SALT LAKE COMMUNITY COLLEGE
EMPLOYEE HEALTH CARE BENEFITS
Summary Plan Description

Group Number: 10003141

Restated: July 1, 2016

MEDICAL	
Regence BlueCross BlueShield 2890 East Cottonwood Parkway Salt Lake City, UT 84121	www.regence.com
Customer Service	(888) 240-9580
Case Management	(866) 543-5765
PHARMACY	
VRx PO Box 9780 Salt Lake City, UT 84109	www.myvrx.com
Customer Service	(855) 586-2569
EAP	
Employee Assistance Program	(866) 750-6327

Salt Lake Community College Employee Health Care Benefits Medical Plan Summary

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

$30 Copay
$400 Deductible
80/60% Coinsurance
Effective Date: July 1, 2016

Benefit Summary	
Deductible per plan year	**In-Network**: $400 Per Claimant / $800 Per Family **Out-of-Network:** $1,000 Per Claimant / $2,000 Per Family
Out-of-Pocket Maximum per plan year	**In-Network:** $2,900 Per Claimant / $5,800 Per Family **Out-of-Network:** $5,000 Per Claimant / $10,000 Per Family
After the Out-of-Pocket Maximum is met, the plan pays	100% for the remainder of the plan year except where noted

Understanding Your Benefits

- The Plan will begin to pay benefits for other covered services in any plan year only after your deductible is satisfied. Your deductible applies for all services unless otherwise specified. Copayments do not count toward the deductible or the coinsurance maximum.
- Once you have satisfied any applicable deductible and any applicable copayment, the Plan pays a percentage of the allowed amount for covered services. When the Plan's payment is less than 100%, you pay the remaining percentage. This is your **Coinsurance** (Claimant Responsibility).
- You can meet the Out-of-Pocket Maximum by payments of deductible, copayments and coinsurance for all categories. Any amounts you pay for non-covered services, deductible, copayments or amounts in excess of the allowed amount do not apply toward the Out-of-Pocket Maximum.

Important Information Regarding Preventive Care: Benefits will be covered under this preventive care benefit if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) or Health Resources and Services Administration (HRSA). In the event any of these bodies adopts a new or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit. For a list of services covered under this benefit, please visit **www.Regence.com** or Customer Service at 1 (866) 240-9580 NOTE: Covered services that do not meet this criteria may be covered under the Expanded Preventive Care benefit, or covered the same as any other illness or injury.

You Select Your Provider and Control Your Out-of-Pocket Expenses

- **In-Network** If you choose to see an in-network provider you will receive the highest benefit and save the most in your out-of-pocket expenses. Choosing an in-network provider means you will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services. You can find a list of in-network providers at **www.Regence.com** or by calling Customer Service at 1-866-240-9580.
- **Out-of-Network** If you choose to see an out-of-network provider that does not have a participating contract with Blue Cross Blue Shield, your out-of-pocket expenses will be higher than in-network. **Also, choosing an out-of-network provider means you may be billed for balances beyond any deductible, copayment, and/or coinsurance.** This is referred to as balance billing.

Unless otherwise noted the deductible applies to all services.		
Covered Medical Services (Per Claimant)	***Claimant Responsibility In-Network***	***Claimant Responsibility Out-of-Network***
Office Visits • Each office visit • For illness or injury • Annual vision and hearing exam • Allergy testing, injections and serum • Medical services, surgical procedures and therapeutic injections performed in the office	$30 copay (deductible waived)	40% + balance billing
Other Professional Services • Services in connection with all other professional care not otherwise specified	20%	40% + balance billing
Outpatient Laboratory and Radiology Services • Includes lab work performed as part of an office visit, emergency room visit or an outpatient setting	20%	40% + balance billing
Preventive Care • Routine visits for preventive care including well-baby care, screenings for women and routine physical exams • Routine radiology and laboratory services including mammography and prostate screening • Routine procedures including routine colonoscopies • Certain family planning services • Immunizations for adults and children	0% (deductible waived)	25% + balance billing
Preventive Care – Expanded benefits • Services billed as preventive care and not covered under the above preventive care benefit	$30 copay (deductible waived)	40% + balance billing
Accidental Dental Care • $1,000 per Claimant per plan year	20%	40% + balance billing
Ambulance Services	20%	20% + balance billing
Blood Bank	20%	20% + balance billing
Clotting Factor Products - Outpatient • Plasma-derived and recombinant clotting factor products used in outpatient replacement therapy for hemophilia, Von Willebrand disease, and similar clotting disorders	20%	100%
Dental Hospitalization	20%	40% + balance billing
Durable Medical Equipment	20%	40% + balance billing
Emergency Room (Including Professional Charges) • Copay waived if admitted directly to a hospital or facility on an inpatient basis	$150 copay (deductible waived)	$150 copay + balance billing (deductible waived)
Home Health Care	$30 copay (deductible waived)	40% + balance billing

Unless otherwise noted the deductible applies to all services.		
Covered Medical Services (Per Claimant)	***Claimant Responsibility In-Network***	***Claimant Responsibility Out-of-Network***
Home Infusion Therapy • $50,000 Total Parenteral Nutrition per Claimant per plan year	$30 copay (deductible waived)	40% + balance billing
Hospice Care	20% (deductible waived)	40% + balance billing
Hospital Care - Inpatient • Medical/Surgical Care • Intensive/coronary care unit	20%	40% + balance billing
Hospital Care - Outpatient • Surgery, radiation and chemotherapy • Preadmission testing	20%	40% + balance billing
Infertility • Diagnosis and treatment • $5,000 per Claimant lifetime maximum benefit	$30 copay (deductible waived)	40% + balance billing
Major Diagnostic Testing • Includes, but not limited to CT scan, MRI, MRA, nuclear medicine, neurological diagnostics and cardiovascular diagnostics	$50 copay after deductible	$50 copay after deductible + 40% + balance billing
Maternity Care • Well Baby Care (baby's deductible waived for well-baby care only)	20%	40% + balance billing
Mental Health/Chemical Dependency Services – Inpatient/Outpatient Care	20%	40% + balance billing
Mental Health/Chemical Dependency Services – Office or Clinic Visits	$30 copay (deductible waived)	40% + balance billing
Nutritional Counseling • For diabetic nutritional therapy only	20%	40% + balance billing
Orthotic Devices • Foot orthotics limit: $200 per Claimant per plan year	20%	40% + balance billing
Prosthetic Devices	20%	40% + balance billing
Rehabilitation Services - Inpatient • 60 days per Claimant per plan year	20%	40% + balance billing
Rehabilitation Services – Outpatient • 30 visits per Claimant per plan year	$30 copay (deductible waived)	40% + balance billing
Skilled Nursing Facility (SNF) Care • 60 inpatient day limit per Claimant per plan year	20%	40% + balance billing
Spinal Manipulations • 20 visits per Claimant per plan year	$30 copay (deductible waived)	40% + balance billing
Temporomandibular Joint (TMJ) Disorders • $500 per Claimant lifetime maximum	20%	40% + balance billing
Transplants	20%	40% + balance billing

Case Management

Receive one-on-one help and support in the event you have a serious or sudden illness or injury. An experienced, compassionate case manager will serve as your personal advocate during a time when you need it most. Your case manager is a licensed health care professional who will help you understand your treatment options, show you how to get the most out of your available Plan benefits and work with your physician to support your treatment plan.

To learn more or to make a referral to case management, please call 1 (800) 543-5765.

BlueCard® Program (Out of Area or Travel)

The BlueCard Program is a unique program that enables you to access hospitals and physicians when traveling outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Find a provider near you at **www.bcbs.com** or call **1 888-849-3661**.

Note: When searching for a provider, Category 1 Providers are also listed as PPO Providers and Category 2 Providers are listed as PAR Providers.

Employee Assistance Program (EAP)

The Employee Assistance Program provides short-term, confidential counseling at no out-of-pocket expense to you. The EAP is available to you and your immediate family, including family members living in your home (who may or may not be enrolled in this coverage). The EAP package includes 24-hour crisis counseling, short-term counseling, referrals and follow-up when necessary and appropriate. Please contact us or your group for more information regarding EAP coverage and for contact information.

General Exclusions

The Plan will not provide benefits 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: 1) 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; or 2) a preventive service as specified under the preventive care benefit.

Medical Exclusions

Abortions/Termination of Pregnancy: Services and supplies in connection with the performance of any induced abortion services except in the following circumstances in accordance with the Utah prohibition against public funding for abortions (U.C.A. 76-7-331, as amended): in the professional judgment of the pregnant woman's attending physician, the abortion is necessary to save the pregnant women's life, the abortion is necessary to prevent permanent, irreparable and grave damage to major bodily function of the pregnant women provided that a caesarian procedure or other medical procedure could also save the life of the child is not a viable option or the pregnancy is the result of rape or incest reported to a law enforcement agency, unless the woman was unable to report the crime for physical reasons or fear of retaliation.

Complementary Care including acupuncture, massage or massage therapy and naturopathic services.

Condition 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.

Condition 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.

Cosmetic/Reconstructive Services and Supplies except to treat a congenital anomaly for Claimants up to age 18, to restore a physical bodily function lost as result of injury or illness or related to breast reconstruction following a medically necessary mastectomy, to the extent required by law.

Counseling in the Absence of Illness

Custodial Care: Non-skilled care and helping with activities of daily living.

Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth**.**

Expenses Before Coverage Begins or After Coverage Ends: Services and supplies incurred before your effective date under the contract or after your termination under the contract, except as may be provided under the other continuation options of the contract.

Medical Exclusions
Fees, Taxes, Interest: Charges for shipping and handling, postage, interest or finance charges that a provider might bill.
Foot Care (Routine): Routine foot care including treatment of corns and calluses and trimming of nails, except when indicated for diabetic patients.
Government Programs: Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program.
Growth Hormone Therapy once bone growth is complete.
Hearing Care except as specifically provided under the routine hearing examinations benefit of the contract, routine hearing examinations, programs or treatment for hearing loss, including, but not limited to, hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion does not apply to cochlear implants.
Infertility except as provided under the infertility treatment benefit of the contract.
Investigational Services: Investigational treatment or procedures (health interventions) and services, supplies and accommodations provided in connection with investigational treatments or procedures.
Mental Health Treatment For Certain Conditions including diagnostic codes 302 through 302.9 found in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders for all ages. Additionally, the Plan will not cover any "V code" diagnoses except the following when medically necessary: parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger and bereavement for children five years of age or younger.
Motor Vehicle Coverage and Other Insurance Liability
Non-Direct Patient Care including appointments scheduled and not kept, charges for preparing or duplicating medical reports and chart notes, itemized bills or claim forms and visits or consultations that are not in person, including telephone consultations and email exchanges.
Obesity or Weight Reduction/Control: Medical treatment, medication, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.
Orthognathic Surgery: Orthognathic surgery means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones. This exclusion does not apply to orthognathic surgery due to a temporomandibular joint disorder, injury, sleep apnea or congenital anomaly
Over the Counter Contraceptives including supplies and oral contraceptives (coverage for these services may be provided under the prescription medication benefit).
Personal Comfort Items: Items that are primarily for comfort, convenience, cosmetics, environmental control or education.
Physical Examinations required by a third-party for example: employment examinations, exams for insurance applications, exams to permit travel outside the United States.
Physical Exercise Programs and Equipment including hot tubs or membership fees at spas, health clubs or other such facilities; applies even if the program, equipment or membership is recommended by the Claimant's provider.
Prescription Medications
Private Duty Nursing including ongoing shift care in the home.
Reversals of Sterilizations including services and supplies related to reversals of sterilization.
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 including diet and weight monitoring services, childbirth-related classes including infant care and breast feeding classes, instruction programs including those to learn how to stop smoking and programs that teach a person how to use durable medical equipment or how to care for a family member.
Services and Supplies Provided by a Member of Your Family
Services and Supplies That Are Not Medically Necessary
Sexual Dysfunction: Services and supplies including medications for or in connection with sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners when mental health services are covered benefits under the contract.
Sexual Reassignment Treatment and Surgery: Treatment, surgery or counseling services for sexual reassignment.
Third-Party Liability: Services and supplies for treatment of illness or injury for which a third-party is or may be responsible.

Medical Exclusions
Tobacco Addiction Treatment except as specifically provided under the preventive care and immunizations benefit**,** the Plan does not cover treatment of tobacco addiction and supportive items for addiction to tobacco, tobacco products or nicotine substitutes.
Travel and Transportation Expenses other than covered ambulance services.
Vision Care: Routine eye exam and vision hardware, except as specifically provided under the vision benefits section of this Plan. Visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversal or revisions of surgical procedures which alter the refractive character of the eye.
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 only exception is if an enrolled employee is exempt from state or federal workers' compensation law.

Please note: This benefit summary provides a brief description of your health care plan benefits, limitations and exclusions under your health care plan and is not a guarantee of payment. Once enrolled, you can view your benefits online at our Website, **www.Regence.com**. Please refer to the Plan for a complete list of benefits, the limitations and exclusions that apply, and a definition of medical necessity.

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Contact Customer Service at 1 (866) 240-9580

www.regence.com

Salt Lake Community College
Employee Health Care Benefits
Prescription Plan Summary

PO Box 9780
Salt Lake City, UT 84109
(855) 586-2569
www.myvrx.com

Effective Date: July 1, 2016

Benefit Summary	
Deductible per plan year	$100 Per Claimant / $300 Per Family
Out-of-Pocket Maximum per plan year	$2,000 Per Claimant / $6,000 Per Family
After the Out-of-Pocket Maximum is met, the plan pays	100% for the remainder of the plan year except where noted

Understanding Your Benefits

- The Plan will begin to pay benefits for other covered services in any plan year only after your deductible is satisfied. Your deductible applies for all services unless otherwise specified. Copayments do not count toward the deductible.
- Once you have satisfied any applicable deductible and any applicable copayment, the Plan pays a percentage of the allowed amount for covered services. When the Plan's payment is less than 100%, you pay the remaining percentage. This is your **Coinsurance** (Claimant Responsibility).
- You can meet the Out-of-Pocket Maximum by payments of deductible, copayments and coinsurance for all categories. Any amounts you pay for non-covered services, deductible, copayments or amounts in excess of the allowed amount do not apply toward the Out-of-Pocket Maximum.

Important Information Regarding Preventive Care: *One element of the Affordable Care Act is the coverage of certain preventive medications at no cost to the member. As required by law, these medications are covered by the Plan at no cost to you when age and gender appropriate, prescribed by a health care professional, and filled at a network pharmacy.*

VRx Participating Pharmacy Network

- You can use your VRx pharmacy benefits at more than 63,000 participating pharmacies. The VRx network includes national pharmacy chains, local and regional chains, many independent pharmacies, and specialty pharmacies. To find out if your pharmacy is participating visit www.myvrx.com or call VRx at (801) 417-9722 or (855) 586-2569.

