

Salt Lake Community College
Employee Health Care Benefits Plan

SUMMARY PLAN DESCRIPTION

Claims Administrator:

Regence BlueCross BlueShield of Utah

2890 East Cottonwood Parkway
Salt Lake City, Utah 84121-7035

PO Box 30270
Salt Lake City, Utah 84130-0270

Plan Administrator:

Salt Lake Community College
4600 South Redwood Road
Salt Lake City, Utah 84123

HANDY PHONE NUMBERS
AND OTHER INFORMATION

	Local	Toll-Free
Customer Service	(801) 333-2100	(800) 624-6519
Care Management Program	(801) 333-2850	(800) 228-8263

And visit the Regence BlueCross
BlueShield of Utah web-site: www.ut.regence.com

SLCC Human Resource Office (801) 957-4210

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

OTHER EMERGENCY NUMBERS

Who to contact in case of Emergency: _____
Relationship: _____
Poison Control Center: _____
Fire, Police, Medical emergencies: 911

INTRODUCTION

This Salt Lake Community College Employee Health Care Benefits Plan Summary Plan Description describes the terms and benefits of coverage effective July 1, 2006, or the date after that on which your coverage became effective. This Summary Plan Description replaces any plan description or booklet previously issued by the Plan Administrator and makes it void.

The Salt Lake Community College Employee Health Care Benefits Plan Document contains all the terms of coverage. The Plan Administrator has a copy. 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.

The first part of the Summary Plan Description is the SUMMARY OF BENEFITS. While only a summary (the complete benefits, conditions, limitations, and exclusions are described later), it includes some important information that can only be found in the SUMMARY OF BENEFITS, such as the percentages paid, Deductibles, Copayments, and Maximum Coinsurance amounts under the Plan.

As you read this Summary Plan Description, please keep in mind that the term "Claims Administrator" refers to Regence BlueCross BlueShield of Utah ("Regence BCBSU"), and the terms "Employer" or "College" mean Salt Lake Community College. The "Plan" refers to the group health plan sponsored by Salt Lake Community College which this Summary Plan Description describes. Other terms are defined in the DEFINITIONS Section at the back of this Summary Plan Description or where they are first used.

The Claims Administrator 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.

Federal law mandates coverage for certain breast reconstruction services in connection with a covered mastectomy. See the COVERED SERVICES Section of this Summary Plan Description for details.

Group health plans and health insurance issuers generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The College 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 dependent's health or treatment status, which may result in the termination or modification of your coverage and/or the coverage for your dependents. Covered Services and Eligible Medical Expenses incurred prior to the Plan's amendment, modification or termination will be paid as provided under the terms of the Plan as it existed at the time they were incurred.

UNDERSTANDING THE PLAN

This Plan is a comprehensive major medical benefit plan. Under a comprehensive major medical plan, the Plan pays benefits at a percentage of the Eligible Medical Expenses for Covered Services.

It is important for you to understand how the Plan works before you or your covered dependents need health care services. Please read this material carefully. If you have any questions about benefits or procedures, please contact the Claims Administrator's Customer Service Department (see the handy phone numbers page located at the front of this Summary Plan Description or visit their website www.ut.regence.com for the phone number).

PARTICIPATING PROVIDERS

The Plan will pay the Participating Provider directly for Covered Services. Participating Providers have agreed to accept Eligible Medical Expenses as full compensation for Covered Services. Your share of Eligible Medical Expenses is any amount you must pay due to Deductible, Copayment and/or Coinsurance. You may be required to pay your share at the time you or your covered dependents receive care or treatment from a Participating Provider.

IT IS GENERALLY TO YOUR FINANCIAL ADVANTAGE TO USE PARTICIPATING PROVIDERS. WHEN A PARTICIPATING PROVIDER IS USED, YOU ARE RESPONSIBLE TO PAY ONLY DEDUCTIBLE, COPAYMENT AND/OR COINSURANCE FOR COVERED SERVICES. WHEN NONPARTICIPATING PROVIDERS ARE USED, YOU ARE RESPONSIBLE NOT ONLY FOR DEDUCTIBLE, COPAYMENTS AND/OR COINSURANCE FOR COVERED SERVICES, BUT ALSO FOR THE DIFFERENCE BETWEEN ELIGIBLE MEDICAL EXPENSES AND THE BILLED CHARGES.

Refer to the CLAIMS ADMINISTRATION Section for additional information about Participating Providers.

NONPARTICIPATING PROVIDERS

Before you will be entitled to payments under the Plan for Covered Services provided by a Nonparticipating Provider, the Claims Administrator must receive all forms, information, statements, and certificates necessary or appropriate to process such claim. Most payments for Covered Services provided by a Nonparticipating Provider will be made directly to you. You will be responsible to ensure that the Nonparticipating Provider is reimbursed in full. **Please note when Nonparticipating Providers are used, you are responsible not only for any Deductible, Copayment and/or Coinsurance for Covered Services, but also for the difference between the Nonparticipating Provider's billed charges and Eligible Medical Expenses.**

Refer to the CLAIMS ADMINISTRATION Section for additional information about Nonparticipating Providers.

HOSPITAL SERVICES, SKILLED NURSING FACILITY AND OTHER FACILITY SERVICES

Participating Hospitals, Skilled Nursing Facilities and other facilities may follow the requirements of the Care Management Program. When you or your covered dependents receive services from Participating Hospitals, Skilled Nursing Facilities and other facilities, your responsibility for payment will be the Deductible, Copayment and/or Coinsurance amounts shown in the SUMMARY OF BENEFITS.

When you or your covered dependents receive services from Nonparticipating Hospitals, Skilled Nursing Facilities and other facilities, your responsibility for payment will be the Deductible, Copayment and/or Coinsurance amounts shown in the SUMMARY OF BENEFITS, plus the difference between the amount charged and Eligible Medical Expenses. The difference will not count toward your Maximum Coinsurance. **It is always your responsibility to ensure that the Claims Administrator is notified of an admission to a Hospital, Skilled Nursing Facility or other facility.**

Refer to the Care Management Program in the CLAIMS ADMINISTRATION Section for additional information about notification requirements.

EMERGENCY MEDICAL CONDITIONS AND URGENT CARE

Your Copayment and/or Coinsurance will vary according to where you or your covered dependents receive care for an Emergency Medical Condition or for urgent care. Costs are usually highest at a Hospital's emergency department, somewhat lower at an urgent care facility, and usually the lowest at a Physician's office. This general range of costs is reflected in your Copayment and/or Coinsurance amounts.

CARE MANAGEMENT PROGRAM

To help ensure appropriateness and cost-effectiveness of care, the Claims Administrator must be notified before certain services are received by you or your covered dependents. Failure to notify the Claims Administrator prior to receiving any of these specified services may result in no coverage. Refer to the Care Management Program in the CLAIMS ADMINISTRATION Section for additional information about notification requirements.

BENEFITS AND LIMITATIONS

Become familiar with the benefits, limitations and exclusions of the Plan. Providers may render or recommend care or suggest Providers that may not be covered. Payment for these services will be your responsibility.

HEALTH CARE POLICIES

The Claims Administrator determines Medically Necessary care in accordance with approved policies, and all claims payments are subject to these policies. You are encouraged to call the Claims Administrator's Medical Services Department for medical policy information prior to receiving services.

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SUMMARY OF MEDICAL BENEFITS - TYPE 3JL

This section is an outline of the benefits of the Plan. The sections following this SUMMARY OF BENEFITS spell out the benefits and other terms of the Plan in detail.

This Plan includes benefits for Participating and Nonparticipating Providers. Your identification card indicates which panel of providers is Participating under this Plan.

NOTE: It is important to use Participating Providers in order to receive the maximum benefits available under the Plan.

Contract Year

July 1 to June 30

Maximum Benefit

For each Claimant Lifetime \$2,000,000

Contract Year Deductible

Services provided by Participating Providers:

\$50 per Claimant per Contract Year for allergy serum

Services provided by Nonparticipating Providers:

Per Claimant	\$200
Per Family Unit	\$400

Deductibles for a Contract Year will cease to apply to all Claimants in the Family Unit when the amounts applied to some or all Claimants' per Claimant Deductible for that Contract Year total the specified Family Unit Deductible

Deductible does not apply to the following services:

- Accidental Injury/Life-Threatening Illness (including Ambulance Services, Dental Care Services and Emergency Department). Refer to the Additional Accidental Injury/Life-Threatening Illness Benefit for details.

