered Person is unable to leave their home, is completing treatment that was initiated in the Hospital, and/or care in the final months of life, by a nurse under the written and general supervision of the Covered Person's physician, when such Home Health/Skilled Nursing Care Providers work within an organization or company licensed by the state to provide such medical care and treatment.

Hospital means a licensed Hospital facility providing diagnostic, therapeutic, and rehabilitative services to both Inpatients and outpatients by, or under the supervision of, physicians.

Illness means a bodily disorder, disease, mental or emotional infirmity, and all Illnesses due to the same or a related cause or causes.

Implant means any FDA approved foreign object or device that is surgically inserted.

Injectable means any fluid drug or medicine introduced into the body (skin, subcutaneous tissue, muscle, blood vessels, or a body cavity) with a sterile syringe for therapeutic benefit.

Inpatient means an individual assigned to a bed in any department of a Hospital, other than an outpatient section, and charged for room and board by the Hospital.

Intensive Care Room means a Hospital section, ward, or wing that operates exclusively for critically ill Covered Persons and provides special supplies, equipment, and constant supervision and care by registered nurses or other highly trained Hospital personnel. Any facility maintained

for the purpose of providing normal post-operative recovery treatment is not an Intensive Care Room.

Late Enrollee means people who enroll for coverage at any point after their first 31 days of employment, except in the case of Special Enrollment.

Life-threatening Condition means an episode or incident where delay in treatment would jeopardize the Covered Person's life or cause permanent damage to the person's health. Life-threatening Conditions include, but are not limited to, loss of heartbeat, loss of consciousness, convulsions, stopped or severely obstructed breathing, food poisoning, or massive uncontrolled bleeding.

Lifetime Maximum Benefit means the maximum amount of benefits paid by the Plan, including the "Prescription Drug Program," that will be allowed under this Plan whether accumulated under this Plan or any combination of policies sponsored by the Covered Person's current Plan Sponsor. There is one Lifetime Maximum Benefit shared by both the Participating Provider and Non-participating Provider Options.

Major Diagnostic Testing, when used in conjunction with a medical procedure or diagnosis, is interpreted according to generally accepted medical practice and definitions. For this Contract Year, a Major Diagnostic Test is defined as a CT Scan, magnetic resonance imaging (MRI), or nuclear medicine (NMR). This distinction is for the benefit or convenience of the Covered Persons and may change without prior notice to Covered Persons.

Medical Supplies include, but are not limited to, items such as oxygen or surgical dressings.

Medically Necessary or **Medical Necessity** means any health care service, supply, or accommodation the Provider renders for the treatment of Illness or injury that meets **all of** the following conditions:

- Consistent with the symptoms or diagnosis.
- Provided in the most cost-effective setting that can be used safely.
- Not for the convenience of a Covered Person, physician, Hospital, or other Provider.
- Appropriate with regard to standards of good medical practice in the community and could not be omitted without adversely affecting the condition or quality of medical care, as determined by established medical review.
- Within the scope of the Provider's licensure.
- Consistent with, and included in, procedures established and recognized by the Claims Administrator or a designated representative.

Medicare means the Hospital and Supplementary Insurance Plan established by Title XVIII of the Social Security Act of 1965, as amended.

New Enrollee means people who enroll for coverage during their first 31 days of employment or under Special Enrollment rights.

Non-participating Provider means health care practitioners operating within the scope of their licenses, i.e., physician, oral surgeon, Dentist, anesthetist, etc., or a facility operating within the scope of its license, who is not a Participating Provider.

Open Enrollment means the period, as defined by the Plan Sponsor, during which Employees may apply for insurance coverage for themselves or their Dependents.

Other Limited Benefits means those limited benefits provided by the Plan that are available only if specific medical criteria, established by the Claims Administrator, on behalf of the Plan Sponsor, are met. The portion the Covered Person pays for these benefits **does not** apply toward the Coinsurance Maximum.

Outpatient Services means services rendered at a Hospital or ambulatory Surgical Center to Covered Persons who are not charged for room and board, but receive treatment and return home the same day.

Participant means the individual employed by the Plan Sponsor and enrolled with the Plan to receive covered services, through whom Dependents may also be enrolled with the Plan. Participants are also Covered Persons. The term Participant may include eligible early retirees.

