

Utah State University

2010-2011 Plan Options

Updated 4/20/2010

| | Wellness Plan (White) | | | High Premium Plan (Blue) | | | High Deductible Plan (Choice) | | |
|----------------------------------|---|-------|------------------------------|--|-------|--|---|-------|--|
| | Cat 1 | Cat 2 | Cat 3 | Cat 1 | Cat 2 | Cat 3 | Cat 1 | Cat 2 | Cat 3 |
| GENERAL INFORMATION | | | | | | | | | |
| Coinsurance Max (White and Blue) | \$3000/\$6000 | | | \$2,500/\$5,000 | | | | | |
| Out-of-Pocket (HDHP) | | | | | | | \$3,500 Single or \$7,000 Family | | |
| Maximum Benefit | \$2,000,000 | | | \$2,000,000 | | | \$2,000,000 | | |
| First Dollar Deductibles | \$750 Individual / \$1500 Family (DED does NOT apply toward the coinsurance max) | | | \$500 Individual / \$1000 Family (DED does NOT apply toward the coinsurance max) | | | \$1,500 Single or \$3,000 Family (deductible applies toward out-of-pocket maximum) Note: The deductible and coinsurance maximum work differently in this high deductible health plan (HDHP) than in the Wellness and High Premium plans. If you elect 2-party or family coverage, the full family deductible must be satisfied before any other benefits, other than preventive, will be paid. Also, the full family coinsurance maximum must be satisfied before the Plan pays at 100%. In other words, the single deductible and single coinsurance maximum should be completely ignored if you have 2-party or family coverage. | | |
| Prescription Drugs | You pay \$5 Generic; 35% Formulary Brand; 50% Non-Formulary Brand. <i>Coinsurance applies to the separate prescription coinsurance maximum of \$1500 per year.</i> | | | You pay \$5 Generic; 35% Formulary Brand; 50% Non-Formulary Brand. <i>Coinsurance applies to the separate prescription coinsurance maximum of \$1250 per year</i> | | | After the deductible, plan pays 80%. | | |
| Preexisting Condition Limitation | First 8 months of coverage for newly eligible employees | | | First 8 months of coverage for newly eligible employees | | | First 8 months of coverage for newly eligible employees | | |
| PREVENTIVE | | | | | | | | | |
| Routine Physical Exams | Paid 100%, deductible waived. | | Paid 60%, deductible waived. | Paid 100%, deductible waived. | | Paid 70%, deductible waived. | Paid 100%, deductible waived. | | Paid 60%, deductible waived. |
| Routine Hearing | Paid 100%, deductible waived. | | Paid 60%, deductible waived. | Paid 100%, deductible waived. (No dollar maximum) | | Paid 70%, deductible waived. (No dollar maximum) | Paid 100%, deductible waived. (No dollar maximum) | | Paid 60%, deductible waived. (No dollar maximum) |
| Routine Vision | Paid 100%, deductible waived. | | Paid 60%, deductible waived. | Paid 100%, deductible waived. (No dollar maximum) | | Paid 70%, deductible waived. (No dollar maximum) | Paid 100%, deductible waived. (No dollar maximum) | | Paid 60%, deductible waived. (No dollar maximum) |

