SUMMARY PLAN DESCRIPTION FOR:

Salt Lake Community College

Group Number: 10003141

Expressions Dental Plan

Regence BlueCross BlueShield of Utah

Introduction

Welcome to participation in the self-funded group dental plan (hereafter referred to as "Plan") provided for You by Your employer. Your employer has chosen Regence BlueCross BlueShield of Utah to administer claims for Your group dental plan. Throughout this Summary Plan Description, Your employer may be referred to as the "Plan Sponsor."

EMPLOYER PAID BENEFITS

Your Plan is an employer-paid benefits plan administered by Regence BlueCross BlueShield of Utah (usually referred to as the "Claims Administrator" in this Summary Plan Description). This means that Your employer, not Regence BlueCross BlueShield of Utah, pays for Your covered dental services and supplies. Your claims will be paid only after Your employer provides Regence BlueCross BlueShield of Utah with the funds to pay Your benefits and pay all other charges due under the Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Because of their extensive experience and reputation of service, Regence BlueCross BlueShield of Utah has been chosen as the Claims Administrator of Your Plan.

The following pages are the Summary Plan Description, the written description of the terms and benefits of coverage available under the Plan. This Summary Plan Description describes benefits effective **July 1, 2016**, or the date after that on which Your coverage became effective. This Summary Plan Description replaces any plan description, Summary Plan Description or certificate previously issued by Regence BlueCross BlueShield of Utah and makes it void.

As You read this Summary Plan Description, please keep in mind that references to "You" and "Your" refer to both the Participant and Beneficiaries (except that in the Who Is Eligible, How To Enroll And When Coverage Begins, When Coverage Ends, and COBRA Continuation sections, the terms "You" and "Your" mean the Participant only). (NOTE: Where a reference is made to spouse, all of the same terms and conditions of the Summary Plan Description will be applied to a domestic partner, except when specified to the contrary.) The term "Agreement" refers to the administrative services contract between the Plan Sponsor and the Claims Administrator. Other terms are defined in the Definitions Section at the back of this Summary Plan Description or where they are first used and are designated by the first letter being capitalized.

This employee benefit plan may be governed by the Employee Retirement Income Security Act (ERISA). Throughout the Summary Plan Description, references to "ERISA" will apply only if the Plan is part of an employee welfare benefit plan regulated under ERISA.

Notice of Privacy Practices: Regence BlueCross BlueShield of Utah has a Notice of Privacy Practices that is available by calling Customer Service or visiting the Web site listed below.

CONTACT INFORMATION

Customer Service: 1 (866) 240-9580
(TTY: 711)

And visit the Claims Administrator's Web site at: **www.Regence.com**

For assistance in a language other than English please call the Customer Service telephone number.

Using Your Summary Plan Description

This Plan, administered by Regence, provides You with great benefits that are quickly accessible and easy to understand, thanks to broad access to providers and innovative tools. With this dental care coverage, You will discover more personal freedom to make informed dental care decisions, as well as the assistance You need to navigate the dental care system.

ACCESSING PROVIDERS

Your Plan allows You to control Your out-of-pocket expenses, such as Coinsurance, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your dental provider under two choices called: "Participating Dentist" and "Nonparticipating Dentist."

- **Participating Dentist.** You choose to see a Participating Dentist and save the most in Your out-of-pocket expenses. Choosing this dental provider option means You will not be billed for balances beyond the Allowed Amount.
- **Nonparticipating Dentist.** You choose to see a Nonparticipating Dentist and Your out-of-pocket expenses will generally be higher than seeing a Participating Dentist. Also, choosing this dental provider option means You may be billed for balances beyond the Allowed Amount. This is sometimes referred to as balance billing.

For each benefit in this Summary Plan Description, the dental provider You may choose and Your payment amount for each dental provider option is indicated. See the Definitions Section in this Summary Plan Description for a complete description of Participating Dentist and Nonparticipating Dentist. You can go to **www.Regence.com** for further dental provider network information.

ADDITIONAL PARTICIPATION ADVANTAGES

Your Plan offers You access to valuable services. The advantages of Regence involvement as the Claims Administrator include admission to personalized health/dental care planning information, health/dental-related events and innovative health/dental-decision tools, as well as a team dedicated to Your personal dental care needs. You also have access to **www.Regence.com**, an interactive environment that can help You navigate Your way through treatment decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE GROUP DENTAL PLAN, BUT ARE NOT INSURANCE.**

- **Go to www.Regence.com.** It is a health power source that can help You lead a healthy lifestyle, become a well-informed health/dental care shopper and increase the value of Your dental care dollar. Have Your Plan identification card handy to log on. Use the Web site to:

    - view recent claims, benefits and coverage;
    - find a contracting dental provider; and
    - participate in online wellness programs and use tools to estimate upcoming healthcare costs.

GUIDANCE AND SERVICE ALONG THE WAY

This Summary Plan Description was designed to provide information and answers quickly and easily. Be sure to understand Your benefits before You need them. You can learn more about the unique advantages of Your dental coverage throughout this Summary Plan Description, some of which are highlighted here. If You have questions about Your dental care coverage, please contact the Claims Administrator.

- **Learn more and receive answers about Your coverage.** Just call: 1 (866) 240-9580 to talk with one of the Claims Administrator's Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. - 6 p.m. You may also visit the Claims Administrator's Web site at: **www.Regence.com**.

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Understanding Your Benefits

In this section, You will discover information to help You understand what is meant by Your Maximum Benefits, Deductibles (if any) and Coinsurance. Other terms are defined in the Definitions Section at the back of this Summary Plan Description or where they are first used and are designated by the first letter being capitalized.

While this Understanding Your Benefits Section defines these types of cost-sharing elements, You need to refer to the Dental Benefits Section to see exactly how they are applied and to which benefits they apply.

MAXIMUM BENEFITS

Some benefits for Covered Services may have a specific Maximum Benefit. For those Covered Services, the Plan will provide benefits will be provided until the specified Maximum Benefit (which may be a number of days, visits, services, supplies, a dollar amount or a specified time period) has been reached. Allowed Amounts for Covered Services provided are also applied toward any Deductible and against any specific Maximum Benefit that is expressed in this Summary Plan Description as a number of days, visits, services or supplies. Refer to the Dental Benefits Section of this Summary Plan Description to determine if a Covered Service has a specific Maximum Benefit.

PERCENTAGE PAID UNDER THE PLAN (COINSURANCE)

Once You have satisfied any applicable Deductible, the Plan pays a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). Your Coinsurance will be based upon the lesser of the billed charges or the Allowed Amount. The percentage the Plan pays varies, depending on the kind of service or supply You received and who rendered it.

The Plan does not reimburse Dentists for charges above the Allowed Amount. However, a Participating Dentist will not charge You for any balances for Covered Services beyond Your applicable Deductible and/or Coinsurance amount. Nonparticipating Dentists, however, may bill You for any balances over the Plan payment level in addition to any applicable Deductible and/or Coinsurance amount. See the Definitions Section for descriptions of Participating and Nonparticipating Dentists.

DEDUCTIBLES

The Plan will begin to pay benefits for Covered Services in any Plan Year only after a Claimant satisfies any Plan Year Deductible. Your plan may not include a Deductible. Check the Dental Benefits section to see if a deductible applies. If Your Plan does not have a Deductible, any references in this Summary Plan Description to Deductibles therefore do not apply to Your coverage. A Claimant satisfies the Deductible by incurring a specific amount of expense for Covered Services during the Plan Year for which the Allowed Amounts total the Deductible.

The Family Plan Deductible is satisfied when three or more covered Family Members' Allowed Amounts for Covered Services for that Plan Year total and meet the Family Deductible amount. One Claimant may not contribute more than the individual Deductible amount.

The Plan does not pay for services applied toward the Deductible. Refer to the Dental Benefits Section to see if a particular service is subject to the Deductible. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not count toward the Deductible.

HOW PLAN YEAR BENEFITS RENEW

Many provisions of the Plan (for example, Deductibles and certain benefit maximums) are calculated on a Plan Year basis. Each July 1, those Plan Year maximums usually begin again.

Some benefits of this Plan have a separate Lifetime Maximum Benefit and do not renew every Plan Year. Those exceptions are specifically noted in the benefits sections of this Summary Plan Description.

Dental Benefits

In this section, You will learn about Your dental plan's benefits and how Your coverage pays for Covered Services. The explanation includes information about Maximum Benefits, Deductibles, Coinsurance, Covered Services and payment. For Your ease in finding the information regarding benefits most important to You, the Plan has listed these benefits alphabetically, with the exception of the Preventive Dental Services.