Copayments

After any Deductible is satisfied, you are responsible to pay the following Copayment amounts:

For services provided by Participating Providers:

\$175 per admission to a Hospital, Rehabilitation Facility. When a Claimant is readmitted to a Hospital, Rehabilitation Facility for the same Illness or Injury within 7 days after discharge, the Copayment for the readmission will be waived.

\$150 per visit to a Hospital emergency department. This Copayment is waived when admitted.

\$50 per visit to Hospital Outpatient facility for major diagnostic testing.

\$20 per visit to a Physician's or Practitioner's office or clinic or for each house visit made by a Physician or Practitioner. For maternity care, this Copayment applies to the first visit only.

For Accidental Injury or Life-Threatening Illness services provided by Participating and Nonparticipating Providers:

\$150 per visit to a Hospital emergency department. This Copayment is waived when admitted.

\$20 per visit to a Physician's or Practitioner's office or clinic.

Percentage Plan Pays For Covered Services (Listed In The Following Paragraphs)

After any Deductible and/or Copayment is satisfied, benefits are paid as follows:

Participating Providers

The Plan pays benefits for Covered Services of a Participating Provider at the percentage listed. For Covered Services provided by a Participating Provider, you pay only the Deductible, Copayment and/or Coinsurance.

Nonparticipating Providers

The Plan pays benefits for Covered Services of a Nonparticipating Provider at the percentage listed. For Covered Services provided by a Nonparticipating Provider, in addition to the Deductible, Copayment and/or Coinsurance, **you pay the difference between billed charges and Eligible Medical Expenses (the "balance of billed charges")**.

NOTE: All payments for Covered Services as detailed in the following summary are based upon Eligible Medical Expenses, expressed as "EME." EME may differ based on the type of Provider rendering services and whether they are Participating or Nonparticipating with the Plan.

Allergy Serum

	Participating Provider	Nonparticipating Provider
Allergy Serum	After \$50 Deductible, Plan pays 100% of EME.	After Deductible, Plan pays 80% of EME and you pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Ambulance Services

	Participating Provider	Nonparticipating Provider
Medically Necessary services to the nearest appropriate Hospital	Plan pays 80% of EME and you pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	Plan pays 80% of EME and you pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Chiropractic Care

	Participating Provider	Nonparticipating Provider
Limited to 20 visits per Claimant per Contract Year	After Copayment, Plan pays 100% of EME.	After Deductible, Plan pays 80% of EME and you pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Dental Care

	Participating Provider	Nonparticipating Provider
Dental care or treatment for an Accidental Injury (including orthodontics)	Plan pays 50% of EME and you pay 50% of EME. 50% of EME will be applied toward Maximum Coinsurance.	Plan pays 50% of EME and you pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.
Limited to \$500 per Claimant per Accidental Injury		

Durable Medical Equipment and Supplies, Prosthetic and Orthotic Devices

	Participating Provider	Nonparticipating Provider
Durable Medical Equipment and supplies, prosthetic and orthotic devices related directly to the treatment of an Illness or Injury	Plan pays 80% of EME and you pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 60% of EME and you pay balance of billed charges. 40% of EME will be applied toward Maximum Coinsurance.
Orthotic devices for the feet limited to \$200 per Claimant per Contract Year	Plan pays 100% of EME.	After Deductible, Plan pays 80% of EME and You pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Emergency Department (Including Professional Services)

	Participating Provider	Nonparticipating Provider
For treatment of an Emergency Medical Condition	After Copayment, Plan pays 100% of EME.	After Copayment, Plan pays 100% of EME and you pay balance of billed charges

Home Health Care

	Participating Provider	Nonparticipating Provider
	After Copayment, Plan pays 100% of EME.	After Deductible, Plan pays 80% of EME and you pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Home Infusion Therapy Services

	Participating Provider	Nonparticipating Provider
Medically Necessary Home Infusion Therapy Services unlimited when Medically Necessary	After Copayment, Plan pays 100% of EME.	After Deductible, Plan pays 80% of EME and you pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.
Total Parenteral Nutrition limited to \$1,000 per Claimant per Contract Year		
Growth Hormones limited to \$8,000 per Claimant per Lifetime	Plan pays 80% of EME and you pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 80% of EME and you pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Hospice Care

	Participating Provider	Nonparticipating Provider
Specified services and supplies for a terminally ill Claimant	After Copayment, Plan pays 100% of EME.	After Deductible, Plan pays 80% of EME and you pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Hospital Inpatient Care (Including Professional Services)

	Participating Provider	Nonparticipating Provider
Semiprivate room Medical/surgical care Intensive/coronary care unit Medically Necessary Hospital services and supplies	After Copayment, Plan pays 80% of EME and you pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 60% of EME and you pay balance of billed charges. 40% of EME will be applied toward Maximum Coinsurance.
Unlimited days when Medically Necessary		

Hospital Outpatient and Ambulatory Service Facility Care (Including Professional Services)

	Participating Provider	Nonparticipating Provider
Outpatient surgery Radiation and Chemotherapy Preadmission Testing Diagnostic x-ray and laboratory	Plan pays 80% of EME and you pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 60% of EME and you pay balance of billed charges. 40% of EME will be applied toward Maximum Coinsurance.
Major Diagnostic Testing	After Copayment, Plan pays 100% of EME.	After Deductible, Plan pays 80% of EME and you pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Inpatient Rehabilitation Services (Including Professional Services)

	Participating Provider	Nonparticipating Provider
Semiprivate room	After Copayment, Plan pays 80% of EME and you pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 60% of EME and you pay balance of billed charges. 40% of EME will be applied toward Maximum Coinsurance.
Limited to 40 days per Claimant per Contract Year (this limit may be increased when approved in advance by the Claims Administrator for certain conditions such as a head or spinal cord Injury, or for treatment of a stroke to a maximum of 60 days per Claimant per Contract Year)		

Limited Covered Services

	Participating Provider	Nonparticipating Provider
Specified services and supplies for a Limited Covered Service as detailed in the Plan:	After Copayment, Plan pays 100% of EME.	After Deductible, Plan pays 80% of EME and you pay balance of billed charges. 20% of EME does not apply toward Maximum Coinsurance.
Primary Infertility treatment limited to \$1,500 per Claimant per Contract Year not to exceed \$5,000 per Claimant Lifetime		
Diagnosis and treatment of Temporomandibular Joint (TMJ) Dysfunction limited to \$500 per Enrollee per Lifetime	Plan pays 50% of EME and you pay 50% of EME. 50% of EME does not apply toward Maximum Coinsurance.	After Deductible, Plan pays 50% of EME and you pay balance of billed charges. 50% of EME does not apply toward Maximum Coinsurance.

Maternity Care

Covered Services for maternity care are the same as any other illness. The Copayment for office or clinic care in connection with maternity care applies to the first visit only.

Office or Clinic Care

	Participating Provider	Nonparticipating Provider
Office or clinic care for the treatment of an illness or Injury	After Copayment, Plan pays 100% of EME.	After Deductible, Plan pays 80% of EME and you pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.
		Note: See the Additional Accidental Injury/Life-Threatening Illness Benefit to determine if a Copayment applies.

Outpatient Rehabilitation Services

Participating Provider

Nonparticipating Provider

Limited to 30 visits per Claimant per Contract Year

After Copayment, Plan pays 100% of EME.

After Deductible, Plan pays 80% of EME and you pay balance of billed charges. 20% of EME will be applied toward Maximum Coinsurance.

Preventive Care Services

	Participating Provider	Nonparticipating Provider
Services for children and adults, including specified immunizations	After Copayment, Plan pays 100% of EME.	Not a Covered Service
Annual Vision & Hearing Examination		

Professional Provider Services (Not Specifically Included With Other Benefits)

	Participating Provider	Nonparticipating Provider
Professional services in connection with all other professional care not otherwise specified	After Copayment, Plan pays 80% of EME and you pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 60% of EME and you pay balance of billed charges. 40% of EME will be applied toward Maximum Coinsurance.

