PEHP
Health & Benefits

# Preferred Choice, Traditional Choice, and Premium Choice Plans

## Dental Master Policy

## 2018

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This Master Policy is the contract between Public Employees Health Program (PEHP) and its Members.

## Recitals

This Master Policy between PEHP and its Members is intended to comply with the provisions of Title 49, Chapter 20 of the Utah Code Annotated which creates the Public Employees Benefits and Insurance Program, also known as PEHP. The right and obligations of PEHP and its Members are set forth in this Master Policy. If any term of this Master Policy is found to be in violation of Title 49, Chapter 20 of the Utah Code Annotated or any other state or federal law, or is unenforceable for any reason, that term shall be null and void and severable from the Master Policy and shall not render the Master Policy null and void as a whole. This contract is governed by, and will be interpreted and enforced according to the laws of the State of Utah.

This contract, including all matters incorporated herein, including, but not limited to, benefit summaries and Enrollment forms, contains the entire agreement and it is binding upon Subscribers, Members and their heirs, successors, personal representatives and assignees in regard to their applicable Employer benefit plan. There are no promises, terms, conditions, or obligations other than those contained herein. This contract supersedes all prior communications, representations, or agreements, either verbal or written, between the parties. In the event there has been a written proposal supplied to the Employer by PEHP, the compliance by the Employer and its Employees with all minimum Enrollment and underwriting factors set forth in the proposal is a condition to the effectiveness of this Contract.

Upon renewal of this contract, PEHP may modify rates, benefits, Exclusions, Limitations, and/or service by providing Employer with advance notice of change.

Paragraph headings appearing in this contract are not to be construed as interpretation of the text, but are only for the convenience of reference for the reader.

## I. PEHP and Member Responsibilities

### 1.1 CONTRACT AMENDMENTS

PEHP may unilaterally change this contract upon plan renewal and upon 30 days written notice to PEHP Subscribers.

### 1.2 NON-ASSIGNABILITY

The parties to this contract may not transfer or assign their rights or obligations without the advance written approval of the other party except that PEHP may designate an affiliated company to administer some or all of the Employer's benefit plan.

### 1.3 AVAILABILITY OF CONTRACT FOR REVIEW

Members are entitled to review a copy of this contract at the offices of the Subscriber's Employer or at www.pehp.org. Members may also request a hard copy of this contract from PEHP.

### 1.4 NO VESTED RIGHTS

Members are only entitled to receive benefits from PEHP while this contract is in effect. Members do not have any permanent or vested interest in any benefits under this contract, and benefits may change or terminate as this contract is renewed, modified or terminated from year to year. Members only have rights to benefits under this contract when they are properly enrolled and recognized by PEHP as Members. Unless otherwise expressly stated in this contract, all benefits end when this contract ends. Members have no right to receive any care, services, treatments, drugs, medications, supplies, or equipment from or through PEHP except in strict compliance with this entire contract.

### 1.5 ACCEPTANCE OF THIS CONTRACT

As a condition to receiving Coverage from PEHP, Members are presumed and required to accept, comply with, and agree to, the terms of this contract. Subscribers are also presumed to agree to the terms of this contract on behalf of eligible Dependents who enroll as Members.

### 1.6 PEHP DETERMINES ELIGIBLE SERVICES

Merely because a Provider orders or recommends care, services, treatments, drugs, medications, supplies, or equipment for a Member does not mean that PEHP will recognize the procedure as being either Medically Necessary or covered

by PEHP under this contract. This is true whether the physician or other Provider is an In-Network or Out-of-Network Provider.

Benefits under the Master Policy will be paid only if PEHP decides in its discretion that the Member is entitled to them. PEHP also has discretion to determine eligibility for benefits, to require verification of any claim for Eligible Benefits and to interpret the terms and conditions of the benefit plan.

### 1.7 AGENCY

Neither the Employer, nor any Member has authority to act as agent for PEHP. PEHP is not the agent of Employer for any purpose. For purposes of this contract, the Employer acts as the agent of its Subscribers (Employees) and Subscribers act as the agent of their eligible Dependent Members.

### 1.8 PROVIDER AGENCY

Providers contracting with PEHP are independent contractors and not Employees or agents of PEHP. PEHP does not control the manner in which In-Network Providers provide professional services. Such Providers are entitled and required to exercise independent professional medical judgment in providing care and services to Members.

PEHP does not promise, represent, warrant, or otherwise guarantee that care or services provided to Members by Providers will achieve any particular result or be provided in any particular manner or at any particular level of care.

It is understood and agreed that PEHP will not be liable for any claim or demand on account of injuries or damages of any kind arising out of or in any manner connected with any conditions or injuries suffered by a Member and resulting from care or services rendered, withheld, covered, limited, excluded, or otherwise provided or not under this Master Policy. Subscribers and Members agree that Providers are solely responsible to Members for care or services rendered, limited, or withheld by such Providers.

### 1.9 MANAGED CARE

Members agree to the managed care features that are a part of the dental benefit program in which they are enrolled. For example, see Section Six of this Master Policy.

### 1.10 BENEFITS ARE LIMITED

Coverage under this contract is limited in defined ways. It is the responsibility of each Member to know the requirements, conditions, Limitations and Exclusions that apply to their Coverage, and to know the Limitations and requirements that apply to their choice of Providers and the timing of their dental care services.

Members are responsible for payment for any care, service, treatment, drug, medication, supply, or equipment that they obtain that is not covered or limited by this contract, or is obtained from Providers that are not authorized to be paid by PEHP. Members are not responsible to pay for claims that are the responsibility of PEHP.

### 1.11 ADMINISTRATIVE PROVISIONS

PEHP will from time to time adopt and enforce reasonable rules, regulations, policies, procedures, and protocols to help it in the administration of this Master Policy and in providing covered services to Members. Employer and Members are subject to such rules, regulations, policies, procedures, and protocols in connection with obtaining covered services and other matters under this Master Policy.

### 1.12 COMPLIANCE RESPONSIBILITIES

Each party is responsible for its own compliance with applicable laws, rules and regulations.

### 1.13 CHANGES IN MEMBER CONTACT INFORMATION

It is the Member's responsibility to keep PEHP informed of any change of address, phone number, and email address of the Subscriber or any eligible Dependent. Members should keep copies of any notices sent to PEHP.

### 1.14 REQUESTS FOR INFORMATION

As a condition of receiving benefits under this Master Policy, Members shall provide PEHP with all information at PEHP's request, including, but not limited to, providing releases for prior Medical Records. Failure by a Member to provide information to PEHP at PEHP's request under this section within a reasonable time, as determined by PEHP shall be a breach of this Master Policy and may result in forfeiture of benefits, termination of Coverage, or PEHP having the right to hold payment of claims for the Member or the Member's dependents until the requested information is

received by PEHP. Unless another timeframe is specifically allowed in another section of this Master Policy, PEHP will only pay retroactive benefits for the greater of 90 days prior to the start of the last plan year or the current plan year, whichever is greater.

### 1.15 NOTICES

Any notice required of PEHP under this Master Policy will be sufficient if mailed by first class mail to the Member or Subscriber at the address appearing on the records of PEHP. Notice to an eligible Dependent will be sufficient if given to the Subscriber under whom the Member is enrolled. Any notice to PEHP will be sufficient if mailed to the principal office of PEHP in Salt Lake City, Utah. Each Subscriber agrees to promptly notify his/her Dependents of all benefit and other plan changes.

### 1.16 RATE CHANGES

PEHP reserves the right to change Payment rates at any time, when actuarially indicated.

### 1.17 PEHP EMPLOYEE RESPONSES

Without the consent of PEHP Administration, individual Employees of PEHP do not have the authority to:

1. Modify the terms and conditions of this Master Policy;
2. Extend or modify the benefits available under this Master Policy, either intentionally or unintentionally;
3. Waive or modify any Exclusion or Limitation; or
4. Waive compliance with PEHP requirements, such as the use of In-Network Providers or the necessity of obtaining Pre-authorizations. Benefits under this Master Policy are determined by and limited to provisions stated in this Master Policy. In the event that PEHP chooses to honor any Coverage or pay for any service mistakenly authorized or provided, such Coverage or payment will be limited to a maximum period of not more than thirty (30) days.

### 1.18 NOTICE OF COBRA RIGHTS

PEHP is providing you and your Dependents notice of your rights and obligations under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") to temporarily continue health Coverage if you are an Employee of an Employer with 20 or more Employees and you or your eligible Dependents, (including newborn and /or adopted children) in certain instances would lose PEHP Coverage. Both you and your spouse should take the time to read this notice carefully. If you have any questions please call the PEHP Office at 801-366-7555 or refer to the Benefits Summary and/or the PEHP Master Policy at www.pehp.org.

#### Qualified Beneficiary

A Qualified Beneficiary is an individual who is covered under the Employer group health plan the day before a COBRA Qualifying Event.

#### Who is Covered

**»Employees**

If you have group health Coverage with PEHP, you have a right to continue this Coverage if you lose Coverage or experience an increase in the cost of the premium because of a reduction in your hours of employment or the voluntary or involuntary termination of your employment for reasons other than gross misconduct on your part.

**»Spouse of Employees**

If you are the spouse of an Employee covered by PEHP, and you are covered the day prior to experiencing a Qualifying Event, you are a "Qualified Beneficiary" and have the right to choose COBRA Coverage for yourself if you lose group health Coverage under PEHP for any of the following Qualifying Events:

1. The death of your spouse;
2. The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse;
4. Your spouse becoming entitled to Medicare; or
5. The commencement of certain bankruptcy proceedings, if your spouse is retired.

**»Dependent Children**
A Dependent child of an Employee who is covered by PEHP on the day prior to experiencing a Qualifying Event, is also a "Qualified Beneficiary" and has the right to COBRA Coverage if group health Coverage under PEHP is lost for any of the following Qualifying Events:

1. The death of the covered parent;
2. The termination of the covered parent's employment (for reasons other than gross misconduct) or reduction in the covered parent's hours of employment;
3. The parents' divorce or legal separation;
4. The covered parent becoming entitled to Medicare;
5. The Dependent ceasing to be a "Dependent child" under PEHP; or
6. A proceeding in a bankruptcy reorganization case, if the covered parent is retired.

A child born to, or placed for adoption with, the covered Employee during a period of COBRA Coverage is also a Qualified Beneficiary.

**Secondary Qualifying Event**
A Secondary Qualifying Event means one Qualifying Event occurring after another. It allows a Qualified Beneficiary who is already on COBRA to extend COBRA Coverage under certain circumstances, from 18 months to 36 months of Coverage from the date of the original Qualifying Event.