MAXIMUM BENEFITS

Preventive and Diagnostic, Basic and Major Dental Services:
Per Claimant: $1,500 per Plan Year

Orthodontic Dental Services, per Claimant: $1,000 per Lifetime

After any applicable Deductible is met, the Plan pays a portion of the Allowed Amount (or, for Orthodontic Dental Services, a portion of the billed charges) for Covered Services, up to the Maximum Benefit amount for each Claimant each Plan Year.

PLAN YEAR DEDUCTIBLES

Not applicable

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

Provider: Participating Dentist	Provider: Nonparticipating Dentist
Payment: The Plan pays 80% and You pay 20% of the Allowed Amount for Covered Services.	**Payment:** The Plan pays 80% of the Allowed Amount and You pay balance of billed charges and services not covered by the Plan.

The Plan covers the following preventive and diagnostic dental services:

- Dental x-rays as required, except that complete mouth x-rays are limited to one in a three-year period, unless special need is shown for more frequent complete mouth x-rays.
- Preventive oral examinations, limited to two per Claimant per Plan Year.
- Problem focused oral examinations.
- Cleanings, limited to two per Claimant per Plan Year.
- Sealants, limited to permanent molars of Claimants under 14 years of age.
- Space maintainers for Claimants under 13 years of age.
- Topical fluoride application for Claimants under 23 years of age, limited to two treatments per Claimant per Plan Year.

BASIC DENTAL SERVICES

Provider: Participating Dentist	Provider: Nonparticipating Dentist
Payment: The Plan pays 80% and You pay 20% of the Allowed Amount for Covered Services.	**Payment:** The Plan pays 80% of the Allowed Amount and You pay balance of billed charges and services not covered by the Plan.

The Plan covers the following basic dental services:

- Endodontic services including pulpotomy, apicoectomy, pulp capping and root canal treatment.
- Extractions, including surgical extraction of bone impacted teeth.
- Fillings consisting of silver amalgam, silicate, and plastic restorations(for other types of fillings payment is limited to the amount that would have been paid for amalgam restorations)
- General dental anesthesia or intravenous sedation (subject to necessity)
- Palliative emergency treatment.
- Periodontal services consisting of:
    - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery);
    - debridement;

- gingivectomy and gingivoplasty;
- periodontal maintenance limited to four per Claimant per Plan Year.; and
- scaling and root planning limited to once per Claimant per quadrant in a year period.

- Repair of dentures and bridges.

MAJOR DENTAL SERVICES

Provider: Participating Dentist	Provider: Nonparticipating Dentist
Payment: The Plan pays 50% and You pay 50% of the Allowed Amount for Covered Services.	**Payment:** The Plan pays 50% of the Allowed Amount and You pay balance of billed charges and services not covered by the Plan.

The Plan covers the following major dental services:

- Bridges, fixed and removable, except that benefits will not be provided for replacement made fewer than five years after placement.
- Inlays, onlays, crown build-ups and crowns, replacement made fewer than five years after placement (for gold inlays, onlays and crowns, payment is limited to the amount that would have been paid for plastic inlays, onlays and crowns unless special need is demonstrated for use of gold)
- Dental Implants.
- Vestibuloplasty.
- Dentures (full and partial): Except no benefits are provided for replacement made fewer than 5-years after placement.
- Benefits are limited to the amount that would have been paid for standard procedures for prosthodonic services when you or your covered spouse (or domestic partner) or child or the Dentist provides personalized restoration or when the Dentist employs special techniques or procedures.

ORTHODONTIC DENTAL SERVICES

Provider: All Dentists
Payment: The Plan pays 50% of billed charges and You pay balance of charges.
Limit: $500 per Claimant per Plan year; $1,000 per Claimant Lifetime

The Plan covers the following orthodontic dental services for Claimants under 26 years of age:

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

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

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

General Exclusions

The following are the general exclusions from coverage under the Plan. Other exclusions may apply and, if so, will be described elsewhere in this Summary Plan Description. Benefits under the Plan will not be provided for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise Covered Service for an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law.

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

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

Collection of Cultures and Specimens

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

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

Connector Bar or Stress Breaker

Cosmetic/Reconstructive Services and Supplies
Except for Dentally Appropriate services and supplies to treat a congenital anomaly and to restore a physical bodily function lost as a result of Injury or Illness, the Plan does not cover cosmetic and/or reconstructive services and supplies.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance (for example, bleaching of teeth).

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

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

Diagnostic Casts or Study Models

Duplicate X-Rays

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

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

Fees, Taxes, Interest
Charges for shipping and handling, postage, interest or finance charges that a Dentist might bill. The Plan also does not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Fractures of the Mandible (Jaw)
Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-Foil Restorations

Government Programs
Benefits that are covered, or would be covered in the absence of this Plan, by any federal, state or government program, except for facilities that contract with the Claims Administrator and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. Expenses from government facilities outside the service area are not covered under the Plan (except as required by law for emergency services).

Home Visits

Implants
Services and supplies provided in connection with implants, whether or not the implant itself is covered, including but not limited to:

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

Investigational Services
Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). Also excluded are any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section in this Summary Plan Description.

Medications and Supplies
Charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies.

Motor Vehicle Coverage and Other Available Insurance
Expenses for services and supplies that are payable under any automobile medical, personal injury protection (PIP), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, benefits will be provided according to this Summary Plan Description.

Nitrous Oxide

Non-Direct Patient Care
Services that are not direct patient care, including:

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

Occlusal Treatment
Services and supplies provided in connection with dental occlusion, including the following:

- occlusal analysis and adjustments; and
- occlusal guards.

Oral Hygiene Instructions

Oral Surgery
Oral surgery treating any fractured jaw and orthognathic surgery. "Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

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

Photographic Images

Pin Retention in Addition to Restoration

Precision Attachments

Prosthesis
Services and supplies provided in connection with dental prosthesis, including the following:

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

Provisional Splinting

Replacements
Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.

Riot, Rebellion and Illegal Acts
Services and supplies for treatment of an Illness, Injury or condition caused by a Claimant's **voluntary participation in** a riot, armed invasion or aggression, insurrection or rebellion or sustained by a Claimant arising directly from an act deemed illegal by an officer or a court of law.

Self-Help, Self-Care, Training or Instructional Programs
Self-help, non-dental self-care and training programs. This exclusion does not apply to services for training or educating a Claimant, when provided without separate charge in connection with Covered Services.

Separate Charges
Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following:

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

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings;
- Your child's or stepchild's spouse or domestic partner; and
- any other of Your relatives by blood, marriage or who shares a residence with You.

Services Performed in a Laboratory

Surgical Procedures
Services and supplies provided in connection with the following surgical procedures:

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

Temporomandibular Joint (TMJ) Dysfunction Treatment
Services and supplies provided in connection with temporomandibular joint (TMJ) dysfunction other than surgical correction of the TMJ required as the result of an Injury.

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

Tooth Transplantation
Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.

Travel and Transportation Expenses
Travel and transportation expenses.

Veneers

Work-Related Conditions
Expenses for services and supplies incurred as a result of any work-related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. The Claims Administrator may require the Claimant to file a claim for workers' compensation benefits before providing any benefits under this coverage. The Plan does not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers' compensation benefit. The only exception is if a Claimant is exempt from state or federal workers' compensation law.

Claims Administration

This section explains a variety of matters related to administering benefits and/or claims, including situations that may arise when Your health care expenses are the responsibility of a source other than the Plan.

PLAN IDENTIFICATION CARD

When Participants enroll in the Plan, they will receive a Plan identification card. The identification card will include important information such as the Participant's identification number, group number and name.

It is important to keep Your Plan identification card with You at all times. Be sure to present it to Your Dentist before receiving care.

If You lose Your card, or if it gets destroyed, You can get a new one by simply calling the Claims Administrator's Customer Service department at 1 (866) 240-9580. You can also view or print an image of Your Plan identification card by visiting the Claims Administrator's Web site at **www.Regence.com** on Your PC or mobile device. If the Agreement terminates, Your Plan identification card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

The Claims Administrator will decide whether to pay You, the provider or You and the Provider jointly. Benefit payments may be made for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child.

You will be responsible for the total billed charges for benefits in excess of Maximum Benefits, if any, and for charges for any other service or supply not covered under this Plan, regardless of the Provider rendering such service or supply.

Timely Filing of Claims

Written proof of loss must be received within one year after the date of service for which a claim is made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. A claim that is not filed in a timely manner will be denied unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. You may, however, Appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner. (If You were covered by more than one health plan on the date of service, see the text of Secondary Health Plan in the Coordination of Benefits provision for an exception to this timely filing rule.)

