Southern Utah University
Self-Funded Employee Benefit Plan

DENTAL PPO BENEFITS

EFFECTIVE as of July 1, 2023

RESTATED as of July 1, 2025

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PLAN DESCRIPTION INFORMATION

1. Proper Name of Plan: The Southern Utah University Self-Funded Employee Benefit Plan

2. *Plan Sponsor* and *Employer*:

Southern Utah University
351 W University Blvd
Cedar City UT 84720
Telephone (435) 586-7754

3. *Plan Administrator*, Named Fiduciary and Claim Fiduciary:

Southern Utah University
Director of Human Resources
351 W University Blvd
Cedar City UT 84720
Telephone (435) 586-7754

4. *Employer* Identification Number: 87-6000481

5. The Plan provides dental benefits for participating *employees* and their enrolled *dependents*.

6. Plan benefits described in this booklet are effective July 1, 2025.

7. The *Plan year* and fiscal year are July 1 through June 30 of each year.

8. Service of legal process may be served upon the *Plan Administrator* as shown above or the following agent for service of legal process:

Southern Utah University
Director of Human Resources
351 W University Blvd
Cedar City UT 84720
Telephone (435) 586-7754

9. The *Third-Party Administrator* is responsible for performing certain delegated administrative duties, including the processing of claims. The *Third-Party Administrator* is:

Town & Country Life Insurance Company,
dba Samera Health
PO Box 126
Smithfield UT 84335
Telephone: (435) 563-0613

10. This is a self-insured dental plan. The cost of the Plan is paid with contributions shared by the *employer* and the *employee*. Benefits under the Plan are provided from the general assets of the *employer* and are used to fund payment of covered claims under the Plan plus administrative expenses. Please see *your employer* for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this Plan.

11. Each *employee* of the *employer* who participates in the Plan receives a *Summary Plan Description*, which is this booklet. This booklet will be provided to *employees* by the *employer*. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.

12. The Plan benefits and/or contributions may be modified or amended from time to time or may be terminated at any time by the *Plan Sponsor*. Significant changes to the Plan, including termination, will be communicated to participants as required by applicable law.

13. Upon termination of the Plan, the rights of the participants to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the participating *employees* and their *dependents* covered by the Plan, except that any taxes and administration expenses may be made from the Plan assets.

14. The Plan does not constitute a contract between the *employer* and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in the Plan will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time.

15. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

SCHEDULE OF BENEFITS

NOTE: Italicized terms within the text are defined in the Definitions section of this booklet.

You may select any *dentist* to provide *your* dental care.

In-network dentists have signed a contract with the Plan or its *Third-Party Administrator*, agreeing to accept reduced fees for the dental procedures they provide. This reduces *your* out-of-pocket costs. They have also agreed not to charge *you* any amount that exceeds the fees agreed upon, aside from deductibles, coinsurance, and fees for procedures not covered.

If *you* have questions about whether a particular *dentist* is an *in-network dentist* or need verification about the status of a provider, please contact the *Third-Party Administrator* at (435)563-0613, or *your Plan Administrator*. *You* can also visit: www.samerahealth.com to locate *dentists* in *your* area.

If *you* choose to receive *your* dental care from an *out-of-network dentist*, *covered expenses* listed below are payable on a *maximum allowable fee* basis.

This schedule provides a brief overview of Plan benefits and is not a complete description. Refer to the text for a detailed description of *your* Plan benefits.

Covered dental expenses are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental expenses. However, benefits will be payable based on the most current dental terminology.

SCHEDULE OF DENTAL BENEFITS		
Individual *Maximum Benefit*	Preventive, Basic, Major Restorative and Prosthodontic *Services*	$2,000 per *plan year*
Plan year Deductible	Individual: None	Family: None
Preventive *Services*	*Covered expense* is payable at 100%	
Basic *Services*	*Covered expense* is payable at 80%.	
Major Restorative *Services*	*Covered expense* is payable at 50%.	
Prosthodontic *Services*	*Covered expense* is payable at 50%.	
Individual *Maximum Benefit* for Orthodontic	Limited to a lifetime *maximum benefit* of $1,500 per *covered person*.	
Orthodontic *Services*	*Covered expense* is payable at 50%.	

PREDETERMINATION OF BENEFITS

If *expense incurred* in performing a dental *service* or one (1) series of dental *services* can reasonably be expected to be $300 or more, the Plan recommends *you* or the provider submit those charges for a *predetermination of benefits*. The *Third-Party Administrator* will advise *you* and the provider what expenses will be covered under the Plan. The *Third-Party Administrator* will take into account *services* or courses of treatment based upon professionally endorsed standards of dental care. A *predetermination of benefits* is not a guarantee of benefits. *Services* will be subject to all terms and provisions of the Plan at the time treatment is rendered.

The pre-treatment estimate expires after sixty (60) days. If treatment is to commence more than sixty (60) days after the date treatment is authorized, the *covered person* should submit another treatment plan to the *Third-Party Administrator*.

Before *you* schedule dental appointments, *you* should discuss with *your dentist* the amount to be paid by the Plan and *your* financial obligation for the proposed treatment.

DENTAL BENEFITS

DEDUCTIBLE AND COINSURANCE INFORMATION

This section describes benefits for *covered expenses*. *Covered expense* means *expense incurred* by *you* for the *services* stated within. The expense must be incurred while *you* are covered for that benefit under the Plan. *Covered expenses* are payable, after satisfaction of the deductible, if any, on a *maximum allowable fee* basis or predetermined charge at the coinsurance percentages and up to the *maximum benefits* shown on the Schedule of Benefits.

DEDUCTIBLE

The deductible applies to each *covered person* each *plan year*. Only charges which qualify as a *covered expense* may be used to satisfy the deductible. The amount of the deductible is stated on the Schedule of Benefits.

MAXIMUM FAMILY DEDUCTIBLE

The total deductible applied to all *covered persons* in one (1) family in a *plan year* is subject to the maximum shown on the Schedule of Benefits.

COINSURANCE

Coinsurance means the shared financial responsibility for *covered expenses* between the *covered person* and the Plan.

Benefits are payable at the applicable percentage rate shown on the Schedule of Benefits after the deductible is satisfied each *plan year*.

ANNUAL MAXIMUM BENEFIT

Annual *maximum benefit* means the maximum amount of benefits payable per *plan year*. The annual *maximum benefit* is stated on the Schedule of Benefits for the stated section.

LIFETIME MAXIMUM (Orthodontic Services Only)

Lifetime maximum means the maximum amount of benefits available while *you* are covered under the Plan. The lifetime *maximum benefit* is stated on the Schedule of Benefits. Under no circumstances does lifetime mean during the lifetime of the *covered person*.

DENTAL COVERED EXPENSES

For all *covered expenses*, the following *services* will be considered an integral part of the entire dental *service*. A separate fee for these *services* is not considered a *covered expense.*

1. Study models/diagnostic casts
2. Bases
3. Temporary dental *services*
4. Local anesthesia
5. Treatment plans
6. Irrigation
7. Tissue preparation associated with impression or placement of a restoration
8. Any recommended integral service as indicated by the American Dental Association standards

PREVENTIVE SERVICES

Oral evaluations. Limited to two (2) per *plan year*.

Cleanings (routine prophylaxis). Limited to two (2) per *plan year*.

Bitewing x-rays. Limited to two (2) sets per *plan year*.

Periapical x-rays. Limited to six (6) per *plan year.*

Full mouth or panoramic x-rays. Limited to one (1) per three (3) years.

Topical fluoride treatment. Limited to two (2) per *plan year*. A prophylaxis performed in conjunction with a fluoride treatment is considered a separate dental *service*.

Sealants for *dependent* children to age twenty-six (26) only. Limited to one (1) per tooth per lifetime and only on the occlusal surface of permanent molars which are free of decay and restoration.

Space maintainers for *dependent* children to age sixteen (16) only. For fixed or removable appliances to maintain a space created by the premature loss of a primary tooth or teeth.

BASIC SERVICES

Palliative (*emergency*) treatment for relief of dental pain. Palliative treatment will be considered as a separate benefit if no other *services*, except x-rays and/or evaluations, are provided during the visit.

Fillings. Limited to one (1) per tooth per eighteen (18) months, regardless of the reason. Multiple restorations on one (1) surface are considered one (1) restoration. 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.

Extractions.

Nitrous.

Basic Services Continued

Oral surgery, including frenectomy; incision and drainage of intraoral abscess; surgical extractions including removal of impacted tooth; surgical exposure of tooth; alveoloectomy; alveoplasty; excision of pericoronal gingival, exostosis, hyperplastic tissue; reimplantation and repositioning of a natural tooth.

Periodontal maintenance. Limited to two (2) times per *plan year* (in lieu of preventive cleaning).

Periodontal scaling and root planing. Limited to one (1) per quadrant per two (2) years.

Periodontal surgery, including three (3) months post-surgical care. If more than one (1) surgical *service* is performed on the same day, only the most inclusive surgical *service* performed will be considered a *covered expense*. Limited to once per three (3) years per *covered expense* in the same area.

Full mouth debridement. Limited to once per five (5) years.