Unless otherwise noted the deductible applies to all covered prescriptions.

	Claimant Responsibility		
	Generic	***Formulary***	***Non-Formulary***
Retail Pharmacy • Not more than a 34-day supply or 100 unit doses, whichever is greater	$7 (deductible waived)	25% to a maximum of $150 per script	30% to a maximum of $175 per script
Mail Order Pharmacy • 90-day supply for each prescription	$7 (deductible waived)	25% to a maximum of $300 per script (deductible waived)	30% to a maximum of $437.50 per script (deductible waived)
Preventive Care Covered Medications • As required by law	0% To find a list of these medications visit www.myvrx.com.		
Diabetic Supplies	20%	20%	20%
Specialty Pharmacy	10% to a maximum of $250 per script	10% to a maximum of $250 per script	15% to a maximum of $300 per script

Prescription Exclusions
Acne Medication. Prescription Medications for the treatment of acne in Claimants over age 39.
Biological Sera, Blood or Blood Plasma, Plasma-derived and Recombinant Clotting Factor Products
Certain Contraceptives. Prescription contraceptives that cannot be self-administered, including Norplant, surgically inserted contraceptive devices, IUDs and Depo-Provera (coverage for these contraceptives may otherwise be provided under the medical benefit).
Cosmetic Purposes. Prescription Medications used for cosmetic purposes, including, but not limited to: removal, inhibition or stimulation of hair growth; retardation of aging; or repair of sun-damaged skin.
Devices or Appliances. Devices or appliances of any type, other than insulin pumps, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Medical Benefits Section).
Foreign Prescription Medications. Except for Foreign Prescription Medications associated with an Emergency Medical Condition while you are traveling outside the United States, or those You purchase while residing outside the United States, the Plan does not cover foreign Prescription Medications. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.
Insulin Pumps and Pump Administration Supplies. Coverage for insulin pumps and supplies is provided under the Medical Benefits Section.
Medications That Are Not Considered Self-Administrable. Coverage for these medications may otherwise be provided under the Medical Benefits Section.
Nonprescription Medications. Medications that by law do not require a Prescription Order and which are not included in the Claims Administrator's definition of Covered Prescription Medications, shown below, unless included on the Formulary.
Off-Label Use Prescription Medications. Prescription Medications that have not yet received FDA approval for the purpose and in the manner they are being prescribed, except as may be provided under the Investigational definition in the Definitions Section found at the back of this Summary Plan Description. However, if a Prescription Drug is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the Prescription Drug may be provided when so used, as determined by the Plan.
Prescription Medications Dispensed in a Facility. Prescription Medications dispensed to you while you are a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed under this benefit if obtained from a Pharmacy.
Prescription Medications Dispensed in Connection with Participation in a Clinical Trial
Prescription Medications for Treatment of Infertility
Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order
Prescription Medications Not within a Provider's License. Prescription medications prescribed by providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.
Prescription Medications with No FDA Proven Therapeutic Indication
Prescription Medications without Examination. Prescriptions made by a provider without recent and relevant in-person examination of the patient, whether the prescription order is provided by mail, telephone, internet or some other means.
Professional Charges for Administration of Any Medication

Please note: This summary provides a brief description of the Prescription Plan benefits, limitations, and exclusions and is not a guarantee of payment. Please refer to the Plan for a complete list of benefits, limitations and exclusions that apply.

Salt Lake Community College Employee Dental Plan

$1,500 Maximum

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Effective Date: July 1, 2016

Benefit Summary	
Deductible per plan year	N/A
Maximum benefit per plan year	$1,500 Per Claimant

Understanding Your Benefits

- The Plan pays a percentage of the allowed amount for covered services up to the maximum benefit. When payment is less than 100%, you pay the remaining percentage. This is your **Coinsurance** (Claimant Responsibility).
- The Plan does not reimburse Dentists for charges above the allowed amount. A **Participating Dentist** will not charge you for any balances for covered services beyond your coinsurance amount. **Nonparticipating Dentists**, however, may bill you for any balances over our payment level in addition to any coinsurance amount. You can find a list of Participating Dentists at **www.Regence.com** or by calling Customer Service at 1 (866) 240-9580.

Covered Dental Services (Per Claimant)	***Participating Dentist Claimant Responsibility***	***Nonparticipating Dentist Claimant Responsibility***
Preventive Dental Services • Bitewing x-rays as required • Complete intra-oral mouth x-rays: Once in a three-year period • Cleanings: two per plan year • Preventive oral examinations: two per plan year • Problem focused oral examinations • Panoramic mouth x-rays: Once in a three-year period • Sealants (limited to permanent molars): Under 15 years of age • Space Maintainers: Under 13 years of age • Topical fluoride application: Under 23 years of age, two treatments per plan year	20%	20% + balance billing
Basic Dental Services • Endodontic services including root canal treatment, pulpotomy and apicoectomy • Extractions, including surgical extraction of bone impacted teeth. • Fillings consisting of composite and amalgam restorations • General dental anesthesia or intravenous sedation (subject to necessity) • Palliative emergency treatment • Periodontic services • Repair of dentures and bridges	20%	20% + balance billing
Major Dental Services • Bridges, fixed and removable inlays, onlays and crowns: Except no benefits are provided for replacement made fewer than 5-years after placement • Dental Implants • Vestibuloplasty • Dentures (full and partial): Except no benefits are provided for replacement made fewer than 5-years after placement	50%	50% + balance billing
Orthodontia Services • Orthodontic treatment: Under 26 years of age • $500 per Claimant per plan year; $1,000 per Claimant lifetime maximum benefit	50%	50% + balance billing

Dental Exclusions
The Plan will not provide benefits 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
Condition 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.
Condition 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 result of injury or illness.
Desensitizing: Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.
Diagnostic Casts or Study Models Unless In Connection With Orthodontics
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 except as may be provided under the other continuation options of 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.
Fractures of the Mandible: 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.
Home Visits
Investigational Services: Investigational treatment or procedures (health interventions) and services, supplies and accommodations provided in connection with investigational treatments or procedures (health interventions).
Medications and Supplies including take home drugs, pre-medications, therapeutic drug injections and supplies.
Motor Vehicle Coverage and Other Insurance Liability
Nitrous Oxide
Non-Direct Patient Care including appointments scheduled and not kept, charges for preparing medical reports, itemized bills or claim forms, and visits or consultations that are not in person, including telephone consultations and email exchanges.
Occlusal Treatment: Services and supplies provided in connection with dental occlusion, including occlusal analysis, adjustments and occlusal guards.
Oral Hygiene Instructions
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 used for personal comfort or convenience, contentment, personal hygiene, aesthetics or other nontherapeutic purposes.
Photographic Images Unless In Connection With Orthodontics
Pin Retention in Addition to Restoration

Dental Exclusions
Precision Attachments
Prosthesis including maxillofacial prosthetic procedures and modification of removable prosthesis following implant surgery.
Provisional Splinting
Pulp Capping Services or supplies for indirect pulp capping in addition to restoration charges. This exclusion does not apply to indirect pulp capping not associated with any other charges.
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
Separate Charges: Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure) including any supplies, local anesthesia and sterilization.
Services and Supplies Provided by a Member of Your Family
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 and surgical procedures for isolation of a tooth with rubber dam.
Temporomandibular Joint (TMJ) Dysfunction Treatment
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
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 only exception is if a Participant is exempt from state or federal workers' compensation law.

Please note: This summary provides a brief description of the Plan benefits, limitations, and exclusions and is not a guarantee of payment. Once enrolled, you can view the Plan benefits online at the Claims Administrator Website, **www.Regence.com**. Please refer to the Plan for a complete list of benefits, limitations and exclusions that apply, and a definition of dentally appropriate.

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Contact Customer Service at 1 (866) 240-9580

www.regence.com

Introduction

Salt Lake Community College (hereafter referred to as the “Plan Sponsor”) has restated the Salt Lake Community College Employee Health Care Benefits (hereafter referred to as the “Plan”) effective **July 1, 2016**. This Summary Plan Description (SPD) describes the terms and benefits of coverage. This Summary Plan Description replaces any plan description or Summary Plan Description previously issued by the Plan Sponsor and makes it void.

The Summary Plan Description is not meant to interpret, extend, or change the provisions of the Plan in any way. Benefits under this Plan will be paid only if the Plan Sponsor decides, in their sole discretion, that you are entitled to them. The provisions of the Plan may only be determined fully and completely from the actual Plan document, which is available from the Plan Sponsor. Prior to amendments, the Plan Document is this Summary Plan Description. If the Plan Document and this Summary Plan Description differ, the Plan Document will prevail. No oral interpretations can change this Plan.

The Summary Plan Description includes **separate** sections for Medical Benefits, Prescription Benefits, and Dental Benefits, all of which are separate and independent plans. While the first portion of each section contains only a summary (the complete benefits, conditions, limitations, and exclusions are described later), it includes some important information that can only be found within that particular portion of the section, such as the percentages paid, Deductibles, Copayments, and Out-of-Pocket Maximum amounts under the Plan.

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, Your Spouse’s (or Domestic Partner’s) and/or Your 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, Your Spouse (or Domestic Partner) and/or Your 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.

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.

The Plan Sponsor is the Plan Administrator. The Plan Sponsor has entered into an agreement with Regence Blue Cross Blue Shield of Utah (hereafter referred to as the “Medical Claims Administrator”) and VRx (hereafter referred to as the “Prescription Claims Administrator” or the “Pharmacy Benefit Manager” PBM), as third-party administrators, to assist the Plan Sponsor in the Plan’s claims administration and certain other administrative matters. The Claims Administrators provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except in the case of claims that exceed certain amounts which may be reinsured.

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Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under the Women's Health and Cancer Rights Act, certain breast reconstruction services in connection with a covered mastectomy are protected. If You are receiving benefits in connection with a mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, coverage under the Plan will be provided (subject to the same provisions as any other benefit) for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending Provider (e.g., Your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan may not, under federal law, require that a Physician or other health care provider obtain preauthorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain preauthorization. For information on preauthorization, contact the Claims Administrator.

NOTICE OF PRIVACY PRACTICES UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

This is a general Notice of Privacy Practices under HIPAA. You also will receive a Notice of Privacy Practices from the Claims Administrator who pays claims under this Plan. The specific Privacy Notice(s) You receive from the Claims Administrator will take precedence over this general Notice, if there is any conflict between the two Notices.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights with respect to your Protected Health Information ("PHI"), including the right to know how your PHI may be used by a group health plan.

This Notice of Privacy Practices ("Notice") covers the following group health plans (collectively referred to as the "Plan"):

- Medical
- Prescription
- Dental
- EAP

The Plan is required by law to maintain the privacy of your PHI and to provide this Notice to you pursuant to HIPAA. This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, health care operations, or for any other purposes that are permitted or required by law. This Notice also provides you with the following important information:

- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan's Privacy Officer and/or to the Secretary of the Office of Civil Rights of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

PHI is health information (including genetic information) in any form (oral, written, electronic) that:

- Is created or received by or on behalf of the Plan;
- Relates to your past, present or future physical or mental condition, or the provision of health care services to you, or the payment for those health care services; and
- Identifies you or from which there is a reasonable basis to believe the information can be used to identify you.

Health information your employer receives during the course of performing non-Plan functions is not PHI. For example, health information you submit to your employer to document a leave of absence under the Family and Medical Leave Act is not PHI.

Section 1. USES AND DISCLOSURES OF YOUR PHI
Under HIPAA, the Plan may use or disclose your PHI under certain circumstances without your consent, authorization or opportunity to agree or object. Such uses and disclosures fall within the categories described below. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

General Uses and Disclosures

Treatment. The Plan may use and/or disclose your PHI to help you obtain treatment and/or services from providers. Treatment includes the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist. The Plan may also disclose information about your prior prescriptions to a pharmacist to determine if any medicines contraindicate a pending prescription.

Payment. The Plan may use and/or disclose your PHI in order to determine your eligibility for benefits, to facilitate payment of your health claims and to determine benefit responsibility. Payment includes, but is not limited to billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. The Plan may also disclose your PHI to another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate payment of benefits.

Health Care Operations. The Plan may use and/or disclose your PHI for other Plan operations. These uses and disclosures are necessary to run the Plan and include, but are not limited to, conducting quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, underwriting, premium and other activities relating to Plan coverage. It also includes cost management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general Plan administrative activities. For example, the Plan may use your PHI in connection with submitting claims for stop-loss coverage. The Plan may also use your PHI to refer you to a disease management program, project future costs or audit the accuracy of its claims processing functions. However, the Plan is prohibited from using or disclosing PHI that is an individual's genetic information for underwriting purposes.

Business Associates. The Plan may contract with individuals or entities known as Business Associates to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide such services, the Business Associates will receive, create, maintain, use and/or disclose your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide pharmacy benefit management services. However, Business Associates will receive, create, maintain, use and/or disclose your PHI on behalf of the Plan only after they have entered into a Business Associate agreement with the Plan and agree in writing to protect your PHI against inappropriate use or disclosure and to require that their subcontractors and agents do the same.

Plan Sponsor. For purposes of administering the Plan, the Plan may disclose your PHI to certain employees of Salt Lake Community College. However, these employees will only use or disclose such information as necessary to perform administration functions for the Plan or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Required By Law. The Plan may disclose your PHI when required to do so by federal, state or local law. For example, the Plan may disclose your PHI when required by public health disclosure laws.

Health or Safety. The Plan may disclose and/or use your PHI when necessary to prevent a serious threat to your health or safety or the health or safety of another individual or the public. Under these circumstances, any disclosure will be made only to the person or entity able to help prevent the threat.

Special Situations

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your PHI without your consent, authorization or opportunity to agree or object. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

Public Health Activities. The Plan may disclose your PHI when permitted for purposes of public health actions, including when necessary to report child abuse or neglect or domestic violence, to report reactions to drugs or problems with products or devices, and to notify individuals about a product recall. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

Health Oversight. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. Oversight activities can include civil, administrative or criminal actions, audits and inspections, licensure or disciplinary actions (for example, to investigate complaints against providers); other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud); compliance with civil rights laws and the health care system in general.

Lawsuits, Judicial and Administrative Proceedings. If you are involved in a lawsuit or similar proceeding, the Plan may disclose your PHI in response to a court or administrative order. The Plan may also disclose your PHI in response to a subpoena, discovery request or other lawful process by another individual involved in the dispute, provided certain conditions are met. One of these conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

Law Enforcement. The Plan may disclose your PHI when required for law enforcement purposes, including for the purposes of identifying or locating a suspect, fugitive, material witness or missing person.