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| Limited Screening Procedures (pap smear, prostate specific antigen, mammography, occult blood, bone density, sigmoidoscopy). | Paid 100%, deductible and copays waived. | | Paid 60%, deductible and copays waived. | Paid 100%, deductible and copays waived. | | Paid 70%, deductible and copays waived. | Paid 100%, deductible and copays waived. | | Paid 60%, deductible and copays waived. |
| Nutritional Counseling | Paid 100%, deductible waived. Limited to 3 counseling sessions per lifetime. | | Paid 60%, deductible waived. Limited to 3 sessions per lifetime. | Paid 100%, deductible waived. Limited to 3 counseling sessions per lifetime. | | Paid 70%, deductible waived. Limited to 3 sessions per lifetime. | Paid 100%, deductible waived. Limited to 3 counseling sessions per lifetime. | | Paid 60%, deductible waived. Limited to 3 sessions per lifetime. |
| Routine Well Baby - up to age 5, and immunizations up to age 18 | Paid 100%, deductible and copays waived. | | Paid 60%, deductible and copays waived. | Paid 100%, deductible and copays waived. | | Paid 70%, deductible and copays waived. | Paid 100%, deductible and copays waived. | | Paid 60%, deductible and copays waived. |
| Colonoscopy Benefit, Preventive | Paid at 100%, Ded waived | Paid at 100%, Ded waived | Paid at 60%, Ded waived | Paid at 100%, Ded waived | Paid at 100%, Ded waived | Paid at 70%, Ded waived | Paid at 100%, Ded waived | Paid at 100%, Ded waived | Paid at 60%, Ded waived |
| ACCIDENT BENEFITS | | | | | | | | | |
| Ortho due to Accident | After ded, plan pays at 70%. | After ded, plan pays at 70%. | After ded, plan pays at 60%. | After ded, plan pays at 80%. | After ded, plan pays at 80%. | After ded, plan pays at 70%. | After ded, plan pays at 80%. | After ded, plan pays at 80%. | After ded, plan pays at 60%. |
| Dental due to Accident | After ded, plan pays at 70%. | After ded, plan pays at 70%. | After ded, plan pays at 60%. | After ded, plan pays at 80%. | After ded, plan pays at 80%. | After ded, plan pays at 70%. | After ded, plan pays at 80%. | After ded, plan pays at 80%. | After ded, plan pays at 60%. |
| Maximum Benefit for Ortho or Dental due to Accident | Limited to \$1,000 per member per year | | | Limited to \$1,000 per member per year | | | Limited to \$1,000 per member per year | | |
| PHYSICIAN AND PROFESSIONAL BENEFITS | | | | | | | | | |
| Office Visits | After ded, You pay \$35; \$40 after hours | After ded, You pay \$35; \$40 after hours | After ded, plan pays at 60% | After ded, You pay \$30; \$35 after hours | After ded, You pay \$30; \$35 after hours | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| Inpatient Physician Visits | After ded, plan pays at 70% | After ded, plan pays at 70% | After ded, plan pays at 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| Emergency Department | After ded, you pay \$250 copay per visit. | After ded, you pay \$250 copay per visit. | After ded, you pay \$400 copay per visit. | After ded, you pay \$200 copay per visit | After ded, you pay \$200 copay per visit | After ded, you pay \$300 copay per visit | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| Routine Pre-Natal & Delivery | After ded, plan pays at 70% | After ded, plan pays at 70% | After ded, plan pays at 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |

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|---|---|---|--|---|---|--|---|---------------------------|--|
| | Cat 1 | Cat 2 | Cat 3 | Cat 1 | Cat 2 | Cat 3 | Cat 1 | Cat 2 | Cat 3 |
| Surgical Expenses | After ded, plan pays at 70% | After ded, plan pays at 70% | After ded, plan pays at 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| Anesthesia Expenses | After ded, plan pays at 70% | After ded, plan pays at 70% | After ded, plan pays at 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| Ambulance | After ded, plan pays at 70% | After ded, plan pays at 70% | After ded, plan pays at 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| Outpatient Surgery | After ded and \$250 copay, plan pays 100% | After ded and \$250 copay, plan pays 100% | After ded and \$400 copay, plan pays 60% | After ded and \$200 copay, plan pays 100% | After ded and \$200 copay, plan pays 100% | After ded and \$300 copay, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| Diagnostic x-ray and Lab Procedures | After ded, plan pays 100% to a maximum of \$1000 per member per plan year | | After ded, plan pays 60% to a max of \$1000 per member per plan year | After ded, plan pays 100% to a maximum of \$1000 per member per plan year | | After ded, plan pays 70% to a max of \$1000 per member per plan year | After ded, plan pays 100% to a maximum of \$1000 per member per plan year | | After ded, plan pays 60% to a max of \$1000 per member per plan year |
| Diagnostic x-ray and Lab Procedures for Preventive services | Paid 100%, deductible waived. (| | Paid 60%, deductible waived. | Paid 100%, deductible waived. | | Paid 70%, deductible waived. | Paid 100%, deductible waived. | | Paid 60%, deductible waived. |
| Preadmission Testing | After ded, Plan pays 100% | After ded, Plan pays 100% | After ded, Plan pays 60% of EME | After ded, Plan pays 100% | After ded, Plan pays 100% | After ded, Plan pays 70% of EME | After ded, Plan pays 100% | After ded, Plan pays 100% | After ded, Plan pays 60% of EME |
| Radiation and Chemotherapy | After ded, plans pays 70% | After ded, plans pays 70% | After ded, plans pays 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| Home Health Care | After ded, plans pays 70% | After ded, plans pays 70% | After ded, plans pays 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| Physical Therapy and Occupational Therapy | After ded, plans pays 70% | After ded, plans pays 70% | After ded, plans pays 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| | <i>Limited to 40 visits per member per year</i> | | | <i>Limited to 40 visits per member per year</i> | | | <i>Limited to 40 visits per member per year</i> | | |
| Speech Therapy | After ded, plans pays 70% | After ded, plans pays 70% | After ded, plans pays 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| | <i>For dependent children under age 18 with speech defect and/or developmental difficulty, coverage is provided until maximum improvement has been made or \$1,500 per member per Contract year has been reached.</i> | | | <i>For dependent children under age 18 with speech defect and/or developmental difficulty, coverage is provided until maximum improvement has been made or \$1,500 per member per Contract year has been reached.</i> | | | <i>For dependent children under age 18 with speech defect and/or developmental difficulty, coverage is provided until maximum improvement has been made or \$1,500 per member per Contract year has been reached.</i> | | |

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| Chiropractic | After ded, you pay \$35 copay per visit | After ded, you pay \$35 copay per visit | After ded, plans pays 60% | After ded, You pay \$30 copay per visit | After ded, You pay \$30 copay per visit | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| | <i>Limited to 20 visits per member per year</i> | | | <i>Limited to 20 visits per member per year</i> | | | <i>Limited to 20 visits per member per year</i> | | |
| Allergy Serum | After ded, plans pays 70% | After ded, plans pays 70% | After ded, plans pays 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| HOSPITAL / FACILITY BENEFITS | | | | | | | | | |
| Inpatient Facility & Ancillary | After ded and \$250 copay per admission, Plan pays 70% | After ded and \$250 copay per admission, Plan pays 70% | After ded and \$250 copay per admission, Plan pays 60% | After ded and \$200 copay per admission, plan pays 80% | After ded and \$200 copay per admission, plan pays 80% | After ded and \$200 copay per admission, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| Skilled Nursing and Extended Care Facility | After ded, plans pays 70% | After ded, plans pays 70% | After ded, plans pays 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| | <i>Limited to 60 days per member per year</i> | | | <i>Limited to 60 days per member per year</i> | | | <i>Limited to 60 days per member per year</i> | | |
| Outpatient Surgery/Facility | After ded and \$250 copay, plan pays 100% | After ded and \$250 copay, plan pays 100% | After ded and \$400 copay, plan pays 60% | After ded and \$200 copay, plan pays 100% | After ded and \$200 copay, plan pays 100% | After ded and \$300 copay, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| Outpatient Radiation and Chemotherapy | After ded, plan pays 70% | After ded, plan pays 70% | After ded, plan pays 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| Hospice Care | After ded, plan pays 70% | After ded, plan pays 70% | After ded, plan pays 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60% |
| | <i>No limit</i> | | | <i>No limit</i> | | | <i>No limit</i> | | |