Scaling (in the presence of moderate or severe gingival inflammation upon oral evaluation). Will combine with preventive cleaning and/or periodontal maintenance. If full mouth scaling is a *covered expense*, *services* for routine or periodontal cleanings, scaling and root planing, and debridement procedures performed on the same date of service will not be a *covered expense*.

Pulp tests.

Endodontics, including Root canal therapy; pulpotomy; pulpal therapy; apexification/recalcification; apicoectomy/periradicular surgery; root amputation; hemisection; intentional reimplantation; retrograde fillings.

Recementation of crowns, bridges and onlays.

MAJOR RESTORATIVE SERVICES

Crowns and their maintenance/repairs.

Onlays and their maintenance/repairs.

Porcelain/ceramic/resin material.

Post/core build-ups for crowns.

Stainless steel crowns, limited to primary teeth.

Night Guards. Once per two (2) years and unserviceable.

General anesthesia or IV sedation when administered by a *dentist* for the following:

- *Dependent* children age seven (7) and younger, once per *Plan Year*.; or
- In conjunction with wisdom tooth extraction for individuals age eight (8) and over is covered based on necessity, not for anxiety management.

Major Services Continued

LIMITATIONS FOR MAJOR RESTORATIVE SERVICES

The following Major Restorative *Services* are a *covered expense* and subject to the following replacement frequencies:

Onlays	Once per five (5) years and unserviceable.
Crowns	Once per five (5) years and unserviceable.

The above replacement frequencies will be waived if replaced as a result of an *accidental injury*.

PROSTHODONTIC SERVICES

Installation and maintenance/repairs of removable or fixed bridgework.

Post/core build-ups for bridgework.

Installation and maintenance/repairs of partial and complete dentures, including six (6) months post-installation care.

Procedures to reline and rebase, but not within six (6) months of the initial placement and not more than once per five (5) years.

Tissue conditioning, but not within six (6) months of the initial placement and not more than once per five (5) years.

Implants, including the abutment prosthesis replacing a missing tooth, and any adjustments/ maintenance/repairs. No alternate *service* benefit will apply. Includes six (6) months post- installation care. Benefits are not coordinated between a medical plan and this Plan; therefore benefits covered under any medical plan will be excluded from coverage under this Plan.

LIMITATIONS FOR PROSTHODONTIC SERVICES

The following Prosthodontic *Services* are a *covered expense* and subject to the following replacement frequencies:

Bridge	Once per five (5) years and unserviceable.
Partial Denture	Once per five (5) years and unserviceable.
Complete Denture	Once per five (5) years and unserviceable.
Implant	Once per five (5) years and unserviceable.
Implant Prosthesis (crown)	Once per five (5) years and unserviceable.

The above replacement frequencies will be waived if replaced as a result of an *accidental injury*.

ORTHODONTIC SERVICES

Benefits for Orthodontic *Services* are payable as shown on the Schedule of Benefits for *covered persons* who are currently in treatment or are a new case. Orthodontic treatment in progress on *your* effective date will be prorated for the remainder of the treatment period under this Plan. *Services*, in progress or a new case, will not exceed the Orthodontic *Services* lifetime *maximum benefit* as shown on the Schedule of Benefits. Lifetime maximum *benefit* is inclusive with prior carriers and will apply even if coverage is interrupted.

Orthodontic treatment means braces and necessary adjustments and *expense incurred* for:

1. Treatment and appliances for tooth guidance, interception and correction; and

2. *Services* related to covered orthodontic treatment, including records.

Benefit payments for orthodontic treatment are pro-rated by the *Third-Party Administrator* over the treatment period. The lesser of twenty-five percent (25%) of the total case fee or the *dentist's* fee will be allowed for the down payment. The balance is pro-rated monthly over the treatment period. If for any reason the treatment plan is terminated before completion of the treatment, no further benefits are payable.

LIMITATIONS AND EXCLUSIONS

The Plan does not provide benefits for:

1. Any *accidental injury* arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:

    a. Benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law; or

    b. Coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually purchased;

2. *Services* and supplies:

    a. For which no charge is made, or for which *you* would not be required to pay if *you* were not covered under this Plan unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law;

    b. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include *Medicare* or Medicaid); or

    c. Furnished for a military service connected *accidental injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;

3. Any loss caused by or contributed to:

    a. War or any act of war, whether declared or not; or

    b. Any act of international armed conflict, or any conflict involving armed forces of any international authority;

4. Completion of forms or failure to keep an appointment with the *dentist*;

5. Any *service* related to birth defects or any *service* which is considered *cosmetic dentistry*, unless such *service* is necessary as a result of an *accidental injury*. Personalization or characterization of prosthetic devices is considered *cosmetic dentistry*;

6. Preventive control programs including but not limited to, oral hygiene instruction, plaque control, take home items or dietary planning;

7. Caries susceptibility testing, lab tests, anaerobic cultures, sensitivity testing;

8. Sterilization/infection control fees;

9. Hypnosis and related analgesia.

10. Benefits for *services* or treatments covered under any medical plan.

Limitations and Exclusions Continued

11. Appliances or restorations for increasing vertical dimension, correction of congenital or developmental malformations, replacing tooth structure lost by attrition, abfraction, abrasion, or erosion or fastening together of two (2) or more teeth for strength or stability by using crowns, inlays, onlays or other restorations;

12. 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.

13. Fees for treatment by other than a *dentist*, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards;

14. Any hospital charges or for *services* of any anesthesiologist;

15. General anesthesia or IV sedation unless administered by a *dentist* for *dependent* children age seven (7) and younger once per *plan year*; or in conjunction with wisdom tooth extraction, when based on necessity, not for anxiety management.

16. Prescription drugs or pre-medications;

17. Major Restorative and Prosthodontic *Services* on other than permanent teeth;

18. *Services* not *dentally* or *medically necessary* or *services* which do not have uniform professional endorsement;

19. Orthodontic *Services* unless specified in the Schedule of Benefits;

20. The extent the expense exceeds the *maximum allowable fee* or predetermined charge for the *service*, treatment or supply in the locality where furnished;

21. Any *expense incurred* prior to *your* effective date under the Plan or after the date *your* coverage under this Plan terminates;

22. Diagnosis and treatment of temporomandibular joint dysfunction (TMJ), including but not limited to charges for: TMJ x-rays and consultations; TMJ surgery, kinesiographic analysis and muscle testing; TMJ splints and appliances; splint equilibration and adjustments or physical therapy for symptoms including but not limited to, headaches;

23. Osteotomies;

24. Reline/repair and adjustments of occlusal guards;

25. Veneers and their maintenance/repairs;

26. Athletic mouth guards;

Limitations and Exclusions Continued

27. Consultations;

28. Overdentures and their maintenance/repairs;

29. Myofunctional therapy;

30. Lab costs for an oral tissue biopsy;

31. Habit-breaking devices or appliances to correct thumb sucking, tongue thrusting, etc.

32. Chemotherapeutic injections.

33. Expenses for services required due to complications associated with, or due to, non-covered services, and where applicable, reversal of non-covered services.

34. Care, treatment, operations, supplies, appliances, aids, devices, or drugs that are not FDA approved;

35. *Services* for any injury or illness which is incurred while voluntarily taking part or attempting to take part in an Act of Aggression or an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence; or (b) resulted from a medical condition (including both physical and mental health conditions).

36. *Services* 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.

37. Any *service* not specifically listed as a *covered expense*;

38. The application of a dental sealant on any tooth that has been previously treated with a temporary or permanent restoration.

39. The application of dental sealants on all Anterior teeth whether Deciduous or permanent teeth.

40. Any *covered expenses* to the extent of any amount received from other for the *accidental injuries* or losses which necessitate such benefits. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, Workers' Compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments, or recovery from any identifiable fund regardless of whether the *beneficiary* was made whole.

41. *Services* provided in a foreign country except for emergent purposes only.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT

One (1) time each year *you* will have a choice of enrolling in this Plan. *You* will be notified in advance when the open enrollment period is to begin and how long it will last. Please see *your employer* for more information.

EMPLOYEE ELIGIBILITY

You are eligible for coverage if the following conditions are met:

1. *You* are an *employee* who meets the Full-time eligibility requirements of the *employer*;

2. *You* complete an enrollment application and file it with *your employer* with 31 days of *your* employment; and

3. *You* are in *active status*.

Your eligibility date is *your* date of hire if *you* enroll within 31 days of *your* employment.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll in a manner acceptable to the *Third-Party Administrator*.

1. If *your* completed enrollment is received by the *Third-Party Administrator* before *your* eligibility date or within thirty-one (31) days after *your* eligibility date, *you* are a *timely applicant* and *your* coverage is effective on *your* eligibility date.

2. If *your* completed enrollment is received by the *Third-Party Administrator* more than thirty-one (31) days after *your* eligibility date, *you* are a *late applicant* and *you* will not be eligible for coverage under this Plan until the next annual open enrollment period.

EMPLOYEE DELAYED EFFECTIVE DATE

If the *employee* is not in *active status* on the effective date of coverage, coverage will be effective the day the *employee* returns to *active status*. The *employer* must notify the *Third-Party Administrator* in writing of the *employee's* return to *active status*.