Skilled Nursing Facility (SNF) Care (Including Professional Services)

	Participating Provider	Nonparticipating Provider
Semiprivate room Medically Necessary SNF services and supplies	Plan pays 80% of EME and you pay 20% of EME. 20% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 60% of EME and you pay balance of billed charges. 40% of EME will be applied toward Maximum Coinsurance.
Limited to 60 visits per Claimant per Contract Year		

Transplants

The Plan covers Medically Necessary services provided in connection with those transplants that are listed as a Covered Service the same as any other Illness or Injury. Please refer to Transplants in the COVERED SERVICES Section for more details.

Contract Year Maximum Coinsurance

Services provided by Participating Providers:

Per Claimant	\$1,500
Per Family Unit	\$3,000

The Maximum Coinsurance for a Contract Year will cease to apply to all Claimants in the Family Unit when the amounts applied to some or all Claimants' per Claimant Maximum Coinsurance for that Contract Year total the specified Family Unit Maximum Coinsurance

The Maximum Coinsurance can be met by payments of 20% Coinsurance for Participating Provider services, but not by payments for non-covered services, Coinsurance for Nonparticipating Provider services, 50% Coinsurance for Limited Covered Services, Mental Health Condition Services, Copayments, or by any other payments made by the Claimant. Coinsurance amounts that do not apply

toward Maximum Coinsurance continue to be charged even after the Maximum Coinsurance has been reached.

All other Covered Services provided by Nonparticipating Providers:

Per Claimant	\$2,000
Per Family Unit	\$4,000

The Maximum Coinsurance for a Contract Year will cease to apply to all Claimants in the Family Unit when the amounts applied to some or all Claimants' per Claimant Maximum Coinsurance for that Contract Year total the specified Family Unit Maximum Coinsurance

The Maximum Coinsurance can be met by payments of 20% and 40% Coinsurance for Nonparticipating Provider services, but not by payments for non-covered services, Coinsurance for Participating Provider services, 20% and 50% Coinsurance for Limited Covered Services, Mental Health Condition Services, Deductible, Copayments, or by any other payments made by the Claimant. Coinsurance amounts that do not apply toward Maximum Coinsurance continue to be charged even after the Maximum Coinsurance has been reached.

Additional Accidental Injury/Life-Threatening Illness Benefit

When initial treatment is sought within 48 hours after an Accidental Injury or within 2 hours of the onset of a Life-Threatening Illness, the Plan will waive the Deductible and pay Covered Services at 100% of EME for 12 months (unless delay in treatment is preauthorized due to Medical Necessity) for an Accidental Injury or for 72 hours for a Life-Threatening Illness. The following Copayments will apply to both Participating and Nonparticipating Providers:

\$150 per visit to a Hospital emergency department. This Copayment is waived when admitted.

\$20 per visit to a Physician's or Practitioner's office or clinic.

SUMMARY OF MENTAL HEALTH BENEFITS

Any amount you pay toward the Deductible, Copayment or Maximum Coinsurance under this MENTAL HEALTH BENEFITS Section does not apply toward any Deductible, Copayment or Maximum Coinsurance amount(s) as applicable in the Summary Plan Description to which this MENTAL HEALTH BENEFITS Section is attached.

Contract Year Deductible

Mental Health Condition Services provided by Nonparticipating Providers:

Per Claimant	\$200
Per Family Unit	\$400

Deductibles for a Contract Year will cease to apply to all Claimants in the Family Unit when the amounts applied to some or all Claimants' per Claimant Deductible for that Contract Year total the specified Family Unit Deductible

Copayments

You are responsible to pay the following Copayment amounts **for services provided by Participating Providers:**

\$175 per admission to a Hospital. When a Claimant is readmitted to a Hospital for the same Illness or Injury within 7 days after discharge, the Copayment for the readmission will be waived.

\$20 per visit to a Physician's or Practitioner's office or clinic or for each house visit made by a Physician or Practitioner.

Percentage We Pay For Covered Mental Health Services (Listed In The Following Paragraph)

After any Deductible and/or Copayment is satisfied, benefits are paid as follows:

Participating Provider

We pay benefits for Covered Mental Health Services of a Participating Provider at the percentage listed. For Covered Mental Health Services provided by a Participating Provider, You pay only the Copayment and/or Coinsurance.

Nonparticipating Provider

We pay benefits for Covered Mental Health Services of a Nonparticipating Provider at the percentage listed. For Covered Mental Health Services provided by a Nonparticipating Provider, in addition to the Deductible and/or Coinsurance, **You pay the difference between billed charges and Eligible Medical Expenses (the "balance of billed charges").**

NOTE: All payments for Covered Mental Health Services as detailed in the following summary are based upon Eligible Medical Expenses, expressed as "EME." EME may differ based on the type of Provider rendering services and whether they are Participating or Nonparticipating with the Plan.

Mental Health Condition Services (Including Drug or Alcohol Use or Abuse)

	Participating Provider	Nonparticipating Provider
Inpatient and outpatient care	After Copayment, Plan pays 50% of EME and You pay 50% of EME. 50% of EME will be applied toward Maximum Coinsurance.	After Deductible, Plan pays 50% of EME and You pay balance of billed charges. 50% of EME will be applied toward Maximum Coinsurance.

Contract Year Maximum Coinsurance

Mental Health Condition Services provided by Participating Providers:

Per Claimant	\$1,500
Per Family Unit	\$3,000

The Maximum Coinsurance for a Contract Year will cease to apply to all Claimants in the Family Unit when the amounts applied to some or all Claimants' per Claimant Maximum Coinsurance for that Contract Year total the specified Family Unit Maximum Coinsurance

The Maximum Coinsurance can be met by payments of 50% Coinsurance for Participating Provider Mental Health Condition services, but not by payments for non-covered services, Coinsurance for Nonparticipating Provider Mental Health Condition services, Copayments, or by any other payments made by the Claimant. Coinsurance amounts that do not apply toward Maximum Coinsurance continue to be charged even after the Maximum Coinsurance has been reached.

Mental Health Condition Services provided by Nonparticipating Providers:

Per Claimant	\$2,000
Per Family Unit	\$4,000

The Maximum Coinsurance for a Contract Year will cease to apply to all Claimants in the Family Unit when the amounts applied to some or all Claimants' per Claimant Maximum Coinsurance for that Contract Year total the specified Family Unit Maximum Coinsurance

The Maximum Coinsurance can be met by payments of 50% Coinsurance for Nonparticipating Provider Mental Health Condition services, but not by payments for non-covered services, Coinsurance for Participating Provider Mental Health Condition services, Deductible, or by any other payments made by the Claimant. Coinsurance amounts that do not apply toward Maximum Coinsurance continue to be charged even after the Maximum Coinsurance has been reached.

SUMMARY OF PRESCRIPTION DRUG BENEFITS - TYPE SN3

Maximum Benefits

The benefits of this COVERED PRESCRIPTION DRUG BENEFITS Section are limited to the Maximum Benefit amount specified in the SUMMARY OF MEDICAL BENEFITS Section.

Contract Year Deductible

Per Claimant	\$50
Per Family Unit	3

Deductible does not apply to:

- Generic Prescription Drugs or Prescription Drugs filled through the Mail Order Program

Deductibles for a Contract Year will cease to apply to all Claimants in the Family Unit when this number of Claimants have satisfied their full per Claimant Deductible for that Contract Year

Any amount you pay toward the Deductible under this COVERED PRESCRIPTION DRUG BENEFITS Section does not apply toward any Deductible amount as applicable in the Summary Plan Description to which this COVERED PRESCRIPTION DRUG BENEFITS Section is attached.

Copayments

After any Deductible is satisfied, you are responsible to pay the following Copayment amounts (for the amount normally prescribed by your Physician, but not more than a 34-day supply or 100 unit doses, whichever is greater):

\$7 for each Prescription Drug Unit of a generic Prescription Drug from a retail Pharmacy

\$25 for each Prescription Drug Unit of a name brand Prescription Drug which is listed in the formulary from a retail Pharmacy

\$50 for each Prescription Drug Unit of a name brand Prescription Drug which is not listed in the formulary from a retail Pharmacy

\$7 for each 90-day supply of a generic Prescription Drug through the Mail Order Program

\$25 for each 90-day supply of a name brand Prescription Drug which is listed in the formulary through the Mail Order Program

\$50 for each 90-day supply of a name brand Prescription Drug which is not listed in the formulary through the Mail Order Program

20% of eligible expenses for diabetic and insulin pump supplies

These Copayments do not apply toward Deductible, Copayment and/or Coinsurance amounts required in the SUMMARY OF MEDICAL BENEFITS Section.