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|---|--|--|--|--|--|--|--|--|--|
| | Cat 1 | Cat 2 | Cat 3 | Cat 1 | Cat 2 | Cat 3 | Cat 1 | Cat 2 | Cat 3 |
| SOLID ORGAN AND BONE MARROW TRANSPLANTS AND MYELOABLATIVE THERAPY | | | | | | | | | |
| Solid Organ and Bone Marrow Transplants | Covered as any other; subject to certain limitations | | | Covered as any other; subject to certain limitations | | | Covered as any other; subject to certain limitations | | |
| Myeloablative Therapy | Covered as any other; subject to certain limitations | | | Covered as any other; subject to certain limitations | | | Covered as any other; subject to certain limitations | | |
| OTHER MEDICAL SERVICES AND SUPPLIES | | | | | | | | | |
| Medical & Surgical Supplies <i>(unrelated to hospital inpatient care)</i> | After ded, plan pays 70% | After ded, plan pays 70% | After ded, plan pays 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70%. | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60%. |
| Durable Medical Equipment | After ded, plan pays 70% | After ded, plan pays 70% | After ded, plan pays 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70%. | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60%. |
| Orthotic and Prosthetic Devices | After ded, plan pays 70% | After ded, plan pays 70% | After ded, plan pays 60% | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 70%. | After ded, plan pays 80%. | After ded, plan pays 80%. | After ded, plan pays 60%. |
| Replacements of Prosthetics, Orthotic or DME. | Paid according to applicable category above | | | Paid according to applicable category above | | | Paid according to applicable category above | | |
| Orthotic Devices for the feet | After ded, plan pays 70%. Limited to \$500 per claimant per year. Over-the-counter orthotics excluded. | After ded, plan pays 70%. Limited to \$500 per claimant per year. Over-the-counter orthotics excluded. | After ded, plan pays 60%. Limited to \$500 per claimant per year. Over-the-counter orthotics excluded. | After ded, plan pays 80%. Limited to \$500 per claimant per year. Over-the-counter orthotics excluded. | After ded, plan pays 80%. Limited to \$500 per claimant per year. Over-the-counter orthotics excluded. | After ded, plan pays 70%. Limited to \$500 per claimant per year. Over-the-counter orthotics excluded. | After ded, plan pays 80%. Limited to \$500 per claimant per year. Over-the-counter orthotics excluded. | After ded, plan pays 80%. Limited to \$500 per claimant per year. Over-the-counter orthotics excluded. | After ded, plan pays 60%. Limited to \$500 per claimant per year. Over-the-counter orthotics excluded. |