DEPENDENT ELIGIBILITY

Each *dependent* is eligible for coverage on:

1. The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;

2. The date of the *employee's* marriage for any *dependent* acquired on that date;

3. The date of birth of the *employee's* natural-born child.

Eligibility and Effective Date of Coverage Continued

4. The date a child is placed for adoption under the *employee's* legal guardianship, or the date which the *employee* incurs a legal obligation for total or partial support in anticipation of adoption; or

5. The date a covered *employee's* child is determined to be eligible as an alternate recipient under the terms of a medical child support order.

The covered *employee* may cover *dependents* only if the *employee* is also covered. Check with *your employer* immediately on how to enroll for *dependent* coverage. Late enrollment will result in denial of *dependent* coverage until the next annual open enrollment period.

In any event, no person may be simultaneously covered as both an *employee* and a *dependent*. If both parents are eligible for coverage, only one (1) may enroll for *dependent* coverage. If an individual's parent and/or spouse are eligible for coverage, only one (1) may enroll the individual for dependent coverage.

DEPENDENT EFFECTIVE DATE OF COVERAGE – WHEN A CHANGE IN THE EMPLOYEE'S LEVEL OF COVERAGE IS NOT REQUIRED

If the *employee* wishes to add a newborn *dependent* to the Plan and a change in the *employee's* level of coverage is not required, enrollment must be completed and submitted to the *Third-Party Administrator*.

The newborn *dependent* will be covered on the date he or she is eligible.

If the *employee* wishes to add a *dependent* (other than a newborn) to the Plan and a change in the *employee's* level of coverage is not required, the *dependent's* effective date of coverage is determined as follows:

1. If completed enrollment is received by the *Third-Party Administrator* before the *dependent's* eligibility date or within thirty-one (31) days after the *dependent's* eligibility date, that *dependent* is a *timely applicant* and covered on the date he or she is eligible.

2. If completed enrollment is received by the *Third-Party Administrator* more than thirty-one (31) days after the *dependent's* eligibility date, the *dependent* is a *late applicant*. The *dependent* will not be eligible for coverage under this Plan until the next annual open enrollment period.

No *dependent's* effective date will be prior to the covered *employee's* effective date of coverage. If *your dependent* child becomes an eligible *employee* of the *employer*, he or she cannot be covered both as *your dependent* and as an eligible *employee*.

DEPENDENT EFFECTIVE DATE OF COVERAGE – WHEN A CHANGE IN THE EMPLOYEE'S LEVEL OF COVERAGE IS REQUIRED

If the *employee* wishes to add a *dependent* to the Plan and a change in the *employee's* level of coverage is required, enrollment must be completed and submitted to the *Third-Party Administrator*.

The *dependent's* effective date of coverage is determined as follows:

1. If completed enrollment is received by the *Third-Party Administrator* before the *dependent's* eligibility date or within thirty-one (31) days after the *dependent's* eligibility date, that *dependent* is a *timely applicant* and covered on the date he or she is eligible.

2. If completed enrollment is received by the *Third-Party Administrator* more than thirty-one (31) days after the *dependent's* eligibility date, the *dependent* is a *late applicant*. The *dependent* will not be eligible for coverage under this Plan until the next annual open enrollment period.

No *dependent's* effective date will be prior to the covered *employee's* effective date of coverage. If *your dependent* child becomes an eligible *employee* of the *employer*, he or she cannot be covered both as *your dependent* and as an eligible *employee*.

MEDICAL CHILD SUPPORT ORDERS

An individual who is a child of a covered *employee* shall be enrolled for coverage under the Plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

A QMCSO is a state court order or judgment, including approval of a settlement agreement that: (a) provides for support of a covered *employee's* child; (b) provides for health care coverage for that child; (c) is made under state domestic relations law (including a community property law); (d) relates to benefits under the Plan; and (e) is "qualified" in that it meets the technical requirements of ERISA or applicable state law. QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under the Plan for the *dependent* child of a non-custodial parent who is (or will become) a *covered person* by a domestic relations order that provides for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the *Plan Administrator*.

SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS

If required contributions are made and *your employer* does not terminate the Plan, *your* coverage will terminate as follows:

Layoff	The date *your employer* ends the continuance.
Medical Leave of Absence (other than FMLA)	The date *your employer* ends the continuance.
Total Disability	The date *your employer* ends the continuance.
Non-Medical Leave of Absence	The date *your employer* ends the continuance.
Military Leave of Absence (other than USERRA)	The date *your employer* ends the continuance.
Part-Time Status	The date *your employer* ends the continuance.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

You may continue *your* coverage and the coverage of *your* covered d*ependents* during an FMLA leave provided *you* continue to pay any required portion of the cost of coverage in accordance with the *Employer*'s FMLA leave policy. The *Employer* shall continue to make the same contributions toward that coverage that it would have made had *you* not taken FMLA leave.

If *your* portion of the cost of coverage is not paid, *you* and *your* covered *dependents'* coverage will be terminated 31 days after the due date of any required payment. Upon *your* return to work, the *your* coverage and the coverage of any previously covered d*ependents* will be reinstated as long as the *you* return to work before or following the expiration of the FMLA leave. If *you* do not return to work before or following the expiration of the FMLA leave, *you* will be treated as a new e*mployee* upon his return and will be entitled to elect coverage for *yourself* and *your* eligible d*ependents* in accordance with the rules applicable to new *employees*.

SPECIAL ENROLLMENT

If *you* previously declined coverage under this Plan for *yourself* or any eligible *dependents*, due to the existence of other dental coverage (including COBRA), and that coverage is now lost, this Plan permits *you*, *your dependent* spouse, and any eligible *dependents* to be enrolled for dental benefits under this Plan due to any of the following qualifying events:

1. Loss of eligibility for the coverage due to any of the following:

    a. Legal separation;
    b. Divorce;
    c. Cessation of *dependent* status (such as attaining the limiting age);
    d. Death;
    e. Termination of employment;
    f. Reduction in the number of hours of employment;

g. Plan no longer offering benefits to a class of similarly situated individuals, which includes the *employee*; or
h. Any loss of eligibility after a period that is measured by reference to any of the foregoing.

However, loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

2. Employer contributions towards the other coverage have been terminated. Employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual

3. COBRA coverage under the other plan has since been exhausted.

The previously listed qualifying events apply only if *you* stated in writing at the previous enrollment the other dental coverage was the reason for declining enrollment, but only if *your employer* requires a written waiver of coverage which includes a warning of the penalties imposed on late enrollees.

If *you* are a covered *employee* or an otherwise eligible *employee*, who either did not enroll or did not enroll *dependents* when eligible, *you* now have the opportunity to enroll *yourself* and/or any previously eligible *dependents* or any newly acquired *dependents* when due to any of the following family status changes:

1. Marriage;

2. Birth; or

3. Adoption or placement for adoption.

You mayelect coverage under this Plan and will be considered a *timely applicant* provided complete enrollment is received within thirty-one (31) days from the qualifying event. *You* MUST provide proof that the qualifying event has occurred due to one (1) of the reasons listed before coverage under this Plan will be effective. Coverage under this Plan will be effective the date immediately following the date of the qualifying event, unless otherwise specified in this section.

In the case of a *dependent's* birth, enrollment is effective on the date of such birth.

In the case of a *dependent's* adoption or placement for adoption, enrollment is effective on the date of such adoption or placement for adoption.

If *you* apply more than thirty-one (31) days after a qualifying event, *you* are considered a *late applicant* and will not be eligible for coverage under this Plan until the next annual open enrollment period.

Please see *your employer* for more details.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the Plan terminates;

2. The end of the period for which any required contribution was due and not paid;

3. The end of the calendar month *you* enter full-time military, naval or air service;

4. The end of the pay period *you* fail to be in an eligible class according to the eligibility requirements of the *employer*;

5. For all *employees*, the end of the pay period in which *you* terminate employment with *your employer*;

6. For all *employees*, the end of the pay period *you* retire;

7. For any benefit, the date the benefit is removed from the Plan;

8. For *your dependents*, the date *your* coverage terminates;

9. For a *dependent*, the end of the calendar month the *dependent* enters full-time military, naval or air service;

10. For a *dependent*, the end of the calendar month such *covered person* no longer meets the definition of a *dependent*; or

11. The end of the pay period *you* request termination of coverage to be effective for yourself and/or *your dependents* provided fulfillment of the change request is permitted by applicable federal law and the provisions of other *employer* documents, including any then-applicable cafeteria plan change in status rules.

IF *YOU* OR ANY OF *YOUR* COVERED *DEPENDENTS* NO LONGER MEET THE ELIGIBILITY REQUIREMENTS, *YOU* AND *YOUR EMPLOYER* ARE RESPONSIBLE FOR NOTIFYING THE *THIRD-PARTY ADMINISTRATOR* OF THE CHANGE IN STATUS. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY, EVEN IF SUCH NOTICE HAS NOT BEEN GIVEN TO THE *THIRD-PARTY ADMINISTRATOR*.