Participating Dentist Claims

You must present Your Plan identification card when obtaining Covered Services from a Participating Dentist. You must also furnish any additional information requested. The Participating Dentist will furnish the Claims Administrator with the forms and information needed to process Your claim.

Participating Dentist Reimbursement

A Participating Dentist will be paid directly for Covered Services. Participating Dentists have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount is any amount You must pay due to Deductible and/or Coinsurance. A Participating Dentist may require You to pay Your share at the time You receive care or treatment.

Nonparticipating Dentist Claims

In order for Covered Services to be paid, You or the Dentist must first send a claim to the Claims Administrator. Be sure the claim is complete and includes the following information:

- an itemized description of the services given and the charges for them;
- the date treatment was given;
- the diagnosis; and

- the patient's name and the group and identification numbers.

Nonparticipating Dentist Reimbursement

In most cases, the Nonparticipating Dentist will be paid directly for Covered Services they provide.

Nonparticipating Dentists have not agreed to accept the Allowed Amount as full compensation for Covered Services. So, You are responsible for paying any difference between the amount billed by the Nonparticipating Dentist and the Allowed Amount in addition to any amount You must pay due to Deductible and/or Coinsurance. For Nonparticipating Dentists, the Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

Reimbursement Examples

Here is an example of how Your selection of a Participating Dentist or Nonparticipating Dentist affects payment to providers and Your cost sharing amount. For purposes of this example, let's assume that Participating Dentist services are subject to a 20 percent Coinsurance and Nonparticipating Dentist services are also subject to a 20 percent Coinsurance. Let's also assume that there is a deductible. Check the Dental Benefits section to see if a deductible applies to Your Plan. The benefit table from the Dental Benefits Section would appear as follows:

Provider: Participating Dentist	**Provider: Nonparticipating Dentist**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 80% of the Allowed Amount and You pay balance of billed charges.

Now, let's assume that the Dentist's charge for a service is $500 and the Allowed Amount for that Dentist's charge is $400. Finally, the Plan will assume that You have met the Deductible. Here's how that Covered Service would be paid:

- Participating Dentist: the Plan would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:

  - Amount Participating Dentist must "write-off" (that is, cannot charge You for): $100
  - Amount the Plan pays (80% of the $400 Allowed Amount): $320
  - **Amount You pay** (20% of the $400 Allowed Amount): $**80**
  - Total: $500

- Nonparticipating Dentist: the Plan would pay 80 percent of the Allowed Amount. Because the Nonparticipating Dentist does not accept the Allowed Amount, You would pay 20 percent of the Allowed Amount, plus the difference between the Nonparticipating Dentist's billed charges and the Allowed Amount, as follows:

  - Amount the Plan pays (80% of the $400 Allowed Amount): $320
  - **Amount You pay** (20% of the $400 Allowed Amount and the $100 difference between the billed charges and the Allowed Amount): $**180**
  - Total: $500

The actual benefits of the Plan may vary, so please read the benefits sections thoroughly to determine how Your benefits are paid. For example, as explained in the Definitions Section, the Allowed Amount may vary for a Covered Service depending upon Your selected Dentist.

Freedom of Choice of Dentist

Nothing contained in the Agreement is designed to restrict You in selecting the Dentist of Your choice for dental care or treatment.

Claims Determinations

Within 30 days of the Claims Administrator's receipt of a claim, You will be notified of the action taken on it. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When action cannot be taken on the claim due to circumstances beyond the Claims Administrator's control, they will notify You within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when the Claims Administrator expects to act on the claim.
- When action cannot be taken on the claim due to lack of information, the Claims Administrator will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

If the Claims Administrator seeks additional information from You, You will be allowed at least 45 days to provide the additional information. If the Claims Administrator does not receive the requested information to process the claim within the time allowed, the claim will be denied.

NONASSIGNMENT

Only You are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else and You (or a custodial parent or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits or payments to any person, corporation or entity. Any attempted assignment, transfer or delegation of benefits will be considered null and void and will not be binding on the Plan. You may not assign, transfer or delegate any right of representation or collection other than to legal counsel directly authorized by You on a case-by-case basis.

CLAIMS RECOVERY

If a benefit to which You were not entitled is paid under the Plan, or if a person who is not eligible for benefits at all is paid under the Plan, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including a provider of services. The Plan's right to recovery for an erroneous payment made on Your or Your Beneficiaries' behalf includes the right to deduct the mistakenly paid amount from future benefits that would have been provided the Participant or any of his or her Beneficiaries under this coverage.

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

For the recovery of overpayments related to the coordination of Primary and Secondary Health Plan benefits, refer to the Coordination of Benefits provision in this Claims Administration Section.

This claims recovery provision in no way reduces the Plan's right to reimbursement or subrogation. Refer to the other-party liability provision in the Claims Administration Section for additional information.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND DENTAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by the Claims Administrator. This information will be used for the purpose of facilitating health care treatment, payment of claims or business operations necessary to administer health care benefits; or as required by law.

The information requested or disclosed may be related to treatment or services received from:

- an insurance carrier or group health plan;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies;
- a clinic, hospital, long-term care or other medical facility; or
- a physician, Dentist, pharmacist or other physical or behavioral health care practitioner.

Health information requested or disclosed by the Claims Administrator may include, but is not limited to:

- billing statements;
- claim records;
- correspondence;
- dental records;

- diagnostic imaging reports;
- hospital records (including nursing records and progress notes);
- laboratory reports; and
- medical records.

The Claims Administrator is required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by calling the Claims Administrator's Customer Service department or visiting their Web site **www.Regence.com**.

You have the right to request, inspect and amend any records that the Claims Administrator has that contain Your personal health information. Please contact the Claims Administrator's Customer Service department to make this request.

NOTE: This provision does not apply to information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services and genetic testing. A specific authorization will be obtained from You in order for the Claims Administrator to receive information related to these health conditions.

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a dental care provider. Neither the Plan nor the Claims Administrator is responsible for the quality of dental care You receive, since all those who provide care do so as independent contractors. Since neither the Plan nor the Claims Administrator provides any dental care services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving dental services or supplies provided by professionals who are neither employees nor agents of the Plan or the Claims Administrator.

In addition, the Claims Administrator will not be liable to any person or entity for the inability or failure to procure or provide the benefits in this Summary Plan Description by reason of epidemic, disaster or other cause or condition beyond the Claims Administrator's control.

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

Coverage under the Plan will not be provided for any medical or dental expenses You incur for treatment of an Injury or Illness if the costs associated with the Injury or Illness may be recoverable from any of the following:

- a third-party;
- worker's compensation; or
- any other source, including automobile medical, personal injury protection ("PIP"), automobile no-fault, homeowner's coverage, commercial premises medical coverage or similar contract or insurance, when the contract or insurance is either issued to, or makes benefits available to You, whether or not You make a claim under such coverage.

Advancement of Benefits

If You have a potential right of recovery for Illnesses or Injuries from a third-party who may have legal responsibility or from any other source, benefits may be advanced pending the resolution of a claim to the right of recovery if all the following conditions apply:

- By accepting or claiming benefits, You agree that the Plan is entitled to reimbursement of the full amount of benefits paid out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which benefits under the Plan have been provided.
- In addition to the Plan's right of reimbursement, the Claims Administrator may choose instead to achieve the Plan's rights through subrogation. The Claims Administrator is authorized, but not obligated, to recover any benefits paid under the Plan directly from any party liable to You, upon mailing of a written notice to the potential payer, to You or to Your representative.
- The Plan's rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment or other characterization of the

recovery by the Claimant and/or any third-party or the recovery source. The Plan is entitled to reimbursement from the first dollars received from any recovery. This applies regardless of whether:

- the third-party or third-party's insurer admits liability;
- the health care expenses are itemized or expressly excluded in the recovery; or
- the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the Plan.

- Reimbursement or subrogation under the Plan will not be reduced due to Your not being made whole.
- You may be required to sign and deliver all legal papers and take any other actions requested to secure the Plan's rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third-party or other source). If You are asked to sign a trust agreement or other document to reimburse the Plan from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.
- You must agree that nothing will be done to prejudice the Plan's rights and that You will cooperate fully with the Claims Administrator, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the Claims Administrator of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:

  - the filing of a lawsuit;
  - the making of a claim against any third-party;
  - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
  - intent of a third-party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Injury or Illness that gives rise to the Plan's right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).