Coroners, Medical Examiners and Funeral Directors. The Plan may disclose your PHI when required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a

cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

Workers' Compensation. The Plan may release your PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

National Security and Intelligence. The Plan may release PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Military and Veterans. If you are a member of the armed forces, the Plan may disclose your PHI as required by military command authorities**.** The Plan may also release PHI about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donations. If you are an organ donor, the Plan may disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Research. The Plan may disclose your PHI for research when the individual identifiers have been removed or when the institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosure to Secretary

The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

Disclosures to Family Members and Personal Representatives

The Plan may disclose your PHI to family members, other relatives and your close personal friends but only to the extent that it is directly relevant to such individual's involvement with a coverage, eligibility or payment matter relating to your care, unless you have requested and the Plan has agreed not to disclose your PHI to such individual. The Plan will disclose your PHI to an individual authorized by you, or to an individual designated as your personal representative, provided the Plan has received the appropriate authorization and/or supporting documents. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

However, the Plan will not disclose information to an individual, including your personal representative, if it has a reasonable belief that:

- You have been, or may be, subjected to domestic violence, abuse or neglect by such person or treating such person as your personal representative could endanger you; and
- In the exercise of professional judgment, it is not in your best interest to disclose the PHI.

This also applies to personal representatives of minors.

Authorization
Any uses or disclosures of your PHI not described above will be made only with your written authorization. Most disclosures involving psychotherapy notes will require your written authorization. In addition, the Plan generally cannot use your PHI for marketing purposes or engage in the sale of your PHI without your written authorization. You may revoke your written authorization at any time, so long as the revocation is in writing. Once the Plan receives your authorization, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2. RIGHTS OF INDIVIDUALS

You have the following rights with respect to your PHI:

Right to Request Restrictions on PHI Uses and Disclosures. You may request in writing that the Plan restrict or limit its uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or to limit disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. For example, you could request that the Plan not use or disclose specific information about a specific medical procedure you had. However, the Plan is not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. The Plan will not ask you the reason for your request, which must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests to receive communications of PHI by alternative means if you clearly provide information that the disclosure of all or part of your PHI could endanger you.

Right to Inspect and Copy PHI. You have a right of access to inspect and obtain a copy of your PHI (including electronic PHI) contained in the Plan's "designated record set," for as long as the PHI is maintained by the Plan in a designated record set. If you request a copy of the information, the Plan may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

"Designated Record Set" includes the medical records and billing records about an individual maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about the individual. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

If your request is granted, the requested information will be provided to you within 30 days after the receipt of your request in the form and format requested, if it is readily producible in such form and format, or if not, in a readable hard copy form (or a readable electronic form and format in the case of PHI maintained in designated records sets electronically) or such other form and format as agreed upon by you and the Plan. If the Plan is unable to comply with request within the 30-day deadline, a one-time 30-day extension is permissible. In such case, you will receive notification of the need for an extension within the initial 30-day period.

Please note that your right does not apply to psychotherapy notes or information compiled in reasonable anticipation of a legal proceeding. The Plan may deny your request to inspect and copy your PHI in very limited circumstances. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI. If you believe that the PHI the Plan has about you is incorrect or incomplete, you have the right to request in writing that the Plan amend your PHI or a record contained in a designated record set for as long as the PHI is maintained by the Plan in the designated record set. The Plan has 60 days after the request is made to act on the request. However, a single 30-day extension is allowed if the Plan is unable to comply with the deadline.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask for the amendment of information that: (1) is not part of the medical information kept by or for the Plan; (2) was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information that you would be permitted to inspect or copy; or (4) is already accurate and complete. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.

The Right to Receive an Accounting of PHI Disclosures. You have the right to receive a list of disclosures of your PHI that have been made by the Plan on or after April 14, 2003 (or January 1, 2011 in the case of disclosures of your PHI from electronic health records maintained by the Plan, if any) over a period of up to six years (three years in the case of disclosures from an electronic health record) prior to the date of your request. Certain disclosures are not required to be included in such accounting of disclosures, including but not limited to disclosures made by the Plan (1) for treatment, payment or health care operations (unless the disclosure is made from an electronic health record), or (2) in accordance with your authorization. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request. You have the right to receive a paper copy of this Notice even if you have agreed to receive this Notice electronically.

To exercise any of your HIPAA rights described above, you or your personal representative must contact the Plan's HIPAA Privacy Officer in writing at Salt Lake Community College 4600 S Redwood Road, Salt Lake City, UT 84123. You or your personal representative may be required to complete a form required by the Plan in connection with your specific request.

Section 3. THE PLAN'S DUTIES

Notice of Privacy Practices. The Plan is required by law to provide individuals covered under the Plan with notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. In the event of any material change to this Notice, a revised version of this Notice will be distributed to all individuals covered under the Plan within 60 days of the effective date of such change by first-class U.S. mail or with other Plan communications.

Breach Notification. The Plan has a legal duty to notify you following the discovery of a breach involving your unsecured PHI.

Minimum Necessary Standard. When using or disclosing PHI, the Plan will use and/or disclose only the minimum amount of PHI necessary to accomplish the intended purposes of the use or disclosure. However, the minimum necessary standard will not apply in the following situations:

- Disclosure to or requests by a health care provider for treatment;
- Uses or disclosures made to you; and
- Uses or disclosures that are required by law.

Section 4. COMPLAINTS
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with the Plan, contact the Plan's HIPAA Privacy Officer in writing at Salt Lake Community College 4600 S Redwood Road, Salt Lake City, UT 84123.

You will not be penalized or in any other way retaliated against for filing a complaint with the Office for Civil Rights or with the Plan.

Section 5. ADDITIONAL INFORMATION
If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan's HIPAA Privacy Officer in writing at Salt Lake Community College 4600 S Redwood Road, Salt Lake City, UT 84123.

The Claims Administrator, Regence BlueCross BlueShield of Utah, has a Notice of Privacy Practices that is available by calling Customer Service at 1 (866) 240-9580, or visiting their website **www.Regence.com**.

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

Understanding Your Benefits

This section contains information to help You better understand what is meant by Allowed Amounts, Deductibles, Copayments, Coinsurance, Out-of-Pocket Maximum, and Maximum Benefits. 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.

ALLOWED AMOUNTS

- For In-Network Providers, the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For Out-of-Network Providers (and those who are not accessed through the BlueCard® Program for the Medical Plan), the amount the Claims Administrator has determined to be reasonable charges for Covered Services or supplies. 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.
- For the Medical Plan, Out-of-Network Providers accessed through the BlueCard® Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to the Claims Administrator as the amount on which it would base a payment to that Provider.

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.

DEDUCTIBLES

The Medical and Prescription Medication Benefits have separate deductibles. Under the medical Benefits there are two separate Deductible amounts: one for In-Network benefits and another for Out-of-Network benefits. The Medical Benefits Section describes this more fully, but in this Summary Plan Description, the term is usually referred to simply as "the Deductible." The Plan will begin to pay benefits for Covered Services in any Plan Year only after a Claimant satisfies the Plan Year Deductible, except for specific services which are noted as “deductible waived.” A Claimant satisfies the Deductible by incurring a specific amount of expenses for Covered Services during the Plan Year for which the Allowed Amounts total the Deductible. The Plan does not pay for services applied toward the Deductible. Refer to the specific benefits section to see if a particular service is subject to the Deductible. Amounts paid toward Covered Services listed in the Medical Benefits Section that show under the “Provider All" will apply toward the In-Network Deductible amount.

Under the Medical Benefit, the Family Plan Year Deductible is satisfied when two or more covered Family members' Allowed Amounts for Covered Services for that Plan Year total and meet the Family Deductible amount. One Claimant shall not contribute more than the individual Deductible amount. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not count toward the Deductible.

Under the Prescription Medication Benefit, the Family Plan Year 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 shall not contribute more than the individual Deductible amount. Any amounts You pay for non-Covered medications, Copayments or amounts in excess of the Allowed Amount do not count toward the Deductible.

COPAYMENTS

Copayments are the fixed dollar amount that You must pay directly to the Pharmacy for covered Prescription Medications, the Provider’s office for office visits, or to the Facility for emergency room visits each time You receive a specified service (as applicable). The Copayment amount will apply after Your Deductible amount has been met, unless otherwise noted in this Summary Plan Document. The Copayment will be the lesser of the fixed dollar amount or the Allowed Amount for the service or medication. Refer to the specific benefits sections to understand what Copayments You are responsible for.

COINSURANCE

Once You have satisfied any applicable Deductible and any applicable Copayment, 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, supply, or medication You received and who rendered it.

The Plan does not reimburse Providers for charges above the Allowed Amount. In-Network Providers will not charge You for any balances for Covered Services beyond Your applicable Deductible, Copayment and/or Coinsurance amount. Out-of-Network Providers, however, may bill You for any balances (Balance Bill) over the Plan payment level in addition to any applicable Deductible, Copayment and/or Coinsurance amount. See the Definitions Section for descriptions of Providers.

Coinsurance amounts applicable to Prescription Medications are located in the Prescription Medication Benefits Section of this Summary Plan Description. Coinsurance amounts applicable to Dental Benefits are located in the Dental Benefits Section of this Summary Plan Description.

OUT-OF-POCKET MAXIMUM

The Medical and Prescription Medication Benefits have separate Out-of-Pocket Maximums. Under the Medical Benefits there are two separate Out-of-Pocket Maximum amounts, one for In-Network benefits and one for Out-of-Network benefits. The Medical Benefits Section and Prescription Medication Benefits Section describe this more fully, but in this Summary Plan Description, the term is usually referred to simply as "the Out-of-Pocket Maximum." A Claimant's Deductible, Copayments, and Coinsurance payment for benefits listed in the Medical Benefits Section and are illustrated as “Provider: All" will apply toward the In-Network Out-of-Pocket Maximum amount. Claimants can meet the Out-of-Pocket Maximum by payments of Deductible, Copayments, and Coinsurance for all categories as specifically indicated in the Medical Benefits Section. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum amounts for the Plan.

Once You reach the Out-of-Pocket Maximum, benefits subject to the Out-of-Pocket Maximum will be paid at 100 percent of the Allowed Amount for the remainder of the Plan Year.

Under the Medical Benefit, the Family Out-of-Pocket Maximum for a Plan Year is satisfied when two or more Family members' Deductible, Copayments, and Coinsurance for Covered Services for that Plan Year total and meet the Family's Out-of-Pocket Maximum amount. One Claimant shall not contribute more than the individual Out-of-Pocket Maximum amount.

Under the Prescription Medication benefit, the Family Out-of-Pocket Maximum for a Plan Year is satisfied when three or more Family members' Deductible, Copayments, and Coinsurance for Covered Services for that Plan Year total and meet the Family's Out-of-Pocket Maximum amount. One Claimant shall not contribute more than the individual Out-of-Pocket Maximum amount.

MAXIMUM BENEFITS

Some benefits for Covered Services may have a specific Maximum Benefit. For those Covered Services, benefits will be provided until the specified Maximum Benefit (which may be a number of days, visits or services, 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 or services. Refer to the specific Benefits Section of this Summary Plan Description to determine if a Covered Service has a specific Maximum Benefit.

HOW PLAN YEAR BENEFITS RENEW

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

Some benefits of the 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.

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 health care coverage throughout this Summary Plan Description, some of which are highlighted here. If You have questions about Your health care coverage, please contact the appropriate Claims Administrator.

- **Learn more and receive answers about Your medical coverage.** Have your identification card handy before calling or going online.
  - Call Regence Customer Service at **1 (866) 240-9580** (TTY: 711), Monday-Friday 6 a.m. - 6 p.m.
  - Online at **www.Regence.com.** View recent claims, get health guidance and support, get access to local events, and use tools for annual planning. It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar.

- **Learn more and receive answers about Your prescription coverage.** Have your identification card handy before calling or going online.
  - Call VRx Customer Service at **1 (877) 417-9722**.
  - Online at **www.myVRx.com.** You can identify Participating Pharmacies, find alternatives to expensive medicines, learn about prescriptions for various Illnesses and even compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

- **Case Management.** You can request that a case manager be assigned or You may be assigned a case manager to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. Call Case Management at 1 (866) 543-5765.

- **Regence Condition Manager.** Receive support and education about various chronic conditions at 1 (866) 543-5765.

- **Special Beginnings.** A program for expectant mother's offering educational materials and nurse guidance. 1 (888) JOY-BABY (569-2229).

- **BlueCard® Program.** Traveling outside of the four-state (Idaho, Oregon, Utah and Washington) Regence area? Learn how to have access to care through the BlueCard® Program. This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area, as well as receive care in 200 countries around the world. 1 (800) 810-BLUE (2583).

Medical Benefits

This section contains information regarding Covered Services. There are no referrals required before You can use any of the benefits of this coverage, including women's health care services. Information regarding benefits have been listed alphabetically, with the exception of the Preventive Care, Office Visits and Other Professional Services benefits.

All covered benefits are subject to the limitations, exclusions and provisions of this Plan. To be covered, medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Also, a Provider practicing within the scope of his or her license must render the service. Please see the Definitions Section in the back of this Summary Plan Description for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

A Health Intervention may be medically indicated yet not be a Covered Service under the Plan or otherwise be Medically Necessary.

If benefits under the Plan change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

PLAN YEAR OUT-OF-POCKET MAXIMUM – IN-NETWORK

Per Claimant: $2,900
Per Family: $5,800

PLAN YEAR OUT-OF-POCKET MAXIMUM – OUT-OF-NETWORK

Per Claimant: $5,000
Per Family: $10,000

COPAYMENTS AND COINSURANCE

Copayments and Coinsurance are listed in the tables for Covered Services for each applicable benefit.

PLAN YEAR DEDUCTIBLES – IN-NETWORK

Per Claimant: $400
Per Family: $800

PLAN YEAR DEDUCTIBLES – OUT-OF-NETWORK

Per Claimant: $1,000
Per Family: $2,000

You do not need to meet any Deductible before receiving benefits for the following services received by an In-Network Provider:

- preventive care services
- office or clinic care visits
- home health care
- home infusion therapy
- hospice care
- immunizations
- maternity care received in an office or clinic
- office visits for mental health or substance use disorder services
- outpatient rehabilitation services
- infertility treatment
- spinal manipulations

You do not need to meet any Deductible before receiving benefits for the following services received by any Provider:

- emergency room

PREVENTIVE CARE AND IMMUNIZATIONS

Benefits will be covered under this Preventive Care and Immunizations benefit, not any other provision of the Summary Plan Description, if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). In the event any of these bodies adopts a new or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit. For a list of services covered under this benefit, please visit **www.Regence.com** or contact Customer Service at 1 (866) 240-9580. NOTE: Covered Services that do not meet these criteria may be covered under the Expanded Preventive Care benefits.