CONTINUATION OF DENTAL BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was signed into law. This federal law applies to employers with twenty (20) or more employees. The law requires that employers offer employees and/or their dependents continuation of dental coverage at group rates in certain instances where there is a loss of group insurance coverage.

ELIGIBILITY

A qualified beneficiary under COBRA law means an *employee*, *employee's* spouse or *dependent* child covered by the Plan on the day before a qualifying event. A qualified beneficiary under COBRA law also includes a child born to the *employee* during the coverage period or a child placed for adoption with the *employee* during the coverage period.

EMPLOYEE: An *employee* covered by the *employer's* Plan has the right to elect continuation coverage if coverage is lost due to one (1) of the following qualifying events:

- Termination (for reasons other than gross misconduct, as defined by *your employer*) of the *employee's* employment; or
- Reduction in the hours of *employee's* employment.

SPOUSE: A spouse covered by the *employer's* Plan has the right to elect continuation coverage if the group coverage is lost due to one (1) of the following qualifying events:

- The death of the *employee*;
- Termination of the *employee's* employment (for reasons other than gross misconduct, as defined by *your employer*);
- Reduction of the *employee's* hours of employment with the *employer*;
- Divorce from the *employee*; or
- The *employee* becomes entitled to *Medicare* benefits (but only if entitlement causes a loss of coverage).

DEPENDENT CHILD: A *dependent* child covered by the *employer's* Plan has the right to continuation coverage if group coverage is lost due to one (1) of the following qualifying events:

- The death of the *employee* parent;
- The termination of the *employee* parent's employment (for reasons other than gross misconduct, as defined by *your employer*);
- Reduction in the *employee* parent's hours of employment with the *employer*;
- The *employee* parent's divorce;
- Ceasing to be a "*dependent* child" under the Plan; or
- The *employee* parent becomes entitled to *Medicare* benefits (but only if entitlement causes a loss of coverage).

COBRA Continued

LOSS OF COVERAGE

Coverage is lost in connection with the foregoing qualified events, when a covered *employee*, spouse or *dependent* child ceases to be covered under the same Plan terms and conditions as in effect immediately before the qualifying event (such as an increase in the premium or contribution that must be paid for *employee*, spouse or *dependent* child coverage).

If coverage is reduced or eliminated in anticipation of an event (for example, an *employer* eliminating an *employee's* coverage in anticipation of the termination of the *employee's* employment, or an *employee* eliminating the coverage of the *employee's* spouse in anticipation of a divorce), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

A loss of coverage need not occur immediately after the event, so long as it occurs before the end of the Maximum Coverage Period.

NOTICES AND ELECTION

The Plan provides that coverage terminates, for a spouse due to divorce or for a child when that child loses *dependent* status. Under the law, the *employee* or qualified beneficiary has the responsibility to inform the *Plan Administrator* (see Plan Description Information) if one (1) of the above events has occurred. The qualified beneficiary must give this notice within sixty (60) days after the event occurs. (For example, an ex-spouse should make sure that the *Plan Administrator* is notified of his or her divorce, whether or not his or her coverage was reduced or eliminated in anticipation of the event). When the *Plan Administrator* is notified that one (1) of these events has happened, it is the *Plan Administrator's* responsibility to notify the qualified beneficiary of the right to elect continuation coverage.

For a qualified beneficiary who is determined under the Social Security Act to be disabled at any time during the first sixty (60) days of COBRA coverage, the continuation coverage period may be extended eleven (11) additional months. The disability that extends the eighteen (18) month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. To be entitled to the extended coverage period, the disabled qualified beneficiary must provide notice to the *Plan Administrator* within the initial eighteen (18) month coverage period and within sixty (60) days after the date of the determination of disability under the Social Security Act. Failure to provide this notice will result in the loss of the right to extend the COBRA continuation period.

For termination of employment, reduction in work hours, the death of the *employee*, the *employee* becoming covered by *Medicare*, it is the *Plan Administrator's* responsibility to notify the qualified beneficiary of the right to elect continuation coverage.

Under the law, continuation coverage must be elected within sixty (60) days after Plan coverage ends, or if later, sixty (60) days after the date of the notice of the right to elect continuation coverage. If continuation coverage is not elected within the sixty (60) day period, the right to elect coverage under the Plan will end.

COBRA Continued

A covered *employee* or the spouse of the covered *employee* may elect continuation coverage for all covered *dependents*, even if the covered *employee* or spouse of the covered *employee* or all covered *dependents* are covered under another group health plan (as an employee or otherwise) prior to the election. The covered *employee*, his or her spouse and *dependent* child, however, each have an independent right to elect continuation coverage. Thus, a spouse or *dependent* child may elect continuation coverage even if the covered *employee* does not elect it.

Coverage will not be provided during the election period. However, if the individual makes a timely election, coverage will be provided from the date that coverage would otherwise have been lost. If coverage is waived before the end of the sixty (60) day election period and the waiver revoked before the end of the sixty (60) day election period, coverage will be effective on the date the election of coverage is sent to the *Plan Administrator*.

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

- Eighteen (18) months for an *employee* and/or *dependent* whose group coverage ended due to termination of the *employee's* employment or reduction in hours of employment;
- Thirty-six (36) months for a spouse whose coverage ended due to the death of the *employee*, divorce, or the *employee* becoming entitled to *Medicare* at the time of the initial qualifying event; or
- Thirty-six (36) months for a *dependent* child whose coverage ended due to the divorce of the *employee* parent, the *employee* becoming entitled to *Medicare* at the time of the initial qualifying event, the death of the *employee*, or the child ceasing to be a *dependent* under the Plan.

DISABILITY

An eleven (11) month extension of coverage may be available if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the sixtieth (60) day of COBRA continuation coverage and must last at least until the end of the eighteen (18) month period of continuation coverage. The qualified beneficiary must provide notice of such determination prior to the end of the initial eighteen (18) month continuation period to be entitled to the additional eleven (11) months of coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the eleven (11) month disability extension if one (1) of them qualifies. If a qualified beneficiary is determined by SSA to no longer be disabled, *you* must notify the Plan of that fact within thirty (30) days after SSA's determination.

COBRA Continued

SECOND QUALIFYING EVENT

An eighteen (18) month extension of coverage will be available to spouses and *dependent* children who elect continuation coverage if a second qualifying event occurs during the first eighteen (18) months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is thirty-six (36) months. Such second qualifying event may include the death of a covered *employee*, divorce from the covered *employee*, the covered *employee's* becoming entitled to *Medicare* benefits (under Part A, Part B, or both), or a *dependent* child's ceasing to be eligible for coverage as a *dependent* under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. *You* must notify the Plan within sixty (60) days after the second qualifying event occurs if *you* want to extend *your* continuation coverage.

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

Continuation coverage will terminate before the end of the Maximum Coverage Period for any of the following reasons:

- The *employer* no longer provides group health coverage to any of its *employees*;
- The premium for continuation is not paid timely;
- The individual on continuation becomes covered under another group health plan (as an *employee* or otherwise);
- The individual on continuation becomes entitled to *Medicare* benefits;
- If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than thirty (30) days after the determination; or
- The occurrence of any event (e.g., submission of a fraudulent claim) permitting termination of coverage for cause under the Plan.

TYPE OF COVERAGE; PREMIUM PAYMENT

If continuation coverage is elected, the coverage must be identical to the coverage provided under the *employer's* Plan to similarly situated non-COBRA beneficiaries. This means that if the coverage for similarly situated non-COBRA beneficiaries is modified, coverage for the individual on continuation will be modified.

The initial premium payment for continuation coverage is due by the 45th day after coverage is elected. The initial premium includes charges back to the date the continuation coverage began. All other premiums are due on the first of the month for which the premium is paid, subject to a thirty-one (31) day grace period. The *employer* must provide the individual with a quote of the total monthly premium.

Premium for continuation coverage may be increased, however, the premium may not be increased more than once in any determination period. The determination period is a twelve (12) month period which is established by the Plan.

COBRA Continued

The monthly premium payment to the Plan for continuing coverage must be submitted directly to the *employer*. This monthly premium may include the *employee's* share and any portion previously paid by the *employer*. The monthly premium must be a reasonable estimate of the cost of providing coverage under the Plan for similarly situated non-COBRA beneficiaries. The premium for COBRA continuation coverage may include a 2% administration charge. However, for qualified beneficiaries who are receiving up to eleven (11) months additional coverage (beyond the first eighteen (18) months) due to disability extension (and not a second qualifying event), the premium for COBRA continuation coverage may be up to 150% of the applicable premium for the additional months. Qualified beneficiaries who do not take the additional eleven (11) months of special coverage will pay up to 102% of the premium cost.

OTHER INFORMATION

Additional information regarding rights and obligations under the Plan and under federal law may be obtained by contacting the *Plan Administrator* or the *Third-Party Administrator*.

It is important for the *covered person* or qualified beneficiary to keep the *Plan Administrator* and *Third-Party Administrator* informed of any changes in marital status, or a change of address.