**Separate Election**
If there is a choice among types of Coverage under the plan, each of you who is eligible for COBRA Coverage is entitled to make a separate election among the types of Coverage. Thus, a spouse or Dependent child is entitled to elect COBRA Coverage even if the covered Employee does not make that election. Similarly, a spouse or Dependent child may elect a different Coverage from the Coverage that the Employee elects.

**Your Duties Under The Law**
It is the responsibility of the covered Employee, spouse, or Dependent child to notify the Employer or Plan Administrator in writing within sixty (60) days of a divorce, legal separation, child losing Dependent status or secondary qualifying event, under the group health plan in order to be eligible for COBRA Coverage. PEHP can be notified at 560 East 200 South, Salt Lake City, UT, 84102. PEHP Customer Service: 801-366-7555; toll free 800-765-7347. Appropriate documentation must be provided, such as: divorce decree, marriage certificate, etc.

Keep PEHP informed of address changes to protect you and your family's rights. It is important for you to notify PEHP at the above address if you have changed marital status, or you, your spouse or your Dependents have changed addresses.

In addition, the covered Employee or a family Member must inform PEHP of a determination by the Social Security Administration that the covered Employee or covered family Member was disabled during the 60-day period after the Employee's termination of employment or reduction in hours, within 60 days of such determination and before the end of the original 18-month COBRA Coverage period. (See "Special rules for disability," below.) If, during continued Coverage, the Social Security Administration determines that the Employee or family Member is no longer disabled, the individual must inform PEHP of this redetermination within 30 days of the date it is made.

**Employers' Duties Under The Law**
Your Employer has the responsibility to notify PEHP of the Employee's death, termination of employment, reduction in hours, or Medicare eligibility. Notice must be given to PEHP within 60 days of the occurrence of the above-listed events. When PEHP is notified that one of these events has happened, PEHP in turn will notify you and your Dependents that you have the right to choose COBRA Coverage. Under the law, you and your Dependents have up to 60 days from the date you would lose Coverage because of one of the events to inform PEHP that you want COBRA Coverage or 60 days from the date of your Election Notice.

**Election of COBRA Coverage**
Members have 60 days from either termination of Coverage or date of receipt of COBRA election notice to elect COBRA. If no election is made within 60 days, COBRA rights are deemed waived and will not be offered again. If you choose COBRA Coverage, your Employer is required to give you Coverage that, as of the time Coverage is being provided, is identical to the

Coverage provided under the plan to similarly situated Employees and their family Members. If you do not choose COBRA Coverage within the time period described above, your group health insurance Coverage will end.

**Premium Payments**
Payments must be made retroactively to the date of the qualifying event and paid within 45 days of the date of election. There is no grace period on this initial premium. Subsequent Payments are due on the first of each month with a thirty (30) day grace period. Delinquent Payments will result in a termination of COBRA Coverage.

The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA Coverage due to a disability, 150 percent) of the cost to the group health plan (including both Employer and Employee contributions) for Coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA Coverage. Claims paid in error by ineligibility under COBRA will be reviewed for collection. Ineligible premiums paid will be refunded.

**How Long Will Coverage Last?**
The law requires that you be afforded the opportunity to maintain COBRA Coverage for a maximum of 36 months, unless you lose group health Coverage because of a termination of employment or reduction in hours. In that case, the required COBRA Coverage period is 18 months**.** Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) may occur while the COBRA Coverage is in effect. Such events may extend an 18-month COBRA period to a maximum of 36 months, but in no event will COBRA Coverage extend beyond 36 months from the date of the event that originally made the Employee or a qualified beneficiary eligible to elect COBRA Coverage. You should notify PEHP if a second Qualifying Event occurs during your 18-month COBRA Coverage period.

**Special Rules For Disability**
If the Employee or covered family Member is disabled at any time during the first 60 days of COBRA Coverage, the COBRA Coverage period may be extended to 29 months for all family Members, even those who are not disabled.

**The criteria that must be met for a disability extension is:**

1. Employee or family Member must be determined by the Social Security Administration to be disabled.
2. Must be determined disabled during the first 60 days of COBRA Coverage.
3. Employee or family Member must notify PEHP of the disability no later than 60 days from the later of:
   a. the date of the Social Security Administration disability determination;
   b. the date of the Qualifying Event;
   c. the loss of Coverage date; or
   d. the date the Qualified Beneficiary is informed of the obligation to provide the disability notice.
4. Employee or family Member must notify Employer within the original 18 month COBRA period.
5. If an Employee or family Member is disabled and another qualifying event occurs within the 29-month COBRA period (other than bankruptcy of your Employer), then the COBRA Coverage period may continue up to a maximum of 36 months after the termination of employment or reduction in hours.

**Special Rules For Retirees**
In the case of a retiree or an individual who was a covered surviving spouse of a retiree on the day before the filing of a Title 11 bankruptcy proceeding by your Employer, Coverage may continue until death and, in the case of the spouse or Dependent child of a retiree, 36 months after the date of death of a retiree.

**COBRA Coverage May Be Terminated**
The law provides that your COBRA Coverage may be terminated prior to the expiration of the 18-, 29-, or 36-month period for *any* of the following reasons:

1. Your Employer no longer provides group health Coverage to any of its Employees.
2. The premium for COBRA Coverage is not paid in a timely manner (within the applicable grace period).
3. The individual becomes covered, after the date of election, under another group health plan (whether or not as an Employee) that does not contain any Exclusion or Limitation with respect to any preexisting condition of the individual.

4. The date in which the individual becomes entitled to Medicare, after the date of election.
5. Coverage has been extended for up to 29 months due to disability (see "Special rules for disability") and there has been a final determination that the individual is no longer disabled.
6. Coverage will be terminated if determined by PEHP that the Employee or family Member has committed any of the following: fraud upon PEHP or Utah Retirement Systems, forgery or alteration of prescriptions; criminal acts associated with COBRA Coverage; misuse or abuse of benefits; or breach of the conditions of the Plan Master Policy.

You do not have to show that you are insurable to choose COBRA Coverage. However, under the law, you may have to pay all or part of the premium for your COBRA Coverage plus two percent.

This notice is a summary of the law and therefore is general in nature. The law itself and the actual Plan provisions must be consulted with regard to the application of these provisions in any particular circumstance. More information regarding COBRA may be found in your Plan's Benefits Summary found at www.pehp.org.

**Questions**
If you have any questions about continuing Coverage, please contact PEHP at 560 East 200 South, Salt Lake City, UT, 84102. Customer Service: 801-366-7555; toll free 800-765-7347.

## II. Definitions

### ACCIDENT, ACCIDENTAL
A single unpremeditated event of violent and external means, which happens suddenly, is unexpected, and is identifiable as to time and place. Injuries resulting from the act of biting or chewing are not considered within the definition of an Accident.

### ALLOWED AMOUNT
The maximum fee allowable for a given procedure, test, Device, or medication established by PEHP and accepted by In-Network Providers. Also referred to as "In-Network Rate."

### ALTERNATE BENEFIT
Provision that allows the plan to determine the benefits based on an alternative procedure that is generally less expensive than the one provided or proposed.

### ANESTHESIA
Anesthetic agent that depresses neuronal function, producing loss of ability to perceive pain and/or other sensations.

1. General – Compound that produces loss of sensation and loss of consciousness.
2. Intravenous – Compound that produces Anesthesia when injected into the circulation via venipuncture.

### COMMUNITY STANDARD
The standard accepted for consensus decisions will be determined by published dental data, in journals sponsored by professional societies and associations, patterns of care within PEHP database, professional review organizations, and consultations with experts who are Board Certified by a specialty board recognized by the American Dental Association. The Community Standard is not necessarily a prevailing level of practice.

### CONTRACTED PROVIDER
A Provider with whom PEHP has a current contractual agreement to render care to covered Members for a specific fee. Also referred to as In-Network Provider.

### COORDINATION OF BENEFITS
The Coordination of Eligible Benefits between two or more plans under which an individual is covered after primary and secondary Coverage determination is made.

### COPAYMENT
The portion of the cost of Eligible Benefits that a Member is obligated to pay under the plan(s). A Copayment may be either a fixed dollar amount, or a percentage of the allowable dental expense.

### COSMETIC DENTISTRY
Those services provided solely for the purpose of improving appearance when function is satisfactory and no caries or pathological conditions exist.

### COVERAGE
The eligibility of a Member for benefits provided under this Master Policy, subject to the terms, conditions, Limitations and Exclusions of this Master Policy.

Benefits must be provided:

1. When this Master Policy is in effect; and
2. Prior to the date that termination occurs.

### DEDUCTIBLE
The amount paid by a Member for eligible charges before any benefits will be paid under the plan.

### DENTALLY NECESSARY (DENTAL NECESSITY)
Dental services provided to you are necessary, appropriate and cannot be performed in a more cost-effective manner. We determine dental necessity on a case-by-case basis. We may establish pre-authorization techniques and apply administrative policies as we deem reasonable and/or necessary in approving the eligibility of members as well as the appropriateness of treatment plans and related charges. The fact that your dentist performed or prescribed a procedure does not mean that it is dentally necessary.

### DENTIST
A duly licensed Dentist legally entitled to practice dentistry at the time and in the place services are performed.

### DEPENDENT
"Dependent" means:

1. a. The Subscriber's lawful spouse under Utah State Law. A valid marriage certificate and/or affidavit of marriage are required to demonstrate the validity of a marriage.

   b. Common-law marriage. A common law spouse is a lawful spouse under Utah State law, but only if the Subscriber and spouse obtains a court order establishing the common law marriage. Eligibility for a common-law spouse may not be established retroactively.

   c. General provisions relating to marriage. When a court purports to retroactively either establish or annul/declare void a marriage or divorce for Benefit eligibility, PEHP will consider the marriage or dissolution of the marriage effective on the date the court order was signed by the court, or the date the order is received by PEHP, whichever is later.

2. Adult designee and their Dependents as defined by the Employer (if applicable).
3. Children or stepchildren of the Subscriber up to the end of the month in which they turn age 26 who have a Parental Relationship with the Subscriber. A valid birth certificate listing Subscriber or legal Spouse as parent is required.
4. Legally adopted children, who are adopted prior to turning 18 years old, foster children up to age 19, and children through legal guardianship up to the age of 26 are eligible subject to PEHP receiving adequate legal documentation. (Legal guardianship must be court appointed and must be obtained prior to the child turning 18 years old.)
5. Children who are incapable of self support because of an ascertainable mental or physical impairment, and who are claimed as a Dependent on the Subscriber's federal tax return, upon attaining age 26, may continue Dependent Coverage, while remaining Totally Disabled, subject to the Subscriber's Coverage continuing in effect. Periodic documentation is required. Subscriber must furnish written notification of the disability to PEHP no later than 31 days after the date the Coverage would normally terminate. In the notification, the Subscriber shall include the name of the Dependent, date of birth, a statement that the Dependent is unmarried, and details concerning:

   a. The condition that led to the Dependent's physical or mental disability;

   b. Income, if any, earned by the Dependent; and

   c. The capacity of the Dependent to engage in employment, attend school, or engage in normal daily activities.