Preventive Care

Provider: In-Network	Provider: Out-of-Network
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 75% and you pay 25% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers the following preventive care services and supplies provided by a professional Provider or facility. Coverage is provided only for those preventive care services designated (which designation may be modified from time to time) by: the USPSTF for services with an A or B rating in the current recommendations; or by HRSA as otherwise specified below:

- routine visits for preventive care, including, but not limited to, well-baby care and routine physical exams, including annual women's examinations;
- routine radiology and laboratory services, including, but not limited to, routine mammography and prostate screening; and
- routine procedures, including, but not limited to, routine colonoscopies.
- immunizations: according to, and as recommended by, the USPSTF and the CDC. Covered expenses do not include immunizations if the Claimant receives them only for purposes of travel, occupation or residence in a foreign country.

EXPANDED PREVENTIVE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After $30 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers preventive care services and supplies provided by a professional Provider or facility that meets age limits and frequency guidelines according to, and as recommended by, the USPSTF, HRSA, or by the CDC. Services rendered must be for preventive care and billed as such. Covered Services that do not meet the above criteria will be covered the same as any other Illness or Injury.

OFFICE VISITS – ILLNESS OR INJURY

Provider: In-Network	Provider: Out-of-Network
Payment: After $30 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers Office Visits. An Office Visit means the evaluation and management of a patient for treatment of an Illness or Injury. The Copayment applies to visits in the office, home or Hospital outpatient department only. The Plan covers medical services, surgical services, including local anesthesia and supplies, and therapeutic injections including allergy testing, injections and serum provided by a professional Provider when received in the Provider's office and when billed as such. Coverage does not include services specifically covered elsewhere in the Summary Plan Description, such as but not limited to, outpatient rehabilitation services. All other professional services performed in the office are subject to the applicable benefit specified elsewhere in the Medical Benefits Section for such service, including any applicable Deductible.

OTHER PROFESSIONAL SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers services and supplies provided by a Practitioner subject to any Deductible and Coinsurance and any specified limits as explained in the following paragraphs:

Medical Services

The Plan covers professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider that are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury. Services and supplies also include foot care associated with diabetes. Services and supplies to treat a congenital anomaly for Claimants up to age 26 are also included.

Professional Inpatient

The Plan covers professional inpatient visits for Illness or Injury. If pre-arranged procedures are performed by an In-Network Provider and You are admitted to an In-Network Hospital, the Plan will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by Out-of-Network Providers at the In-Network benefit level. However, You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact the Claims Administrator's Customer Service for further information and guidance.

If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level up to billed charges until the patient is stable and can be safely moved to an In-Network facility. If the patient does not elect to be transferred to an In-Network facility after they are stable, any subsequent charges for Covered Services will be paid at the Out-of-Network benefit level, based upon the Allowed Amount. You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance.

Radiology and Laboratory

The Plan covers radiology and laboratory services for treatment of Illness or Injury incurred during an inpatient or outpatient visit. Note that when treatment is for preventive care or major diagnostic testing at an outpatient facility, benefits under the Plan will be paid according to those benefits.

Diagnostic Procedures

The Plan covers services for diagnostic procedures incurred during an inpatient or outpatient visit, such as cardiovascular testing, pulmonary function studies, sleep studies and neurology/neuromuscular procedures. Note that when the procedures are billed as preventive care or major diagnostic testing at an outpatient facility, benefits under the Plan will be paid according to those benefits.

Surgical Services

The Plan covers surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist.

AMBULANCE SERVICES

Provider: All
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.

The Plan covers ambulance services to the nearest Hospital equipped to provide treatment, when any other form of transportation would endanger Your health and the purpose of the transportation is not for personal or convenience purposes. Covered ambulance services include licensed ground and air ambulance Providers.

APPROVED CLINICAL TRIALS

The Plan covers Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating subject to any Deductible, Coinsurance and/or Copayments and Maximum Benefits as specified in the Medical Benefits and Prescription Medications Benefit in this Summary Plan Description. Additional specified limits are as further defined. If a Preferred Provider is participating in the Approved Clinical Trial and will accept You as a trial participant, these benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If the Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care.

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Approved Clinical Trials benefit:

<u>Approved Clinical Trial</u> means a phase I, phase II, phase III or phase IV clinical trial conducted in relation to prevention, detection, or treatment of cancer or other Life-threatening Condition and that is a study or investigation:

- Approved or funded by one or more of:
  - The National Institutes of Health (NIH), the CDC, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid, or a cooperative group or center of any of those entities or of the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
  - A qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or
  - The VA, DOD or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review; or
- Conducted under an investigational new drug application reviewed by the Food and Drug Administration or that is a drug trial exempt from having an investigational new drug application.

<u>Life-threatening Condition</u> means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

<u>Routine Patient Costs</u> means items and services that typically are Covered Services for a Claimant not enrolled in a clinical trial, but do not include:

- An Investigational item, device or service that is the subject of the Approved Clinical Trial;
- Items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Claimant;
- A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis; or

- Services, supplies or accommodations for direct complications or consequences of the Approved Clinical Trial.

AUTISM SPECTRUM DISORDER SERVICES

Inpatient & Outpatient Care

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

Office or Clinic Visits

Provider: In-Network	Provider: Out-of-Network
Payment: After $30 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers services for Autism Spectrum Disorder such as diagnosis (including assessments, evaluations or tests) and treatment (including Applied Behavioral Analysis, Behavioral Health, Pharmacy Care, psychiatric care, psychological care, or Therapeutic Care, and related equipment).

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Autism Spectrum Disorder Services benefit:

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorder means pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Behavioral Health means counseling and treatment programs, including Applied Behavior Analysis, that are: necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and provided or supervised by a: board certified behavior analyst; or a person licensed under state law, whose scope of practice includes mental health services.

Pharmacy Care means health-related services to determine the need or effectiveness of Prescription Medications. For coverage of Prescription Medications, refer to the Prescription Medication Benefits Section in this Summary Plan Description.

Therapeutic Care means services provided by duly licensed or certified speech therapists, occupational therapists, or physical therapists.

BLOOD BANK

Provider: All
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.

The Plan covers the services and supplies of a blood bank, excluding storage costs.

CLOTTING FACTOR PRODUCTS – OUTPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** You pay 100% of billed charges. Your payment will not be applied toward the Deductible or the Out-of-Pocket Maximum.

The Plan covers plasma-derived and recombinant clotting factor products used in outpatient replacement therapy for hemophilia, Von Willebrand disease, and similar clotting disorders. This benefit does not cover these products when provided by a retail Pharmacy.

DENTAL HOSPITALIZATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia), if hospitalization in an Ambulatory Surgical Center or Hospital is necessary to safeguard Your health. Benefits are not available for services received in a dentist's office.

DETOXIFICATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers Medically Necessary detoxification.

DIABETES SUPPLIES AND EQUIPMENT

The Plan covers supplies and equipment for the treatment of diabetes. Please refer to the Other Professional Services, Diabetic Education, Durable Medical Equipment, Nutritional Counseling, Orthotic Devices or Prescription Medication benefits in this Summary Plan Description for coverage details of such covered supplies and equipment.

DIABETIC EDUCATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers services and supplies for diabetic self-management training and education when requested by the attending physician, if provided by an accredited or certified program.

DURABLE MEDICAL EQUIPMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Claimant's home. Examples include oxygen equipment, wheelchairs, insulin pumps and insulin pump supplies. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Provider: In-Network	Provider: Out-of-Network
Payment: After $150 Copayment per visit, the Plan pays 100% of the Allowed Amount. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment:** After $150 Copayment per visit, the Plan pays 100% of the Allowed Amount. You are responsible for any Balance Bill. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.

The Plan covers emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. For the purpose of this benefit, "stabilization" means to provide Medically Necessary treatment: 1) to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during, or to result from, the transfer of the member from a facility; and 2) in the case of a covered female member, whom is pregnant, to perform the delivery (including the placenta). Emergency room services do not need to be pre-authorized. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. However, You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance. See the Hospital Care benefit in this Medical Benefits Section for coverage of inpatient Hospital admissions.

FAMILY PLANNING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers certain professional Provider contraceptive services and supplies, including, but not limited to, vasectomy. See the Prescription Medication Benefits Section for coverage of prescription contraceptives.

Please see the Preventive Care and immunizations benefit for coverage of women's contraceptive methods, sterilization procedures, and patient education and counseling services in accordance with any frequency guidelines according to, and as recommended by HRSA.

GENETIC TESTING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers certain genetic testing when determined to be Medically Necessary based on the Plan's medical policy.

HOME HEALTH CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After $30 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers home health care when provided by a licensed agency or facility for home health care. Home health care includes all services for homebound patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. Durable Medical Equipment associated with home health care services is covered under the Durable Medical Equipment benefit of this Summary Plan Description.

HOME INFUSION THERAPY

Provider: In-Network	Provider: Out-of-Network
Payment: After $30 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.
Limit: $50,000 per Claimant per plan year for Parenteral Nutrition.	

The Plan covers home infusion therapy when provided in the home by a licensed home infusion therapy agency when the patient is under the care of a Physician and when the home infusion therapy regimen is Medically Necessary for the treatment of an Illness or Injury as follows:

- professional skilled nursing services of a registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN) required for:
    - training the patient and/or alternative care giver;
    - the administration of therapy; or
    - monitoring the intravenous therapy regimen;
- medical surgical supplies which are customarily furnished by the home infusion therapy agency for its patients and which are necessary to administer the home infusion therapy regimen;
- Non-replaced blood, blood plasma, blood derivatives; and their administration; and
- Prescribed drugs furnished by the home infusion therapy agency which are part of the home infusion therapy regimen. The administration of such drugs must require the professional skills of a nurse (RN, LPN, or LVN) and does not include prescribed drugs that can be self-administered or administered by a non-professional caretaker.

HOSPICE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: The Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and his or her family during the final stages of Illness. Respite care: The Plan covers respite care to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant. Durable Medical Equipment associated with hospice care is covered under Durable Medical Equipment in this Summary Plan Description.

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers the inpatient and outpatient services and supplies of a Hospital or the outpatient services and supplies of an Ambulatory Surgical Center for Injury and Illness (including services of staff Providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level up to billed charges until the patient is stable and can be safely moved to an In-Network facility. If the patient does not elect to be transferred to an In-Network facility after they are stable, any subsequent charges for Covered Services will be paid at the Out-of-Network benefit level, based upon the Allowed Amount. You may be

billed for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance. See the Emergency Room benefit in this Medical Benefits Section for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

If benefits under the Plan change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

INFERTILITY TREATMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After $30 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.
Limit: $5,000 per Claimant lifetime	

The plan covers services to diagnose such condition and treatment of the underlying condition such as surgery, injections, ovulation tests and disorders of the reproduction system. The plan will not cover services for assisted reproduction including, but not limited to, IVF, GIFT, fertility meds, storage, etc.

KIDNEY DIALYSIS – OUTPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.
Limit: 42 treatment per treatment period per Claimant	

The Plan covers professional services, supplies, medications, labs and facility fees related to outpatient hemodialysis, peritoneal dialysis and hemofiltration services during the first treatment period. For the purpose of this benefit the "first treatment period" will be three months (42 treatments) of hemodialysis treatment (or 30 days of peritoneal dialysis treatment). Dialysis treatments that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. If more than 42 treatments are necessary in the first treatment period prior to Medicare coverage enrollment, the Claims Administrator must be contacted to approve the additional treatment and document Your progress. See the Supplemental Kidney Dialysis in this benefit for coverage after the first 42 treatments in the first treatment period.

The Plan will pay regular Plan benefits when services are rendered outside the country, even if you have enrolled in the Supplemental Kidney Dialysis program.

Supplemental Kidney Dialysis – Outpatient

For any subsequent outpatient kidney dialysis beyond the first treatment period, until Your 34th month after beginning dialysis, the Plan will provide additional supplemental coverage as described here if You have enrolled in this program. Supplemental dialysis benefits will not be retroactively covered if You choose to enroll after the first treatment period. This Supplemental Kidney Dialysis benefit covers 150 percent of the current Medicare reimbursement amount, for the same or similar services as provided under the Kidney Dialysis benefit above.

In addition, a Claimant with end stage renal disease (ESRD) is eligible to have Medicare Part B premiums reimbursed by the Plan as an eligible Plan expense for the duration of the Claimant's ESRD treatment, as long as the Claimant continues to be enrolled under Medicare Part B and continues to be eligible for coverage under this Plan. Proof of payment of the Medicare Part B premium will be required prior to reimbursement.

Notwithstanding the above, in the event a Provider accepts Medicare assignment as payment in full, the eligible expenses are the lesser of the total amount of charges allowable by Medicare and the total eligible expenses allowable under this Plan, exclusive of Coinsurance and regardless of Your Medicare

enrollment. This Supplemental Kidney Dialysis benefit applies to all Providers providing kidney dialysis related services.

MAJOR DIAGNOSTIC TESTING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $50 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible and $50 Copayment per visit, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers Major Diagnostic Tests including, but not limited to, a CT scan, magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), nuclear medicine, neurological diagnostics, and cardiovascular diagnostics.

MATERNITY CARE – OFFICE VISIT

Provider: In-Network	Provider: Out-of-Network
Payment: After $30 Copayment, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Copayment for office visits in connection with maternity care applies to the first visit only.

MATERNITY CARE - INPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers pre-natal and post-natal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy, and related conditions for all female Claimants. Also covered is the related routine nursery care of the newborn. **The Deductible will be waived for the newborn when delivery is without complications.** There is no limit for the mother and her newborn's length of inpatient stay. Where the mother is attended by a Physician, the attending Physician will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit in this Summary Plan Description to see how services and supplies in excess of routine nursery care of Your newborn is covered.

Certain services such as screening for gestational diabetes, breastfeeding support, supplies and counseling are covered under Your Preventive Care benefit.

Coverage for termination of pregnancy (abortion) will be provided for all female Claimants only for the following:

- when necessary to avert the death of the female Claimant on whom the abortion is performed; or
- where the female Claimant is pregnant as a result of rape, rape of a child or incest.

MEDICAL FOODS (PKU)

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers medical foods for inborn errors of metabolism including, but not limited to, formulas for Phenylketonuria (PKU).

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES

Inpatient & Outpatient Care

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

Office or Clinic Visits

Provider: In-Network	Provider: Out-of-Network
Payment: After $30 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers Mental Health and Substance Use Disorder Services for treatment of Mental Health Conditions or Substance Use Disorders.

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Mental Health or Substance Use Disorder Services benefit:

Mental Health or Substance Use Disorder Services mean Medically Necessary outpatient services, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is determined to be Medically Necessary).

Mental Health Conditions means mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association except as otherwise excluded in this Plan. Mental disorders that accompany an excluded diagnosis are covered.

Residential Care means care received in an organized program which is provided by a residential facility, Hospital, or other facility licensed, for the particular level of care for which reimbursement is being sought, by the state in which the treatment is provided.