- You and/or Your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to Your benefit or on Your behalf that in any manner relates to the Injury or Illness giving rise to the Plan's right of reimbursement or subrogation, until the Plan's right is satisfied or released.
- In the event You and/or Your agent or attorney fails to comply with any of these conditions, any such benefits advanced for any Illness or Injury may be recovered through legal action.
- Any benefits provided or advanced under the Plan are provided solely to assist You. By paying such benefits, neither the Plan nor the Claims Administrator is acting as a volunteer and is not waiving any right to reimbursement or subrogation.

Motor Vehicle Coverage

If You are involved in a motor vehicle accident, You may have rights both under motor vehicle insurance coverage and against a third-party who may be responsible for the accident. In that case, this Right of Reimbursement and Subrogation Recovery provision still applies.

Workers' Compensation

Here are some rules which apply in situations where a workers' compensation claim has been filed:

- You must notify the Claims Administrator in writing within five days of any of the following:

  - filing a claim;
  - having the claim accepted or rejected;
  - appealing any decision;
  - settling or otherwise resolving the claim; or
  - any other change in status of Your claim.

- If the entity providing workers' compensation coverage denies Your claim and You have filed an Appeal, benefits may be advanced for Covered Services if You agree to hold any recovery obtained in a segregated account for the Plan.

Fees and Expenses
Neither the Plan nor the Claims Administrator is liable for any expenses or fees incurred by You in connection with obtaining a recovery. However, You may request that a proportional share of attorney's fees and costs be paid at the time of any settlement or recovery to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid under the Plan. The Claims Administrator has discretion whether to grant such requests.

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

COORDINATION OF BENEFITS
If You are covered under any other individual or group medical contract or policy (referred to as "Other Plan" and defined below), the benefits under this Plan and those of the Other Plan will be coordinated in accordance with the provisions of this section.

Benefits Subject to this Provision
All of the benefits provided under this Plan are subject to this Coordination of Benefits provision.

Definitions
In addition to the definitions in the Definitions Section, the following are definitions that apply to this Coordination of Benefits Section:

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

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

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

Birthday, for purposes of these Coordination of Benefits provisions, means only the day and month of birth, regardless of the year.

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

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

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

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

Other Plan does not include:

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

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

- The plan has no order of benefit determination provision or its order of benefit determination provision differs from the order of benefit determination provision included herein; or
- Both plans use the order of benefit determination provision included herein and under that provision the plan determines its benefits first.

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

Year, for purposes of this Coordination of Benefits provision, means Calendar Year (January 1 through December 31).

Order of Benefit Determination

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

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

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

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

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

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

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

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

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

Your length of time covered under a Plan is measured from Your first date of coverage under that Plan. If that date is not readily available for a group Plan, the date You first became a member of the group will be used as the date from which to determine the length of time coverage under the present Plan has been in force.

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

Primary Health Plan Benefits

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

Secondary Health Plan Benefits

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

The benefits that would have been paid under this Plan for a service if this Plan were the Primary Plan will be calculated. That calculated amount will be applied to any Allowable Expense under this Plan for that service that is unpaid by the Primary Plan. Regence will:

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

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

Right to Receive and Release Needed Information

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

Right of Recovery

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

- From You, if payment was made to You. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentations. This Plan will be entitled to recover the amount of such excess by the reversal of payment from You and You agree to reimburse this Plan on demand for any and all such amounts. You also agree to pay this Plan interest at 18 percent per annum until such debt is paid in full, which will begin accruing the date the demand for reimbursement is made. If a third-party collection agency or attorney is used to collect the overpayment, You agree to pay collection fees incurred, including, but not limited to, any court costs and attorney fees. If You do not pay, future benefits under this Plan may be withheld to offset the

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

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

INTERNAL COORDINATION OF BENEFITS (ICOB)
When spouses or domestic partners are both employed at Salt Lake Community College in benefit eligible positions, and wish to cover themselves and eligible family members with medical and/or dental coverage, only the employee whose birthday comes first in the year must enroll in the Plan for self, spouse (or domestic partner) and all desired Eligible Children. Under this arrangement, full coordination of benefits is extended to all enrolled family members according to the definition of the Plan. The following are exceptions specific only to those enrolled in ICOB coverage.

ICOB Dental Benefits

Eligible Dental Expenses from participating In-Network providers will be paid at 100% of to the below Maximum Benefit amounts.

Out-of-Network Providers:
Preventive Services paid at 100%
Basic and Restorative Services paid at 100%
Major Services paid at 100%

Preventive, Basic and Major Dental Services:
Per Claimant per Plan year: $3,000

Orthodontic Dental Services:
Per Claimant per Plan Year: $1,000
Per Claimant Lifetime: $2,000

Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action under the Plan and wishes to have it reviewed, You may Appeal. There are two levels of Appeal, as well as additional voluntary Appeal levels You may pursue. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Claims Administrator at: Attn: Appeals, Regence BlueCross BlueShield of Utah P.O. Box 2998 Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526. Verbal requests can be made by calling the Claims Administrator at 1 (866) 240-9580.

Each level of Appeal, except voluntary external review, must be pursued within 180 days of Your receipt of the Claims Administrator's determination (or, in the case of the first level, within 180 days of Your receipt of the Claims Administrator's original adverse decision that You are Appealing). If You don't Appeal within these time periods, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum.

If Your health could be jeopardized by waiting for a decision under the regular Appeal process, an Expedited Appeal may be requested. Please see Expedited Appeals later in this section for more information.

First-Level Appeals

First-level Appeals are reviewed by a Claims Administrator employee or employees who were not involved in the initial decision that You are Appealing. In Appeals that involve issues requiring medical or dental judgment, the decision is made by the Claims Administrator's staff of health care professionals. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 14 days of the Appeal.

Panel-Level (Second-Level) Appeals

Second-level Appeals are reviewed by a panel of Claims Administrator employees who were not involved in, or subordinate to anyone involved in, the first-level decision. You, or Your Representative on Your behalf, will be given a reasonable opportunity to provide written materials. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 14 days of receipt of the Appeal.

VOLUNTARY EXTERNAL APPEAL - IRO

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

The Claims Administrator coordinates voluntary external Appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the Appeal documentation. The IRO will make its decision and provide You with its written determination within 45 days after their receipt of the request. Choosing the voluntary external Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section, except to the extent other remedies are available under State or Federal law.

The voluntary external Appeal by an IRO is optional and You should know that other forums may be utilized as the final level of Appeal to resolve a dispute You have under the Plan. This includes but is not limited to civil action under Section 502(a) of ERISA, where applicable.

EXPEDITED APPEALS

An Expedited Appeal is available if one of the following applies:

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

Panel-Level (First-Level) Expedited Appeal

The first-level Expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. First-level Expedited Appeals are reviewed by a panel of Claims Administrator's employees who were not involved in, or subordinate to anyone involved in, the initial denial determination. You, or Your Representative on Your behalf, will be given the opportunity (within the constraints of the Expedited Appeals timeframe) to provide written materials. A verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. A written notification of the decision will be mailed to You within three calendar days of the verbal notification.

Voluntary Expedited Appeal – IRO

If You disagree with the decision made in the panel-level Appeal and You or Your Representative reasonably believes that preauthorization remains clinically urgent (Pre-Service or concurrent), You may request a voluntary Expedited Appeal to an IRO. The criteria for a voluntary Expedited Appeal to an IRO are the same as described above for non-urgent Expedited Appeal.

The Claims Administrator coordinates voluntary Expedited Appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the Appeal documentation. Verbal notice of the IRO's decision will be provided to You and Your Representative by the IRO as soon as possible after the decision, but no later than within 72 hours of its receipt of Your request, followed by written notification within 48 hours of the verbal notification. Choosing the voluntary Expedited Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section.

The voluntary Expedited Appeal by an IRO is optional and You should know that other forums may be used as the final level of Expedited Appeal to resolve a dispute You have under the Plan, including, but not limited to, civil action under Section 502(a) of ERISA, where applicable.

INFORMATION

If You have any questions about the Appeal process outlined here, You may contact the Claims Administrator's Customer Service department at: 1 (866) 240-9580 or You can write to the Claims Administrator's Customer Service department at the following address: Regence BlueCross BlueShield of Utah, P.O. Box 2998, Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

Appeal means a written or verbal request from a Claimant or, if authorized by the Claimant, the Claimant's Representative, to change a previous decision made under the Plan concerning:

- access to health care benefits, including an adverse determination made pursuant to utilization management;
- claims payment, handling or reimbursement for health care services;
- matters pertaining to the contractual relationship between a Claimant and the Plan; and
- other matters as specifically required by state law or regulation.