SUMMARY OF DENTAL BENEFITS - TYPE AQ9

Maximum Benefits

Preventive and Diagnostic, Basic and Prosthodontic Dental Services:	
Per Claimant each Contract Year	\$1,500
Orthodontic Dental Services:	
Per Claimant each Contract Year	\$500
Per Claimant Lifetime	\$1,000

Contract Year Deductible

Not applicable

Percentage Plan Pays For Covered Services (Listed In The Following Paragraphs)

Benefits are paid as follows:

Participating Dentist

The Plan pays benefits for Covered Services of a Participating Dentist at the percentage listed. For Covered Services provided by a Participating Dentist, you pay only the Coinsurance.

Nonparticipating Dentist

The Plan pays benefits for Covered Services of a Nonparticipating Dentist at the percentage listed. For Covered Services provided by a Nonparticipating Dentist, in addition to the Coinsurance, ***you pay the difference between billed charges and Eligible Dental Expenses (the "balance of billed charges").***

NOTE: All payments for Covered Services as detailed in the following summary are based upon Eligible Dental Expenses, expressed as "EDE." EDE may differ based on the type of Provider rendering services and whether they are Participating or Nonparticipating with Us.

Basic Dental Services

Participating Dentist	Nonparticipating Dentist
Plan pays 80% of EDE and you pay 20% of EDE.	Plan pays 80% of EDE and you pay balance of billed charges.

Orthodontic Dental Services

	Participating Dentist	Nonparticipating Dentist
For Claimants under 26 years of age	Plan pays 50% of EDE and you pay 50% of EDE.	Plan pays 50% of EDE and you pay balance of billed charges.

Preventive and Diagnostic Dental Services**Participating Dentist**

Plan pays 80% of EDE and you pay 20% of EDE.

Nonparticipating Dentist

Plan pays 80% of EDE and you pay balance of billed charges.

Prosthodontic Dental Services**Participating Dentist**

Plan pays 50% of EDE and you pay 50% of EDE.

Nonparticipating Dentist

Plan pays 50% of EDE and you pay balance of billed charges.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employee Assistance Program (EAP) is offered through Reliant Behavioral Health (RBH or Reliant), an independent company. Coverage provided through the EAP is not subject to and does not apply toward the Mental Health benefits otherwise available under the Plan.

The following services are provided:

- Up to 4 visits per incident free of charge for employees and covered dependents for personal problems such as stress, family or marital problems, finances, parenting, alcohol or drugs;
- 24-hour crisis assistance;
- supervisor referral services; and
- educational services.

To access the EAP or for 24-hour crisis assistance, please call 1-866-750-6327.

SPECIAL BEGINNINGS® PROGRAM

Special Beginnings® is a confidential maternity monitoring program administered by registered nurses dedicated to helping make every member's pregnancy a healthy experience.

The expectant mother may be contacted by one of the Special Beginnings® nurses to participate in the program, or she may call Special Beginnings® at any time up to her 36th week of pregnancy. A nurse will ask a series of confidential questions during a short telephone call to screen and evaluate the potential for high-risk pregnancy. For example, an expectant mother will be asked questions about her family and medical history, daily schedule, eating habits or other behaviors that may affect the outcome of her pregnancy. The nurse will also provide basic educational information that emphasizes the importance of proper medical care and physical health during pregnancy.

Each expectant mother will be mailed individually-tailored educational materials from nationally-recognized organizations, will receive a book about pregnancy (mothers may choose from five books by well-known authors), and will receive a gift certificate upon completion of the program. A specific nurse will be assigned to follow the mother's progress throughout the pregnancy. The Special Beginnings® nurse will also contact the mother's physician to encourage communication and exchange of information.

An important feature of the program is that the information a mother shares will not be given to the Group, her family or anyone else who is not directly involved in her medical care. It is also helpful for her to share as much information as possible with her assigned nurse. The more the nurse knows, the more she will be able to tailor the monitoring program to meet each mother's individual needs.

As an additional benefit, expectant mothers will also have access to a toll-free nurse help line that is available 24-hours per day, 7 days per week.

To participate in the Special Beginnings® program or for 24-hour nurse access, please call 1-800-228-8263.

BENEFITS

This Plan is a comprehensive major medical benefit plan. Under a comprehensive major medical plan, the Plan pays benefits at a percentage of the Eligible Medical Expenses for Covered Services.

The other key points about how the coverage under the Plan works, such as how Deductibles and Copayments (if any) work, and how Covered Services are paid are explained in the following sections.

MAXIMUM BENEFITS

The Plan pays a portion of Eligible Medical Expenses after any applicable Deductible and/or Copayment amount up to the Maximum Benefit amount shown in the SUMMARY OF BENEFITS for each Claimant. The Maximum Benefit amount includes amounts paid for benefits provided under this Plan and earlier Plans issued by the Employer. When a Claimant's benefits cumulatively total the Maximum Benefit amount, the Plan and all coverage under it will terminate with respect to that Claimant. In addition, benefits under the Plan may be limited to Maximum Benefits for specified Covered Services. For specified Covered Services, payments are made as indicated until the Maximum Benefit applicable to a specified Covered Service has been provided. Maximum Benefits for specified Covered Services apply toward the cumulative Maximum Benefit amount. Any benefit payments that were made on your or your covered dependents behalf under the College's previous health plan, will be applied toward the Maximum Benefit amount of this Plan.

DEDUCTIBLES

The amount of the Deductible is shown in the SUMMARY OF BENEFITS. The Plan will not begin to pay benefits for Covered Services in any Contract Year until the Deductible amount is satisfied.

COPAYMENTS

After the Deductible is satisfied, some of the Covered Services of the Plan may be subject to a Copayment (a fixed dollar amount) which must be paid to the Provider at the time a service or supply is received. Refer to the SUMMARY OF BENEFITS to see if a particular service or supply is subject to a Copayment.

PERCENTAGE PAID UNDER THE PLAN

Once any applicable Deductible and/or Copayment amount is satisfied, the Plan pays a percentage of the Eligible Medical Expenses for Covered Services you or your covered dependents receive under the Plan, up to the maximum shown in the SUMMARY OF BENEFITS. See the DEFINITIONS Section for a detailed description of what is meant by Eligible Medical Expenses. When the Plan payment is less than 100%, the remaining percentage is your Coinsurance. The percentage the Plan pays varies, depending on the kind of service or supply and who rendered it. Refer to the SUMMARY OF BENEFITS for a description of percentages paid, cost-sharing, and Maximum Coinsurance.

Charges in excess of Eligible Medical Expenses are not reimbursable under the Plan. However, Participating Providers will not charge you for any balances beyond any Deductible, Copayment, and/or Coinsurance amount for Covered Services. Nonparticipating Providers, however, may bill you for any

balances over the Plan payment level in addition to any Deductible, Copayment, and/or Coinsurance amount.

MAXIMUM COINSURANCE

When a Claimant has met the Maximum Coinsurance for the year, no further Coinsurance is charged for the remainder of the year for most types of Covered Services received by the Claimant. When the Family Unit has met the Maximum Coinsurance for the year, no further Coinsurance is charged for the remainder of the year for most types of Covered Services received by the Family Unit. The types of Covered Services or Coinsurance amounts which do not apply toward the Maximum Coinsurance and which continue to be charged after the Maximum Coinsurance has been met are shown in the SUMMARY OF BENEFITS.

ADDITIONAL ACCIDENTAL INJURY/LIFE-THREATENING ILLNESS BENEFIT

When you or your covered dependents are treated for an Accidental Injury or Life-Threatening Illness, payments will be provided to you as outlined in the SUMMARY OF BENEFITS for each separate incident of Accidental Injury or Life-Threatening Illness. No Deductible or Coinsurance will be required for Covered Services received as a result of an Accidental Injury or Life-Threatening Illness when services are received within the time frame outlined below:

- Covered Services when the initial Eligible Medical Expenses are incurred within 48 hours after an Accidental Injury, subject to any Copayments and limitations shown in the SUMMARY OF BENEFITS. Benefits under this special provision of the Plan do not apply to care or treatment received more than 12 months after the date of the Accidental Injury (unless delay in treatment is preauthorized due to Medical Necessity); care or treatment of pregnancy; care or treatment of Injuries resulting from routine or normal body movements such as stooping, bending, twisting, or chewing; care or treatment of Injuries not demonstrable by visual palpation or x-ray.