Substance Use Disorders means substance-related disorders included in the most recent edition of the DSM. Substance Use Disorder does not include addiction to or dependency on tobacco, tobacco products or foods.

NEURODEVELOPMENTAL THERAPY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible and $30 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Outpatient limit: Coverage is limited to 30 visits per Claimant per Plan Year**,** combined with outpatient rehabilitation visit limit, up to age 18.	

The Plan covers inpatient and outpatient neurodevelopmental therapy services. To be covered, such services must be to restore or improve function for a Claimant age six and under with a neurodevelopmental delay. For the purpose of this benefit, neurodevelopmental delay means a delay in normal development that is not related to any documented Illness or Injury. Covered Services include only physical therapy, occupational therapy and speech therapy and maintenance services, if significant deterioration of the Claimant's condition would result without the service. You will not be eligible for both the Rehabilitative Services benefit and this benefit for the same services for the same condition. Outpatient neurodevelopmental therapy visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

NEWBORN CARE

Provider: In-Network	Provider: Out-of-Network
Payment: The Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers services and supplies billed in addition to routine nursery care under the newborn's own coverage. The newborn child must be eligible and enrolled as explained later in the Who Is Eligible, How to Enroll and When Coverage Begins Section. There is no limit for the newborn's length of inpatient stay.

NUTRITIONAL COUNSELING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: Diabetic nutritional therapy only	

ORTHOTIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.
Limit: $200 per Claimant per Plan Year for orthotic devices of the feet. (this limit does not apply to orthotics for a diabetic condition)	

The Plan covers benefits for the purchase of braces, splints, orthopedic appliances and orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body. Benefits under the Plan may be reduced for a less costly alternative item. The Plan does not cover off-the-shelf shoe inserts and orthopedic shoes.

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers prosthetic devices for functional reasons to replace a missing body part, including artificial limbs, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility provision (Hospital inpatient care or Hospital outpatient and Ambulatory Surgical Center care) in this Medical Benefits Section. Repair or replacement of a prosthetic device due to normal use or growth of a child will be covered under the Plan.

REHABILITATION SERVICES - INPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.
Inpatient limit: 60 days per Claimant per Plan Year	

REHABILITATION SERVICES - OUTPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After $30 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.
Outpatient limit: Coverage is limited to 30 visits per Claimant per Plan Year**,** combined with neurodevelopmental therapy visit limit.	

The Plan covers inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services only) and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness. Rehabilitation days or visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

REPAIR OF TEETH

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.
Limit: $1,000 per Claimant per Plan Year	

The plan covers services and supplies for treatment required as a result of damage to or loss of sound natural teeth when such damage or loss is due to an injury.

SKILLED NURSING FACILITY (SNF) CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.
Limit: 60 inpatient days per Claimant per Plan Year	

The Plan covers the inpatient services and supplies of a Skilled Nursing Facility for Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary. Days for these services that are applied toward any Deductible are considered benefits provided and are applied against any Maximum Benefit limit on these services. Ancillary services and supplies, such as physical therapy, Prescription Medications, and radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward any Maximum Benefit limit on Skilled Nursing Facility care.

SPINAL MANIPULATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: After $30 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.
Limit: 20 visits per Claimant per Plan Year	

The Plan covers chiropractic manipulative treatment performed by any Provider. Coverage for spinal manipulations includes all associated modalities and services performed at the same time on the same date of service. Once the limit of 20 spinal manipulations has been met, no further coverage for spinal manipulations will be provided, however, associated modalities and services may continue to be covered according to the other benefits of the Plan.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.
Limit: $500 per Claimant Lifetime	

The Plan covers inpatient and outpatient services for treatment of temporomandibular joint (TMJ) disorders which have one or more of the following characteristics:

- an abnormal range of motion or limitation of motion of the TMJ;
- arthritic problems with the TMJ;
- internal derangement of the TMJ; and/or
- pain in the musculature associated with the TMJ.

"Covered Services" for the purpose of this TMJ benefit, mean those services that are:

- reasonable and appropriate for the treatment of a disorder of the TMJ, under all the factual circumstances of the case;
- effective for the control or elimination of one or more of the following, caused by a disorder of the TMJ: pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food;
- recognized as effective, according to the professional standards of good medical practice; and
- not Investigational or primarily for Cosmetic purposes.

Temporomandibular joint (TMJ) disorders that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

TRANSPLANTS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and you pay 40% of the Allowed Amount. You are responsible for any Balance Bill.

The Plan covers transplants, including transplant-related services and supplies for covered transplants. A transplant recipient who is covered under this Plan and fulfills Medically Necessary criteria will be eligible for the following transplants: heart, lung, kidney, pancreas, liver, cornea, multivisceral, small bowel, islet cell and hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors, for example, either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions). This list of transplants is subject to change. Claimants can contact the Claims Administrator for a current list of covered transplants.

Donor Organ Benefits

The Plan covers donor organ procurement costs if the recipient is covered for the transplant under this Plan. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ and other such procurement costs that are determined to be paid under the Plan.

Prescription Medication Benefits

Administered by VRx

Regence does not administer the benefits or services described within this provision. The Plan Sponsor has retained the services of an independent Third Party Administrator to process prescription claims and handle other duties for this self-funded plan. The Third Party Administrator for this prescription plan is VRx. VRx does not assume liability for benefit payable under this plan, since they are solely a claims paying agent for the Plan Sponsor.

This Prescription drug program is administered separately from the medical plans outlined in this Summary Plan Document. All aspects of the Prescription Medication Benefits shown in this Schedule of Benefits are separate from the Medical Benefits. Separate prescription Deductibles, Co-pays, Coinsurance, and Out-of-Pocket maximums under this Prescription Medication Benefit will not apply toward the Medical Benefits provision of the Medical Plan.

BENEFIT ADVOCATES

VRx's Benefit Advocates team is available to assist you Monday through Friday 7:00 AM – 7:00 PM Mountain Time (MT) Monday through Friday. To better serve you, the first hours on Wednesday are dedicated to training and the VRx Benefit Advocates are available by 9:00 AM MT.

Local (801) 417-9722
Toll Free (855) 586-2569

COVERAGE TIERS

Prescriptions covered by the Plan are categorized in three separate tiers as listed below.

- Type of Medication — Tier
- Generic — Tier 1
- Formulary Brand — Tier 2
- Non-Formulary Brand — Tier 3

Your plan has a separate benefit for specialty mediations. Specialty medications treat chronic complex conditions such as Rheumatoid Arthritis, Cancer, Multiple Sclerosis, Hepatitis C, Chrohn's Disease, Bleeding Disorders, Asthma, Psoriasis, and more Specialty prescriptions covered by the Plan are categorized in four separate specialty tiers as listed below.

- Type of Medication — Tier
- Specialty Preferred — Tier 1
- Specialty Formulary — Tier 2
- Specialty Non-Formulary — Tier 3

Your financial responsibility for each tier is based upon the benefits offered by your plan. For more information regarding your coverage and estimated drug costs, visit the Benefit Information section of the VRx website at www.myvrx.com or call the VRx Benefit Advocates at (801) 417-9722 or (855) 586-2569.

PLAN YEAR DEDUCTIBLES

Per Claimant: $100
Per Family: $300

You do not need to meet the Deductible when You fill a prescription for a Generic Medication or when you fill a prescription through the Mail Order Supplier. You also do not need to meet the Deductible when You fill a prescription for a Self-Administrable Cancer Chemotherapy Medication.

This Deductible is calculated separately from any other Deductible of the Plan. Costs in excess of the Covered Prescription Medication Expense that are charged by a Nonparticipating Pharmacy do not count toward the Deductible.

COPAYMENTS AND COINSURANCE

Once the applicable deductible is met, You are responsible for the following Copayment and/or Coinsurance (at the time of purchase, if the pharmacy submits the claim electronically).

RETAIL PHARMACY

Supply	Cost
34-day supply or 100 unit doses; whichever is greater	• $7 for each Generic Medication (deductible waived)
	• 25% for each Formulary Brand Name Medication; up to a $150 maximum copayment per prescription
	• 30% for each Brand Name Medication; up to a $175 maximum copayment per prescription

MAIL-ORDER PHARMACY

Supply	Cost
90-day supply from WellDyneRx Mail-Order Pharmacy	• $7 for each Generic Medication (deductible waived)
	• 25% for each Formulary Brand Name Medication; up to a $300 maximum copayment per fill (deductible waived)
	• 30% for each Brand Name Medication; up to a $437.50 maximum copayment per fill (deductible waived)

SPECIALTY PHARMACY

Cost
• 10% for each Generic Medication; up to a $250 maximum copayment per prescription
• 10% for each Formulary Brand Name Medication; up to a $250 maximum copayment per prescription
• 15% for each Brand Name Medication; up to a $300 maximum copayment per prescription

DIABETIC SUPPLIES

Cost
• 20% for diabetic supplies (deductible waived for supplies received by Mail-Order or Specialty Pharmacy)

PLAN YEAR OUT-OF-POCKET MAXIMUMS

Per Claimant: $2,000
Per Family: $6,000

This Prescription Medication Out-of-Pocket Maximum is calculated separately from any other Out-of-Pocket Maximum in the Summary Plan Description.

Your Copayments and/or any Coinsurance for Prescription Medications obtained from a Participating Pharmacy will be waived during the remainder of a Plan Year once Your Prescription Medication Out-of-Pocket Maximum amount is met.

DEFINITIONS

GENERIC MEDICATIONS

Generics have the same active ingredients in the same dose as brand-name drugs and have been approved by the Food and Drug Administration (FDA) to be safe and effective. Generic drugs generally cost less than brand-name drugs. These savings are passed on to you when you receive a generic medication. Talk to your doctor or pharmacist to see if a generic (tier 1) drug is right for you.

COVERED FORMULARY BRAND MEDICATIONS

Brand drugs that are covered by your plan.

COVERED NON-FORMULARY BRAND MEDICATIONS

Non-formulary brand medications are drugs that are covered by your plan, but at more of a cost to you. Non-formulary brand medications may have a generic equivalent available, or there may be another brand medication that is used to treat the same condition that is generally more cost effective without compromising quality.

SPECIALTY MEDICATIONS

Specialty medications treat chronic complex conditions such as Rheumatoid Arthritis, Cancer, Multiple Sclerosis, Hepatitis C, Chrohn's Disease, Bleeding Disorders, Asthma, Psoriasis, and more. These high cost drugs come in many forms and may be taken orally, injected with a syringe and needle, or even inhaled with a nebulizer. These medications require special handling or a higher level of support than traditional medications. Your specialty medication can be delivered to your home, your provider's office, or any approved location.

FORMULARY DRUG LIST DEVELOPMENT & CHANGES

The VRx Pharmacy and Therapeutics Committee may, in its professional judgment, modify Medications and supplies on the Formulary Products List as follows:

- Place products on the Prescription Drug Formulary and remove products from the Prescription Drug Formulary.
- Place certain products on the Prior Authorization List and remove products from the Prior Authorization List.
- Categorize certain Non-Prescription Products (over-the-counter products) as a Covered Expense, according to Covered Expenses as listed in the Summary Plan Description.
- Place Medications into and remove Medications from the Specialty Pharmacy Program.
- Place and remove limitations or restrictions on products based on clinical best practice as published in peer reviewed literature. This includes quantity limits, age limits, concurrent therapy, and other administration methods to provide clinically appropriate products to Covered Persons.
- Exclude medications from coverage based on factors such as FDA labeled use, other available therapies, safety concerns, or waiting for sufficient broad-population utilization data on new medications.

Actions by the Pharmacy and Therapeutics Committee take place quarterly, as medical technology evolves, as indications change, or as FDA (Food and Drug Administration) guidelines change. The Pharmacy Benefits Administrator, VRx, will inform participants of the actions taken by the Pharmacy and Therapeutics Committee as appropriate, including when benefits under this Plan are affected.

DRUGS WITH SPECIAL REQUIREMENTS

Your health, safety, and well-being are important. VRx works closely with your doctor in order to ensure that you are taking the right medication at the right time. Preauthorization, step therapy, and clinical edits are some of the programs that VRx uses. For a list of drugs that have specific requirements visit the Benefit Information section of the VRx website at www.myvrx.com.

Preauthorization Some medications require preauthorization and are only approved for certain conditions. Your doctor must submit a preauthorization request to VRx to determine coverage. Once VRx has reviewed the request your doctor will be notified of the decision. If the request is approved VRx will work with the pharmacy to get the prescription ready for you to pick up. If the request is denied, a representative of VRx will contact you to discuss the decision, provide alternative coverage if available, and provide direction for follow up with your doctor.

Step Therapy Other medications require step therapy, which means that you must have tried and failed other medications that treat the same condition and are generally more cost effective without compromising quality. Step therapy may be waived (with a preauthorization request) if determined to be medically necessary. The use of samples does not waive the step therapy requirement.

Quantity Limits Quantity Limits are placed on certain medications to ensure that the amounts prescribed are within the recommended dosages specified by the Food and Drug Administration (FDA). Quantity limits are set to ensure appropriate use and safety. Limits can be accumulative which means that the number of pills or units dispensed will be counted over time and across strengths and formulations of the same medication or medications that treat the same condition.

Your physician can request an exception to quantity limits and step therapy through the preauthorization process.

FILLING A PRESCRIPTION

You have multiple options to obtain your prescriptions.

Retail When your prescription is filled at a retail pharmacy, you may receive up to a 34-day supply or 100 unit doses, whichever is greater per copay. Contact a VRx Benefit Advocate at (801) 417-9722 or (855) 586-2569 to locate a participating pharmacy.

Mail Order By using the mail order benefit, you can receive up to a 90-day supply of your prescription delivered to your home at no additional charge. To learn more about mail order visit the mail service page on the VRx website at www.myvrx.com or call VRx at (801) 417-9722 or (855) 586-2569. A copay applies each time a prescription is filled through mail order.

Specialty VRx has contracted with specialty pharmacies to meet the needs of members using specialty medications. If you are using a Specialty Medication, please contact a Benefit Advocate for additional details. Each fill of a Specialty Medication may be for up to a 30-day supply.

In order to fill a prescription for a 90-day supply (through Retail or Mail Order), your prescriber must write your prescription for a 90-day supply.

VRX PARTICIPATING PHARMACY NETWORK

You can use your VRx pharmacy benefits at more than 65,000 participating pharmacies. The VRx network includes national pharmacy chains, local and regional chains, many independent pharmacies, and specialty pharmacies. To find out if your pharmacy is participating visit www.myvrx.com or call VRx at (801) 417-9722 or (855) 586-2569.