PLAN CONTACT INFORMATION

Plan Administrator and Employer:
Southern Utah University
Director of Human Resources
351 W University Blvd
Cedar City UT 84720
Telephone (435) 586-7754

Third-Party Administrator:
Town & Country Life Insurance Co.,
dba Samera Health
P.O. Box 126
Smithfield UT 84335
Telephone (435) 563-0613

THE UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

CONTINUATION OF BENEFITS

Effective October 13, 1994, federal law requires that health plans must offer to continue coverage for *employees* who are absent due to service in the uniformed services and/or their *dependents*. Coverage may continue for up to twenty-four (24) months after the date the *employee* is first absent due to uniformed service.

ELIGIBILITY

An *employee* is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, the commissioned corps of the Public Health Service or any other category of person designated by the President of the United States of America in a time of war or national emergency. Duty includes absence for active duty, active duty for training, initial active duty for training, full-time National Guard duty, inactive duty training and for the purpose of an examination to determine fitness for duty.

An *employee's dependent* who has coverage under the Plan immediately prior to the date of the *employee's* covered absence is eligible to elect continuation under USERRA.

PREMIUM PAYMENT

If continuation of Plan coverage is elected under USERRA, the *employee* or *dependent* is responsible for payment of the applicable cost of coverage. If the *employee* is absent for thirty (30) days or less, the cost will be the amount the *employee* would otherwise pay for coverage. For absences exceeding thirty (30) days, the cost may be up to 102% of the cost of coverage under the Plan. This includes the *employees* share and any portion previously paid by the *employer*.

DURATION OF COVERAGE

Elected continuation coverage under USERRA will continue until the earlier of:

- Twenty-four (24) months beginning the first day of absence from employment due to service in the uniformed services; or
- The day after the *employee* fails to apply for or return to employment as required by USERRA, after completion of a period of service.

Under federal law, the period of coverage available under USERRA shall run concurrently with the COBRA period available to an *employee* and/or eligible *dependents*.

OTHER INFORMATION

Employees should contact their *employer* with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the *employer* of any changes in marital status, or a change of address.

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

Benefits described in this Plan are coordinated with benefits provided by other plans under which *you* are also covered. This is to prevent duplication of coverage and a resulting increase in the cost of dental coverage.

For this purpose, a plan is one which covers medical or dental expenses and provides benefits or *services* by group, franchise or blanket insurance coverage. This includes group-type contracts not available to the general public, obtained and maintained only because of the *covered person's* membership in or connection with a particular organization or group, whether or not designated as franchise, blanket, or in some other fashion. Plan also includes any coverage provided through the following:

1. Employer, trustee, employee benefit, or other association; or

2. Governmental programs, programs mandated by state statute, or sponsored or provided by an educational institution.

This Coordination of Benefits provision does not apply to any individual policies or Blanket Student Accident Insurance provided by or through an educational institution. Allowable expense means any eligible expense, a portion of which is covered under one (1) of the plans covering the person for whom claim is made. Each plan will determine what is an allowable expense according to the provisions of the respective plan. When a plan provides benefits in the form of *services* rather than cash payments, the reasonable cash value of each *service* rendered will be deemed to be both an allowable expense and a benefit paid.

EFFECT ON BENEFITS

One (1) of the plans involved will pay benefits first. This is called the primary plan. All other plans are called secondary plans.

When this Plan is the secondary plan, the sum of the benefit payable by this Plan when added to the primary plan's benefits will not exceed this Plan's normal liability.

ORDER OF BENEFIT DETERMINATION

In order to pay claims, it must be determined which plan is primary and which plan(s) are secondary. A plan will pay benefits first if it meets one (1) of the following conditions:

1. The plan has no coordination of benefits provision;

2. The plan covers the person as an *employee*;

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* pays before the plan covering the other parent. If the birthdates of both parents are the same, the Plan which has covered the person for the longer period of time will be determined the primary plan;

Coordination of Benefits Continued

If a plan other than this Plan does not include provision three (3), then the gender rule will be followed to determine which plan is primary.

4. In the case of *dependent* children covered under the plans of divorced or separated parents, the following rules apply:

    a. The plan of a parent who has custody will pay the benefits first;

    b. The plan of a stepparent who has custody will pay benefits next;

    c. The plan of a parent who does not have custody will pay benefits next;

    d. The plan of a stepparent who does not have custody will pay benefits next.

There may be a court decree which gives one (1) parent financial responsibility for the medical or dental expenses of the *dependent* children. If there is a court decree, the rules stated above will not apply if they conflict with the court decree. Instead, the plan of the parent with financial responsibility will pay benefits first.

5. If a person is laid off or is retired or is a *dependent* of such person, that plan covers after the plan covering such person as an active *employee* or *dependent* of such *employee*. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

If the above rules do not apply or cannot be determined, then the plan that covered the person for the longest period of time will pay first.

RIGHT OF RECOVERY

The Plan reserves the right to recover benefit payments made for an allowable expense under the Plan in the amount which exceeds the maximum amount the Plan is required to pay under these provisions. This right of recovery applies to the Plan against:

1. Any person(s) to, for or with respect to whom, such payments were made; or

2. Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

The Plan alone will determine against whom this right of recovery will be exercised.

REIMBURSEMENT/SUBROGATION

The *beneficiary* agrees that by accepting and in return for the payment of *covered expenses* by the Plan in accordance with the terms of this Plan:

1. The Plan shall be repaid the full amount of the *covered expenses* it pays from any amount received from others for the *accidental injuries* or losses which necessitated such *covered expenses*. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, Workers' Compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments, or recovery from any identifiable fund regardless of whether the *beneficiary* was made whole.

2. The Plan's right to repayment is, and shall be, prior and superior to the right of any other person or entity, including the *beneficiary*.

3. The right to recover amounts from others for the *accidental injuries* or losses which necessitate *covered expenses* is jointly owned by the Plan and the *beneficiary*. The Plan is subrogated to the *beneficiary's* rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse the Plan as prescribed above; the Plan has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which the Plan is subrogated are, and shall be, prior and superior to the rights of any other person or entity, including the *beneficiary*.

4. The *beneficiary* will cooperate with the Plan in any effort to recover from others for the *accidental injuries* or losses which necessitate *covered expense* payments by the Plan. The *beneficiary* will notify the Plan immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of the Plan. Neither the Plan nor the *beneficiary* shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

RIGHT TO COLLECT NEEDED INFORMATION

The *beneficiary* agrees to cooperate with the *Third-Party Administrator* and assist the *Third-Party Administrator* by:

- Authorizing the release of dental information including the names of all providers from whom *you* received dental attention;
- Obtaining dental information and/or records from any provider as requested by the *Third-Party Administrator*;
- Providing information regarding the circumstances of *your accidental injury*;
- Providing information about other insurance coverage and benefits, including information related to any *accidental injury* for which another party may be liable to pay compensation or benefits; and
- Providing information the *Third-Party Administrator* requests to administer the Plan.

Failure to provide the necessary information will result in denial of any pending or subsequent claims, pertaining to an *accidental injury* for which the information is sought, until the necessary information is satisfactorily provided.

Reimbursement/Subrogation Continued

DUTY TO COOPERATE IN GOOD FAITH

The *beneficiary* agrees to cooperate with the *Third-Party Administrator* in order to protect the Plan's recovery rights. Cooperation includes promptly notifying the *Third-Party Administrator* that *you* may have a claim, providing the *Third-Party Administrator* with relevant information, and signing and delivering such documents as the *Third-Party Administrator* reasonably requests to secure the Plan's recovery rights. *You* agree to obtain the Plan's consent before releasing any party from liability for payment of dental expenses. *You* agree to provide the *Third-Party Administrator* with a copy of any summons, complaint or any other process served in any lawsuit in which *you* seek to recover compensation for *your accidental injury* and its treatment.

The *beneficiary* agrees to do whatever is necessary to enable the *Third-Party Administrator* to enforce the Plan's recovery rights and will do nothing after loss to prejudice the Plan's recovery rights.

The *beneficiary* agrees not to attempt to avoid the Plan's recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

Failure of the *covered person* to provide the *Third-Party Administrator* such notice or cooperation, or any action by the *covered person* resulting in prejudice to the Plan's rights will be a material breach of this Plan and will result in the *covered person* being personally responsible to make repayment. In such an event, the Plan may deduct from any pending or subsequent claim made under this Plan any amounts the *covered person* owes the Plan until such time as cooperation is provided and the prejudice ceases.

GENERAL PROVISIONS

The following provisions are to protect *your* legal rights and the legal rights of the Plan.

RESCISSION

This Plan will rescind coverage only due to fraud or an intentional misrepresentation of a material fact. Rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay premium or costs of coverage.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

1. Made in error; or

2. Made to *you* or any party on *your* behalf where the Plan determines the payment to *you* or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against *you* if the Plan has paid *you* or any other party on *your* behalf.

WORKERS' COMPENSATION NOT AFFECTED

The Plan is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease Act or Law.

MEDICAID

This Plan will not take into account the fact that an *employee* or *dependent* is eligible for medical assistance or Medicaid under state law with respect to enrollment, determining eligibility for benefits, or paying claims.