Independent Review Organization (IRO) is an independent physician review organization which acts as the decision-maker for voluntary external Appeals and voluntary Expedited Appeals, through an

independent contractor relationship with the Claims Administrator and/or through assignment to the Claims Administrator via state regulatory requirements. The IRO is unbiased and is not controlled by the Claims Administrator.

Post-Service means any claim for benefits under the Plan that is not considered Pre-Service.

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

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

Who Is Eligible, How to Enroll and When Coverage Begins

This section contains the terms of eligibility described in this Summary Plan Description for an employee, his or her spouse (or domestic partner) and all children. It explains how to complete enrollment when first eligible, during a period of special enrollment, following a change in status event or during an annual enrollment period. It also describes when coverage under the Plan begins once enrollment is complete. Payment of any corresponding monthly costs is required for coverage to begin on the indicated dates.

Applications for coverage should be filed with the College's Human Resource Office.

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

Upon first becoming eligible for coverage under the eligibility requirements in effect with the Plan Sponsor, You will be entitled to apply for coverage for Yourself and/or Your eligible Spouse (or Domestic Partner) and all Children within 30 days of becoming eligible. Coverage for You, Your Spouse (or Domestic partner) and Your Eligible Children will commence on either the 1st or the 16th of the month, whichever corresponds with or immediately follows Your date of hire or date You first become eligible.

Employees

Full-time regular employees (75% FTE or more) hired in a designated benefits eligible position are eligible to participate in this Plan.

Employee's Spouse (or Domestic Partner) and Eligible Children

Your Spouse (or Domestic Partner) and Children are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when the Claims Administrator has enrolled them in coverage under the Plan. Eligibility is limited to the following:

- Your Spouse - The person to whom You are legally married.
- Your Domestic Partner, provided that all of the following conditions are met:
    - Are unmarried in the State of Utah;
    - Both are at least 18 years of age or older;
    - Mentally competent to consent to this partnership;
    - Not related by blood in the way that prohibits lawful marriage;
    - Share the same primary residence and have been in a mutually exclusive relationship for at least the last six (6) months, and have plans to continue this arrangement on an indefinite basis; and
    - Are jointly responsible for the common welfare of each other and share financial obligations.
- Eligible Child - Your (or Your Spouse's or Your Domestic Partner's) child who is under age 26 and who meets any of the following criteria:
    - Your (or Your Spouse's or Your Domestic Partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Domestic Partner) for adoption;
    - a child for whom You (or Your Spouse or Domestic Partner) have court-appointed legal guardianship; and
    - a child for whom You (or Your Spouse or Your Domestic Partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your Spouse's or Your Domestic Partner's) Child who is age 26 or over and who is a Disabled Dependent due to a Physical Impairment or a Mental Impairment that began before his or her 26th birthday, if You complete and submit the Claims Administrator's affidavit of dependent eligibility form, with written evidence of the child's impairment, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
    - he or she is a covered claimant immediately before his or her 26th birthday; or
    - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your Eligible Child on accident and health insurance since that birthday.

The Claims Administrator's affidavit of dependent eligibility form is available by visiting their Web site at **www.Regence.com** or by calling their Customer Service department at: 1 (866) 240-9580.

NEWLY ELIGIBLE CHILDREN

If you participate in the Plan, You may enroll a child who becomes eligible for coverage under the eligibility requirements in effect with the Plan by completing and submitting to the Plan Sponsor a signed group change request (and, for a domestic partner, an affidavit of qualifying domestic partnership form) within 30 days of the child attaining eligibility.

- Coverage for a new child by birth, adoption, or placement for adoption will become effective the day of the triggering event and will not be considered a Late Enrollee.

NOTE: When the addition of a new child by birth, adoption or placement for adoption does not cause a change in Your payment under the Plan (as of the date of birth, date of adoption or date of placement for adoption), You will have 30 days as of the date the Claims Administrator first sends a denial of a claim for benefits for such new child to submit a signed group change request.

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your eligible spouse (or Your Domestic Partner) and/or a child if You failed to do so when first eligible. For example:

- Loss of coverage under another group or individual health benefit plan due to:
    - the exhaustion of federal COBRA or any state continuation;
    - the loss of eligibility due to legal separation, divorce, termination of domestic partnership, death, termination of employment, reduction in hours;
    - exhaustion of any lifetime maximum on total benefits;
    - or the employer contributions were terminated;
    - involuntary loss of coverage under Medicare, CHAMPUS/Tricare, Indian Health Service, or a publicly sponsored or subsidized health plan; or
    - involuntary loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP). Enrollment must be requested within 60 days of the loss of coverage.

In all of the above situations, You and/or Your eligible spouse (or Your Domestic Partner, except as noted) and/or child become eligible for coverage under this Plan on the date the other coverage ends. Note that loss of eligibility does not include a voluntary termination of coverage, a loss because premiums were not paid in a timely manner, or termination of coverage because of fraud. Unless otherwise noted, enrollment must be requested within 30 days of the loss of coverage.

- If you declined coverage when You were first eligible and You subsequently marry or begin a domestic partnership, You become eligible for coverage under the Plan on behalf of Yourself, Your Spouse (or Your Domestic Partner) and any Eligible Children on the date of marriage. Enrollment must be requested within 30 days of the date of marriage.
- If you declined coverage when You were first eligible (or You declined coverage for Your Spouse (or Your Domestic Partner) when he or she was first eligible) and You subsequently acquire a new Child by birth, adoption, or placement for adoption, You become eligible for coverage under this Plan along with Your Eligible Spouse (or Your Domestic Partner) and eligible children including the newly acquired child on the date of the birth, adoption, or placement for adoption. Enrollment must be request within 30 days of acquiring the new dependent. NOTE: When the addition of a new Child by birth, adoption, or placement for adoption does not cause a change in the premium amount (as of the date of birth, date of adoption, or date of placement for adoption), You will have 30 days from the date the Claims Administrator first sends a denial of a claim for benefits for such new Child, to submit to the Claims Administrator a signed group change request.
- If you declined coverage when You were first eligible and You subsequently become eligible for premium assistance through a state subsidy program, You become eligible for coverage under the Plan on behalf of Yourself, Your Spouse (or Your Domestic Partner) and any Eligible Children on the date of eligibility for premium assistance. Enrollment must be requested within 60 days of the determination of becoming eligible for the state subsidy.

As described above, Special Enrollment opportunities last for either 30 or 60 days beginning with the day of the triggering event, except the Special Enrollment Period following exhaustion of a lifetime maximum on total benefits does not end until 30 days after the first claim is denied on the basis of lifetime maximum exhaustion.

CHANGE IN STATUS

- You may make a prospective mid-year election change (adding or dropping of coverage) for You and/or Your Spouse (or Domestic Partner) and/or any Eligible Child if You and/or Your Spouse (or Domestic Partner) and/or any Eligible Child becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If you and/or Your Spouse (or Your Domestic Partner and/or any Eligible Child who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan as outlined under Special Enrollment.
- You may make prospective mid-year election change (adding or dropping coverage) for You and/or Your Spouse (or Your Domestic Partner) and/or any Eligible Child if the election change is on account of and corresponds with a change made under the plan of an employer of Your Spouse (or Domestic Partner) or an Eligible Child for the following:

    - The period of coverage and open enrollment period of the other plan is different from this Plan's period of coverage. For example, if You gain coverage under Your Spouse's (or Domestic Partner's) employer plan during their open enrollment period, with an effective date of July 1, then You would have the ability to make a corresponding mid-year election change to drop your coverage from this Plan effective July 1.
    - You and/or Your Spouse (or Domestic Partner) and/or Eligible Child become covered under another employer's plan triggered by new hire status or initial eligibility status.

The plan of the other employer must be a qualified cafeteria plan under IRS guidelines. The Plan Sponsor in its sole discretion shall determine, based on prevailing IRS guidance, whether a requested election change satisfies the consistency requirement. Election changes must be requested within 30 days of the effective date of change under the other employer's plan.

ANNUAL ENROLLMENT PERIOD

The annual enrollment period is the only time, other than initial eligibility, change in status, or a special enrollment period, during which You and/or Your Spouse (or Domestic Partner, except as noted) and/or Eligible Children may enroll or waive coverage. You must submit an enrollment form (and, in the case of a domestic partner, a completed affidavit of qualifying domestic partnership form) on behalf of all individuals You want enrolled or wish to waive coverage for. Coverage for You and Your Spouse and/or Eligible Children will begin on the Plan Effective Date.

When Coverage Ends

This section describes the situations when coverage will end for You and/or Your Spouse (or Domestic partner) and/or Children. You must notify the Claims Administrator within 60 days of the date on which Your Spouse (or Domestic Partner) and/or Children are no longer eligible for coverage.