If proof of disability is approved, the Dependent's Coverage may be continued as long as he/she remains Totally Disabled and unable to earn a living, and as long as none of the other causes of termination occur.

At the time of a Dependent's approval for continued PEHP Coverage, PEHP shall provide the Subscriber with a date of renewal for their Dependent. At the time of their renewal, the Subscriber shall provide proof of Dependent's continued disability 30 days prior to the renewal date. If the Subscriber fails to provide proof of disability 30 days prior to the date of renewal, the Dependent's Coverage will terminate on the renewal date.

6. When you or your lawful spouse are required by a court order to provide health Coverage for a child, the child will be enrolled in your Coverage according to PEHP guidelines and only to the minimum extent required by applicable law. A Qualified Medical Child Support Order (QMCSO) can be issued by a court of law or by a state or local child welfare agency. If ordered, you and your Dependent child may be enrolled without regard to annual enrollment restrictions. The effective date for a qualified order will be the start date indicated in the order.
7. In the event of divorce, Dependent children for whom the Subscriber is required to provide medical insurance as ordered in a divorce decree may continue Coverage. The former spouse and/or stepchildren may not continue Coverage but may be eligible to convert to a COBRA plan. PEHP will not recognize Dependent eligibility for a former spouse or stepchildren as a result of a court order or divorce decree.
8. Stepchildren who no longer have a Parental Relationship with a Subscriber will no longer be eligible to receive benefits under PEHP.
9. Dependent does not include an unborn fetus.

**DEPENDENT DISABILITY**
A person age 26 or older who is incapable of self support due to a definable mental or physical impairment, who is not married or living independently, and is claimed as a Dependent on the Subscriber's income taxes.

**DEVICE**
Any instrument, apparatus, appliance, material, or other article, whether used alone or in combination, including the software necessary for its proper application intended by the manufacturer to be used for the purpose of:

1. Diagnosis, prevention, monitoring, treatment, or alleviation of illness or injury;
2. Diagnosis, monitoring, treatment, alleviation, or compensation for a handicap;
3. Investigation, replacement, or modification of the anatomy or of a physiological process, or;
4. Which does not achieve its principal intended action in or on the human body by pharmacological, immunological, or metabolic means, but which may be assisted in its function by such means.

**DURABLE MEDICAL EQUIPMENT**
Medical equipment that is all of the following:

1. Used only to benefit in the care and treatment of an illness or injury;
2. Durable and useful over an extended period of time;
3. Used only for a medical purpose rather than convenience or contentment;
4. Is prescribed by a Provider; and
5. Not used by other family Members for non-therapeutic purposes.

**ELECTIVE TREATMENT**
Non-emergency services that can be scheduled 48 hours after diagnosis.

**ELIGIBLE BENEFIT**
Medical expenses which are covered under this Master Policy. If a group is a grandfathered plan under the Affordable Care Act, Preventive care services (Section 6.14) are covered in accordance with the applicable Benefits Summary.

**EMERGENCY MEDICAL CONDITION**
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or,

with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. A determination of emergency will be made by PEHP on the basis of the final diagnosis.

**DIAGNOSTIC**
Procedures that assist the Dentist in evaluating the existing conditions to determine the required dental treatment, including clinical oral examinations and Diagnostic x-rays (not including services relating to Orthodontia).

**ELIGIBLE BENEFIT**
Dental expenses which are covered under this Master Policy.

**EMERGENCY CARE**
Care provided for an acute dental condition with a sudden unexpected onset, which requires immediate attention in order to prevent damage to the Member's dental or medical health. A determination of emergency will be made by PEHP on the basis of the final diagnosis.

**EMPLOYEE**
An Employer's Employee who is eligible for Coverage in the Group Insurance Program of Title 49, Chapter 20 of the Utah Code Annotated.

**EMPLOYER**
The State, its educational institutions and political subdivisions that are eligible to participate and have elected to participate in the Group Insurance Program of Title 49, Chapter 20 of the Utah Code Annotated.

**ENDODONTICS**
Procedures for pulpal therapy and root canal filling (treatment of non-vital teeth).

**ENROLLMENT**
The process whereby an Employee makes written application for Coverage through PEHP, subject to specified time periods and plan provisions.

**EXCLUSIONS**
Those services or supplies incurred by the Member, which are not eligible under this policy.

**EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN**
Those services, supplies, devices, or pharmaceutical (drug) products which are not recognized or proven to be effective for treatment of illness or injury in accordance with generally accepted standards of medical practice as solely determined by PEHP.

**FDA APPROVED**
Pharmaceuticals, Devices, or Durable Medical Equipment which have been approved by the FDA for a particular diagnosis.

**GROUP INSURANCE PROGRAM**
The program of Coverage created by Title 49, Chapter 20 of the Utah Code Annotated.

**IMMEDIATE FAMILY MEMBER**
Immediate Family Members are considered to be (for purposes of this policy): Anyone that lives in the same home and for which one party is dependent on the other for financial support, including domestic partners or adult designees.

**IMPLANT**
An artificial tooth root placed into the jaw to hold a replacement tooth or bridge in place.

**IN-NETWORK PROVIDER**
A Provider with whom PEHP has a current contractual agreement to render care to covered Members for a specific fee.

**IN-NETWORK RATE**
The maximum fee allowable for a given procedure, test, Device, or medication established by PEHP and accepted by In-

Network Providers. Also referred to as "Allowed Amount."

**INDUSTRIAL CLAIM**
An illness or injury arising out of or in the course of employment covered by the Worker's Compensation Fund or Employer Liability laws.

**LIMITATIONS**
Provisions in the plan indicating services or supplies that are not fully covered or covered only when specific criteria is met, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

**MAXIMUM BENEFIT**
The maximum dollar amount the plan will pay toward the cost of dental care incurred by Member in a plan year.

**MEMBER**
A Subscriber, a Subscriber's spouse, a Subscriber's Dependents who are enrolled in active Coverage or individuals who have converted to COBRA Coverage, Utah mini-COBRA Coverage, or a retired individual who is eligible for Coverage and has continued to pay contributions.

**ORAL SURGERY**
Extractions, surgical exposure of teeth, alveoloplasty, excision or biopsy of lesions, tumors or cysts that are dental in origin, incision and drainage of dental abscess, frenulectomy and repair of dental lacerations or traumatic wounds, including pre- and post-operative care; does not include temporomandibular joint (TMJ/TMD), maxillofacial, or orthognathic jaw surgery.

**ORTHODONTICS**
Treatment involving Orthodontic appliances for correction of malocclusion or malaligned teeth.

**PARENTAL RELATIONSHIP**
The relationship between a natural child or stepchild and a parent while the child or stepchild is Dependent on the parent for Coverage. Stepchildren will no longer be eligible to receive benefits when the marriage between their natural parent and the subscriber step-parent is terminated for any reason.

**PAYMENT**
Amount paid by the Subscriber for the purchase of a dental benefits plan.

**PERIODONTICS**
Procedures for treatment of the periodontal tissues that support the teeth.

**PREAUTHORIZATION**
The administrative process whereby a Member and Provider can learn, in advance of treatment, the level of benefits provided by the Master Policy for the proposed treatment plan. A detailed Treatment Plan, including pre-treatment x-rays or other Diagnostic information should be submitted in writing for this pre-determination of benefits. Pre-authorization does not guarantee payment should Coverage terminate, should there be a change in benefits, should benefit limits be used by submission of claims in the interim, or should actual circumstances of the case be different than originally submitted.

**PREVENTIVE**
Prophylaxis (cleaning), topical application of fluoride solutions, sealants and space maintainers.

**PROPHYLAXIS**
Scaling and polishing procedure performed on dental patients in normal or good periodontal health to remove coronal plaque, calculus, and stains to prevent caries and periodontal disease.

**PROSTHODONTICS**
Procedures for construction of crowns, implants, inlays, bridges, partial and complete dentures. Crowns and inlays will be provided as Prosthodontic benefits when teeth cannot be restored with conventional filling materials as determined by the Dental Review Committee.

**PROVIDER**
A duly licensed Dentist or Oral Surgeon legally entitled to practice dentistry at the time and in the place services are performed.

**QUADRANT**
A section of the mouth extending distally from the midline of the maxillary or mandibular arch in which five or more teeth are present.

**RESTORATIVE**
Amalgam, synthetic, and plastic restorations for treatment of decay. Crowns are provided as a Prosthodontic benefit with Pre-Authorization when teeth cannot be restored with the above materials.

**SUBROGATION**
PEHP's right to recover payments it has made on behalf of a covered Member because of an injury caused by a liable party.

**SUBSCRIBER**
An Employer's Employee who has enrolled for Coverage in the Group Insurance Program of Title 49, Chapter 20 of the Utah Code Annotated.

**TREATMENT IN PROGRESS**
Any procedure started prior to the date the Member became eligible or prior to the effective date of the group contract.

**TREATMENT PLAN**
A detailed statement from a Dentist or specialist of the proposed services to be rendered and the fees to be charged.

**WAITING PERIOD**
The period of time between the effective date of dental Coverage and the date when a Member becomes eligible and may receive benefits for Prosthodontic, Implant or Orthodontic treatment.

## III. Enrollment, Eligibility & Termination

### 3.1 GENERAL
Employees and their Dependents are eligible for Coverage as set forth herein. All Employees are required to enroll by completing and submitting a PEHP Enrollment form or by completing an electronic Enrollment form through PEHP's online Enrollment portal. All information gathered and the information contained on the Enrollment form is incorporated into this contract. Any Enrollment or Coverage changes must be done in writing, by completing and submitting a PEHP Enrollment form or by completing an electronic Enrollment form through PEHP's online Enrollment portal.

### 3.2 ELIGIBILITY
The eligibility of Employees and eligible Dependents is determined based on the Employer's personnel policies and the Employee's representations made on their verified individual Enrollment form, which form is a part of this contract. Copies of Member's completed Enrollment forms are available upon request. Members who commit fraud or any other crime against PEHP are not eligible for Coverage.

#### 3.2.1 ENROLLMENT PERIOD
An Employee has 60 days from his/her hire date to enroll for Coverage. Coverage will be effective in accordance with the Employer's personnel policies. If the Employee fails to enroll during this time period, he/she is a late enrollee and must wait until the next annual Enrollment period to enroll and Coverage will become effective on the Employer's annual renewal date.