If payment for Medicaid benefits has been made under a state Medicaid plan for which payment would otherwise be due under this Plan, payment of benefits under this Plan will be made in accordance with a state law which provides that the state has acquired the rights with respect to a covered *employee* to the benefits payment.

WORKERS' COMPENSATION

If benefits are paid by the Plan and the Plan determines *you* received Workers' Compensation for the same incident, the Plan has the right to recover as described under the Reimbursement/Subrogation provision. The Plan will exercise its right to recover against *you* even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that an *accidental injury* was sustained in the course of or resulted from *your* employment;

General Provisions Continued

3. The amount of Workers' Compensation due to dental care is not agreed upon or defined by *you* or the Workers' Compensation carrier; or

4. The dental benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the Plan, *you* will notify the *Third-Party Administrator* of any Workers' Compensation claim *you* make, and that *you* agree to reimburse the Plan as described above.

CONSTRUCTION OF PLAN TERMS

The Plan has the sole right to construe and prescribe the meaning, scope and application of each and all of the terms of the Plan, including, without limitation, the benefits provided thereunder, the obligations of the *beneficiary* and the recovery rights of the Plan; such construction and prescription by the Plan shall be final and uncontestable.

PRIVACY OF PROTECTED HEALTH INFORMATION

The Plan is required by law to maintain the privacy of *your protected health information* in all forms including written, oral and electronically maintained, stored and transmitted information and to provide individuals with notice of the Plan's legal duties and privacy practices with respect to *protected health information*.

The Plan has policies and procedures specifically designed to protect *your* health information when it is in electronic format. This includes administrative, physical and technical safeguards to ensure that *your* health information cannot be inappropriately accessed while it is stored and transmitted to the *Third-Party Administrator* and others that support the Plan.

In order for the Plan to operate, it may be necessary from time to time for health care professionals, the *Plan Administrator*, individuals who perform Plan-related functions under the auspices of the *Plan Administrator*, the *Third-Party Administrator* and other service providers that have been engaged to assist the Plan in discharging its obligations with respect to delivery of benefits, to have access to what is referred to as *protected health information.*

A *covered person* will be deemed to have consented to use of *protected health information* about him or her for the sole purpose of health care operations by virtue of enrollment in the Plan. The Plan must obtain authorization from a *covered person* to use *protected health information* for any other purpose.

Individually identifiable health information will only be used or disclosed for purposes of Plan operation or benefits delivery. In that regard, only the minimum necessary disclosure will be allowed. The *Plan Administrator*, *Third-Party Administrator*, and other entities given access to *protected health information*, as permitted by applicable law, will safeguard *protected health information* to ensure that the information is not improperly disclosed.

General Provisions Continued

Disclosure of *protected health information* is improper if it is not allowed by law or if it is made for any purpose other than Plan operation or benefits delivery without authorization. Disclosure for Plan purposes to persons authorized to receive *protected health information* may be proper, so long as the disclosure is allowed by law and appropriate under the circumstances. Improper disclosure includes disclosure to the *employer* for employment purposes, *employee* representatives, consultants, attorneys, relatives, etc. who have not executed appropriate agreements effective to authorize such disclosure.

The *Third-Party Administrator* will afford access to *protected health information* in its possession only as necessary to discharge its obligations as a service provider, within the restrictions noted above. Information received by the *Third-Party Administrator* is information received on behalf of the Plan.

The *Third-Party Administrator* will afford access to *protected health information* as reasonably directed in writing by the *Plan Administrator*, which shall only be made with due regard for confidentiality. In that regard, the *Third-Party Administrator* has been directed that disclosure of *protected health information* may be made to the person(s) identified by the *Plan Administrator*.

Individuals who have access to *protected health information* in connection with their performance of Plan-related functions under the auspices of the *Plan Administrator* will be trained in these privacy policies and relevant procedures prior to being granted any access to *protected health information*. The *Third-Party Administrator* and other Plan service providers will be required to safeguard *protected health information* against improper disclosure through contractual arrangements.

In addition, *you* should know that the *employer* / *Plan Sponsor* may legally have access, on an as-needed basis, to limited health information for the purpose of determining Plan costs, contributions, Plan design, and whether Plan modifications are warranted. In addition, federal regulators such as the Department of Health and Human Services and the Department of Labor may legally require access to *protected health information* to police federal legal requirements about privacy.

Covered persons may have access to *protected health information* about them that is in the possession of the Plan, and they may make changes to correct errors. *Covered persons* are also entitled to an accounting of all disclosures that may be made by any person who acquires access to *protected health information* concerning them and uses it other than for Plan operation or benefits delivery. In this regard, please contact the *Plan Administrator*.

Covered persons are urged to contact the originating health care professional with respect to dental information that may have been acquired from them, as those items of information are relevant to dental care and treatment. And finally, *covered persons* may consent to disclosure of *protected health information*, as they please.

CLAIMS PROCEDURES

SUBMITTING A CLAIM

This section describes what a *covered person* (or his or her authorized representative) must do to file a claim for Plan benefits.

- A claim must be filed with the *Third-Party Administrator* in writing and delivered to the *Third-Party Administrator*, to the Claims Address. However, a submission to obtain pre-authorization may also be filed with the *Third-Party Administrator* by telephone (this applies only with respect to *urgent care claims*).

- Claims must be submitted to the *Third-Party Administrator* at the address indicated in the documents describing the Plan or *claimant's* identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

- Also, claims submissions must be in a format acceptable to the *Third-Party Administrator* and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of *protected health information* and/or electronic claims standards will not be accepted by the Plan.

- Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than twelve (12) months after the date of loss, except if *you* were legally incapacitated. Plan benefits are only available for claims that are incurred by a *covered person* during the period that he or she is covered under the Plan.

- Claims submissions must be complete. They must contain, at a minimum:

    - The name of the *covered person* who incurred the *covered expense*;
    - The name and address of the dental provider;
    - The diagnosis of the condition;
    - The procedure or nature of the treatment;
    - The date of and place where the procedure or treatment has been or will be provided;
    - The amount billed and the amount of the *covered expense* not paid through coverage other than Plan coverage, as appropriate; and
    - Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

A general request for an interpretation of Plan provisions will not be considered to be a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the Plan, should be directed to the *Plan Administrator*.

Claims Procedures Continued

Dental claims and correspondence should be mailed to the following Claims Address:

Samera Health
P.O. Box 126
Smithfield UT 84335

PROCEDURAL DEFECTS

If a *pre-service claim* submission is not made in accordance with the Plan's procedural requirements, the *Third-Party Administrator* will notify the *claimant* of the procedural deficiency and how it may be cured no later than within five (5) days (or within twenty-four (24) hours, in the case of an *urgent care claim*) following the failure. A *post-service claim* that is not submitted in accordance with these claims procedures will be returned to the submitter.

ASSIGNMENTS AND REPRESENTATIVES

A *covered person* may assign his or her right to receive Plan benefits to a dental provider only with the consent of the *Third-Party Administrator*, in its sole discretion, except as may be required by applicable law. Assignments must be in writing. If a document is not sufficient to constitute an assignment, as determined by the *Third-Party Administrator*, then the Plan will not consider an assignment to have been made. An assignment is not binding on the Plan until the *Third-Party Administrator* receives and acknowledges in writing the original or copy of the assignment before payment of the benefit.

If benefits are assigned in accordance with the foregoing paragraph and a dental provider submits claims on behalf of a *covered person*, benefits will be paid to that dental provider.

In addition, a *covered person* may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The designation must be explicitly stated in writing and it must authorize disclosure of *protected health information* with respect to the claim by the Plan, the *Third-Party Administrator* and the authorized representative to one another. If a document is not sufficient to constitute a designation of an authorized representative, as determined by the *Third-Party Administrator*, then the Plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to the *Third-Party Administrator* in advance, or at the time an authorized representative commences a course of action on behalf of a *claimant*. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the *claimant* to the *claimant*, which the *Third-Party Administrator* may verify with the *claimant* prior to recognizing the authorized representative status.

- In any event, a dental provider with knowledge of a *claimant's* dental condition acting in connection with an *urgent care claim* will be recognized by the Plan as the *claimant's* authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of the *covered person*, such as whether and how to appeal a claim denial.

Claims Procedures Continued

CLAIMS DECISIONS

After submission of a claim by a *claimant*, the *Third-Party Administrator* will notify the *claimant* within a reasonable time, as follows:

PRE-SERVICE CLAIMS

The *Third-Party Administrator* will notify the *claimant* of a favorable or adverse determination within a reasonable time appropriate to the dental circumstances, but no later than fifteen (15) days after receipt of the claim by the Plan.

However, this period may be extended by an additional fifteen (15) days, if the *Third-Party Administrator* determines that the extension is necessary due to matters beyond the control of the Plan. The *Third-Party Administrator* will notify the affected *claimant* of the extension before the end of the initial fifteen (15) day period, the circumstances requiring the extension, and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the *claimant's* failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The *claimant* will have at least forty-five (45) days from the date the notice is received to provide the specified information.