NOTE: A re-injury which causes the original Injury to recur or become more severe is not considered a separate incident of Accidental Injury.

- Covered Services for which Eligible Medical Expenses are incurred within 72 hours after the onset of a Life-Threatening Illness subject to any Copayments and limitations shown in the SUMMARY OF BENEFITS; provided, however, that initial treatment for the Life-Threatening Illness commences within 2 hours of the onset of symptoms and Covered Services are received by you or your covered dependents at the nearest facility equipped to treat the condition.

ADOPTION BENEFIT

An Adoption Benefit will be available to the Plan Participant when all of the following conditions are met:

- Coverage is in effect on the date a newborn child is placed for the purpose of adoption.
- A newborn child is placed for the purpose of adoption with the Plan Participant within 90 days after the child's birth and the date of placement is on or after the Plan Participant's Effective Date.
- The Plan 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 (e.g., 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
PO Box 30270
Salt Lake City, Utah 84130-0270

The Adoption Benefit is subject to the same cost-sharing provisions as maternity benefits provided under this Plan (e.g., Deductibles, Copayment and/or Coinsurance, and Maximum Coinsurance) and will not exceed \$4,000 per pregnancy.

In the event of the adoption of more than one newborn from a single pregnancy (for example, twins), the Adoption Benefit applies only to the pregnancy and not to each child adopted as a result of the pregnancy.

In the event the Plan Participant and/or the Plan Participant's spouse is covered by more than one compliant health benefit plan, the Adoption Benefit will be pro-rated between or among the plans so that the full amount provided by both or all of the plans does not exceed \$4,000 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 Plan Participant will be liable for re-payments of the Adoption Benefit. The full amount of such benefit will be refunded by the Plan Participant to the Plan, upon request, within 30 days after the date the child is removed from placement.

WOMEN'S HEALTH AND CANCER RIGHTS

If you or your covered dependents are receiving benefits in connection with a mastectomy and, in consultation with the attending Physician, elect breast reconstruction, the Plan will provide coverage 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.

Reconstruction benefits are subject to the same provisions as any other benefit provided under this Plan (e.g., Deductibles, Copayment and/or Coinsurance, and Maximum Coinsurance).

COVERED MEDICAL SERVICES

The following sections describe the Covered Services under the Plan.

Except for any covered preventive care, the services and supplies you or your covered dependents receive must be Medically Necessary for the treatment of an Illness or Injury in order to be considered a Covered Service. See the DEFINITIONS Section for a description of Medically Necessary.

AMBULANCE SERVICES

The Plan covers ambulance services to the nearest appropriate Hospital when any other form of transportation is inadvisable.

Specific Limitations and Exclusions

The Plan does not cover the following ambulance services:

- ambulance services when the patient could be safely transported by means other than ambulance, whether or not such other transportation is available; and
- air ambulance services when the patient could be safely transported by ground ambulance or by means other than ambulance.

CHIROPRACTIC CARE

The Plan covers chiropractic manipulative treatment (except for reduction of fractures and dislocations otherwise defined as surgical services) for treatment of an Illness or Injury. To be a Covered Service, chiropractic care must be due to an Illness or Injury with an identifiable onset and conclusion.

DENTAL CARE

The Plan covers Dental Services required as a result of damage to or loss of sound natural teeth due to an Accidental Injury (other than from chewing).

DURABLE MEDICAL EQUIPMENT AND SUPPLIES, PROSTHETIC AND ORTHOTIC DEVICES

The Plan covers Durable Medical Equipment, supplies, prosthetic and orthotic devices when ordered by the attending Provider in connection with an Illness or Injury as follows:

Supplies

Medical and surgical supplies including colostomy bags, catheters, surgical dressings, and syringes/needles for injection of prescribed medication. Diabetic supplies, including but not limited to lancets, swabs, syringes (hypodermic needles), diabetic testing strips and insulin pump supplies including tubing, dressings, infusion reservoirs, and power kits (batteries).

Prosthetic devices

Prosthetic devices including artificial limbs, artificial eyes, breast prostheses, and eyeglasses or contact lenses required as replacements of natural lenses surgically removed (cataract surgery). This includes

the professional services for fitting, adjusting, and repairing prosthetic devices and replacements together with professional services related to replacement.

Orthotic devices

Orthotic devices including braces, trusses, and other orthopedic appliances or apparatuses used to support, align, or correct deformities or to improve the function of moving parts of the body. This also includes the professional services for fitting, adjusting, and repairing prosthetic devices and replacements together with professional services related to replacement.

Durable Medical Equipment

Durable Medical Equipment means medical equipment that is all of the following:

- intended only for the patient's use and benefit in the care and treatment of an illness or injury; and
- durable and usable over an extended period of time; and
- used primarily and customarily for a medical purpose, rather than for convenience or comfort; and
- prescribed for the patient by the attending Physician or Practitioner.

Durable Medical Equipment includes crutches, wheelchairs, hospital-type beds, insulin pumps, and similar equipment.

NOTE: Any Maximum Benefit for Durable Medical Equipment indicated in the SUMMARY OF MEDICAL BENEFITS does not apply to any Durable Medical Equipment used in the treatment of diabetes or breast cancer.

Specific Limitations and Exclusions

The Plan does not cover the following Durable Medical Equipment, supplies, prosthetic or orthotic devices:

- devices to increase vertical dimensions or restore occlusion;
- corrective shoes unless they are an integral part of a lower body brace, foot orthotics (other than Medically Necessary foot orthotics), arch supports, and special shoe accessories;
- wigs, hairpieces, cosmetics, and other items of a similar nature;
- replacements required as a result of loss, theft, negligence, or of willful damage and replacements when the device being replaced is one that would continue to meet the patient's basic medical needs;
- air conditioners, air filtration units, humidifiers, vaporizers, hydrotherapy devices, water spas, exercise equipment and machines, communication devices, heating pads, lamps or other devices containing heating elements, contour chairs, vibrating chairs and beds, and other items which do not qualify as Durable Medical Equipment;
- modifications to vehicles or places of residence; and
- deluxe equipment when standard equipment is adequate to meet the patient's basic medical needs.

NOTE: Eligible Medical Expenses will be limited to the lesser of the purchase price or the rental cost of Durable Medical Equipment.

NOTE: When a custom or deluxe prosthetic device, orthotic device or piece of Durable Medical Equipment is prescribed for a condition for which a standard prosthetic device, orthotic device or piece of Durable Medical Equipment is Medically Necessary as determined by the Plan, the Eligible Medical Expenses for a standard prosthetic device, orthotic device or piece of Durable

Medical Equipment will be allowed toward the cost of the custom or deluxe prosthetic device, orthotic device or Durable Medical Equipment.

EMERGENCY DEPARTMENT

The Plan covers services in a Hospital's emergency department when due to an Emergency Medical Condition.

HOME HEALTH CARE

Home health care includes all professional services, technical and ancillary medical services, health aide services, and medical supplies and equipment which would be covered if the patient were a bed-patient in a Hospital or Skilled Nursing Facility. The Plan covers services provided in the home by a licensed community Home Health Care Agency or an approved Hospital program for home health care when the patient is essentially homebound for medical reasons, is physically unable to obtain necessary medical care on an outpatient basis and has a condition which requires the services of a licensed health care Provider, and is under the care of a Physician as follows:

- professional skilled nursing services of a registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN);
- physical therapy, speech therapy, and occupational therapy (but not maintenance therapy) by a duly licensed therapist and one medical social service consultation;
- health aide services furnished to the patient while receiving skilled nursing services or therapy specified above;
- medical and surgical supplies which are customarily furnished by the Home Health Care Agency or program for its patients, including oxygen and its administration; and
- prescribed drugs furnished by the Home Health Care Agency or program. The administration of such drugs must require the professional skills of a nurse (RN, LPN or LVN) at the time the patient is receiving nursing services specified above and does not include prescribed drugs that can be self-administered or administered by a non-professional caretaker.