Newly eligible Dependents may be enrolled within 60 days from the date of birth, or placement in your home, or from the date of marriage. For such Dependents, Coverage will become effective on the date of birth, placement in home, or the date of marriage. If not enrolled during this time period, Dependents are late enrollees and must wait until the next annual Enrollment period to enroll and Coverage will become effective on the Employer's annual renewal date. See Section 3.2.3 of this Master Policy for special Enrollment exceptions.

### 3.2.2 LATE ENROLLEES

An eligible Employee or eligible Dependent who is not enrolled with PEHP at the time of initial eligibility or due to a special Enrollment event, as described in Section 3.2.3 of this Master Policy, is a late enrollee. A late enrollee is not eligible to enroll until the next annual Enrollment period and is subject to any dental benefit Waiting Period specified by the Employer's dental plan(s).

### 3.2.3 SPECIAL ENROLLMENT

Eligible Employees who do not enroll themselves or their eligible Dependents during the initial Enrollment period, may enroll in Coverage prior to the next annual Enrollment period if they meet the qualifications for a special Enrollment period. PEHP shall allow special Enrollment in the following circumstances:

**Loss of Other Coverage**

Eligible Employees and/or their eligible Dependents who do not initially enroll in Coverage may enroll at a time other than annual Enrollment only if:

The eligible Employee and/or their eligible Dependents declined to enroll in this Coverage due to the existence of other dental plan Coverage; and

The eligible Employee and/or eligible Dependents who lost the other Coverage must enroll in this Coverage within 60 days after the date the other Coverage is lost.

Proof of loss of the other Coverage (Certificate of Creditable Coverage) must be submitted to PEHP at the time of application. Proof of loss of other Coverage or other acceptable documentation, must be submitted before any benefits will be paid on applicable Members. In the absence of a Certificate of Creditable Coverage, PEHP will accept the following:

1. A letter from a prior employer indicating when group coverage began and ended;
2. Any other relevant documents that evidence periods of Coverage; or;
3. A telephone call from the other Insurer to PEHP verifying dates of Coverage.

**Family Status Change**

PEHP shall also allow an Employee and/or Dependents to enroll if the Employee gains an eligible Dependent through marriage, birth, adoption or placement for adoption. At the time the Employee enrolls his/her Dependents, the Employee may also be enrolled. In the case of birth or adoption of a child, the Employee may also enroll the Employee's eligible spouse, even if he/she is not newly eligible as a Dependent. However, special Enrollment is permitted only when the Enrollment takes place within 60 days of the marriage, birth, adoption or placement for adoption. PEHP must receive a copy of the adoption/placement papers before a Dependent who has been adopted or placed for adoption can be enrolled in Coverage.

If a divorce decree is set aside by a court of competent jurisdiction, PEHP shall treat the Dependent(s) as eligible for re-Enrollment on the date the decree was set aside. Dependent(s) shall not be eligible during the time the divorce decree was in effect.

### 3.2.4 LEGAL GUARDIANSHIP

Dependent children who are under age 26 and who are placed under the legal guardianship (through testamentary appointment or court order) of the Subscriber or the Subscriber's lawful spouse prior to turning age 18, are eligible to be enrolled for Coverage.

### 3.2.5 TRANSFER OF COVERAGE

Should Coverage be transferred from one PEHP plan to another, or should Coverage terminate and at a later date be reinstated, plan provisions for limited benefits, yearly maximum benefits, and Lifetime Limits will be maintained and be continuous from the point of transfer or termination. If there is a lapse in Coverage, the six-month Waiting Period will apply beginning with the new effective date. Coverage for Dependents may be switched from one Subscriber to another without completing a new Waiting Period if previously satisfied through continuous Coverage on the other plan.

### 3.2.6 WAITING PERIOD FOR ORTHODONTIC, IMPLANT AND PROSTHODONTIC BENEFITS

There may be a Waiting Period of six months from the effective date of Coverage for Orthodontic, Implant and Prosthodontic benefits.

## 3.3 COVERAGE WHILE ON LEAVE

### 3.3.1 LEAVE OF ABSENCE

When a Subscriber is on temporary leave of absence approved by the Employer, Coverage may be maintained for maximum period of six months. In order to continue Coverage, the Subscriber must remit the Payment for Coverage directly to PEHP. Upon Employer notification that the Subscriber is on leave, PEHP will establish a billing cycle for the Subscriber to remit payment directly to PEHP.

Should a Subscriber be granted an unpaid leave of absence and neglect to remit the Payment within 30 days, Coverage will be cancelled retroactively to the end of the day through which Payment has been made. If there is lapse in Payment while on leave, re-enrollment cannot take place for a period of two years from the next annual Enrollment period.

**Military Leave**

Members called to active duty in the military are excluded from Coverage under this Master Policy, unless proper application for continuation of Coverage is made pursuant to the Uniformed Services Employment and Re-employment Act of 1994.

Subscribers may elect to continue Coverage for Dependents that were covered under the plan at the time of the Subscriber's call to active duty at the group rate. The Subscriber is responsible to ensure that the Subscriber's share of Payment for Coverage is made in a timely manner to PEHP. If Payment is not received by the date it is due or during the allowed grace period, Coverage will be cancelled. The Employer must continue paying the Employer share of the group rate.

If the Subscriber elects not to continue Coverage for themselves in whole or for their Dependents, Coverage may be reinstated within 90 days of discharge without being subject to the Missing Tooth Clause, six-month Waiting Period for Prosthodontic, Implant and Orthodontic treatment or any Treatment in Progress limitations.

**Family and Medical Leave Act of 1993 (FMLA)**

The Employer shall maintain Coverage during periods of Leave approved pursuant to the Family and Medical Leave Act of 1993. The Subscriber is responsible to ensure that Subscriber's share of Payment for Coverage is made in a timely manner to PEHP. If Payment is not received by the date it is due or during the allowed grace period, Coverage will be cancelled. The Employer must continue paying the Employer share of the group rate. If the Subscriber elects not to continue Coverage for themselves in whole or for their Dependents, Coverage may be reinstated within 60 days of returning to work.

**Personal Leave (Leave without Pay)**

Members who have exhausted their annual FMLA allowance, sick and annual time, may continue PEHP coverage during their leave of absence by paying the full cost of Coverage. Upon Employer notification that the Subscriber is on personal leave, PEHP will establish a billing cycle for the Subscriber to remit 100% of the group rate directly to PEHP.

Should a Subscriber be granted an unpaid leave of absence and neglect to remit the Payment within 30 days, Coverage will be cancelled retroactively to the end of the day through which Payment has been made. The Subscriber will be subject to applicable Waiting Period upon re-Enrollment. If Coverage is cancelled for non-payment, or voluntarily cancelled while on personal leave, the Subscriber will not be eligible for PEHP dental plans for two years from the next annual Enrollment period.

## 3.4 TERMINATION OR LIMITATION OF COVERAGE

Coverage for a Member will terminate if the Member ceases to be eligible for the following reasons:

1. Termination of employment – Coverage will terminate at the end of last day of work, the end of the last day of Employer's payroll period or the end of the last day of the month, according to the Employer's internal policies.
2. Dependent child turns age 26 – Coverage will terminate at the end of the month in which the Dependent child turns age 26.
3. Dependent child (legal guardianship) turns age 26 – Coverage will terminate at the end of the month in which the Dependent child turns age 26. If Employer elects to provide guardianship benefits between ages 19-26, coverage will terminate as if the child was a natural child of Subscriber.
4. Dependent child (foster care) turns age 19 – Coverage will terminate at the end of the day prior to the 19th birthday.
5. Divorce – Coverage will terminate for ex-spouses and stepchildren at the end of the day prior to the date on the court-

signed divorce decree.

6. Death of Subscriber – Coverage will terminate at the end of last day of work, the end of the last day of Employer's payroll period, or the end of the last day of the month, according to Employer's internal policies. Coverage for Dependents may be extended an additional one month if allowed by the applicable risk pool.
7. Failure to make timely Payment of Rates to PEHP –
   Coverage will terminate at the end of the day through which previous Payment has been received by PEHP.
8. Employer group terminates PEHP group coverage.

The Subscriber may not terminate coverage for Dependents anytime during the year unless one of the following conditions are met:

a. Dependent enrolls in other group coverage;

b. Commencement or termination of employment of Dependent;

c. A change from part-time to full-time status (or vice versa) by the Subscriber or the Dependent, only if the change results in loss of coverage; or

d. A significant change in the health Coverage of the Subscriber, Subscriber's spouse or Dependent attributable to their employment.

If a Subscriber voluntarily cancels dental Coverage during the annual Enrollment period or lets Coverage lapse while on leave, re-enrollment cannot take place for a period of two years from the next annual Enrollment period. Re-enrollment will be subject to new plan provisions, and would become effective at the beginning of the Employer's subsequent plan year."

It is the Subscriber's responsibility to make written notification when a Dependent is no longer eligible for Coverage. PEHP will not refund Payments made for ineligible Dependents. The Subscriber will be held responsible to reimburse PEHP for the claims processed beyond eligible service dates.

Pursuant to Section 76-6-521 of the Utah Code Annotated, anyone who fails to notify PEHP of Dependents ineligibility for Coverage is committing insurance fraud, a Class B Misdemeanor, punishable by fines or imprisonment.

PEHP shall have the right to deny claims, terminate any or all Coverages of a Member and seek reimbursement of claims paid upon the determination by PEHP that the Member has committed any of the following:

1. Fraud upon PEHP or Utah Retirement Systems;
2. Forgery or alteration of prescriptions;
3. Criminal acts associated with Coverage;
4. Misuse or abuse of benefits; or
5. Breached the conditions of this Master Policy.

#### 3.4.1 LIABILITY FOR SERVICES AFTER TERMINATION

All care, services, treatments, drugs, medications, supplies, or equipment obtained after the date of termination are the responsibility of the Member or the subsequent carrier or other Provider of Coverage, and not the responsibility of PEHP, no matter when the condition arose and despite care or treatment anticipated or already in progress.

### 3.5 EXTENSION OF BENEFITS

#### 3.5.1 COBRA COVERAGE

PEHP shall provide COBRA Coverage to Members originally enrolled through an Employer group who become entitled to such Coverage by operation of law. To be eligible for such Coverage a Member must strictly comply with all applicable deadlines and notice requirements in accordance with Section 1.15. COBRA Coverage will only be provided during the term of this Master Policy, and unless otherwise expressly stated in the Master Policy, and only for the minimum time and only to the minimum extent required by applicable state and federal law. COBRA Coverage will run concurrently with any other extension of Coverage, such as early retirement Coverage.