URGENT CARE CLAIMS

The *Third-Party Administrator* will determine whether a claim is an *urgent care claim*. This determination will be made on the basis of information furnished by or on behalf of a *claimant*. In making this determination, the *Third-Party Administrator* will exercise its judgment, with deference to the judgment of a *dentist* with knowledge of the *claimant's* condition. Accordingly, the *Third-Party Administrator* may require a *claimant* to clarify the dental urgency and circumstances that support the *urgent care claim* for expedited decision-making.

The *Third-Party Administrator* will notify the *claimant* of a favorable or adverse determination as soon as possible, taking into account the dental circumstances particular to the *claimant's* situation, but not later than seventy-two (72) hours after receipt of the *urgent care claim* by the Plan.

However, if a claim is submitted that does not provide sufficient information to determine whether, or to what extent, expenses are covered or payable under the Plan, notice will be provided by the *Third-Party Administrator* as soon as possible, but not more than twenty-four (24) hours after receipt of the *urgent care claim* by the Plan. The notice will describe the specific information necessary to complete the claim.

- The *claimant* will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information but not less than forty-eight (48) hours.

- The *Third-Party Administrator* will notify the *claimant* of the Plan's *urgent care claim* determination as soon as possible, but in no event more than forty-eight (48) hours after the earlier of:

    1. The Plan's receipt of the specified information; or

2. The end of the period afforded the *claimant* to provide the specified additional information.

CONCURRENT CARE DECISIONS

The *Third-Party Administrator* will notify a *claimant* of a *concurrent care decision* that involves a reduction in or termination of benefits that have been pre-authorized. The *Third-Party Administrator* will provide the notice sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination on review of the adverse determination before the benefit is reduced or terminated.

A request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided by the *Third-Party Administrator* as soon as possible, taking into account the dental circumstances. The *Third-Party Administrator* will notify a *claimant* of the benefit determination, whether adverse or not within twenty-four (24) hours after receipt of the claim by the Plan, provided that the claim is submitted to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

POST-SERVICE CLAIMS

The *Third-Party Administrator* will notify the *claimant* of a favorable or adverse determination within a reasonable time, but not later than thirty (30) days after receipt of the claim by the Plan.

However, this period may be extended by an additional fifteen (15) days, if the *Third-Party Administrator* determines that the extension is necessary due to matters beyond the control of the Plan. The *Third-Party Administrator* will notify the affected *claimant* of the extension before the end of the initial thirty (30) day period, the circumstances requiring the extension, and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the *claimant's* failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The *claimant* will have at least forty-five (45) days from the date the notice is received to provide the specified information. The *Third-Party Administrator* will make a decision no later than fifteen (15) days after the earlier of the date on which the information provided by the *claimant* is received by the Plan or the expiration of the time allowed for submission of the additional information.

TIMES FOR DECISIONS

The periods of time for claims decisions presented above begin when a claim is received by the Plan, in accordance with these claims procedures.

PAYMENT OF CLAIMS

Many *dentists* will request an assignment of benefits as a matter of convenience to both *dentist* and patient. Also as a matter of convenience, the *Third-Party Administrator* will, in its sole discretion, assume that an assignment of benefits has been made to certain *dentists*. In those instances, the *Third-Party Administrator* will make direct payment to the *dentist's* office, unless the *Third-Party Administrator* is advised in writing that *you* have already paid the bill. If *you* have paid the bill please indicate on the original statement "paid by *employee*" and send it directly to the *Third-Party Administrator*. *You* will receive a written explanation of an adverse determination. The *Third-Party Administrator* reserves the right to request any information required to determine benefits or process a claim. *You* or the provider of *services* will be contacted if additional information is needed to process *your* claim.

Claims Procedures Continued

When an *employee's* child is subject to a medical child support order, the *Third-Party Administrator* will make reimbursement of eligible expenses paid by *you*, the child, the child's non-employee custodial parent, or legal guardian, to that child or the child's custodial parent, or legal guardian, or as provided in the medical child support order.

Payment of benefits under this Plan will be made in accordance with an assignment of rights for *you* and *your dependents* as required under state Medicaid law.

Benefits payable on behalf of *you* or *your* covered *dependent* after death will be paid, at the Plan's option, to *your* estate.

The *Third-Party Administrator* will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the Plan from further liability.

Any payment made by the *Third-Party Administrator* in good faith will fully discharge it to the extent of such payment.

Payments due under the Plan will be paid upon receipt of written proof of loss.

INITIAL DENIAL NOTICES

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, through website access, or by FAX, as appropriate, within the time frames noted above.

However, notices of adverse decisions involving *urgent care claims* may be provided to a *claimant* orally within the time frames noted above for expedited *urgent care claim* decisions. If oral notice is given, written notification will be provided to the *claimant* no later than three (3) days after the oral notification.

A claims denial notice will state the specific reason or reasons for the adverse determination, the specific Plan provisions on which the determination is based, and a description of the Plan's review procedures and associated timeline. The notice will also include a description of any additional material or information necessary for the *claimant* to perfect the claim and an explanation of why such material or information is necessary.

The notice will describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of the *claimant's* right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request.

If the adverse determination is based on *dental necessity*, *medical necessity*, experimental, investigational or for research purposes, or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the *claimant's* dental circumstances, or a statement that such explanation will be provided free of charge upon request.

Claims Procedures Continued

In the case of an adverse decision of an *urgent care claim*, the notice will provide a description of the Plan's expedited review procedures applicable to such claims.

APPEALS OF ADVERSE DETERMINATIONS

A *claimant* must appeal an adverse determination within one-hundred-eighty (180) days after receiving written notice of the denial (or partial denial). With the exception of *urgent care* and *concurrent care claims*, the Plan uses a two (2) level appeals process for all adverse determinations. The *Third-Party Administrator* will make the determination on the first level of appeal. If the *claimant* is dissatisfied with the decision on this first level of appeal, or if the *Third-Party Administrator* fails to make a decision within the time frame indicated below, the *claimant* may appeal to the *Plan Administrator*. *Urgent care* and *concurrent care claims* are subject to a single level appeal process only, with the *Third-Party Administrator* making the determination.

- A first level and second level appeal must be made by a *claimant* by means of written application, in person, or by mail (postage prepaid), addressed to:

  Samera Health
  P.O. Box 126
  Smithfield UT 84335

Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the *claimant* relating to the claim.

A *claimant* may review relevant documents free of charge and may submit issues and comments in writing. In addition, a *claimant* on appeal may, upon request, discover the identity of dental experts whose advice was obtained on behalf of the Plan in connection with the adverse determination being appealed, as permitted under applicable law.

If the claims denial being appealed was based in whole, or in part, on a dental judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not *dentally necessary*, *medically necessary*, or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the dental judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Claims Procedures Continued

Time Periods for Decisions on Appeal – First Level

Appeals of claims denials will be decided and notice of the decision provided as follows:

Urgent Care Claims	As soon as possible, but not later than seventy-two (72) hours after the *Third-Party Administrator* receives the appeal request. (If oral notification is given, written notification will follow in hard copy or electronic format within the next three (3) days).
Pre-Service Claims	Within a reasonable period, but not later than fifteen (15) days after the *Third-Party Administrator* receives the appeal request.
Post-Service Claims	Within a reasonable period but not later than thirty (30) days after the *Third-Party Administrator* receives the appeal request.
Concurrent Care Decisions	Within the time periods specified above, depending upon the type of claim involved.

Time Periods for Decisions on Appeal – Second Level

Appeals of claims denials will be decided and notice of the decision provided as follows:

Pre-Service Claims	Within a reasonable period, but not later than fifteen (15) days after the *Third-Party Administrator* receives the appeal request.
Post-Service Claims	Within a reasonable period but not later than thirty (30) days after the *Third-Party Administrator* receives the appeal request.

APPEAL DENIAL NOTICES

Notice of a benefit determination on appeal will be provided to *claimants* by mail, postage prepaid, or by FAX, as appropriate, within the time frames noted above.

A notice that a claim appeal has been denied will state the specific reason or reasons for the adverse determination and the specific Plan provisions on which the determination is based.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim on appeal. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request.

If the adverse determination is based on *dental necessity*, *medical necessity*, experimental, investigational or for research purposes or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the *claimant's* dental circumstances, or a statement that such explanation will be provided free of charge upon request.

Claims Procedures Continued

In the event of a denial of an appealed claim, the *claimant* on appeal will be entitled to receive upon request and without charge, reasonable access to and copies of any document, record or other information:

1. Relied on in making the determination;

2. Submitted, considered or generated in the course of making the benefit determination;

3. That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations; and/or

4. That constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on.

EXHAUSTION

Upon completion of the appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the Plan. If the *Third-Party Administrator* fails to complete a claim determination or appeal within the time limits set forth above, the *claimant* may treat the claim or appeal as having been denied, and the *claimant* may proceed to the next level in the review process. After exhaustion, a *claimant* may pursue any other legal remedies available to him or her, which may include bringing a civil action under ERISA § 502(a) for judicial review of the Plan's determinations. Additional information may be available from a local U.S. Department of Labor Office.

LEGAL ACTIONS AND LIMITATIONS

No action at law or inequity may be brought with respect to Plan benefits until all remedies under the Plan have been exhausted and then prior to the expiration of the applicable limitations period under applicable law.