HOME INFUSION THERAPY SERVICES

The Plan covers home infusion therapy services 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 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: 1) training the patient and/or alternative care giver; 2) the administration of therapy; and 3) monitoring the intravenous therapy regimen;
- medical and 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

Hospice care includes palliative care and treatment of a patient with a life expectancy of 6 months or less, where the unit of care is the entire family and the focus of the interdisciplinary team is the acknowledgement of death, dealing with it in both its physical and psychological aspects. When provided prior to the death of the patient and in place of all other benefits, the Plan covers services provided by a hospice or other facility under the direction of a hospice during a Hospice Benefit Period as follows:

- inpatient hospice care (i.e., respite care);
- Physician services;
- home health services;
- emotional support services;
- homemaker services; and
- prescription drugs and medications furnished by the hospice program. 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.

NOTE: Hospice Benefit Period means a benefit period which begins on the date the attending Physician certifies in writing to the Plan that a Claimant is terminally ill and ends at the earlier of the death of the terminally ill Claimant or 6 months after the date of the attending Physician's certification; provided, however, that if the Claimant is living at the end of the 6 month period, a new 6 month period may begin when the attending Physician certifies in writing to the Plan that the Claimant is still terminally ill.

HOSPITAL INPATIENT CARE

Accommodations

The Plan covers the following accommodations (including bed, board and general nursing care) during an admission to a Hospital for acute care or intensive care:

- semi-private (or multi-bed unit) room; or
- private room accommodations, but only when a severe medical condition requires the patient be placed in a private room, or the Hospital furnishes private rooms as the principal room accommodations for its patients.

NOTE: The semi-private room rate will be allowed toward the private room rate when the patient receives private room accommodations for reasons other than those specified above.

- intensive care unit (including cardiac care unit), special nursing care and ICU equipment.

Services and Supplies

The Plan covers the following services and supplies as customarily furnished to patients by a Hospital:

- operating, recovery, and treatment rooms and delivery and labor rooms and their equipment;
- anesthesia materials and anesthesia administration by facility personnel;
- diagnostic and therapeutic radiological (x-ray), including radiation therapy, clinical pathology and laboratory, electrocardiograms, electroencephalograms, and other electronic diagnostic medical procedures required to diagnose an illness, injury, or other condition;

- drugs and medicines which have been approved for use in the United States by the United States Food and Drug Administration and intravenous injections and solutions;
- dressings, splints, casts, and other supplies for medical treatment provided by the facility from a central sterile supply department as well as devices or appliances surgically inserted into the body;
- oxygen and its administration and non-replaced blood, blood plasma, blood derivatives, and their administration and processing; and
- inhalation therapy.

Specific Limitations and Exclusions

The Plan does not cover the following in connection with Hospital inpatient care:

- inpatient comprehensive and/or multidisciplinary pain management programs; and
- vocational rehabilitation services, private duty nursing services, personal convenience or hygiene items, and late discharge billing for the convenience of the patient.

HOSPITAL OUTPATIENT AND AMBULATORY SERVICE FACILITY CARE

Services and Supplies

The Plan covers the following services and supplies as customarily furnished to patients by a Hospital or Ambulatory Service Facility:

- operating, recovery, and treatment rooms and delivery and labor rooms and their equipment;
- anesthesia materials and anesthesia administration by facility personnel;
- diagnostic and therapeutic radiological (x-ray), clinical pathology and laboratory, electrocardiograms, electroencephalograms, and other electronic diagnostic medical procedures required to diagnose an illness, injury, or other condition;
- dialysis treatment, respiration therapy, radiation and chemotherapy, other than Myeloablative Therapy;
- drugs and medicines which have been approved for use in the United States by the United States Food and Drug Administration and intravenous injections and solutions;
- dressings, splints, casts, and other supplies for medical treatment provided by the facility from a central sterile supply department as well as devices or appliances surgically inserted into the body;
- oxygen and its administration and non-replaced blood, blood plasma, blood derivatives, and their administration and processing; and
- inhalation therapy.

INPATIENT REHABILITATION SERVICES

The Plan covers inpatient rehabilitation services received in a Hospital, Skilled Nursing Facility or Rehabilitation Facility when part of an active rehabilitation program consisting of treatment directed toward the restoration of normal form and function after Injury or Illness. An acute condition must have stabilized to a level so that occupational therapy, physical therapy and/or speech therapy can be started with a realistically attainable goal for the patient.

Accommodations

The Plan covers the following accommodations (including bed, board and general nursing care) during an admission to a Hospital, Skilled Nursing Facility or Rehabilitation Facility for inpatient rehabilitation services:

- semi-private (or multi-bed unit) room.

Services and Supplies

In addition to the same services and supplies that would customarily be furnished to patients by a Hospital or Skilled Nursing Facility, the Plan also covers the following services when provided to the patient during an admission for inpatient rehabilitation:

- occupational therapy, which is treatment to restore or improve functions impaired by Illness or Injury and to improve a Claimant's ability to satisfactorily accomplish daily living tasks;
- physical therapy, which is remedial treatment of an Injury or Illness by means of therapeutic massage and exercise, heat, light, and sound waves, electrical stimulation, hydrotherapy and manual traction; and
- speech therapy, which is treatment for the correction of a speech, voice or language impairment resulting from Illness, Injury, birth defect or previous therapeutic process.

Specific Limitations and Exclusions

The Plan does not cover the following in connection with inpatient rehabilitation services:

- vocational rehabilitation services, private duty nursing services, personal convenience or hygiene items, and late discharge billing for the convenience of the patient; and
- physical therapy, speech therapy and occupational therapy provided solely to maintain the Claimant's condition at the level to which it has been restored with no expectation of significant improvement.

LIMITED COVERED SERVICES

The Plan covers the following specified services and supplies as a Limited Covered Service;

Primary Infertility

The Plan covers treatment of Primary Infertility. Primary Infertility means a condition where a person has never been able to conceive a child.

Temporomandibular Joint (TMJ) Dysfunction

The Plan covers the following in regards to the diagnosis and treatment of Temporomandibular joint (TMJ) dysfunction:

- medical and surgical services in connection with temporomandibular joint dysfunction; and
- devices in connection with temporomandibular joint dysfunction.

Specific Limitations and Exclusions

The Plan does not cover the following limited benefits:

- treatment of Secondary Infertility. Secondary Infertility means a condition where a person has been able to conceive at least once; and

- any limited benefit in excess of the specified Maximum Benefit as indicated in the SUMMARY OF BENEFITS Section.

MATERNITY CARE

The Plan covers maternity (pregnancy) care, childbirth and related conditions and/or complications for all Claimants the same as any other Illness including:

- Hospital services and supplies, Ambulatory Service Facility services and supplies;
- medical services, surgical services and anesthesia services;
- diagnostic radiological and pathological laboratory services for antepartum and postpartum care;
- delivery (vaginal or cesarean) threatened premature termination of pregnancy and premature termination of pregnancy; and
- routine nursery care of the newborn.

To the extent the Plan provides coverage for maternity care, the Plan will not limit benefits for the mother and her newborn's length of inpatient stay to less than 48 hours for a vaginal delivery and 96 hours for a cesarean section. However, the attending Physician, in consultation with the mother may decide on an early discharge. Such hospitalization does not need to follow the provisions of the Care Management Program.

MENTAL HEALTH CONDITION SERVICES (INCLUDING DRUG OR ALCOHOL USE OR ABUSE)

See the SUMMARY OF MENTAL HEALTH BENEFITS and COVERED MENTAL HEALTH BENEFITS Sections for information on Mental Health Condition Services.

OFFICE OR CLINIC CARE

The Plan covers professional services by a Physician or Practitioner which are generally recognized and accepted procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury as follows:

- direct physical or mental examination of the patient, patient's body or substance(s) from the body, and associated cognitive services for prescribing or administering treatment, but not counseling or patient education unless provided at no additional charge;
- diagnostic services which are radiology, ultrasound, nuclear medicine, laboratory, pathology, and electronic diagnostic medical procedures; and
- other Covered Services when received as appropriate in an office or clinic but which may be specified elsewhere, including but not limited to Medical Services, Surgical Services and Consultations listed under Professional Services.

OUTPATIENT REHABILITATION SERVICES

The Plan covers rehabilitative services by a Physician or Practitioner for treatment of an Illness or Injury when received in an office, clinic or Hospital on an outpatient basis. Covered Services include only the following:

- physical therapy and occupational therapy when provided to restore or improve bodily function lost as a result of Illness or Injury; and

- speech therapy when provided to restore or improve speech function lost as a result of Illness or Injury. Additionally, the Plan covers speech therapy services for Claimants through age 12 when provided to restore or improve speech function resulting from congenital anomalies or a medical condition.