It is the responsibility of the covered Employee, spouse, or Dependent child to notify the Employer or PEHP in writing

within 60 days of a divorce, legal separation, child losing Dependent status or secondary qualifying event, under the group health plan in order to be eligible for COBRA Coverage. Notice should be sent to:

**PEHP**
**560 East 200 South**
**Salt Lake City, Utah, 84102**

Appropriate documentation must be provided as determined by PEHP. When PEHP is notified of a Qualifying Event, PEHP in turn will notify the Member that they have 60 days from either termination of Coverage or the date of COBRA election notice to elect COBRA. If no election is made within 60 days, COBRA rights are deemed waived and will not be offered again.

**Premium Payments**
Payments must be made by the Member retroactively to the date of the qualifying event and paid within 45 days of the date of election of continuation Coverage. There is no grace period on this initial premium. Subsequent Payments are due on first of each month with a 30-day grace period. Delinquent Payments will result in a termination of Coverage. PEHP will collect on claims paid in error because of ineligibility for continuation Coverage. Ineligible rates paid by the Member for continuation Coverage will be refunded.

**Continuation Coverage May Be Terminated**
Continuation Coverage may be terminated for any of the following reasons:

1. Employer no longer provides group dental Coverage;
2. The rate for continuation Coverage is not paid in a timely manner (within the acceptable grace period);
3. Member becomes covered, after the date of election, under another group dental plan (whether or not as an Employee) that does not contain any exclusion or limitation with respect to Pre-existing Conditions of the Member;
4. Member becomes entitled to Medicare, after the date of election;
5. Coverage has been extended for up to 29 months due to disability and there has been a final determination that the Member is no longer disabled; or
6. Determination by PEHP that the Employee or family Member has committed any of the following, fraud upon PEHP or the Utah Retirement Systems; forgery or alterations of prescriptions; criminal acts associated with COBRA Coverage; misuse or abuse of benefits; or breach of the conditions of this Master Policy.

### 3.5.2 UTAH MINI-COBRA

Under state law, dental Coverage may be extended to Members, if Coverage is provided by an Employer group with fewer than 20 Employees and the Member has been continuously covered by PEHP for at least three months immediately prior to termination. The Coverage shall be extended for a period of 12 months after termination, unless employment was terminated due to gross misconduct of the Subscriber, or the Member is eligible for any extension of Coverage required by federal law. The cost to continue Coverage is paid entirely by the Member electing Coverage. Continuation of Coverage will terminate on the earliest of:

1. The date 12 months after the extension Coverage begins;
2. The date the terminated Member fails to make timely Payments;
3. The date the terminated Member violates a material term of the contract;
4. The date the terminated Member becomes eligible for similar Coverage under another group plan; or
5. The date the Employer Coverage is terminated.

The extension of benefits Coverage will be administered in accordance with Utah State Law.

### 3.5.3 EARLY RETIREMENT

Subscribers who retire prior to age 65 may continue Coverage with PEHP until they reach age 65 provided that their Employer has adopted an early retiree program in the Employer contract with PEHP and all Payment for Coverage is made as set forth in the Employer's contract with PEHP. If Payment is not received by PEHP, Coverage will terminate at the end of the day through which previous Payment has been received by PEHP. Early retiree Coverage runs concurrently

with COBRA.

## 3.6 COORDINATION OF BENEFITS

### 3.6.1 COORDINATION OF BENEFITS WITH OTHER CARRIERS

The Coordination of Benefits provision applies when a Subscriber or the Subscriber's covered eligible Dependents have dental care Coverage under more than one dental benefit plan, except those specifically excluded in Section 3.6.6 of this Master Policy. Coordination of Benefits will be administered in accordance with Utah Insurance Code rules. When a Subscriber or Subscribers covered Eligible Dependents have dental Coverage under more than one benefit plan, one plan shall pay benefits as the primary plan and the other plan shall pay benefits as the secondary plan.

The Subscriber must inform PEHP of other dental Coverage in force by completing a duplicate Coverage form. If applicable, the Subscriber will be required to submit court orders or decrees. Subscribers must also keep PEHP informed of any changes in the status of other Coverage.

### 3.6.2 ORDER OF BENEFIT DETERMINATION

PEHP determines the order of benefits using the first of the following rules that applies:

1. The benefits of the plan that covers the person as an Employee, or Subscriber, are determined before those of the plan that covers the person as a Dependent.
2. *Dependent Child—Parents not Separated or Divorced*

   The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are as follows:

   a. The benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the year. (The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.)

   b. If both parents have the same birthday, benefits of the plan that covered the parent longer are determined before the shorter Coverage.

3. *Dependent Child— Parents Separated or Divorced*

   If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

   a. First, the plan of the parent who is ordered by divorce decree to maintain Coverage. If neither or both parents are ordered, the plan of the Subscriber whose birthday falls earlier in the calendar year;

   b. Then, the plan of the spouse of the parent who is ordered by divorce decree to maintain Coverage. If neither or both parents are ordered, the plan of the Subscriber whose birthday falls second among Subscribers in the calendar year;

   c. Then the plan of the parent who is not ordered by divorce decree to maintain coverage. If neither or both parents are ordered, the plan of the Subscriber whose birthday falls third among Subscriber in the calendar year;

   d. Finally, the plan of the spouse of the parent who is not ordered by divorce decree to maintain Coverage. If neither or both parents are ordered, the plan of the Subscriber whose birthday falls last among Subscribers in the calendar year.

After the Dependent turns 18, the plan of the parent with whom the Dependent resides shall be the primary payer. If the Dependent does not reside with either parent, all Subscriber's birthdates will be considered. Please refer to 3.6.2.3 a-d above. A copy of the divorce decree may be requested for file documentation.

There are many circumstances that affect order of benefit determination. Please contact PEHP Customer Service for further clarification.

### 3.6.3 COORDINATION OF BENEFITS RULES

When PEHP is the primary plan, its Eligible Benefits are paid before those of the other dental benefit plan and without considering the other dental plan's benefits. When PEHP is the secondary plan, its Eligible Benefits are determined after those of the other dental benefit plan and may be reduced to prevent duplication of benefits.

When secondary, PEHP calculates the amount of Eligible Benefits it would normally pay in the absence of the primary plan coverage, including Deductible, Copayments, coinsurance, and the application of credits to any policy maximums. PEHP then determines the amount the Member is responsible to pay after the primary carrier has applied its allowed contracted amount. PEHP will then pay the amount of the Member's responsibility after the primary plan has paid, up to the maximum amount it would have paid as the primary carrier. In no event will PEHP pay more that the Member is responsible to pay after the primary carrier has paid the claim.

Coverage under this Master Policy is primary only when required to be primary by law or by this Master Policy. If the other dental benefit plan does not have rules for Coordination of Benefits, then Coverage under the other plan will be primary to Coverage under this Master Policy.

When a payment between PEHP and a Provider/facility has been coordinated incorrectly, PEHP will make proper payment adjustment if the request is submitted to PEHP within 12 months from the date of payment.

#### 3.6.4 DUAL COVERAGE

When a Dependent enrolls on a second PEHP plan creating "dual Coverage" (a combination of two or more PEHP plans), that plan is subject to the six-month Waiting Period for Prosthodontic, Implant and Orthodontic services. Eligible Benefits will be adjudicated in the same order as any other Coordination of Benefits. Exception: The Waiting Period will be waived if previously satisfied with other continuous PEHP-sponsored dental Coverage. This does not affect Treatment in Progress provisions.

For plans with limited benefits, the plan covering the patient as primary will pay up to the plan allowance. The secondary plan will pay Eligible balances not to exceed Allowed Amount.

#### 3.6.5 CORRECTION OF PAYMENT ERROR

PEHP shall have the right to pay to any organization making payments under other plans that should have been made under this Master Policy, any amount necessary to satisfy the payment of claims under this Master Policy. Amounts so paid by PEHP shall be considered benefits paid under this Master Policy, and PEHP shall be fully discharged from liability under this Master Policy to the extent of such payments. Corrections will be made a maximum of 24 months from date of service except in the cases of Medicaid, Medicare, or when ordered by a hearing officer or court of competent jurisdiction.

#### 3.6.6 NO COORDINATION OF BENEFITS WITH OTHER TYPES OF PLANS

PEHP does not coordinate with school plans, sports plans, Accident only Coverage, specified disease Coverage, nursing home or long term care plans, disability income protection Coverage, Veterans Administration plans, or Medicare Advantage Supplement plans.

## IV. General Provisions

### 4.1 MASTER POLICY

This Master Policy, with a complete description of benefits, is maintained by PEHP solely for use by its Members. PEHP does not authorize any other use of this Master Policy.

This Master Policy and the applicable Benefits Summary for your Employer Group's Eligible Benefits are intended to work in conjunction with one another. In any conflict regarding Eligible Benefits, the Master Policy supersedes the Benefits Summary.

### 4.2 AUTHORIZATION TO OBTAIN/RETAIN/SHARE INFORMATION

By enrolling with PEHP and accepting or receiving services and/or benefits through PEHP, all Members agree that PEHP and dental care Providers are authorized to obtain, retain and share information (including but not limited to sensitive medical information contained in dental records) necessary or reasonably believed to be necessary to properly diagnose and treat Members, in order to process and evaluate claims for services rendered. PEHP will maintain the confidentiality of such information in its possession as regulated by 45 CFR 160 and 164 as amended, Utah Code Annotated §49-11-618 and applicable Utah State Retirement Board resolution(s). Upon receiving appropriate documentation, PEHP may provide a custodial parent information regarding claims payment for the covered Dependent.

## V. Conditions of Service

### 5.1 EXCESS PAYMENT OR MISTAKEN PAYMENTS

PEHP will have the right at any time to recover any payment made in excess of PEHP's obligations under this Master Policy, whether such payment was made in error or otherwise. Such right will apply to payments made to Members, Providers or Facilities. If an excess payment is made by PEHP, the Member agrees to promptly refund the amount of the excess. PEHP may, at its sole discretion, offset any future payment against any excess or mistaken payment already made to a Member or for a Member to a Provider or Facility. The making of a payment in error or under a mistaken understanding of the relevant facts is not recognition by PEHP that the service in question is covered under this Master Policy. If a claim incurred due to false pretenses, whether intentional or not, false representation, or actual fraud is discovered, PEHP may deny or seek reimbursement for payment, including associated costs and legal fees made in association with such claim.

## VI. Covered Benefits

The following are covered benefits under the PEHP dental plans.

Notwithstanding any other statements in this benefits summary, in rare instances PEHP will not cover any amounts billed by certain Providers that PEHP has determined have an unsafe practice record, or maintain a pattern of overbilling patients.