DEFINITIONS

Accidental injury means damage to the mouth, teeth, and supporting tissue, due directly to an accident and independent of all other causes. *Accidental injury* does not include damage to the teeth, appliances, or prosthetic devices which results from chewing or biting food or other substances.

Active status means the *employee* performing on a regular full-time basis all customary occupational duties, for thirty (30) hours per week, at the *employer's* business locations or when required to travel for the *employer's* business purposes. Each day of a regular paid vacation and any regular non-working holiday will be deemed *active status* if *you* were in an *active status* on *your* last regular working day prior to the vacation or holiday.

Beneficiary means *you* and *your* covered *dependent(s)*, or legal representative of either, and anyone to whom the rights of *you* or *your* covered *dependent(s)* may pass.

Bodily injury means bodily damage other than a *sickness*, including all related conditions and recurrent symptoms. However, bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a *sickness* and not a *bodily injury*.

Calendar year means a period of time beginning on January 1 and ending on December 31.

Claimant means a *covered person* (or authorized representative) who files a claim.

Third-Party Administrator means Town & Country Life Insurance Company, dba Samera Health. The *Third-Party Administrator* provides services to the *Plan Administrator,* as defined under the Administrative Services Agreement. The *Third-Party Administrator* is not the *Plan Administrator* or the *Plan Sponsor.* The *Third-Party Administrator* is not an insurer of the health benefits and is not a fiduciary of the Plan and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator.* The *Third-Party Administrator* is not responsible for financing and does not guarantee the availability of benefits under this Plan.

Concurrent care decision means a decision by the Plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the Plan (other than by Plan amendment or termination) or a decision with respect to a request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that has been approved by the Plan.

Cosmetic dentistry means those *services* provided by *dentists* solely for the purpose of improving the appearance when form and function are satisfactory and no pathologic conditions exist.

Covered expense means the *maximum allowable fee* or predetermined charge for a *dentally* or *medically necessary* covered *service* incurred by *you* or *your* covered *dependent(s)*.

Covered person means the *employee* or any of the *employee's* eligible covered *dependents* enrolled for benefits provided under this Plan.

Dentally necessary or ***dental necessity*** means the extent of care and treatment which is the generally accepted, proven and established practice by most *dentists* with similar experience and training where the *service* is provided. To determine *dental necessity*, the *Third-Party Administrator* may require preoperative dental x- rays and any other pertinent information to help determine if benefits are payable for the *service* submitted for consideration.

Definitions Continued

Dentist means an individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental *service* is performed and is operating within the scope of that license.

Dependent means a covered *employee's*:

1. Legally recognized spouse;

2. Natural blood related child, stepchild, legally adopted child or child placed with the *employee* for adoption, or child for which the *employee* has legal guardianship, whose age is less than the limiting age.

   The limiting age for each *dependent* child is the end of the calendar month he or she attains the age of twenty-six (26) years. *Your* child is covered to the limiting age regardless if the child is:

   - Married;
   - A tax dependent;
   - A student;
   - Employed;
   - Residing with or receives financial support from *you*; or
   - Eligible for other coverage through employment.

3. A covered *employee's* child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a medical child support order.

You must furnish satisfactory proof to the *Third-Party Administrator* upon request that the above conditions continuously exist. If satisfactory proof is not submitted to the *Third-Party Administrator*, the child's coverage will not continue beyond the last date of eligibility.

A covered *dependent* child who attains the limiting age while covered under the Plan will remain eligible for benefits if all of the following exist at the same time:

1. Permanently mentally disabled or permanently physically handicapped;

2. Incapable of self-sustaining employment;

3. The child meets all of the qualifications of a *dependent* as determined by the United States Internal Revenue Service;

4. Declared on and legally qualify as a *dependent* on the *employee's* federal personal income tax return filed for each year of coverage; and

5. Unmarried.

You must furnish satisfactory proof to the *Third-Party Administrator* that the above conditions continuously exist on and after the date the limiting age is reached. The *Third-Party Administrator* may not request such proof more often than annually after two (2) years from the date the first proof was furnished. If satisfactory proof is not submitted to the *Third-Party Administrator*, the child's coverage will not continue beyond the last date of eligibility.

Definitions Continued

Emergency means the necessary procedures for treatment of pain and/or injury. *Services* include *emergency* procedures for treatment to the teeth and supporting structures.

Employee means *you*, as an *employee*, when *you* are regularly employed and paid a salary or other compensation and are in an *active status* at *your employer's* place of business.

Employer means the sponsor of the Group Plan or any subsidiary(s).

Expense incurred means the actual fee charged for an incurred expense by a *covered person*.

Expense incurred date means the date on which:

1. The teeth are prepared for fixed bridges, crowns, or onlays;

2. The final impression is made for dentures or partials;

3. The pulp chamber of a tooth is opened for root canal therapy;

4. Periodontal surgery is performed; or

5. The *service* is performed for *covered expenses* not listed under one (1), two (2), three (3), or four (4) above.

In-network dentist means a dental provider who is contracted with the *Third-Party Administrator* and agrees to accept a negotiated fee for a *covered expense*.

Late applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for dental coverage more than thirty one (31) days after the eligibility date.

Maximum allowable fee for a *service* means the lesser of:

1. The contracted amount of payment to which in-network providers have agreed.

2. The fee most often charged by the provider;

3. The fee which is recognized as reasonable by a prudent person;

The fee schedule established for in-network providers in the same geographic area where the *services* were performed.

Maximum benefit means the maximum amount that may be payable for each *covered person*, for *expense incurred*. The applicable *maximum benefit* is shown on the Schedule of Benefits. No further benefits are payable once the *maximum benefit* is reached.

Definitions Continued

Medically necessary or ***medical necessity*** means the extent of *services* required to diagnose or treat a *bodily injury* or *sickness* which is known to be safe and effective by the majority of *qualified practitioners* who are licensed to diagnose and treat such *bodily injury* or *sickness*. Such *services* must be:

1. Performed in the least costly setting procedure required by *your* condition;

2. Not provided primarily for the convenience of the patient or the *qualified practitioner*;

3. Appropriate for and consistent with *your* symptoms or diagnosis of the *sickness* or *bodily injury* under treatment;

4. Furnished for an appropriate duration and frequency in accordance with accepted medical practices and which are appropriate for *your* symptoms, diagnosis, *sickness* or *bodily injury*; and

5. Substantiated by the records and documentation maintained by the provider of *service*.

Medicare means Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

Out-of-network dentist means a dental provider who is NOT contracted with the *Third-Party Administrator*. Out-of- network *dentists* are not required to limit charges to a negotiated fee and can balance bill the *covered person* for the difference between the *maximum allowable fee* and the dental provider's billed charges.

Plan Administrator means the person named in the documents describing the Plan as responsible for the operation and administration of the Plan. If no such person is designated, then the *employer* is the *Plan Administrator*. The *Plan Administrator* under this Plan is Southern Utah University.

Plan Sponsor means a designated party, usually a company or employer, that sets up a dental plan for the benefit of the organization's employees and is responsible for ensuring a source of funding for Plan benefits. The *Plan Sponsor* under this Plan is Southern Utah University.

Plan year means a period of time beginning on the Plan anniversary date of any year and ending on the day before the same date of the succeeding year. Benefits accumulate on under this plan on a *plan year* basis.

Post-service claim means any claim for a benefit under a group dental plan that is not a *pre-service claim*.

Predetermination of benefits means a review by the *Third-Party Administrator* of a *dentist's* planned treatment and expected charges, including diagnostic charges, prior to the rendering of *services*.

Pre-service claim means a claim with respect to which the terms of the Plan condition receipt of a Plan benefit, in whole or in part, on approval of the benefit by the *Third-Party Administrator* in advance of obtaining dental care.

Protected health information means individually identifiable health information about a *covered person*, including: (a) patient records, which includes but is not limited to all health records, *dentist* and provider notes and bills and claims with respect to a *covered person*; (b) patient information, which includes patient records and all written and oral information received about a *covered person*; and (c) any other individually identifiable health information about *covered persons*.

Definitions Continued

Qualified practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license.

Services means procedures, surgeries, exams, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

Sickness means a disturbance in function or structure of *your* body which causes physical signs or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of *your* body.

Summary Plan Description (SPD) means this document which outlines the benefits, provisions and limitations of this Plan.

Timely applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for dental coverage within thirty one (31) days of the eligibility date.

Urgent care claim means a claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function; or

- In the opinion of a *dentist* with knowledge of the *claimant's* dental condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- Generally, whether a claim is a claim involving urgent care will be determined by the *Third-Party Administrator*. However, any claim that a *dentist* with knowledge of a *claimant's* dental condition determines is a "claim involving urgent care" will be treated as a "claim involving urgent care."

You and ***your*** means *you* as the *employee* and any of *your* eligible covered *dependents*, unless otherwise indicated.

BY THIS AGREEMENT The Southern Utah University Self-Funded Employee Benefit Plan amended 07/01/2025 is hereby adopted as shown.

Southern Utah University

By_____

Its_____