No person shall have or acquire a vested right to receive any benefits after the date this Plan is terminated. Termination of Your or Your Spouse's (or Domestic Partner's) and/or Children's' coverage under this Plan for any reason shall completely end the Plan's obligations to provide You or Your Spouse (or Domestic Partner) and/or Children benefits for Covered Services received after the date of termination whether or not You or Your Spouse (or Domestic Partner) and/or Child is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while this Plan was in effect.

AGREEMENT TERMINATION

If the Plan is terminated by the Employer, coverage ends for You and Your Spouse (or Domestic Partner) and/or Children on the date the Plan is terminated.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, Your, Your Spouse's (or Domestic partner's) and Children's' coverage ends as indicated. However, it may be possible to continue coverage under the Plan according to the COBRA continuation of coverage provisions of this Summary Plan Description.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Plan, Your coverage will end for You, Your Spouse (or Domestic Partner) and all Children on the last day of the pay period in which eligibility ends. For example, if You terminate employment on or before the 15th of the month, Your coverage will end at 12:00 A.M. on the 16th day of that month. If You terminate employment on or after the 16th of the month through the end of the month, Your coverage will end at 12:00 A.M. on the 1st day of the following month.

NONPAYMENT

If You fail to make the required contribution in a timely manner, Your coverage will end for You, Your Spouse and all Children on the date You fail to make such a required contribution.

TERMINATION BY YOU

- If you terminate coverage for You, Your Spouse (or Domestic Partner) and/or Eligible Children because of a Change in Status event, coverage will end when the corresponding coverage begins under the other employers plan.
- You may terminate/waive coverage for You, Your Spouse and/or Eligible Children at Annual Enrollment. Coverage will end the last day of the Plan Year.
- Please note you may not reenroll in the Plan until the next Annual Enrollment.

FAMILY AND MEDICAL LEAVE

If the Plan Sponsor grants You a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3) the following rules will apply. You will be entitled to continued coverage under this provision only to the extent You are eligible for leave under the terms of the FMLA:

- You and Your covered Spouse (or Domestic Partner) and/or Children will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period as provided under the FMLA for one of the following:
  - in order to care for Your newly born child;
  - in order to care for Your spouse, domestic partner, child or parent, if such spouse, child or parent has a serious health condition;
  - the placement of a child with You for adoption or foster care;

- You suffer a serious physical Illness or Mental Health Condition.
- A qualifying exigency arises because Your spouse, son, daughter, or parent is on active duty (or have been notified of a call or order to active duty) in the Armed Forces in support of a "contingency operation."

- Under the Service Member Family Leave under FMLA, Section 585 of the National Defense Authorization Act, You, as an eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member (a member of the Armed Forces, including the National Guard or Reserves) are entitled to up to 26 weeks of leave during a 12-month period to care for a service member with a serious injury or illness incurred in the line of duty on active duty in the Armed Forces.

Persons entitled to coverage under this paragraph will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this paragraph. Entitlement to FMLA leave does not constitute a qualifying event for the purpose of COBRA continuation. However, a person entitled to COBRA continuation as a result of not returning to active employment following FMLA leave may be entitled to COBRA continuation coverage, the duration of which will be calculated from the date the person fails to return from the FMLA leave.

- Timely payment of the monthly premium must continue to be made to The Plan Sponsor. The provisions described here will not be available if this Plan terminates.
- If You and/or Your Spouse and or Children elect not to remain enrolled during the leave, You (and/or Your Spouse and/or Children) will be eligible to be reenrolled under the Plan on the date You return from the FMLA leave. In order to reenroll after You return from a FMLA leave, You must sign a new application just as if You were a newly eligible employee.

In this situation, if You reenroll within the required time, all of the terms and conditions of the Plan will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Spouse and/or Children) will receive credit for any waiting period served prior to the FMLA leave and You will not have to re-serve any probationary period under this Plan, although You and/or Your Spouse and/or Children will receive no waiting period credits for the period of noncoverage.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern.

MILITARY LEAVE OF ABSENCE

If you take a leave of absence for active military duty, you may continue coverage under the Plan as follows:

- if the leave of absence is 30 calendar days or less, you may continue coverage through timely payment of your contribution of the monthly premium to The Plan Sponsor; or
- if the leave of absence is more than 30 calendar days, you may continue coverage by paying the full monthly premium plus 2%, for up to 24 months to the Plan Sponsor.

If you are called to active military duty and you do not elect to continue coverage under the Plan during your leave, your coverage will be terminated. You may reenroll in coverage upon your return to work (if such return is within the time limits set by the Uniformed Services Employment and Reemployment Rights Act "USERRA").

It is the intent of the Plan to comply with all existing regulations of USERRA. If the Plan differs from the actual regulations of USERRA, the Plan reserves the right to administer the Plan in accordance with the USERRA regulations. Coverage under this provision runs concurrently with coverage continued under COBRA.

LEAVE OF ABSENCE

If You are granted a non-FMLA temporary leave of absence by the Plan Sponsor, You can continue coverage for up to twelve months from either the last working day, or the last day of FMLA. Premiums must be paid to the Plan Sponsor in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by the Plan Sponsor at Your request during which You are still considered to be employed and are carried on the employment records of the employer. A leave can be granted for any reason acceptable to the Plan Sponsor, including disability and pregnancy.

WHAT HAPPENS WHEN YOUR SPOUSE (OR DOMESTIC PARTNER) OR CHILD IS NO LONGER ELIGIBLE

If your Spouse (or Domestic Partner) or Children are no longer eligible as explained in the following paragraphs, their coverage will end as indicated. However, it may be possible for Your ineligible spouse or child to continue coverage under the Plan according to the COBRA continuation of coverage provisions of this Summary Plan Description.

Divorce or Annulment

Eligibility ends for Your enrolled spouse and the spouse's children (unless such children remain eligible by virtue of their continuing relationship to You) at 12:00 A.M. on the day following the date the divorce or annulment is final.

If You Die

If You die, coverage for Your Spouse (or Domestic Partner) and/or Children ends at 12:00 A.M. on the 1st day of the month following the month in which Your death occurs.

Termination of Domestic Partnership

If Your domestic partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) at 12:00 A.M. on the day following the termination of the domestic partnership. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence.

Loss of Eligible Child Status

- For an enrolled child who is no longer considered an Eligible Child due to exceeding the age limit, coverage ends at 12:00 A.M. on the 1st day of the month following the month in which the child exceeds the age limit.
- For an enrolled child who is no longer eligible due to disruption of placement prior to legal adoption and the child is removed from placement, coverage ends on the date the child is removed from placement.
- For an enrolled child who is no longer considered an Eligible Child for any other cause (except by reason of divorce or Your death), coverage ends on the last day of the pay period in which the child is no longer an Eligible Child. If an enrolled child is no longer eligible on or before the 15th of the month, coverage for that enrolled child will end at 12:00 A.M. on the 16th day of the month. If an enrolled child is no longer eligible on or after the 16th of the month, coverage for that enrolled child will end at 12:00 A.M. on the 1st day of the following month.

Fraudulent Use of Benefits

If any Claimant engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of material fact in connection with coverage, coverage under the Plan will terminate for that Claimant. The Claimant may reenroll 12 months after the date of discontinuance if the Plan Sponsor's coverage is in effect at the time the Claimant applies to reenroll.

Fraud or Misrepresentation in Application

Coverage under the Plan is based upon all information furnished to the Claims Administrator, for the benefit of the Plan by You or on behalf of You and Your Beneficiaries. In the event of any intentional

misrepresentation of material fact or fraud, the Plan will have the following rights in accordance with Utah Code 31A-22-721 (or any successor thereto):

- With regard to a Claimant's health status, a retrospective adjustment to the cost of coverage under the Plan may be made as would have been appropriate if true, accurate or complete information had been provided at the time of enrollment.
- With regard to a Claimant (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Plan), coverage will be retroactively adjusted to the terms that would have existed if true, accurate or complete information had been received.

Any discovery of intentional material misrepresentation of fact or fraud regarding a Claimant will be subject to the Plan's Right of Recovery.

CERTIFICATES OF CREDITABLE COVERAGE

Requests for and inquiries about required certificates relating to period(s) of creditable coverage under the Plan should be directed to the Plan Sponsor, or to the Claims Administrator at P.O. Box 2998, Tacoma, WA 98401-2998.

COBRA Continuation of Coverage

Under certain circumstances called Qualifying Events, Claimants may have the right to continue coverage beyond the time coverage would have ordinarily have ended. The following rights and obligations regarding continuation of coverage are governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. In the event of any conflict between this continuation of coverage provision and COBRA, the minimum requirements of COBRA will govern. This provision will automatically cease to be effective when federal law requiring continuation of eligibility for coverage no longer applies to the Employer. A full and more complete description of COBRA is available from the Plan Sponsor.