To look at the list of PEHP In-Network Providers and a list of those that PEHP will not pay, use the PEHP Provider Look-up Tool found at www.pehp.org.

### 6.1 IN-NETWORK PROVIDERS

When a Member receives services from an In-Network Provider, the Member pays the specified Deductible and/or Copayments at the time of service and the balance is paid by PEHP. When an Out-of-Network Dental Provider is used, PEHP will pay Eligible Benefits up to the Allowed Amount, minus applicable Copayments. The Member will be responsible to pay the Deductible and/or Copayment and any remaining balance. When using an Out-of-Network Provider, it is the Member's responsibility to ensure that the claim is filed with PEHP.

### 6.2 OUT-OF-COUNTRY DENTAL CARE

If a Member receives dental care in another country, allowable fees will be eligible billed charges. PEHP will translate the claim into English and convert the charges to U.S. currency.

### 6.3 BASIC BENEFITS

Eligible Benefits are payable according to the Allowed Amount, up to the maximum benefit per plan year, including Prosthodontic and Implant benefits.

#### 6.3.1 ORAL EXAMINATIONS

1. Periodic oral exam fees are allowed twice in a plan year. A re-evaluation is considered included in the primary procedure and is not payable separately.
2. Comprehensive oral evaluation is eligible for an initial extensive evaluation and recording of the extra-oral and intra-oral hard and soft tissue, along with interpretation of other Diagnostic procedures.
3. A specialist exam is allowable for the initial visit when specific treatment is required by a specialist (oral surgeon, endodontist, periodontist, pediadontist, prosthodontist) and may be payable in addition to a periodic exam by another Dentist. A periodic exam is not allowable in addition to a specialist exam by the same Dentist. A consultation is allowable as a service provided by a dental specialist other than the practitioner providing treatment.
4. Emergency exam is allowable when necessary to alleviate acute symptoms on an episodic basis. It is not eligible with a regular appointment. An Emergency exam may be reported together with palliative treatment or specific treatment codes, but not both.
5. Emergency palliative treatment is allowable for treatment of dental pain when no other treatment except x-ray is given. If definitive treatment is provided and the patient does not need to return for more definitive, additional treatment for the same condition that prompted the "Emergency visit," then the service that was performed is calculated

as treatment and payment will be made only for that procedure.

6. The benefit for dental services in a hospital Emergency room, including physicians' charges, is limited to the eligible fee for an Emergency exam.
7. Office visits after regularly scheduled hours, may be allowable in lieu of Emergency exam when the visit is after regularly scheduled hours for that Dentist (night-time, weekends, holidays) and may be billed with either palliative treatment or specific treatment codes, but not both.
8. When specifically requested by PEHP, a second opinion consultation will be paid at 100% of AA and the Copayment will be waived.

### 6.3.2 DIAGNOSTIC X-RAYS/SERVICES

1. Complete mouth x-rays (posterior bitewing films and 14 periapical films plus bitewings) are allowed once during any three-year period for members age 13 and over, in lieu of panorex x-ray.
2. Full series bitewing x-rays (4) are allowed only twice in a plan year.
3. Supplemental periapical (PA) x-rays or oral/facial images are allowed when necessary for specific Diagnostic purposes. Multiple PAs in any one visit will be limited to the amount allowed for complete mouth x-rays, but will not apply to the time limit for complete mouth x-rays of once in a three-year period.
4. A panorex is allowable once during any three-year period in lieu of complete mouth x-ray.
5. Vertical bitewings are payable up to eight films.
6. Oral pathology laboratory services are allowable as necessary.

### 6.3.3 PREVENTIVE

1. Prophylaxis (cleaning) is allowed twice in a plan year. A child Prophylaxis will be allowed through age 13. An adult Prophylaxis will be allowed for age 14 and over.
2. Fluoride application is allowed when in conjunction with a Prophylaxis unless otherwise stated in this policy.
3. Fluoride application may be allowed separately only following an adult periodontal Prophylaxis or for a child three years of age or younger when a Prophylaxis cannot be done.
4. Space maintainers for eligible Dependents through 16 years of age are allowed if used to maintain the present position of the tooth, but not to move the tooth, which involves Orthodontics. Recementation of space maintainers is allowed once in an 18-month period. Replacement of a space maintainer is allowed once in an 18-month period.
5. Sealants on permanent molars are allowed once during any five-year period for eligible Dependents through 17 years of age. Permanent molars include teeth numbers 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, and 32. (Permanent molars with occlusal restoration are ineligible.)

### 6.3.4 ORAL SURGERY

1. Surgery that is dental in origin:
   a. Extraction of teeth (allowable fee includes local Anesthesia and post-op care);
   b. Alveoloplasty;
   c. Vestibuloplasty;
   d. Excision of cysts;
   e. Excision of exostosis;
   f. Incision and drainage of abscess;
   g. Frenectomy;
   h. Surgical exposure of a tooth;
   i. Dental lacerations; and
   j. Biopsy of oral tissue involving the teeth or gingival tissue.
2. Histopathic examination following biopsy of abnormal tissue(s).

3. Fiberotomy is allowable separate from Orthodontic benefits.
4. Tooth re-implantation will only be considered under the dental Accident benefit.
5. Intravenous sedation is allowed with eligible apicoectomy, osseous and Oral Surgery procedures. It is not eligible with root canal therapy, simple extractions, or for dental phobia or anxiety without Pre-authorization (except for children under six years of age).
6. General Anesthesia is allowed when necessary for extraction of impacted teeth or some other oral surgeries. It is not allowable in conjunction with simple extractions, or for dental phobia or anxiety without Pre-authorization (except for children under six years of age).
7. Surgical stents are only payable following eligible surgery.

#### 6.3.5 RESTORATIVE

1. One restoration per surface for treatment of decay or fracture will be allowed during any 18-month period, regardless of the number of restorations placed on the surface.
2. Except on anterior teeth, fillings on adjacent surfaces will be coded as combined surfaces. Fillings on opposite sides of a tooth may be coded separately.
3. The Restorative benefit will be limited to the allowance for a standard filling regardless of the technique used.
4. One stainless steel crown will be allowed during any 24-month period.
5. The Maximum Benefit on a primary tooth will be the cost for a stainless steel crown. A stainless steel crown with resin window is not eligible on posterior teeth.
6. A crown buildup and/or pins is allowable as a Restorative benefit.
7. A sedative filling is eligible and may be payable in addition to palliative care or a permanent filling on the same tooth.
8. A post is payable only following root canal therapy on the tooth. A cast post and core is eligible once in an 18-month period, or once in five years when done in conjunction with a crown.
9. A gold foil restoration is only eligible up to an amount equal to a composite filling.
10. Provisional crown is eligible as a one-time restorative benefit when utilized as an interim restoration of at least six months duration to allow healing. This is not to be used as a temporary crown for a routine prosthetic restoration.
11. Recementation of crowns is payable as a Restorative benefit.

#### 6.3.6 RECONSTRUCTION

Appropriate payment will be made for the cost of procedures necessary to eliminate oral disease. Appliances or restorations necessary to increase vertical dimension, stabilize periodontally involved teeth, or restore or equilibrate the occlusion are not eligible and the cost will remain the responsibility of the Member.

#### 6.3.7 ENDODONTIC

1. Only one root canal benefit is payable per tooth. Only one pulpotomy benefit is payable per primary tooth. Retreatments by the same Provider may be considered for payment if Pre-authorized by PEHP. Root canal treatment is payable in addition to a previous pulpotomy on the same tooth.
2. Final restorations are considered separate procedures following endodontic treatment and are allowed separately.
3. Benefits may be considered for treatment of root canal obstruction; non-surgical access, incomplete Endodontic therapy; inoperable or fractured tooth, or interval root repair of perforation defects.
4. One pulp cap per tooth will be allowed during any 18-month period. Additional payment for a cement base will not be allowed separately.

#### 6.3.8 PERIODONTIC

1. Payment for periodontal surgery includes postoperative care for six months following treatment.
2. Full mouth periodontal scaling and curettage is allowed once during any 12-month period.
3. Periodontal Prophylaxis is allowed once during any three-month period.
4. Gingivectomy, gingivoplasty, gingival curettage, osseous surgery, and/or free soft tissue graft procedure are allow-

able once in any 12-month period.

5. Emdogain is eligible in conjunction with eligible periodontal surgery. Calcitite is eligible as a synthetic bone graft substitute.
6. Benefits will be allowable for a full Quadrant if there are 5–8 teeth present. Whenever the anatomical Quadrant contains fewer than five teeth, the benefit will be calculated as a fraction of the full Quadrant fee.
7. Provisional splinting is a covered benefit once in a three-year period.
8. Crown lengthening may be considered for benefits with Pre-authorization and submission of x-rays.
9. Periodontal charting may be requested for review of claims. No benefits are payable separately for periodontal charting.

### 6.4 PROSTHODONTIC BENEFITS

Eligible Benefits are payable according to the Allowed Amount, up to the maximum benefit per plan year, including Basic and Implant benefits.

1. Prosthodontic benefits include procedures for construction of crowns, implants, onlays and bridges, partial and complete dentures for treatment of severe decay, fracture or extraction. Crowns and onlays will be provided as Prosthodontic benefits when teeth cannot be restored with conventional filling materials.
2. Prosthodontic appliances, including crowns, implants, onlays, bridges, and dentures, may be considered once per tooth during a five-year period.
3. An inlay is only eligible up to an amount equal to a composite filling.
4. If Prosthodontic benefits are paid and a tooth or teeth are subsequently extracted requiring another form of prosthetic within a five-year period, the amount previously paid will be deducted to determine if further Prosthodontic benefits are payable.
5. Replacement of extracted teeth with complete or partial dentures or fixed bridges may be allowed once in a five-year period. If a cast chrome or acrylic partial denture will restore the tooth, and the patient or Dentist selects any other type of appliance, PEHP will allow the fee for the minimum service for restoration. (See missing tooth Exclusion under Limitations.)
6. The benefit for a partial denture is a global fee and includes the teeth and two clasps. If, at a later date, additional teeth are extracted, an additional benefit is allowable for adding teeth to an existing partial. Replacement teeth are allowed only once in an 18-month period.
7. In the event a stainless steel or resin crown is approved and is later replaced by a permanent crown within two years the amount originally paid for the stainless steel or resin crown will be deducted from the benefit for the permanent prosthesis.
8. If, in the construction of a denture, the patient or Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, PEHP will allow the fee for the minimum service for restoration.
9. Replacement of an existing denture will be payable only if it is nonfunctional. This benefit is payable once in a 5-year period.
10. One laboratory reline is allowed at any time after the initial placement of a denture and once during any three-year period thereafter. Office relines are considered temporary and not allowable benefits.
11. The first four denture adjustments by the same Dentist following a new denture are included in the fee for the denture and will not be payable separately. Thereafter, the plan will allow two per year.
12. Tissue conditioning is allowable as a Prosthodontic benefit. Repeat procedures require a narrative and are subject to review by the PEHP Dental Review Committee.
13. Restorative dental services in connection with an overdenture are not covered, except root canal therapy.
14. An occlusal guard for severe bruxism may be allowed once in a five-year period.
15. A post is payable only following root canal therapy on the tooth. A replacement post is eligible once in an 18-month period or after five years if placed in conjunction with a crown.