Participating Provider means health care practitioners operating within the scope of their licenses, i.e., physician, oral surgeon, Dentist, anesthetist, etc., or a facility operating within the scope of its license, who has contracted with the Plan to render covered services and who has otherwise met the criteria and requirements for participation in the Plan.

Period of Confinement means the time the Covered Person is confined in a medical facility on an Inpatient basis.

Plan Sponsor means Utah Valley University.

Plan Year means the 12-month period beginning each July 1, and ending on the following June 30.

Preauthorization means the procedure a Provider and/or Covered Person must follow in order to assure the medical necessity and appropriateness of care, as well as benefit eligibility. Preauthorization procedures must be followed in order for a Covered Person to receive the maximum benefits available under this Plan for Inpatient stays and other specified procedures.

Preexisting Condition means a condition (regardless of the cause of the condition) for which medical advice, diagnosis, care, or treatment was recommended or received within the six months prior to the enrollment date. Preexisting Condition also means a disability which is the result of a complication of a Preexisting Condition. Please refer to the *Preexisting Condition Limitation* section of this Plan for information on the benefit restrictions that may be imposed on some Preexisting Conditions.

Preexisting Condition Limitation means the time Covered Persons must wait after enrolling in a new plan before they can be covered for some Preexisting Conditions. Please refer to the *Preexisting Condition Limitation* and *Waiver of Preexisting Condition Exclusion* sections of this policy.

Primary Infertility means a person has never been able to conceive a child.

Prosthesis means an artificial substitute for a missing body part, such as an arm, leg, or eye, used for functional reasons.

Provider means health care practitioners operating within the scope of their license, i.e., physician, oral surgeon, Dentist, chiropractor, anesthetist, etc. Provider also means a facility operating within the scope of its license.

Reconstructive, Cosmetic, or Plastic Surgery means any surgery performed primarily to improve physical appearance.

Reliable Evidence means only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying the same drug, device, medical treatment, or procedure.

Routine Exam means a hearing, vision, gynecological, or physical exam, including well-baby care, when the physician bills using a preventive diagnosis code rather than a medical diagnosis code.

Secondary Infertility means a condition where a person has been able to conceive at least once.

Significant Medication means a new drug with the FDA New Drug Application (NDA) classification of 1P that represents an important therapeutic advance and is the only medication available to treat a disease or condition as supported by at least one of the following sources: United States Pharmacopeia Drug Information, American Hospital Formulary Service Drug Information, findings and guidelines developed by federal government agencies or peer-reviewed literature. A medication that is approved or used for multiple diseases or conditions, but is the only available medication to treat a particular, narrow-niche indication is not included in this category.

Special Enrollment means the right of individuals to enroll during the Plan Year, rather than waiting for the next Open Enrollment period, if they have experienced a qualifying event (including marriage, divorce, birth, adoption, placement for adoption, or loss of other insurance coverage) under HIPAA regulations. The Participant must complete a new enrollment form and submit it to the Plan Sponsor within 31 days of any change in coverage or status.

Spouse means the person to whom the Participant is lawfully married or the person to whom the Participant is lawfully recognized as a common law Spouse.

Subrogation means the right that the Plan has by virtue of this contract, and also by virtue of common law, to recover from a third party monies that the Plan has advanced or paid to or on behalf of a Covered Person, where such monies were paid as a result of an injury to the Covered Person that was the fault of the third party.

Summary of Benefits means the outline of benefits as established by this Plan.

Surgical Center means any facility duly licensed and operating within the scope of its licensure.

Table of Allowances means the schedule for payment of Eligible Expenses established by the Plan. The schedule of payment is used for all Providers regardless of their panel status.

Their, They, Them, Themselves means the covered Participant, Employee, Spouse, and/or Dependents.

Total Disability or Totally Disabled, during the waiting period and for the first 24 months of disability, means the inability of Participants to perform their regular occupations. Participants are not disabled if they are capable of performing similar duties for the same or a different employer.

Transplant means an organ or tissue taken from the body for grafting into another area of the same body or into another individual. (Notwithstanding this definition, refer to the covered Transplant section in the Plan description.)