QUALIFYING EVENTS

- Qualifying Events are certain events defined by COBRA regulations that cause an individual to lose health care coverage. If You experience one of these Qualifying Events You and/or Your Enrolled Spouse and/or Child may elect COBRA Continuation Coverage for a maximum of 18 months following the date that Your coverage would have normally ended:
- Your employment is terminated (unless the termination is for gross misconduct); or
- Your hours of work are reduced, resulting in a loss of eligibility for coverage.
- If coverage for Your Enrolled Spouse and/or Children terminates due to any of the following Qualifying Events, that Enrolled Spouse or Child may elect COBRA Continuation Coverage for a maximum of 36 months following the date his or her coverage would have normally been lost:
- Your death;
- You and Your Spouse divorce or the marriage is annulled;
- You become entitled to Medicare benefits; or
- Your Enrolled Child is no longer considered an Eligible Child under the Plan.

NOTIFICATION RESPONSIBILITIES

You or Your Enrolled Spouse or Child must inform the Plan Sponsor in writing within 60 days of divorce, legal separation, annulment, or a loss of Eligible Child status. The Plan is responsible for notifying You and/or Your Enrolled Spouse and/or Child of the right to elect COBRA Continuation Coverage due to any of the other Qualifying Events. If written notice is not provided to the Plan Sponsor within 60 days of the Qualifying Event, all rights of that individual to elect COBRA Continuation Coverage will be lost.

Once the Plan Sponsor is notified or aware of a Qualifying Event, it will send You and/or Your Enrolled Spouse and/or Child information concerning continuation options, including the necessary COBRA Continuation election forms. You and/or Your Enrolled Spouse and/or Child will have 60 days from the later of the date of the Qualifying Event or when You and/or Your Enrolled Spouse and/or Child receives notice from the Plan Sponsor in which to make an election.

If You or Your Enrolled Spouse or Child qualifies for a Social Security Disability extension, You must provide written notice to the Plan Sponsor within 60 days of the date Social Security Administration determination is made and while still within the 18 month COBRA Continuation Coverage period following a termination or a reduction in hours Qualifying Events. You must also provide a written notice to the Plan Sponsor within 30 days if a final determination is made that You or Your Enrolled Spouse or Child are no longer disabled.

If You experience a Second Qualifying Event, You must provide a written notice to the Plan Sponsor within 30 days of the Second Qualifying Event and during the original 18 month COBRA Continuation Coverage period in order to extend COBRA Continuation Coverage up to 36 months.

Social Security Disability

COBRA Continuation Coverage following a Qualifying Event of termination of employment or a reduction in hours can be extended up to 29 months if You or Your Enrolled Spouse or Child is determined to have been to be disabled on the day of the Qualifying Event or during the first 60 days of the COBRA Continuation Coverage. You must obtain the Social Security Administration determination and provide documentation to the Plan Sponsor within 60 days of the determination and while still within the 18 month continuation period. If coverage is extended, Your premiums will be adjusted to 150% of the full cost during the extended 11 month coverage period.

Second Qualifying Event

Any Enrolled Spouse or Child who enrolled in COBRA Continuation Coverage as a result of termination of employment or a reduction in hours, who experience another Qualifying Event, may extend COBRA Continuation Coverage up to 36 months. The Plan Sponsor must receive written notice of the Second Qualifying Event within 60 days from the date of the event. Second Qualifying Event includes:

- Your death;
- You and Your Spouse divorce or the marriage is annulled; or
- Your Enrolled Child is no longer considered an Eligible Child under the Plan.

When You Acquire a New Child While on COBRA

Children born to You or placed with You for adoption while You are on COBRA may be added to COBRA Continuation Coverage and have all the rights extended to You and/or Your other Enrolled Children or Spouse who have elected COBRA Continuation Coverage. Written notification must be provided to the Plan Sponsor within 30 days of the birth or placement.

If You Become Entitled to Medicare Before Electing COBRA

If You become entitled to Medicare before electing COBRA in connection with a termination of employment or reduction in hours Qualifying Event, You may maintain both Medicare and up to 18 months of COBRA Coverage and Your Enrolled Spouse and Children will be allowed to continue their COBRA Continuation Coverage until the later of:

- up to 18 months from the Qualifying Event; or
- up to 36 months from the date you became entitled to Medicare.

ELECTING COBRA CONTINUATION COVERAGE

You and Your Enrolled Spouse and Children will have 60 days from the later of the date of the Qualifying Event or when You and Your Enrolled Spouse and Children receives notice from the Plan Sponsor in which to make a COBRA Continuation Coverage election. You and Your Enrolled Spouse and/or Children can each elect COBRA Continuation Coverage independently, even if You choose not to elect COBRA Continuation Coverage. COBRA Continuation Coverage is available to each person who had coverage on the day before the Qualifying Event.

If You or Your Enrolled Spouse or Child do not elect COBRA Continuation Coverage, coverage under the Plan will end according to the terms described in the Summary Plan Description and claims under the Plan for services provided on and after the date coverage ends will not be paid. Further, this may jeopardize Your, Your Spouse's or Your Child's future eligibility for an individual plan.

COBRA CONTINUATION PREMIUM PAYMENT

If You elect COBRA coverage, You will be responsible for the Total Cost of the coverage plus an administrative fee of 2% for any period of continuation; 50% for Social Security Disability determinations. Coverage will cease of timely payments are not made.

- Initial payment must be received by the Plan Sponsor within 45 days of the date You elect COBRA Continuation Coverage. Your first payment must include premiums due retroactive to the date You lost coverage as a result of Your Qualifying Event. If Your first payment is not received timely, COBRA Continuation Coverage will not be effective and You will lose all rights to COBRA Continuation Coverage.
- Subsequent payments for each subsequent period are due on the first day of the month for which coverage is to be provided. You will have a 30 day grace period from the premium due date to make subsequent payments. If the COBRA Continuation premiums are not paid within the grace period, Your COBRA Continuation Coverage will terminate as of the end of the last period for which payment was received and You will lose all further rights to COBRA Continuation Coverage.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA Continuation Coverage under this Plan will end for You and/or Your Enrolled Spouse and/or Children if any of the following occur:

- The required premium payments are not paid within the timeframe allowed;
- You notify the Plan Sponsor that You wish to cancel Your coverage;
- The applicable period of COBRA coverage ends;
- You become entitled to Medicare benefits;
- The date You reach the Life Maximum Benefit under the Plan;
- The Plan Sponsor terminates its group health plan(s);
- You have extended COBRA coverage through Social Security disability and a final determination is made that You are no longer disabled, coverage for You and Your Enrolled Spouse (or Domestic Partner, except as noted) and/or Children for the disability extension will end the later of:

    - The last day of the 18 months of continuation coverage; or
    - The first day of the month that is more than 30 days following the date of the final determination of the nondisability;

- After the date of Your COBRA election, you become covered under another group health plan that does not contain any exclusion or limitation for any of Your pre-existing conditions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the extent to which health plans may impose pre-existing condition limitations. If You become covered by another group health plan with a pre-existing condition limitation that affects You, Your COBRA coverage may continue. If the plan's pre-existing condition rule does not apply to You by reason of HIPAA's restrictions on pre-existing condition clauses, You are no longer eligible to continue COBRA coverage; or
- An event occurs that permits termination of coverage under the Plan for an individual covered other than pursuant to COBRA (e.g. submitting fraudulent claims).

Notice

The complete details on the COBRA Continuation provisions outlined here are available from the Plan Sponsor.

General Provisions

This section explains various general provisions regarding Your benefits under this coverage.

CHOICE OF FORUM

Any legal action arising out of the Plan benefit option described herein must be filed in a court in the state of Utah.

GOVERNING LAW AND DISCRETIONARY LANGUAGE

. The Plan will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the State of Utah without regard to its conflict of law rules. The Plan Administrator, the Plan Sponsor, delegates the Claims Administrator discretion for the purpose of paying benefits under this coverage only if it is determined that You are entitled to them and of interpreting the terms and conditions of the Plan. Final determinations pursuant to this reservation of discretion do not prohibit or prevent a claimant from seeking judicial review of those determinations in federal court. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when You seek judicial review of a determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the Plan. The Claims Administrator is not the Plan Administrator, but does provide claims administration under the Plan, and the court will determine the level of discretion that it will accord the Claims Administrator's determinations.