#### 6.4.1 LIMITATIONS

The following limitation may not apply on your plan. Please refer to your Employer or call PEHP for details.

There is a six-month Waiting Period for Prosthodontic benefits. All benefit Pre-authorizations for prosthetics during the first six months of Coverage are subject to the six-month Waiting Period. No benefits will be payable for services performed before the six-month Waiting Period has been met, even if Pre- authorized during that period.

Services in progress at the time of eligibility or prior to benefit inception will not be eligible for benefit payments.

Services must be completed in order for payment to be made. Services related to the preparation, supplying or installation of a prosthetic onlay, crown, or other services requiring more than one session are considered for payment only after insertion or completion.

Tooth preparations, light curing, acid etching, adhesives, cement bases, impressions and local Anesthesia are considered a part of the restoration process and are not payable separately. Temporary restorations are payable under the prosthodontic benefit once per tooth in a five year period. Payment will be deducted from the payment of the permanent restoration, if the permanent restoration is payable.

Complete Mouth x-rays are not covered for children under age 13. PEHP will allow 2 periapicals and 2 bitewings or 4 bitewings every six months. Panorex x-rays are allowed for all Members once during any three-year period. PEHP will allow either an eligible Panorex x-ray or a Complete Mouth x-ray once during any three-year period.

#### 6.4.2 MISSING TOOTH EXCLUSION

The following limitation may not apply on your plan. Please refer to your Employer or call PEHP for details.

Services to replace teeth that are missing prior to effective date of Coverage are not eligible for a period of five years from the date of continuous Coverage with PEHP. However, the plan may review the abutment teeth for eligibility of Prosthodontic benefits. The Missing Tooth Exclusion does not apply if a bridge, denture, or implant was in place at the time the Coverage became effective.

### 6.5 IMPLANT BENEFITS

Eligible Benefits are payable according to the Allowed Amount, up to the maximum benefit per plan year, including Basic and Prosthodontic benefits.

1. Implants may be considered once per tooth during a five year period.
2. All eligible services performed in conjunction with Implants are payable at 50% of the Allowed Amount.

There may be a six-month Waiting Period for Implant benefits. Please refer to your Employer or call PEHP for details. If applicable, no benefits will be payable for services performed before the six-month Waiting Period has been met, even if Pre-authorized during that period.

Treatment in progress at the time of eligibility or prior to benefit inception will not be eligible for benefit payments.

Services must be completed in order for payment to be made.

### 6.6 ORTHODONTIC BENEFITS

Eligible Benefits are payable at 50% of billed charges up to a Lifetime Maximum of $1,500. The Member is responsible for any difference in cost.

1. Orthodontic benefits do not require written Preauthorization.
2. Payment of Eligible Benefits will automatically be processed for payment on a quarterly basis over a period of 12 to 24 months per individual case. A minimum of 18 months will be considered for full Orthodontic treatment.
3. Orthodontic records, study models and x-rays necessary to diagnose and determine Orthodontic treatment are considered under this benefit.
4. Benefits will be prorated per phase of treatment.

#### 6.6.1 LIMITATIONS

There may be a six-month Waiting Period for Orthodontic benefits. Please refer to your Employer or call PEHP for details. If applicable, no benefits will be payable for services started before the six-month Waiting Period has been met.

No cases in progress at the time of eligibility or prior to benefit inception or started during the six-month Waiting Period

may qualify for payment. When banding has not been done, but previous minor therapy or records have been completed, the benefit will be subject to review of prior Orthodontic records.

Services must be completed in order for payment to be made. Services related to the preparation, supplying or installation of an Orthodontic appliance or other services requiring more than one session are considered for payment only after insertion or completion of banding.

If Orthodontic treatment is terminated for any reason before completion, or Member becomes ineligible, benefits will cease with payment through the month in which termination occurs. If such services are resumed, benefits for the services, to the extent remaining, shall be resumed if there is no lapse in payment and Coverage is continuous.

Orthodontic benefits are payable for functionally related problems and not purely Cosmetic Dentistry.

In the event the Member switches between PEHP-offered dental plans while Orthodontics are in progress, benefits will continue as long as there is no lapse in Coverage.

Treatment must be completed prior to the 26th birthday for eligible Dependent children. No payment will be made for costs incurred after the 26th birthday, unless Coverage is continued with a COBRA dental policy.

### 6.7 DENTAL ACCIDENT BENEFIT

PEHP will allow up to $500 in addition to the yearly benefit for Accidental injuries to sound, natural teeth (teeth that are whole or properly restored) occurring while a covered Member of PEHP, including their replacement. Charges are payable towards Copayments or at the Allowed Amount for eligible services if the yearly maximum is met. This benefit is available for a period not to exceed 12 months from the date of the Accident. Total supplemental benefits for any one Accident may not exceed $500 per individual.

To be eligible for the Dental Accident benefit, the Accident must have occurred while a Member of PEHP. Coverage must also be continuous and in effect at time of service.

The six-month Waiting Period may be waived for Prosthodontics and Implants as a result of an Accidental injury.

This coverage is only available if you do not have PEHP medical coverage.

## VII. General Limitations and Exclusions

### 7.1 PREAUTHORIZATION LIMITATIONS

A written Pre-authorization and Treatment Plan is only required for Prosthodontic services on teeth numbers 7–10 and 23–26, and for crown lengthening. Written Pre-authorization is not required for Orthodontics,. If requested, a written Pre-authorization will be provided for other services.

A Treatment Plan should include a detailed statement of the proposed services, applicable CDT codes, and the fees to be charged, along with submission of pre-treatment x-rays. When indicated, a narrative report may be used to furnish additional information to support the clinical findings. The Treatment Plan should be discussed and agreed upon with the Provider prior to treatment.

PEHP shall approve for benefits only those treatments that are in keeping with the terms of this Master Policy and will not approve any treatment for benefits until proper proof of loss is accepted as a liability against the terms of this Master Policy. Pre-authorization does not guarantee payment. Benefits are payable according to availability of benefits and eligibility at the time the claim is processed.

If Pre-authorized services are not completed by the end of the plan year from date approved, a new Pre-authorization will be required.

PEHP will not be responsible for Pre-authorizations made by other insurance carriers. **Pre-authorized benefits are subject to change with new plan year provisions.**

Once services are completed, the dated Treatment Plan should be submitted to PEHP for payment. Eligible Prosthodontic services are considered completed on the date they are placed.

All treatment must be completed prior to termination of Coverage to be eligible. A COBRA policy is available for continuation of Coverage.

### 7.2. GENERAL EXCLUSIONS

Charges for the following circumstances are excluded as benefits under PEHP:

1. All charges for services received as a result of an Industrial Claim (on-the-job) injury or illness, where any portion of which, is payable under Worker's Compensation or Employer's liability laws.
2. Services provided by any federal, state or provincial government agency or provided without cost to the Member by any municipality, county or other political subdivision or community agency.
3. Dental services started or incurred prior to the effective date of Coverage.
4. Dental services incurred or completed after termination of Coverage.
5. General Anesthesia, except when approved with written Pre-authorization and administered by a Dentist or certified anesthetist in connection with eligible Oral Surgery.
6. Prescription drugs.
7. Therapeutic drug injection.
8. Hospital services or Ambulatory Surgical Facilities.
9. Injury, sickness or any conditions resulting from any act or incident of war, whether declared or undeclared.
10. Services incurred in connection with injury or illness arising from the commission of
    a. a felony;
    b. an assault, riot or breach of peace;
    c. a Class A misdemeanor;
    d. any criminal conduct involving the illegal use of firearm or other deadly weapon;
    e. other illegal acts of violence.

    Such claims shall be denied at the time the Member is charged with an assault or felony, but will be reevaluated in accordance with this Master Policy if the Member is later acquitted of the assault or felony.
11. Tooth implantation, transplantation or surgical repositioning of teeth.
12. Nitrous oxide, local Anesthesia or non-intravenous conscious sedation.
13. Plaque control programs, oral hygiene instruction, or nutritional counseling.
14. Dental services or supplies for which benefits are payable under any other medical plan, but only to the extent that benefits are payable under such other provisions or policies.
15. Appliance or restorations necessary to increase vertical dimension of teeth or restore or equilibrate the occlusion; occlusal analysis or adjustment.
16. Charges for services with respect to congenital malformation or cosmetic surgery, or Dentistry for solely cosmetic reasons, including but not limited to bleaching, bonding, veneers and crowning of peg laterals.
17. Any surgery, Orthodontics, or procedure to diagnose, correct or treat temporomandibular joint syndrome or myofunctional therapy (TMJ/TMD).
18. Recording or charting of jaw movements and chewing functions (gnathological recordings).
19. Application of sealants on other than permanent molars, for Dependents through age 17. Application of sealants on the Subscriber or Dependents 18 years or older.
20. Replacement of tooth structure lost by attrition or abrasion or crowns done to alter vertical dimension.
21. Inlays (benefits will be given for composite filling where decay is present) or recementation of inlays.
22. Athletic mouth guards.
23. Habit appliances.
24. Study molds or Diagnostic casts, except in conjunction with eligible Orthodontic treatment.
25. Replacement restorations for other than decay or fracture.
26. Replacement of fillings for possible toxicity.