Make sure to present your Insurance ID card that includes the VRx logo with your prescription. If you use a pharmacy that is not in the VRx network or do not present your Insurance ID card, you will be required to pay the full cost of the prescription and then submit for reimbursement. If the prescription is covered you will be reimbursed the contracted rate, less any applicable deductible or copay/coinsurance. In most cases, the pharmacy's cash price is more than VRx's contracted rate, which will leave you responsible to pay for an additional amount. To avoid paying any unnecessary expenses make sure to use a participating pharmacy.

VRX SECURE WEBSITE

You can learn more about your prescription benefits online. Visit www.myvrx.com, register your information and log into the secure member portal. You can find the following helpful information and tools on the VRx website:

Benefit Information

- Prescription copay information
- Estimated drug costs
- Prescription claim history report
- Find a participating pharmacy
- Find a list of covered drugs as well as those that have special requirements

Order Mail Order Prescriptions Online

- Register for home delivery mail order
- View order status
- Request a refill

Customer Support

- View or print a copy of the VRx formulary
- Print a member reimbursement form
- Contact VRx

PRESCRIPTION COORDINATION OF BENEFITS
Coordination of Benefits is when you have coverage through more than one insurance company and they work together to pay for a prescription. This plan does allow for coordination of benefits on pharmacy claims.

PREVENTIVE MEDICATIONS
One element of the Affordable Care Act is the coverage of certain preventive medications at no cost to the member. As required by law, these medications are covered by the Plan at no cost to you when age and gender appropriate, prescribed by a health care professional, and filled at a network pharmacy. Types of preventive medications include:
- Contraceptives: including; oral, vaginal, transdermal and injectable.
- Emergency contraception
- Fluoride
- Aspirin
- Folic Acid
- Certain Vitamins
- Smoking Cessation Medications
- Immunizations

VRx has determined that contraceptives containing the same progestin are equivalent to each other. Each unique progestin contraceptive medication is represented as a Preventive Care Medication to ensure women have access to a broad range of contraceptives at no cost. All other contraceptives may be covered in other tiers at the applicable copay.

Unless specifically stated, medications available without a prescription over-the-counter (OTC) are not covered by the plan.

COVERED PRESCRIPTION MEDICATIONS
- Diabetic supplies (including glucometers, test strips, glucagon emergency kits, insulin and insulin syringes, but not insulin pumps and their supplies), when obtained with a Prescription Order (insulin pumps and their supplies are covered under the Durable Medical Equipment benefit);
- Prescription Medications;
- Certain preventive medications (including, but not limited to, aspirin, fluoride, iron and Generic Medications for tobacco use cessation) according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), when obtained with a Prescription Order;
- Women’s contraception methods as recommended by the Health Resources and Services Administration (HRSA);
- Immunizations for adults and children according to, and as recommended by, the Centers for Disease Control and Prevention (CDC);
- Specialty Medications;
- Self-Administrable Cancer Chemotherapy Medication (all Prescription Medications for Self-Administrable Cancer Chemotherapy Medications must be provided by a Specialty Pharmacy). See below for Special Provisions for Cancer Drug Treatment Regimen; and
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Compound and Injectable Medications).

EXCLUSIONS
In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Prescription Medication Benefits Section, unless specifically defined by the Claims Administrator:
- Acne Medication. Prescription Medications for the treatment of acne in Claimants over age 39.
- Biological Sera, Blood or Blood Plasma, Plasma-derived and Recombinant Clotting Factor Products
- Certain Contraceptives. Prescription contraceptives that cannot be self-administered, including Norplant, surgically inserted contraceptive devices, IUDs and Depo-Provera (coverage for these contraceptives may otherwise be provided under the medical benefit).

- Cosmetic Purposes. Prescription Medications used for cosmetic purposes, including, but not limited to: removal, inhibition or stimulation of hair growth; retardation of aging; or repair of sun-damaged skin.
- Devices or Appliances. Devices or appliances of any type, other than insulin pumps, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Medical Benefits Section).
- Foreign Prescription Medications. Except for Foreign Prescription Medications associated with an Emergency Medical Condition while you are traveling outside the United States, or those You purchase while residing outside the United States, the Plan does not cover foreign Prescription Medications. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.
- Insulin Pumps and Pump Administration Supplies. Coverage for insulin pumps and supplies is provided under the Medical Benefits Section.
- Medications That Are Not Considered Self-Administrable. Coverage for these medications may otherwise be provided under the Medical Benefits Section.
- Nonprescription Medications. Medications that by law do not require a Prescription Order and which are not included in the Claims Administrator's definition of Covered Prescription Medications, shown below, unless included on the Formulary.
- Off-Label Use Prescription Medications. Prescription Medications that have not yet received FDA approval for the purpose and in the manner they are being prescribed, except as may be provided under the Investigational definition in the Definitions Section found at the back of this Summary Plan Description. However, if a Prescription Drug is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the Prescription Drug may be provided when so used, as determined by the Plan.
- Prescription Medications Dispensed in a Facility. Prescription Medications dispensed to you while you are a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed under this benefit if obtained from a Pharmacy.
- Prescription Medications Dispensed in Connection with Participation in a Clinical Trial
- Prescription Medications for Treatment of Infertility
- Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order
- Prescription Medications Not within a Provider's License. Prescription medications prescribed by providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.
- Prescription Medications with No FDA Proven Therapeutic Indication
- Prescription Medications without Examination. Prescriptions made by a provider without recent and relevant in-person examination of the patient, whether the prescription order is provided by mail, telephone, internet or some other means.
- Professional Charges for Administration of Any Medication.

PRESCRIPTION APPEALS PROCEDURES

Requests for coverage determination or appeals relating to the pharmacy benefit should be sent in writing along with any other pertinent information you wish VRx to review in conjunction with your appeal. Send all information to:

VRx
Attn: Appeals
PO Box 9780
Salt Lake City, UT 84109-0780

If your appeal is denied, VRx will provide written notification to you or your authorized representative. Written notification will include:

- The specific reason(s) for the denial;
- Reference to the specific Plan provision on which the adverse benefit determination was based;

Second Level Appeal
If your appeal is denied, you or your authorized representative may request further review by VRx. This request for a second-level appeal must be made, in writing, within sixty (60) days of the date you are notified of the original appeal decision.

VRx will promptly conduct a full and fair review of your appeal, independently from the individual(s) who considered your first level appeal or anyone who reports to such individual(s) and without affording deference to the initial denial.

Second-level appeals will be decided by VRx within a reasonable period of time, but not later than thirty (30) days after VRx receives the appeal. VRx's decision will be provided to you in writing, and if the decision is a second denial, the notification will include all of the information described above.

Voluntary External Appeal – IRO
A voluntary Appeal to an Independent Review Organization (IRO) is available, but only after you have exhausted all of the applicable non-voluntary Appeals, or if VRx 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.
VRx will coordinates voluntary external appeals, and the decision is made by an IRO at no cost to you. VRx will provide the IRO with the appeal documentation. The IRO will make its decision and provide you with its written determination. 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 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.

Please refer to the Claims Review Process section of this SPD for additional details.

ADDITIONAL INFORMATION ON PRESCRIPTION BENEFITS
For more information about these Prescription benefits, please call the Pharmacy Benefits Administrator, VRx at (855) 586-2569, or visit the website at www.myvrx.com.

Dental Benefits

This section contains information regarding the Dental Benefits, including information about Maximum Benefits, Coinsurance, Covered Services and payment. Preventive Dental Services are listed first, followed by all other Covered Services in alphabetical order. The Dental Benefits are separate from the Medical Benefits and have been combined in one SPD for your convenience.

MAXIMUM BENEFITS
Preventive and Diagnostic, Basic and Major Dental Services**:**
Per Claimant per Plan year: $1,500

If basic or major dental services are expected to exceed $300 it is recommended that the provider submit a pre-determination of benefits before dental work is provided. This allows you the opportunity to anticipate your out-of-pocket expenses.

Dental pre-determinations are usually completed within 10 days from the date of receipt unless additional information is required. Both you and your provider will receive a letter indicating what would be covered for each procedure submitted. The predetermination will include plan year maximum and the amount applied to the maximum.

Actual benefits payable will depend on member and provider eligibility, provider contract status, contract limitation, benefits available, and benefit maximums in effect when services are completed.

Orthodontic Dental Services:
Per Claimant per Plan Year: $500
Per Claimant Lifetime: $1,000

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 1 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 15 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 approval 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.

Care Management and Wellness Programs

Under the Plan You have access to the care management and wellness programs.

CASE MANAGEMENT

Receive one-on-one help and support in the event You have a serious or sudden Illness or Injury. An experienced, compassionate case manager will serve as Your personal advocate during a time when You need it most. Your case manager is a licensed health care professional who will help You understand Your treatment options, show You how to get the most out of Your available Plan benefits and work with Your Physician to support Your treatment plan.

To learn more or to make a referral to case management, please call 1 (866) 543-5765.

HUBBUB

HUBBUB offers an array of wellness resources to help you make informed decision about your health with tools, information and support for a healthy lifestyle. HUBBUB offers Health Coaches that can help you stay inspired, answer questions and provide guidance.
On HUBBUBhealth.com you will find a socially interactive website with group challenges, messaging, and more.

- Unlimited health challenge platform – join SLCC's challenges, create your own challenges, challenge a friend or a co-worker, or accept a friend's challenge invite.
- Friend and family access – it is more fun and engaging to get your friends and family involved.
- Health Coaching – expert motivators via Skype, email, and hubbub messaging.
- Hubbub360 – answer 11 simple questions and get matched to two fun challenges tailored to your person health goals.
- Have a fitbit®, Withings or UP by Jawbom™ device? With HUBBUB's device integration you can sync your devices or manual track you biometric stats, along with health and wellness goals.
- Also available on your mobile devices – check in or join challenges from any location, at any time.

For additional details on SLCC's Employee Wellness Benefit Programs and incentives please visit **www.slcc.edu/hr/wellness**.

Please note: HUBBUB and the SLCC Employee Wellness Benefit Program and related services, although mentioned in this plan document are separate and independent of the medical, prescription, and dental program.

REGENCE CONDITION MANAGER

Regence Disease Management is a support and education program for people with chronic conditions such as diabetes, heart disease, asthma and/or depression. The Claims Administrator's nurses and behavioral health care coordinators provide tailored educational materials, tools and other services to help You get on track with Your care--and stay there. They can help You understand the care plan You've developed with Your Physician, and make smarter choices for better health.

To learn more, please call 1 (866) 543-5765.

BABYWISE

Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions. BabyWise can provide answers and assistance so that You can relax and enjoy those nine life-changing months.

This program offers expectant mothers access to a nurse 24 hours a day, 7 days a week and educational materials tailored to their needs. Since BabyWise is most beneficial when a woman enrolls early in her pregnancy, call 1 (888) JOY-BABY (569-2229) or send an e-mail to BabyWise@regence.com right away to get started.

Employee Assistance Program

An Employee Assistance Program ("EAP") is an important component of a group-sponsored preventive care package and the Plan Sponsor has chosen to provide this benefit to You. The EAP provides short-term, confidential counseling at no out-of-pocket expense to You. The EAP is available to You and Your immediate family, including family members living in Your home (who may or may not be enrolled in this coverage). Please contact the Claims Administrator or the Plan Sponsor for more information regarding EAP coverage and for contact information. To access the EAP, please call 1-866-750-6327.

SERVICES PROVIDED

The following services are provided as part of the EAP package:

24-Hour Crisis Counseling

The EAP hotline number is answered by professional counselors 24 hours a day, 7 days per week.

Short-Term Counseling

If the problem can be resolved within the scope of the EAP, the counselor provides this service to the individual(s). Up to four counseling sessions will be allowed per incident. An "incident" means a discrete event or events occurring in the client's life. Each family member affected by an incident will be allowed a total of four counseling sessions. If two or more members of the same family are seen together in a conjoint session, the session is counted as one visit for each attending family member. Eligible family members are those individuals living in the same residence with You.

Referral

If the counselor and client determine the problem cannot be handled in short-term counseling, the counselor will refer the individual to community resources that are best suited to address the issue.

Follow-up

When necessary and appropriate, the counselor follows up with the client after short-term counseling and/or referral to assess the appropriateness of the referral and to see if the EAP service can be of further assistance.

Adoption Assistance Program

The Plan pays up to $3,000 for a legal adoption for a single pregnancy (for example twins are considered a single pregnancy). This benefit is not part of the medical plan benefits; but rather, is a flat dollar benefit. This benefit is payable when a Participant meets all of the following conditions:

- Coverage is in effect on the date a newborn child is placed for the purpose of adoption.
- The newborn child is placed for the purpose of adoption with the Participant within 12 months of the child's birth and the date of placement is on or after the Participant's Effective Date.
- The newborn must be enrolled (via special enrollment) in the medical plan within 30 days of placement.
- The Participant submits a written request for the adoption benefit along with proof of placement for adoption. Proof of placement will be a copy of the court order or its equivalent (for example, a letter from the adoption agency) showing the date of placement for adoption. The written request must contain the child's name, date of birth and a statement regarding any other health coverage of the adoptive parent(s). The written request will be addressed to:

Regence BlueCross BlueShield of Utah
P.O. Box 30272
Salt Lake City, UT 84130-0272

As previously stated, if a Participant adopts more than one newborn from a single pregnancy (for example, twins), only a single $3,000 adoption benefit is available (subject to reduction for other coverage below).

In the event the Participant and/or the Participant's spouse (or domestic partner) are covered by more than one adoption benefit plan, the adoption benefit will be prorated between or among the plans. The full amount provided by both or all of the plans will not exceed $3,000 per pregnancy.

In the event the post-placement evaluation disapproves the adoption placement and a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety, the Participant will be liable for repayment of the adoption benefit. The Participant will refund the full amount of such benefit to the Plan, upon request, within 30 days after the date the child is removed from placement.

General Plan 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.

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.

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.

Fees, Taxes, Interest

Charges for shipping and handling, postage, interest or finance charges that a Provider 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.

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 for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).

Investigational Services

Except as provided under the Approved Clinical trials benefit in this Summary Plan Description, The Plan does not covers 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.

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 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 motor vehicle 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 the Summary Plan Description.

Non-Direct Patient Care

Services that are not direct patient care, including:

- appointments scheduled and not kept ("missed appointments");
- charges for preparing medical reports;
- 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).

Personal Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps and light boxes are not covered.

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.

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.

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

Travel and Transportation Expenses
Travel and transportation expenses other than covered ambulance services provided under the Plan.

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 the Plan. 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.

General Exclusions - Medical

In addition to the exclusion in the General Plan Exclusions Section, the following exclusions apply to the Medical Benefits. Other exclusions may apply and, if so, will be described elsewhere in this Summary Plan Description.

EXCLUSION EXAMPLES

The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under the Plan, including related secondary medical conditions and are not inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
  - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
  - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- complications that result from an Injury or Illness resulting from active participation in illegal activities.