Specific Limitations and Exclusions

The Plan does not cover the following rehabilitative services:

- physical therapy, speech therapy and occupational therapy provided solely to maintain the Claimant's condition at the level to which it has been restored with no expectation of significant improvement; and
- assistance in learning a new language, voice training, or therapy to reduce an accent.

PREVENTIVE CARE SERVICES

Professional Exams

Regardless of Medical Necessity, the Plan covers professional exams by a Physician to assess the Claimant's state of health, including routine diagnostic tests at the time of the exam as follows:

- 5 professional exams per year up to 2 years of age;
- 4 professional exams each year from age 2 through age 5; and
- 1 professional exam each year for a Claimant age 6 and older.

Screening Procedures

The Plan covers screening procedures when appropriate for the Claimant as follows:

- 1 pap smear each year;
- 1 prostate specific antigen (PSA) test each year for a Claimant age 40 or older;
- 1 mammography screening each year for a Claimant age 35 or older;
- annual test of the stool for occult blood for a Claimant age 40 or older;
- 1 bone density scan each year for a Claimant age 40 or older; and
- 1 sigmoidoscopy or colonoscopy each year for a Claimant age 40 or older.

Immunizations

The Plan covers routine and adult immunizations as follows:

- routine immunizations for childhood diseases for a Claimant through age 19.
- the following adult immunizations subject to documentation that the stated criteria are met:
 - 1 annual influenza immunization for each Claimant;
 - pneumovax for a Claimant with chronic Illness or if over age 65;
 - hepatitis B for each adult Claimant;
 - hepatitis A for a Claimant who has been exposed to hepatitis A;
 - rubella for a Claimant with low antibody titer;
 - diphtheria as recommended by the Claimant's Physician;
 - tetanus toxoid as recommended by the Claimant's Physician;
 - varicella if test results are negative for varicella; and

- measles and mumps for a Claimant who has not been previously immunized.

Routine Vision and Hearing Examinations

The Plan covers one routine vision examination and one routine hearing examination for each Claimant each Contract Year.

Specific Limitations and Exclusions

The Plan does not cover the following preventive care services:

- physical examinations required by a third party: for example, employment examinations, examinations for insurance applications, examinations to permit travel outside the United States;
- "wellness" educational materials such as books, pamphlets, audiotapes and video-tapes; except as provided herein;
- mental examinations and psychological tests; and
- examinations, x-rays and laboratory procedures in the absence of presenting signs and symptoms, except preventive care services specified above.

PROFESSIONAL SERVICES

Reimbursement for some professional services may be included with the benefit for the facility services, as applicable. Refer to the SUMMARY OF BENEFITS for determination.

Anesthesia Services

The Plan covers the administration of anesthetics to achieve general or regional (but not local) anesthesia and related resuscitative procedures.

Consultations

The Plan covers the services of a Provider whose opinion or advice is requested by the attending Provider for further evaluation of an Illness or Injury.

Diabetic Education

The Plan covers services for diabetic self-management training and education, including nutritional therapy, when requested by the attending Physician. Services must be provided by an accredited or certified program.

Family Planning

The Plan covers basic evaluative services for family planning, birth control devices, injectable contraceptives and sterilization procedures.

Medical Services

The Plan covers professional services by a Physician or Practitioner which are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury as follows:

- direct physical or mental examination of the patient, patient's body or substance(s) from the body, and associated cognitive services for prescribing or administering treatment, but not counseling or patient education unless provided at no additional charge;

- diagnostic services which are radiology, ultrasound, nuclear medicine, laboratory, pathology, and electronic diagnostic medical procedures;
- non-replaced blood, blood plasma, blood derivatives, and their administration; and
- dialysis treatment, respiration therapy, radiation and chemotherapy, other than Myeloablative Therapy.

Surgical Assistants

The Plan covers the services of an assistant surgeon when performed in connection with a surgical procedure which is a Covered Service.

Surgical Services

The Plan covers surgical services which are generally recognized and accepted procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury as follows:

- cutting or laser operative procedures;
- suturing of wounds and debridement of wounds, burns, or infections;
- reduction of fractures or dislocations and orthopedic casting;
- endoscopic examination of internal organs of the body;
- use of a needle or cannula for biopsy, aspiration, or injection of a tendon sheath, joint, major body cavity, or blood vessel (vein or artery), but not routine venipuncture (drawing blood for laboratory tests is a medical service);
- intraarterial, intravenous, or intracardiac catheterization;
- electrical, chemical, or mechanical destruction of tissue;
- oral surgery, but not dental (teeth and gums) surgery except for surgical extraction of bone impacted teeth; provided, however, that when the Claimant is covered under a dental plan which provides benefits for surgical extraction of bone impacted teeth, benefits are not provided under the Plan.; and
- orthognathic surgery.

Specific Limitations and Exclusions

The Plan does not cover the following professional services:

- services of an assistant surgeon when the Hospital provides or makes available qualified staff personnel (including Physicians in training status) as surgical assistants; services of more than one assistant surgeon at one operative procedure; and services of an assistant surgeon when the complexity of the surgery does not warrant the services of an assistant;
- acupuncture, hypnosis, and administration of anesthesia by the primary or the assistant surgeon other than dental general anesthesia by a dentist or oral surgeon; and
- reversal of voluntary surgical sterilization or subsequent re-sterilization.

SKILLED NURSING FACILITY (SNF) CARE

Accommodations

The Plan covers the following accommodations (including bed, board and general nursing care) during an admission to a Skilled Nursing Facility for extended care:

- semi-private (or multi-bed unit) room.

Services and Supplies

The Plan covers the following services and supplies as customarily furnished to patients by a Skilled Nursing Facility:

- drugs and medicines which have been approved for use in the United States by the United States Food and Drug Administration and intravenous injections and solutions;
- dressings, splints, casts, and other supplies for medical treatment provided by the facility from a central sterile supply department;
- oxygen and its administration; and
- inhalation therapy.

Specific Limitations and Exclusions

The Plan does not cover the following in connection with Skilled Nursing Facility care:

- vocational rehabilitation services, private duty nursing services, personal convenience or hygiene items, and late discharge billing for the convenience of the patient.

TRANSPLANTS

The Plan covers the following transplant procedures when Medically Necessary and **only** when the provisions of the Care Management Program have been followed before services are received (the prenotification provision of the Care Management Program does not apply to kidney and cornea transplants).

Solid Organ and Bone Marrow Transplants

Covered Solid Organ Transplants

The Plan covers only the following solid organ transplants:

- kidney;
- cornea;
- small bowel;
- heart;
- heart/lung;
- lung (single or double);
- liver; and
- pancreas.

Services and Supplies for Solid Organ Transplants

The Plan covers services and supplies directly related to covered solid organ transplants as follows:

- Organ Procurement Expenses which means those diagnostic or medical services to evaluate, select, store, identify or test an organ or tissue. It also means the donor's surgical and Hospital services directly related to the removal of an organ or tissue. Organ Procurement Expenses also include those expenses incurred by recipients in the medical process to locate a compatible donor. Transportation of the donor or for the donated organ or tissue is not an Organ Procurement Expense;
- pre-operative, post-operative and follow-up care; and

- medications to inhibit rejection of the transplant.

Covered Bone Marrow Transplants for Treatment of Non-Malignant Diseases

The Plan covers only the following bone marrow transplants for treatment of non-malignant diseases:

- non-malignant diseases in which native bone marrow is insufficient to provide essential blood elements.

Services and Supplies for Bone Marrow Transplants

The Plan covers services and supplies directly related to covered bone marrow transplants for treatment of non-malignant diseases as follows:

- bone marrow or peripheral stem cell identification, donation and storage expenses;
- pre-transplant chemotherapy and/or radiation treatment;
- allogeneic bone marrow or peripheral stem cell transplant;
- post-transplant outpatient care directly related to the transplant; and
- re-transplantation.