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|---|---|---|--|---|---|--|---|---|--|
| | Cat 1 | Cat 2 | Cat 3 | Cat 1 | Cat 2 | Cat 3 | Cat 1 | Cat 2 | Cat 3 |
| MENTAL HEALTH & SUBSTANCE ABUSE SERVICES | | | | | | | | | |
| Inpatient Facility | After ded and \$250 copay, plan pays 70% | After ded and \$250 copay, plan pays 70% | After ded, play pays 50%. Does not apply toward coins. Max | After ded and \$200 copay, plan pays 80% | After ded and \$200 copay, plan pays 80% | After ded, play pays 50%. Does not apply toward coins. Max | After ded, plan pays 80% | After ded, plan pays 80% | After ded, play pays 50%. Does not apply toward coins. Max |
| | <i>Limited to 40 days per member per year</i> | | | <i>Limited to 40 days per member per year</i> | | | <i>Limited to 40 days per member per year</i> | | |
| Inpatient Physician Visits | After ded, plan pays 70% | After ded, plan pays 70% | After ded, play pays 50%. Does not apply toward coins. Max | After ded, plan pays 80% | After ded, plan pays 80% | After ded, play pays 50%. Does not apply toward coins. Max | After ded, plan pays 80% | After ded, plan pays 80% | After ded, play pays 50%. Does not apply toward OOP Max |
| | <i>Limited to 40 visits per member per year; 1 visit per day</i> | | | <i>Limited to 40 visits per member per year; 1 visit per day</i> | | | <i>Limited to 40 visits per member per year; 1 visit per day</i> | | |
| Outpatient Treatment | After ded, plan pays 70% | After ded, plan pays 70% | After ded, play pays 50%. Does not apply toward coins. Max | After ded, plan pays 80% | After ded, plan pays 80% | After ded, play pays 50%. Does not apply toward coins. Max | After ded, plan pays 80% | After ded, plan pays 80% | After ded, play pays 50%. Does not apply toward OOP Max |
| | <i>Limited to 40 visits per member per year; 1 visit per day.</i> | | | <i>Limited to 40 visits per member per year; 1 visit per day.</i> | | | <i>Limited to 40 visits per member per year; 1 visit per day.</i> | | |
| Attention Deficit Disorder | After ded, plan pays 70% | After ded, plan pays 70% | After ded, play pays 50%. Does not apply toward coins. Max | After ded, plan pays 80% | After ded, plan pays 80% | After ded, play pays 50%. Does not apply toward coins. Max | After ded, plan pays 80% | After ded, plan pays 80% | After ded, play pays 50%. Does not apply toward OOP Max |
| | <i>Limited to 6 outpatient visits for diagnosis only</i> | | | <i>Limited to 6 outpatient visits for diagnosis only</i> | | | <i>Limited to 6 outpatient visits for diagnosis only</i> | | |
| Drug/Alcohol Use or Abuse Treatment Program | After ded, plan pays 70%. Plan's payment limited to \$10,000 per member per year. | After ded, plan pays 70%. Plan's payment limited to \$10,000 per member per year. | Not covered | After ded, plan pays 80%. Plan's payment limited to \$10,000 per member per year. | After ded, plan pays 80%. Plan's payment limited to \$10,000 per member per year. | Not covered | After ded, plan pays 80%. Plan's payment limited to \$10,000 per member per year. | After ded, plan pays 80%. Plan's payment limited to \$10,000 per member per year. | Not covered |
| LIMITED BENEFITS | | | | | | | | | |
| Orthognathic Procedures | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% |
| Diagnosis and Treatment of TMJ | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% |
| | <i>Limited to \$1000 lifetime per claimant</i> | | | <i>Limited to \$1000 lifetime per claimant</i> | | | <i>Limited to \$1000 lifetime per claimant</i> | | |

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|---------------------|--|--|--|--|--|--|--|--|--|
| | Cat 1 | Cat 2 | Cat 3 | Cat 1 | Cat 2 | Cat 3 | Cat 1 | Cat 2 | Cat 3 |
| Pain Clinics | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% | After ded, You pay 50% |
| Primary Infertility | After ded, plan pays 50%. Limited to \$2000 lifetime per claimant. | After ded, plan pays 50%. Limited to \$2000 lifetime per claimant. | After ded, plan pays 50%. Limited to \$2000 lifetime per claimant. | After ded, plan pays 50%. Limited to \$2000 lifetime per claimant. | After ded, plan pays 50%. Limited to \$2000 lifetime per claimant. | After ded, plan pays 50%. Limited to \$2000 lifetime per claimant. | After ded, plan pays 50%. Limited to \$2000 lifetime per claimant. | After ded, plan pays 50%. Limited to \$2000 lifetime per claimant. | After ded, plan pays 50%. Limited to \$2000 lifetime per claimant. |
| Adoption Benefit | Plan pays up to \$4,000 of medical and/or legal adoption expenses per child for a child under age 6 at the time the child is placed in the Plan Participant's home on a permanent basis. The adoption of stepchildren, nieces, nephews, brothers, sisters or grandchildren is not covered. | | | Plan pays up to \$4,000 of medical and/or legal adoption expenses per child for a child under age 6 at the time the child is placed in the Plan Participant's home on a permanent basis. The adoption of stepchildren, nieces, nephews, brothers, sisters or grandchildren is not covered. | | | Plan pays up to \$4,000 of medical and/or legal adoption expenses per child for a child under age 6 at the time the child is placed in the Plan Participant's home on a permanent basis. The adoption of stepchildren, nieces, nephews, brothers, sisters or grandchildren is not covered. | | |

DISCLAIMER:

This summary provides a brief description of the Plan benefits only and should not be relied upon for detailed information regarding your coverage. Please refer to the Utah State University Summary Plan Description for complete details regarding covered benefits, limitations, exclusions, eligibility and other important information. If there are any differences between this summary and the SPD, the SPD will prevail.