SPECIFIC MEDICAL EXCLUSIONS

The Plan will not provide benefits 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: 1) 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; or 2) a preventive service as specified under the Preventive Care and Immunizations benefit in the Medical Benefits Section or in the Prescription Medication Benefits provision.

Assisted Reproductive Technologies

The Plan does not cover any assisted reproductive technologies (including, but not limited to, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception), or associated drugs, testing or supplies, regardless of underlying condition or circumstance.

Complementary Care

The Plan does not cover complementary care, including, but not limited to, the following: acupuncture, massage or massage therapy and naturopathic services.

Cosmetic/Reconstructive Services and Supplies

Cosmetic and/or reconstructive services and supplies, except in the treatment of the following:

- to treat a congenital anomaly for Claimants up to age 26;
- to restore a physical bodily function lost as a result of Injury or Illness; or
- related to breast reconstruction following a Medically Necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice in this Summary Plan Description.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

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.

Counseling in the Absence of Illness

Except for certain preventive services as specified under the Preventive Care and Immunizations benefit, the Plan does not cover counseling in the absence of Illness (for example, educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; Employee Assistance Program ("EAP") services, except as specifically provided under the EAP Section, if applicable; wilderness programs; premarital or marital counseling; family counseling (however family counseling will be covered when the identified patient is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment when Mental Health Services are covered benefits under the Plan).

Custodial Care

Non-skilled care and helping with activities of daily living.

Dental Services

The Plan does not cover Dental Services provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth. Does not apply to Covered Services for accidental injury.

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 for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services)

Growth Hormone Therapy

Growth hormone therapy once bone growth is complete.

Hearing Care

Except as provided under the routine hearing examinations benefit of the contract, routine hearing examinations, programs or treatment for hearing loss, including, but not limited to, hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion does not apply to cochlear implants.

Infertility

Except as provided under the Infertility Treatment benefit of the Plan, the Plan does not cover treatment of infertility, except to the extent Covered Services are required to diagnose such condition including, but not limited to fertility drugs and medications.

Investigational Services

Investigational treatments or procedures (Health Interventions) and 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.

Mental Health Treatment For Certain Conditions

The Plan will not cover Mental Health Conditions for diagnostic codes 302 through 302.9 found in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders for all ages. Additionally, the Plan will not cover any "V code" diagnoses except the following when Medically Necessary: parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger and bereavement for children five years of age or younger. "V code," means codes for additional conditions that may be a focus of clinical attention as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders that describes Relational Problems, Problems Related To Abuse Or Neglect or other issues that may be the focus of assessment or treatment. This would include, but is not limited to, such issues as occupational or academic problems.

Motor Vehicle Coverage and Other Available Insurance Liability
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.

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).

Nutritional Counseling
Except as specifically provided under the diabetic education benefit of the contract.

Obesity or Weight Reduction/Control
Except as may be specifically provided in this Summary Plan Description, the Plan does not cover medical treatment, medication, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.

Orthognathic Surgery
Services and supplies for orthognathic surgery in the absence of significant physical functional impairment, including but not limited to when used for altering or improving bite or for improvement of appearance, or in the absence of medical necessity. “Orthognathic surgery,” means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from Injury, congenital anomaly or abnormal development to restore the proper anatomic and functional relationship of the facial bones. This exclusion does not apply to orthognathic surgery due to Injury, sleep apnea or congenital anomaly. Orthognathic surgery may be considered medically necessary to correct jaw and craniofacial deformities when all of the Regence medical criteria are met.

Over-the-Counter Contraceptives
Except where provided under the Prescription Medication Benefits in this Summary Plan Description, the Plan does not cover Over-the-counter contraceptive supplies.

Physical Examinations required by a Third-party
Physical examinations required by a third-party, including but not limited to, employment examinations, examinations for insurance applications, examinations to permit travel outside the United States.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment, including hot tubs or membership fees at spas, health clubs or other such facilities. This exclusion applies even if the program, equipment or membership is recommended by the Claimant's Provider.

Prescription Medications Dispensed By a Pharmacy
Prescription medications dispensed by a Pharmacy, except for Medically Necessary diabetic medications and supplies when they are purchased through a Pharmacy. See the Diabetic Medication and Supplies Section for a description.

Private-Duty Nursing
Private-duty nursing, including ongoing shift care in the home.

Reversals of Sterilizations
Services and supplies related to reversals of sterilization.

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.

Routine Foot Care
The Plan does not cover routine foot care. This exclusion does not apply to foot care associated with diabetes.

Self-Help, Self-Care, Training or Instructional Programs
Except as may be provided in this Summary Plan Description, the Plan does not cover self-help, non-medical self-care, training programs, including:

- diet and weight monitoring services;
- childbirth-related classes including infant care; and
- instruction programs including those that teach a person how to use Durable Medical Equipment or how to care for a family member.

This exclusion does not apply to services for training or educating a Claimant when provided without separate charge in connection with Covered Services.

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 and Supplies That Are Not Medically Necessary
Except for preventive care benefits provided in this Summary Plan Description, the Plan does not cover services and supplies that are not Medically Necessary for the treatment of an Illness or Injury

Sexual Dysfunction
Except for counseling services provided by covered, licensed Practitioners, the Plan does not cover services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause.

Sexual Reassignment Surgery

Telehealth

Telemedicine

Termination of Pregnancy (Abortion)
Services and supplies in connection with the performance of any induced abortion services except in the following circumstances in accordance with the Utah prohibition against public funding for abortions (U.C.A. 76-7-331, as amended):

- in the professional judgment of the pregnant woman's attending physician, the abortion is necessary to save the pregnant woman's life.
- the pregnancy is the result of rape or incest reported to law enforcement agencies, unless the woman was unable to report the crime for physical reasons or fear of retaliation; or
- in the professional judgment of the pregnant woman's attending physician, the abortion is necessary to prevent premature, irreparable, and grave damage to a major bodily function of the pregnant woman provided that a caesarian procedure or other medical procedure that could also save the life of the child is not a viable option.

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

Tobacco Addiction Treatment
Except as specifically provided in this Summary Plan Description, the Plan does not cover treatment of tobacco addiction and supportive items for addiction to tobacco, tobacco products or nicotine substitutes.

Vision Care
Other than an annual routine eye exam, visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.

General Exclusions - Dental

In addition to the exclusions in the General Plan Exclusions Section, the following exclusions apply to the Dental Benefits. 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 for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).

Home Visits

Investigational Services
Investigational treatments or procedures (Health Interventions) and 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 the 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 unless in connection with orthodontics

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

Pulp Capping
Services or supplies for indirect pulp capping in addition to restoration charges. This exclusion does not apply to indirect pulp capping not associated with any other charges.

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 and Supplies That Are Not Medically Necessary

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.

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 Provider 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.

Claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the locale in which the equipment was received. Durable Medical Equipment is received where it is purchased at retail or, if shipped, where the Durable Medical Equipment is shipped to. Please refer to Your Blue plan network where supplies were received for coverage of shipped Durable Medical Equipment.

Claims for independent clinical laboratory services will be submitted to the Blue plan in the locale in which the specimen was drawn or otherwise acquired, regardless of where the examination of the specimen occurred. Please refer to Your Blue plan network where the specimen was drawn for coverage of independent clinical laboratory services.

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.)

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.

MEDICAL CLAIMS

Freedom of Choice of Provider

Nothing contained in this Summary Plan Description is designed to restrict You in selecting the Provider of Your choice for care or treatment of an Illness or Injury.

In-Network Provider Claims

You must present Your Plan identification card when obtaining Covered Services from an In-Network Provider. You must also furnish any additional information requested. The Provider will furnish the Claims Administrator with the forms and information needed to process Your claim.

In-Network Provider Reimbursement

An In-Network Provider will be paid directly for Covered Services. These Providers 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, Copayment and/or Coinsurance. These Providers may require You to pay Your share at the time You receive care or treatment.

Out-of-Network Provider Claims

In order for Covered Services to be paid, You or the Out-of-Network Provider must first send the Claims Administrator a claim. 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, group number and identification numbers.

If the treatment is for an Injury, include a statement explaining the date, time, place and circumstances of the Injury when You send the claim.

Out-of-Network Provider Reimbursement

In most cases, You will be paid directly for Covered Services provided by an Out-of-Network Provider.

Out-of-Network Providers 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 Out-of-Network Provider and the Allowed Amount in addition to any amount You must pay due to Deductible, Copayment and/or Coinsurance. For Out-of-Network Providers, 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 by Provider

Here is an example of how Your selection of In-Network or Out-of-Network Providers affects payment to Providers and Your cost sharing amount. For purposes of this example, let's assume the Plan pays 80 percent of the Allowed Amount for In-Network Providers and 60 percent of the Allowed Amount for Out-of-Network Providers. The benefit table from the Medical Benefits Section (or other benefits section) would appear as follows:

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

- Now, let's assume that the Provider's charge for a service is $5,000 and the Allowed Amount for that charge is $4,000 for an In-Network Provider. Finally, let's assume that You have met the Deductible and that You have not met the Out-of-Pocket Maximum. Here's how that Covered Service would be paid:

- In-Network Provider: the Plan would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:

  - Amount In-Network Provider must "write-off" (that is, cannot charge You for): $1,000
  - Amount the Plan pays (80% of the $4,000 Allowed Amount): $3,200
  - **Amount You pay** (20% of the $4,000 Allowed Amount): **$800**
  - Total: $5,000

- Out-of-Network Provider: the Plan would pay 60 percent of the Allowed Amount. Because the Out-of-Network Provider does not accept the Allowed Amount, You would pay 40 percent of the Allowed Amount, plus the $1,000 difference between the Out-of-Network Provider's billed charges and the Allowed Amount, as follows:

  - Amount the Plan pays
  - (60% of the $4,000 Allowed Amount): $2,400
  - **Amount You pay** (40% of the $4,000 Allowed Amount and the $1,000 difference between the billed charges and the Allowed Amount): **$2,600**
  - Total: $5,000

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 Provider.

Ambulance Claims

When You or Your Provider forwards a claim for ambulance services to the Claims Administrator, it must show where the patient was picked up and where he or she was taken. It should also show the date of service, the patient's name and the patient's group and identification numbers.

OUT-OF-AREA SERVICES

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain health care services outside of the Claims Administrator's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between the Claims Administrator and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the Claims Administrator's service area, You will obtain care from health care Providers that have a contractual agreement (for example, are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some

instances, You may obtain care from nonparticipating Providers. The Claims Administrator's payment practices in both instances are described below.

BlueCard Program

Under the BlueCard Program, when You access Covered Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for fulfilling contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever You access Covered Services outside the Claims Administrator's service area and the claim is processed through the BlueCard Program, the amount You pay for Covered Services is calculated based on the lower of:

- The billed covered charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Claims Administrator uses for Your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to Your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate Your liability for any Covered Services according to the applicable law.

Negotiated National Account Arrangements

As an alternative to the BlueCard Program, Your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price above) made available to the Claims Administrator by the Host Blue.

Nonparticipating Providers Outside the Claims Administrator's Service Area

- Member Liability Calculation. When Covered Services are provided outside of the Claims Administrator's service area by nonparticipating Providers, the amount You pay for such services will generally be based on either the Host Blue's nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.
- Exceptions. In certain situations, the Claims Administrator may use other payment bases, such as billed covered charges, the payment the Claims Administrator would make if the health care services had been obtained within the Claims Administrator's service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Claims Administrator will pay for services rendered by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

BLUECARD WORLDWIDE®

BlueCard Worldwide® coverage is also accessible to You. With BlueCard Worldwide®, You have access to inpatient and outpatient Hospital care and Physician services when You're traveling or living outside the United States or any other areas covered by the domestic BlueCard® Program, as well as medical assistance and claims support services.

When You need health care outside of the United States or its territories, follow these simple steps:

- Always carry Your current Plan identification card.
- If You need emergency medical care outside the United States, go to the nearest Hospital.
- If You are admitted, call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177.
- For non-emergency medical care, call the BlueCard Worldwide Service Center. The Service Center will facilitate hospitalization if necessary at a BlueCard Worldwide Hospital or make an appointment with a Physician. BlueCard Worldwide® Service Center staff are available to assist You 24 hours a day, 7 days a week.
- You will only be responsible for out-of-pocket expenses such as any applicable Deductible, Copayment, Coinsurance and non-covered services for Your inpatient care. For outpatient Hospital care or Physician services, You will be responsible for paying the Hospital or Physician at the time of service and then must complete an international claim form and send it to the BlueCard Worldwide® Service Center for reimbursement of Covered Services.

You can obtain an international claim form and find additional information about the BlueCard Worldwide® program at **www.bcbs.com**.

DENTAL CLAIMS

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 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, group number 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 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% Coinsurance and Nonparticipating Dentist services are also subject to a 20% Coinsurance of the Allowed Amount for Covered Services. 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 for Covered Services.	**Payment:** After Deductible, the Plan pays 80% of the Allowed Amount and You pay balance of billed charges and for services not covered by the Plan.

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. Here's how that Covered Service would be paid:

- Participating Dentist: the Plan would pay 80% of the Allowed Amount and You would pay 20% 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% of the Allowed Amount. Because the Nonparticipating Dentist does not accept the Allowed Amount, You would pay 20% 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.

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 the Participant's or any of his or her Beneficiary's 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 Plan.

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 MEDICAL AND DENTAL RECORDS

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 health care Provider. Neither the Plan nor the Claims Administrator is responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since neither the Plan nor the Claims Administrator provides any health care services, neither can be held liable for any claim for damages connected with Injuries You suffer while receiving health 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 of the Plan 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 and vision, if applicable) or Prescription Medication 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 You 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
In the event of a work-related Injury or Illness, these are some rules which may apply:

- 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 Medical 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"), 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.

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 spouse or a child 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: A Plan that covers You as an employee, member, subscriber or retiree or as a spouse or a child 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. 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. The Claims Administrator 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 are paid 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 Medical Benefits

PLAN YEAR OUT-OF-POCKET MAXIMUM – IN-NETWORK

Per Claimant: $2,900
Per Family: $5,800

PLAN YEAR OUT-OF-POCKET MAXIMUM – OUT-OF-NETWORK

Per Claimant: $5,000
Per Family: $10,000

COINSURANCE – IN-NETWORK

Coinsurance for Covered Services will be 100% after applicable deductible and/or copayments.

COINSURANCE – OUT-OF-NETWORK

Coinsurance for Covered Services will be after applicable deductible and/or copayments. Balance Billing may apply:

- Unless otherwise noted the Coinsurance for Covered Out-of-Network services will be 40%.
- The following Out-of-Network services will be 20%
  - Ambulance Services
  - Blood Bank
- Preventive Care Out-of-Network services will be 25%.