PLAN SPONSOR IS THE FIDUCIARY

The Plan Sponsor is Your fiduciary for all purposes under the Plan and not the agent of Regence. You may be entitled to health care benefits pursuant to the Plan. In the Agreement, the Plan Sponsor agrees to act as a fiduciary for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in the Summary Plan Description. You, through the enrollment form signed by the Participant, and as Claimants of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Summary Plan Description.

NO WAIVER

The failure or refusal of either party to demand strict performance of the Plan or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the Plan will be considered waived unless such waiver is reduced to writing and signed by one of the Plan Sponsor's authorized officers.

NOTICES

Any notice to Claimants or to the Plan Sponsor required in the Plan will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Participant or to the Plan Sponsor will be addressed to the Participant or to the Plan Sponsor at the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address form (COA) for a Participant, the Claims Administrator will update its records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the plan administrator or Plan Sponsor if it becomes aware that it doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be given by mail addressed to: Regence BlueCross BlueShield of Utah, P.O. Box 2998, Tacoma, WA 98401-2998; provided, however that any notice to the Claims Administrator will not be considered to have been given to and received by it until physically received.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Plan Sponsor on behalf of itself and its Claimants expressly acknowledges its understanding that the Agreement constitutes an agreement solely between the Plan Sponsor and Regence, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association), permitting Regence to use the Blue Cross and Blue Shield Service Marks in the state of Utah and that Regence is not contracting as the agent of the Association. The Plan Sponsor on behalf of itself and its Claimants further acknowledges and agrees that it has not entered into the Agreement based upon representations by any

person or entity other than Regence and that no person or entity other than Regence will be held accountable or liable to the Plan Sponsor or the Claimants for any of Regence's obligations to the Plan Sponsor or the Claimants created under the Agreement. This paragraph will not create any additional obligations whatsoever on the part of Regence other than those obligations created under other provisions of the Agreement.

REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements You make in an enrollment form will be considered representations and not warranties. No statement made for the purpose of obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered under the Plan, they must be incurred while coverage is in effect. Coverage is in effect when all of the following conditions are met:

- the person is eligible to be covered according to the eligibility provisions described in the Plan Document; and
- the person has enrolled in coverage and has been enrolled by the Claims Administrator.

The expense of a service is incurred on the day the service is provided and the expense of a supply is incurred on the day the supply is delivered to You.

Definitions

The following are definitions of important terms used in this Summary Plan Description. Other terms are defined where they are first used.

Affiliate means a company with which the Claims Administrator has a relationship that allows access to Providers in the state in which the Affiliate serves and includes the following companies: Regence BlueShield of Idaho in the state of Idaho, Regence BlueCross BlueShield of Oregon in the state of Oregon and Regence BlueShield in parts of the state of Washington.

Allowed Amount means, for the purpose of this Dental Benefits Section only:

- With respect to Participating Dentists, the amount Participating Dentists have contractually agreed to accept as full payment for Covered Services.
- With respect to Nonparticipating Dentists, reasonable charges for Covered Services as determined by the Claims Administrator.

Charges in excess of the Allowed Amount are not considered reasonable charges and are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, please contact the Claims Administrator.

Beneficiary means a Participant's eligible dependent who is listed on the Participant's completed enrollment form and who is enrolled under the Plan.

Calendar Year means the period from January 1 through December 31 of the same year.

Claimant means a Participant or a Beneficiary.

Covered Service means those services or supplies that are required to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues and are Dentally Appropriate. These services must be performed by a Dentist or other provider practicing within the scope of his or her license.

Dentally Appropriate means a dental service recommended by the treating Dentist or other provider, who has personally evaluated the patient, and determined by the Claims Administrator (or their designee) to be all of the following:

- appropriate, based upon the symptoms, for determining the diagnosis and management of the condition;
- appropriate for the diagnosed condition, disease or Injury in accordance with recognized national standards of care;
- not able to be omitted without adversely affecting the Claimant's condition; and
- not primarily for the convenience of the Claimant, Claimant's family or provider.

A DENTAL SERVICE MAY BE DENTALLY APPROPRIATE YET NOT BE A COVERED SERVICE UNDER THE PLAN.

Dentist means an individual who is licensed to practice dentistry (including a doctor of medical dentistry or doctor of dental surgery. A Dentist also means a dental hygienist who is permitted by his or her respective state licensing board, to independently bill third parties.

Effective Date means the date Your coverage under the Agreement begins after acceptance for enrollment under the Plan.

Family means a Participant and his or her Beneficiaries.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following: disease, Illness, Injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself,

but also by the medical condition and patient indications for which it is being applied. A Health Intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

Health Outcome means an outcome that affects health status as measured by the length or quality of a person's life. The Health Intervention's overall beneficial effects on health must outweigh the overall harmful effects on health.

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy.

Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of Illness or any other cause. An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

Investigational means a Health Intervention that the Claims Administrator has classified as Investigational. The Claims Administrator will review Scientific Evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is Investigational. A Health Intervention not meeting all of the following criteria is, in the Claims Administrator's judgment, Investigational:

- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Injury or Illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

Lifetime means the entire length of time a Claimant is covered under the Plan (which may include more than one coverage) through the Plan Sponsor with the Claims Administrator.

Nonparticipating Dentist means a Dentist who does not have an effective participating contract with the Claims Administrator to provide services and supplies to Claimants, or any other Dentist that does not meet the definition of a Participating Dentist under this Plan.

Participant means an employee of the Plan Sponsor who is eligible under the terms described in this Summary Plan Description, has completed an enrollment form and is enrolled under this coverage.

Participating Dentist means a Dentist who has an effective participating contract with the Claims Administrator to provide services and supplies to Claimants in accordance with the provisions of the Plan. In addition, if Your employer may select from more than one participating network, then the network through which the Participating Dentist has agreed to provide services and supplies under this Summary Plan Description must also be the network selected by Your employer.

Plan Year means the 12-month period from July 1 through June 30 of the following Year; however, the first Plan Year begins with the Claimant’s Effective Date. The Deductible provisions are calculated on a Plan Year basis. If the Deductible amount increases during the Plan Year, You will need to meet the new requirement.

Regence refers to Regence BlueCross BlueShield of Utah.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed

literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Summary Plan Description (SPD) is a summary of the benefits provided by the Group Health Plan (GHP). A GHP with different benefit plan options may describe them in one SPD or in separate SPDs for each alternative benefit plan option.

General Plan Description

TYPE OF PLAN
Welfare Benefit Plan: Dental.

CLAIMS ADMINISTRATOR
Regence BlueCross BlueShield of Utah
2890 East Cottonwood Parkway
Salt Lake City, Utah 84121
1 (888) 370-6159

The processing of claims for benefits under the terms of the Plan is provided through a third-party contracted by the Plan Sponsor which hereinafter is referred to as the Claims Administrator.

AGENT FOR LEGAL PROCESS
Attn: Director of Employee Benefits
Salt Lake Community College
4600 South Redwood Road
Salt Lake City, Utah 84123
1 (801) 957-4595

SOURCES OF CONTRIBUTIONS TO THE PLAN
All benefits under the Plan are self-insured by the Plan Sponsor. Participants and the Plan Sponsor share the cost of providing benefits. The cost of providing benefits are charged first to Participants' contributions and then paid out of the general assets of the Plan Sponsor. The Plan Sponsor shall from time to time determine the amount of contributions payable by Participants.

PLAN YEAR
July 1 - June 30

PLAN TERMINATION PROVISIONS
The Plan Sponsor intends the Plan to be permanent, but since future conditions affecting the Plan Sponsor cannot be anticipated or foreseen, the Plan Sponsor reserves the right to amend, modify or terminate the Plan, or any portion thereof, in any manner, at any time, regardless of Your or Your Spouse's (or Domestic Partner's) or Child's health or treatment status, which may result in the termination or modification of Your coverage and/or the coverage for Your Spouse (or Domestic Partner) and/or Children. If the Plan is amended, modified, or terminated, the rights of You or Your Spouse (or Domestic Partner) or Children are limited to services and Allowed Amounts incurred prior to the Plan's amendment, modification or termination, which will be paid as provided under the terms of the Plan as it existed at the time they were incurred.

PLAN INTERPRETATION PROVISIONS
The Plan Sponsor reserves the right to interpret the Plan's coverage and meaning in the exercise of its sole discretion.

ASSISTANCE WITH YOUR QUESTIONS
If You have any questions about the Plan, You should contact the Plan Sponsor.

For more information contact the Claims Administrator at
1 (866) 240-9580 or P.O. Box 2998, Tacoma, WA 98401-2998

www.Regence.com