27. Pulp vitality testing; Caries susceptibility tests.
28. Bacteriologic studies.
29. N2 or Sargenti root canal procedure.
30. Recording charts, exam data, pulp testing, sterilization of equipment, OSHA requirements, dressing changes, etc. are considered all-inclusive and are not payable separately.
31. Behavioral management.
32. Pulse oximeter, ECG monitor.
33. Overutilization, services that are not medically or functionally necessary to treat the condition, or services not within Community Standard.
34. Replacement of teeth missing prior to effective date of Coverage for a period of five years from effective date of continuous Coverage with PEHP when the exclusion is applicable to the Employer Plan. Exception: Benefits may be eligible if a prior prosthesis is in place on the effective date of Coverage (subject to six-month Waiting Period if applicable to Plan).
35. Maxillofacial or orthognathic jaw surgery.
36. Maxillofacial prosthetics.
37. Removal of non-odontogenic cyst or tumor or other procedures that are not dental in origin.
38. Crowns with facings posterior to the second bicuspid.
39. Care, treatment, operations or supplies that are illegal, generally considered Experimental, Investigational, Unproven, or for research purposes by the dental profession, that are not recognized or proven to be effective for treatment of illness or injury in accordance with generally accepted dental practices.
40. Care, treatment, operations, or supplies, or any appliances, aids, devices, or drugs, that are not FDA approved.
41. Charges for services as a result of an auto related injury and covered under No Fault insurance or that would have been covered if Coverage was in effect as required by law.
42. Lost, stolen, or broken dentures, bridges, Orthodontic appliances or other dental appliances.
43. Hypnosis and relative analgesia.
44. Hospital visits by a physician or Dentist.
45. Separate charges for tooth preparation, desensitizing medication, cement bases, silicate cement, impressions or local Anesthesia.
46. Diagnostic videos.
47. Claims submitted past the timely filing limit allowed per Section 8.1 of this Master Policy.
48. Care, treatment or services the Member is not, in the absence of this policy, legally obligated to pay.
49. Office relines.
50. Expenses in connection with appointment scheduled and not kept.
51. Expenses in connection with telephone consultations.
52. Expenses in connection with shipping, handling, postage, interest, or finance charges.
53. Charges made for completion or submission of claim forms or for dental records necessary for review of claims.
54. Office calls for observation.
55. Charges for remote dental evaluation and manage ment, including prescriptive services provided by the Internet, Telephone or Catalog without personal evaluation by a licensed Dentist or Provider.
56. Unbundling or fragmentation of codes.
57. Home fluoride.
58. Charges for special equipment, machines, or devices in the Dentist's office used to enhance Diagnostic or therapeutic

services in a Dentist's practice.

59. Any services or supplies not specifically identified as an Eligible Benefit.
60. PEHP is not responsible to pay any benefits given verbally or assumed except as written in a Preauthorization, documented by Customer Service or as described in this policy.
61. Charges for dental care rendered by an immediate family member.
62. Charges in excess of contract limitations or the Allowed Amount.
63. Charges incurred while a Member is incarcerated or in police custody.

## 7.3 SUBROGATION AND CONTRACTUAL REIMBURSEMENT

### 7.3.1 CONTRACTUAL REIMBURSEMENT

The Member agrees to seek recovery from any person(s) who may be obligated to pay damages arising from occurrences or conditions caused by the person(s) for which Eligible Benefits are provided or paid for by PEHP and promises to keep PEHP informed of his/her efforts to recover from those person(s). If the Member does not diligently seek such recovery, PEHP, at its sole discretion, reserves the right to pursue any and all claims or rights of recovery on the Member's behalf.

In the event that Eligible Benefits are furnished to a Member for bodily injury or illness, the Member shall reimburse PEHP with respect to a Member's right ( to the extent of the value of the Benefits paid) to any claim for bodily illness or injury, regardless of whether the Member has been "made whole" or has been fully compensated for the illness or injury. PEHP shall have a lien against any amounts advanced or paid by PEHP for the Member's claim for bodily injury or illness, no matter how the amounts are designated, whether received by suit, settlement, or otherwise on account of a bodily injury or illness. PEHP's right to reimbursement is prior and superior to any other person or entity's right to the claim for bodily injury or illness, including, but not limited to, any attorney fees or costs the Member chooses to incur in securing the amount of the claim.

### 7.3.2 SUBROGATION

The Member agrees to seek recovery from any person(s) who may be obligated to pay damages arising from occurrences or conditions caused by the person(s) for which Eligible Benefits are provided or paid for by PEHP and promises to keep PEHP informed of his/her efforts to recover from those person(s). If the Member does not diligently seek such recovery, PEHP, at its sole discretion, reserves the right to pursue any and all claims or rights of recovery on the Member's behalf. The Member will cooperate fully with PEHP and will sign and deliver instruments and papers and do whatever else is necessary on PEHP's behalf to secure such rights and to authorize PEHP to pursue these rights.

In the event that Eligible Benefits are furnished to a Member for bodily injury or illness, PEHP shall be and is hereby subrogated (substituted) with respect to a Member's right (to the extent of the value of the Benefits paid) to any claim for bodily illness or injury, regardless of whether the Member has been "made whole" or has been fully compensated for the illness or injury. PEHP shall have a lien against any amounts advanced or paid by PEHP for the Member's claim for bodily injury or illness, no matter how the amounts are designated, whether received by suit, settlement, or otherwise on account of a bodily injury or illness. PEHP's right to reimbursement is prior and superior to any other person or entity's right to the claim for bodily injury or illness, including, but not limited to, any attorney fees or costs the Member chooses to incur in securing the amount of the claim.

At the time of PEHP discovery of a possible Subrogation case, PEHP will send a Request For Medical Claim Information questionnaire to the Subscriber advising response is required within 30 days and that claims related to the incident will be held until the questionnaire is received. If not received within 12 months of the request, no payment will be made for the claims related to the incident. If received later than 90 days but less than 12 months from the request, payment will only be made for claims received in the 90 days prior to receipt of the information.

### 7.3.3 ACCEPTANCE OF BENEFITS AND NOTIFICATION

Acceptance of the benefits hereunder shall constitute acceptance of PEHP's rights to reimbursement or Subrogation rights as explained above.

### 7.3.4 RECOUPMENT OF BENEFIT PAYMENT

In the event the Member impairs PEHP's reimbursement or Subrogation rights under this contract through failure to notify PEHP of potential liability, settling a claim with a responsible party without PEHP's involvement, or otherwise, PEHP

reserves the right to recover from the Member the value of all benefits paid by PEHP on behalf of the Member resulting from the party's acts or omissions.

No judgment against any party will be conclusive between the Member and PEHP regarding the liability of the party or the amount of recovery to which PEHP is legally entitled unless the judgment results from an action of which PEHP has received notice and has had a full opportunity to participate.

## VIII. Claims, Submission & Appeals

PEHP reserves the right at its discretion to determine whether a claim is an Eligible Benefit or to require verification of any claim for Eligible Benefits. In order to be considered for payment, expenses must be incurred while Member is eligible under the plan. The date the medical or dental service is received shall be the date the medical or dental expenses are incurred. PEHP shall not be responsible for any expenses that are not Eligible Benefits.

PEHP may request the dental records, operative reports, pathology reports, x-rays, photos, etc. of a Member. PEHP may review the dental records or have the records reviewed by qualified Providers or other qualified entities to audit claims for eligibility, Pre-existing Condition, Medical Necessity, and appropriateness of services with the Community Standard or usual patterns of care as determined by PEHP.

Benefits are adjudicated in conjunction with the Allowed Amount and code review systems implemented by PEHP. Claims may be returned for incomplete or improper coding. If, after a second request, necessary records are not received, the claim(s) will be denied for insufficient documentation.

### 8.1 CLAIMS SUBMISSION

When an In-Network Provider is used, the Provider will submit the claims directly to PEHP. Payment will be made directly to the In-Network Provider. It is the In-Network Provider's responsibility to ensure the claim is received by PEHP within 12 months from the date of service when PEHP is the primary payer, and 15 months from the date of service when PEHP is the secondary or further payer. Claims denied for untimely filing are not the Member's responsibility, with the following exception:

a. When the Member provides inaccurate or incomplete information regarding Dental Plan Coverage to the Provider.

In the event that eligible services are recieved from a covered Out-of-Network Provider who holds no contract with PEHP, payment will be sent to the Member regardless of the assignment of benefits.

When an out-of-network Provider is used, it is the responsibility of the Member to ensure that the claim is filed. PEHP accepts paper and electronic claims. Claims that are not received within the timely filing limits above will be Member's responsibility in full.

#### 8.1.1 REQUIRED INFORMATION FOR CLAIMS SUBMISSION

Claims should include an itemization of services, applicable CDT codes, and fees for each date of service. Any charges above the Allowed Amount by an Out-of-Network Provider are the Member's responsibility

Claims may be submitted electronically, or mailed to:

**Public Employees Health Program**
**Claims Division**
**560 East 200 South**
**Salt Lake City, Utah 84102-2004**

### 8.2 CLAIMS APPEAL PROCESS

If a Member disagrees with a PEHP decision regarding benefits, the Member may request a full and fair review by completing the PEHP Appeal form located on each explanation of benefit statement, or available online at pehp.org, and returning the form to PEHP within 180 days after PEHP's initial determination. If the appeal form is not received by PEHP within 180 days, the appeal shall be denied. PEHP shall allow for expedited appeals only when required by federal law and at the request of the Member. The Member shall include with the appeal form all applicable information necessary to assist PEHP in making a determination on the appeal. Requests for a review of claims should be sent to the following address or fax number:

**PEHP Appeals and Policy Management Department**
**P.O. Box 3836**
**Salt Lake City, Utah 84110-3836**

**Fax: 801-320-0541**

PEHP shall review and investigate the appeal. If PEHP requires additional information to investigate the appeal, it shall inform the Member of what information is required, and the Member shall have 45 days to provide the information to PEHP. Unless an expedited appeal or unless PEHP requests additional information from the Member, PEHP shall decide the appeal and inform the Member of the decision within 60 days from its receipt of the appeal form. PEHP's investigation shall include a review by the Executive Director of Utah Retirement Systems in accordance with Utah Code Annotated § 49-11-613(1)(c).

In accordance with federal law, if PEHP's decision on the appeal involved a medical judgment, a member may request an external review of PEHP's decision by completing PEHP's external review form and returning the form to PEHP. The member shall pay $25 for filing a request for an external review unless the member provides evidence to PEHP that they are indigent (unable to pay). The request for external review and the $25 fee must be received by PEHP within 30 days of the date of PEHP's decision. Following the external reviewer's decision, PEHP shall notify the member of the decision. If PEHP's original decision is overturned by the external reviewer, PEHP shall refund the $25 filing amount to the Member.

If PEHP's decision on the appeal did not involve a medical judgment, or if a member contests the decision of the external reviewer, a member may, within 30 days of the denial, file a written request for a formal administrative hearing before the Utah State Retirement Board's hearing officer, in accordance with the procedure set forth in Utah Code Annotated § 49-11-613. The Member must file the petition to the hearing officer on a standard form provided by and returned to the Retirement Office. Once the hearing process is complete, the hearing officer will prepare an order for the signature of the Utah Retirement Board. See the Master Policy for a more complete list of definitions. Find the Master Policy at www.pehp.org or call PEHP.