PLAN YEAR DEDUCTIBLES – IN-NETWORK

Per Claimant: $200
Per Family: $400

PLAN YEAR DEDUCTIBLES – OUT-OF-NETWORK

Per Claimant: $500
Per Family: $1,000

COPAYMENTS – IN-NETWORK

For the following In-Network services you do not need to meet the In-Network Deductible but You are responsible for the applicable copayment before receiving benefits:

$15 copayment per visit	$25 copayment per test	$75 copayment per visit
• Office Visits • Preventive Care – Expanded Benefits • Spinal Manipulations • Home Health Care • Home Infusion Therapy • Infertility	• Major Diagnostic Testing	• Emergency Room copayment is waived if admitted

• Office or Clinic Visits for Mental Health or Chemical Dependency Services • Outpatient Rehabilitation Services • Outpatient Habilitation Services		

ICOB Prescription Medication Benefits

PLAN YEAR OUT-OF-POCKET MAXIMUM
Per Claimant: $2,000
Per Family: $6,000

PLAN YEAR DEDUCTIBLES
Per Claimant: $50
Per Family: $150

Unless otherwise noted the deductible applies to all covered prescriptions.

COPAYMENTS AND COINSURANCE
Once the applicable deductible is met, You are responsible for the following Copayment or Coinsurance.

RETAIL PHARMACY

34-day supply or 100 unit doses; whichever is greater	• $3.50 for each Generic Medication (deductible waived)
	• 12% for each Formulary Brand Name Medication; up to a $75 maximum copayment per prescription
	• 15% for each Brand Name Medication; up to a $87.50 maximum copayment per prescription

MAIL-ORDER PHARMACY

90-day supply	• $3.50 for each Generic Medication (deductible waived)
	• 12% for each Formulary Brand Name Medication; up to a $150 maximum copayment per fill (deductible waived)
	• 15% for each Brand Name Medication; up to a $175 maximum copayment per fill (deductible waived)

SPECIALTY PHARMACY

• 5% for each Generic Medication; up to a $125 maximum copayment per prescription
• 5% for each Formulary Brand Name Medication; up to a $125 maximum copayment per prescription
• 7% for each Brand Name Medication; up to a $150 maximum copayment per prescription

DIABETIC SUPPLIES

• 20% for diabetic supplies (deductible waived)

ICOB Dental Benefits

Eligible Dental Expenses from participating 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 80%
Major Services paid at 50%

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

Medical and Dental 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 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). You, or Your Representative on Your behalf, will be given a reasonable opportunity to provide written materials. If You don't Appeal within this time period, 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 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 receipt 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. 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 medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, 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 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 the Claims Administrator's staff of healthcare professionals who were not involved in, or subordinate to anyone involved in, the initial denial determination. 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 External Appeal - IRO

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

The Claims Administrator coordinates voluntary expedited 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. 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 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 in the manner required by 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. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as require by the ACA regulations. The President Emeritus, as on file with the Plan Sponsor.

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 January 1, then You would have the ability to make a corresponding mid-year election change to drop your coverage from this Plan effective January 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.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and you do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 26-week period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact the Plan Sponsor.

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, unless otherwise indicated, 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.

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. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. 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.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally does not accept Late Enrollees.

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 the 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 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.

Allowed Amount for purpose of the Medical Benefits Section only:

- For In-Network Providers (see definition of "In-Network" below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For Out-of-Network Providers (see definition of "Out-of-Network" below) who are not accessed through the BlueCard Program, the amount We have determined to be reasonable charges for Covered Services or supplies. The Allowed Amount may be based upon the billed charges for some services, as determined by Us or as otherwise required by law.
- For Out-of-Network Providers accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to Us as the amount on which it would base a payment to that Provider.

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 Us.

Allowable Expense for the purposes of coordination of benefits 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.

Ambulatory Surgical Center means a facility or that portion of a facility licensed by the state in which it is located, that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission. An Ambulatory Surgical Center must be a freestanding facility, meaning that it exists independently or is physically separated from another health care facility by fire walls and doors and is administered by separate staff with separate records.

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.

Balance Billing/Balance Bill means charges for services or supplies, incurred under an Out-of-Network Provider, that exceed the Claims Administrators Allowed Amount. You are responsible for these excess charges. Balance Bill amounts do not apply toward Your Coinsurance Maximums.

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

Claims Administrator means Regence BlueCross BlueShield of Utah, as a third-party administrator, in Agreement with Salt Lake Community College to assist in the Plan's claims administration and certain other administrative matters.

Child or Children means Your or Your Spouses' natural child, step child, adopted child or child legally place for adoption; a child for whom You (or Your Spouse) have court-appointed legal guardianship; or a child for who Your (or Your Spouse) are required to provide coverage by a legal Qualified Medical Child Support Order (QMCSO).

Claimant means a Participant or the legal spouse or Eligible Child of a Participant.

Coinsurance means the percentage of the Allowed Amount for incurred for covered services, supplies, or prescription medications that You are responsible for.

Copayments mean the fixed dollar amount that You must pay directly to the Provider for specified services, supplies, or prescription medications.

Covered Service means a service, supply, treatment or accommodation that is listed in the benefits sections of this Summary Plan Description.

Custodial Care means care that is for the purpose of watching and protecting a patient, rather than being a Health Intervention. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily for the purpose of separating the patient from others or preventing self-harm.

Custodial Parent for the purposes of coordination of benefits 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.

Deductible(s) means the dollar amount a Claimant is responsible to pay before the Plan will pay for services, supplies, or prescription medications.

Dental Services means services or supplies (including medications) provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

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.

Dependent means a Participant's eligible spouse and/or child who is listed on the Participant's completed enrollment form and who is enrolled under the Plan. **NOTE:** the term “Dependents” does not necessarily mean that the spouse and/or child(ren) are financially dependent upon You.

Disabled Dependent, specific to eligibility and enrollment, means a Child who is and continues to be: 1) unable to engage in substantial gainful employment to the degree that the Child can achieve economic independence due to a medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and 2) dependent on You for more than 50% of their support.

Domestic Partner means the Participant’s same or opposite sex domestic partner/Civil Union Partner that meets the specific requirements outlined in this Summary Plan Description and submits a signed affidavit to the Plan Sponsor at the time of enrollment.

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

Eligible Child or Eligible Children means Your or Your Spouse’s (or Domestic Partner’s) Child who is under the age of 26 or a Disabled Dependent over the age of 26 that meets the following criteria:

- A Disabled Dependent is a Child who is age 26 or over and who is Disabled 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 a continuously covered Child on Your accident and health insurance since that birthday.

Eligible Spouse means the person to whom you are legally married.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency room to result in any one of the following:

- placing the Claimant's health, or with respect to a pregnant Claimant, her health or the health of her unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Employer means Salt Lake Community College.

Enrolled Spouse (or Enrolled Domestic Partner) or Enrolled Child means each individual who was covered under the Plan on the day before a COBRA Qualifying Event and has an independent right to purchase COBRA Continuation Coverage.

Enrollment Date/Enrolled Date means:

- If You enrolled during Your initial period of eligibility, Enrollment Date means Your Effective Date of coverage or, if earlier, the first day of any waiting period for coverage applied to You.
- If You enrolled during a Special Enrollment, the enrollment date is the Effective Date of coverage.
- If you enrolled during an annual open enrollment, the Enrollment Date is the Effective Date of coverage.

Family means a Participant and his or her spouse (or domestic partner) and/or children.

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).

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.

Hospital means a facility that is licensed as a general acute or specialty Hospital by the state in which the Hospital is located. A Hospital provides continuous 24-hour nursing services by registered nurses. A Hospital has an attending medical staff consisting of one or more Physicians. A Hospital under this definition is not, other than incidentally, a place for rest, a nursing home or a facility for convalescence.

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy. Illness does not include any state of mental health or mental disorder (which is otherwise defined in this Summary Plan Description).

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary external Appeals and voluntary expedited external 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.

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.

In-Network means a Provider that has an effective participating contract with the Claims Administrator that designates him, her or it as a network provider, who is a member of the Plan Sponsor's chosen provider network, to provide services and supplies to Claimants in accordance with the provisions of this coverage. In-Network also means a Provider that has an effective participating contract with one of the Claims Administrator's Affiliates or a Provider outside the area that the Claims Administrator or one of its Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as a Provider in the "In-Network") to provide services and supplies to Claimants in accordance with the provisions of this Summary Plan Description, then Providers contracted under the network selected by the Plan Sponsor will be considered the only In-Network providers for purpose of payment of benefits in the Summary Plan Description. For In-Network Provider reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

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:

- If a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the medication may be provided when so used. To be considered effective for other than its FDA-approved use, the Oregon Health Resources Commission must have determined that the medication is effective for the treatment of that condition; or are determined by the Claims Administrator to be in an Investigational status.
- 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.

Maintenance Therapy means a Health Intervention after the patient has reached maximum rehabilitation potential or functional level and has shown no significant improvement for one to two weeks, and instruction in the maintenance program has been completed. This is particularly applicable to patients with chronic, stable conditions where skilled supervision/intervention is no longer required and further clinical improvement cannot reasonably be expected from continuous ongoing care. This includes but is not limited to:

- a general exercise program to promote overall fitness;
- ongoing treatment solely to improve endurance and fitness;
- passive exercise to maintain range of motion that can be carried out by non-skilled persons;
- programs to provide diversion or general motivation;
- therapy that is intended to maintain a gradual process of healing or to prevent deterioration or relapse of a chronic condition; or
- therapy that is supportive rather than corrective in nature.

Major Diagnostic Test means a CT scan, magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), nuclear medicine, neurological diagnostics, and cardiovascular diagnostics.

Maximum Benefits means the maximum Allowed Amount the Plan will pay per Participant for services, supplies, and/or prescription medications. Maximum amounts may be Lifetime and/or Plan Year limits.

Medically Necessary or Medical Necessity means health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an Illness or Injury or its symptoms in a manner that is:

- in accordance with generally accepted standards of medical practice in the United States;
- clinically appropriate in terms of type, frequency, extent, site, and duration;
- not primarily for the convenience of the patient, Physician, or other health care Provider; and
- covered under the Plan.

When a medical question-of-fact exists, Medical Necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and that is known to be effective. For Health Interventions not yet in widespread use, the effectiveness shall be based on Scientific Evidence. For established Health Interventions, the effectiveness shall be based on first Scientific Evidence; then professional standards; and then expert opinion.

A HEALTH INTERVENTION MAY BE MEDICALLY INDICATED YET NOT BE A COVERED SERVICE UNDER THE PLAN OR OTHERWISE MEET THIS DEFINITION OF MEDICAL NECESSITY.

Mental Impairment, specific to eligibility and enrollment, means a mental or psychological disorder such as: 1) mental retardation; 2) organic brain syndrome; 3) emotional or mental illness; or 4) specific learning disabilities as determined by 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.

Other Plan for the purposes of coordination of benefits 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.

Out-of-Network refers to a Provider that are not In-Network. For reimbursement of these Out-of-Network Provider services, You may be billed for balances over plan payment level in addition to any Deductible, Copayment and/or Coinsurance amount for Covered Services provided inside or outside the area that the Claims Administrator or one of its Affiliates serves.

Out-of-Pocket Costs are Your expenses for medical care, dental services, or prescription costs that aren't reimbursed by the plan. These costs include deductibles, coinsurance, and copayments for Covered Services.

Out-of-Pocket Maximum refers to the maximum amount of Out-of-Pocket Costs that you must pay during a policy year before the plan starts to pay 100% for Covered Services.

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 the Plan Sponsor 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 the Plan Sponsor.

Physical Impairment, specific to eligibility and enrollment, means a physiological disorder, condition, or disfigurement, or anatomical loss affecting one or more of the following body systems: 1) neurological; 2) musculoskeletal; 3) special sense organs; 4) respiratory organs; 5) speech organs; 6) cardiovascular; 7) reproductive; 8) digestive; 9) genito-urinary; 10) hemic and lymphatic; 11) skin; or 12) endocrine.

Physician means an individual who is duly licensed to practice medicine and surgery in all of its branches or to practice as an osteopathic Physician and surgeon.

Plan, The means the Salt Lake Community College Employee Health Care Benefits

Plan Sponsor means Salt Lake Community College.

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.

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

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include podiatrists, chiropractors, psychologists, certified nurse midwives, certified registered nurse anesthetists, dentists and other professionals practicing within the scope of his or her respective licenses.

Pre-Service for the purpose of the Appeal process 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.

Primary Plan for the purposes of coordination of benefits 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.

Provider means a Hospital, Skilled Nursing Facility, Ambulatory Surgical Center, Physician, Practitioner or other individual or organization which is duly licensed to provide medical or surgical services.

Rehabilitation Facility means a facility or distinct part of a facility that is licensed as a Rehabilitation Facility by the state in which it is located and that provides an intensive, multidisciplinary approach to rehabilitation services under the direction and supervision of a Physician.

Regence refers to Regence BlueCross BlueShield of Utah.

Representative for the purpose of the Appeal process 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 purposes of the Appeal. No authorization is required from the parent(s) or legal guardian of a Claimant who is a child and is less than 13 years old. For Expedited Appeals only, a health care professional with knowledge of Your medical 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.

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.

Secondary Plan for the purposes of coordination of benefits means a plan that is not a Primary Plan.

Skilled Nursing Facility means a facility or distinct part of a facility which is licensed by the state in which it is located as a nursing care facility and which provides skilled nursing services by or under the direction and supervision of a registered nurse.

Summary Plan Description (SPD) is the description of the benefits of the Plan. The Summary Plan Description is part of the Plan Document.

Total Cost for the purposes of COBRA Continuation Coverage, Family Medical Leave Act (FMLA), and Uniformed Services Employment and Reemployment Rights Act (USERRA) means the entire monthly premium including both the employee and the Plan Sponsor contribution amounts. Total Cost may include any associated administrative fees for continuation of coverage.

Year, for purposes of coordination of benefits provision, means calendar year.

You and Your in the context of the Summary Plan Description refer to both the Participant, his or her spouse (or Domestic Partner) and Children.

You and Your under the context of Who is Eligible, How to Enroll, and When Coverage Begins, When Coverage Ends, and COBRA Continuation, You and Your mean the Participant only.

General Plan Description

PLAN NAME
Salt Lake Community College Employee Health Care Benefits

PLAN SPONSOR
Salt Lake Community College
4600 South Redwood Road
Salt Lake City, Utah 84123
1 (801) 957-4595

EMPLOYER IDENTIFICATION NUMBER
87-6000448

TYPE OF PLAN
Welfare Benefit Plan: Medical and dental.

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

The processing of medical 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 Medical Claims Administrator.

PRESCRIPTION CLAIMS ADMINISTRATOR
VRx
19 East 200 South, Floor 10
Salt Lake City, Utah 84111
1 (855) 586-2569

The processing of prescription 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 Prescription 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

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