Specific Limitations and Exclusions

The Plan does not cover the following in connection with solid organ and bone marrow transplant services:

- services, supplies or accommodations in connection with artificial heart, artificial pancreas, or artificial liver implants; and any other organ or artificial organ which may become available for transplant or implant after the Effective Date of the Plan. This exclusion does not apply to left ventricular assist devices (LVADs);
- services, supplies or accommodations in connection with a transplant which is not listed as a Covered Service, including but not limited to: 1) any bone marrow transplant in the treatment of diseases or conditions resulting from infection from a human T-cell leukemia virus (e.g., AIDS); 2) any intestine transplant; 3) any transplant of a non-human organ or non-human bone marrow; 4) any bone marrow transplant in the treatment of brain cancer; and 5) implantation of any artificial organ, regardless of whether implantation is a temporary measure while awaiting an available human organ; and
- services, supplies or accommodations for or in connection with transplant donor charges unless the recipient is a Claimant under the Plan. In the event both the donor and recipient are covered through the Claims Administrator or through one of their affiliate or subsidiary companies, donor charges will only be eligible under the recipient's coverage.

Myeloablative Therapy (MAT) with Hematopoietic Stem Cell Support (HSCS) for Malignancies Services (MAT/HSCS Transplant Services)

Definitions Specific to MAT/HSCS Services

In addition to the definitions in the DEFINITIONS Section, the following are definitions that apply to MAT/HSCS transplant services:

- Allogeneic Hematopoietic Stem Cell Support is the harvesting of bone marrow stem cells and/or peripheral stem cells from a healthy donor for infusion into a patient whose bone marrow is compromised.

- Autologous Hematopoietic Stem Cell Support is an infusion of primitive cells capable of replication and differentiation into mature blood cells. They are harvested from the Claimant's blood stream or bone marrow prior to the administration of the Myeloablative Therapy.
- Colony Stimulating Factor is a substance that increases the reproduction, differentiation and maturation of blood cellular components.
- Myeloablative Therapy is a course of therapy which is expected to destroy the bone marrow.

Patient Selection Criteria

Before the Plan will cover MAT/HSCS transplant services, it must be shown that a Claimant's proposed treatment meets the criteria for health and age standards as determined by the Plan, in addition to the following criteria:

- the probability of achieving a durable complete remission is greater with MAT than with standard dose therapies, considering the Claimant's disease characteristics and treatment history;
- the Claimant does not have central nervous system metastases from a solid tumor; and
- the Claimant does not have a concurrent condition which would seriously jeopardize the achievement of a durable complete remission with MAT.

Covered Diseases

The Plan covers MAT/HSCS transplant and/or autologous peripheral stem cell transplant services only for treatment of the following diseases:

- lymphoma;
- Hodgkin's disease;
- neuroblastoma;
- acute leukemia;
 - lymphocytic;
 - myelogenous;
- germ cell tumors;
- Ewing's sarcoma, recurrent or refractory;
- medulloblastoma, recurrent or refractory;
- Wilm's tumor, high risk or recurrent;
- primitive neuroectodermal tumor; and
- multiple myeloma.

The Plan covers Allogeneic MAT/HSCS transplant only for the treatment of the following conditions:

- aplastic anemia;
- acute leukemia;
 - Lymphocytic;
 - Myelogenous;
- severe combined immunodeficiency (not AIDS);
- infantile malignant osteopetrosis;

- Albers - Schonberg syndrome;
- marble bone disease;
- chronic myelogenous leukemia;
- lymphoma;
- Wiskott-Aldrich Syndrome;
- Neuroblastoma;
- homozygous beta-thalassemia (thalassemia major);
- Hodgkin's disease;
- myelodysplastic syndrome;
- mucopolysaccharidoses;
- mucopolipidoses;
- myeloproliferative disorders;
- sickle cell anemia;
- Kostmann's syndrome;
- leucocyte adhesion deficiencies;
- x-linked lymphoproliferative syndrome;
- Wilm's tumor, high risk or recurrent;
- Ewing's sarcoma, recurrent or refractory; and
- other transplants determined by the Plan to be a covered transplant since the Summary Plan Description was issued.

Services and Supplies

The Plan covers services and supplies directly related to covered MAT/HSCS transplant services as follows:

- allogeneic bone marrow and/or peripheral stem cell transplant/rescue which is the harvesting of bone marrow stem cells and/or peripheral stem cells from a healthy donor for infusion into a patient whose bone marrow is compromised;
- Autologous Hematopoietic Stem Cell Support including collection, processing and storage;
- high dose chemotherapy which is the administration of cytotoxic agents at doses several times greater than the standard therapeutic dose and may include whole body or localized radiotherapy;
- Myeloablative Therapy;
- Colony-Stimulating Factors; and
- post-transplant care for 60 days, including immunosuppressive drugs.

Specific Limitations and Exclusions

The Plan does not cover the following in connection with MAT/HSCS transplant services:

- services, supplies or accommodations related to any evaluation, treatment or therapy involving the use of MAT/HSCS which are not specifically identified as Covered Services, including but not limited to services, supplies or accommodations related to non-human bone marrow; and

- services, supplies or accommodations related to any evaluation, treatment or therapy involving the use of MAT/HSCS in the treatment of diseases not specifically listed as Covered Diseases or which do not meet the criteria set forth for Covered Diseases, including but not limited to: 1) the treatment of diseases or conditions resulting from infection from a human T-cell leukemia virus or HIV (e.g., AIDS); 2) chronic lymphocytic leukemia/small lymphocytic lymphoma; 3) primary intrinsic tumors of the brain in adults; 4) epithelial ovarian cancer; 5) lung cancer, small cell or non-small cell; 6) mesothelioma; 7) malignant melanoma; 8) tumors of the gastrointestinal tract, including those of the colon, rectum, pancreas, stomach, esophagus, gall bladder, and bile duct; 9) renal cell carcinoma, and carcinomata of the cervix, uterus, fallopian tubes, and prostate gland; 10) nasopharyngeal tumors, paranasal sinus neuroendocrine tumors, and tumors of unspecified histology; 11) soft tissue sarcomas or osteogenic sarcomas, unless specifically provided in the Plan; 12) thyroid tumors; 13) tumors of the thymus; 14) undifferentiated tumors; and 15) tumors of unknown primary origin.

COVERED MENTAL HEALTH BENEFITS

MENTAL HEALTH CONDITION SERVICES (INCLUDING DRUG OR ALCOHOL USE OR ABUSE)

The Plan covers Mental Health Condition services which means a pathological state of mind (whether of biological, non-biological, chemical or non-chemical origin and irrespective of cause, basis or inducement) producing clinically significant psychological or physiological symptoms together with impairment in one or more major areas of functioning when improvement can reasonably be anticipated with therapy. In addition, a Mental Health Condition includes alcoholism, drug abuse, and other conditions related to the use or abuse of alcohol or controlled substances (drugs).

Your Inpatient and Outpatient benefits are subject to the dollar and visit limits listed in the SUMMARY OF MENTAL HEALTH BENEFITS Section.

LIMITATIONS AND EXCLUSIONS

Specific Limitations and Exclusions

The Plan does not cover the following in connection with Mental Health Condition services

- marital or family problems;
- social, occupational, religious, or other social maladjustment;
- conduct disorder, attention deficit disorder;
- chronic adjustment disorder;
- psychosexual disorder;
- chronic organic brain syndrome or any organic symptom or cause;
- personality disorder;
- developmental disorder, learning disability; and
- mental retardation.

COVERED PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG BENEFITS

When you or your covered dependents incur expenses for Prescription Drugs purchased from a duly licensed pharmacy pursuant to a Prescription Order, Prescription Drug benefits will be provided as follows:

- When you or your covered dependents present the Prescription Order **and** a valid Prescription Drug Card to a Participating Pharmacy, you or your covered dependents will be entitled to have the Prescription Order filled, subject only to the applicable Deductible and/or Copayment amounts specified in the SUMMARY OF PRESCRIPTION DRUG BENEFITS Section, to be paid at the time of purchase.
- Unless otherwise provided under Special Provisions above, benefits for Prescription Drugs purchased by mail will only be provided if purchased through the Mail Order Pharmacy up to a 90 day supply. Forms for the purchase of Prescription Drugs by mail can be obtained from the Claims Administrator or the Employer.
- When you or your covered dependents present the Prescription Order to a Participating Pharmacy without also presenting a valid Prescription Drug Card, or when you or your covered dependents present the Prescription Order to a Nonparticipating Pharmacy, you will be required to make full payment for Prescription Drugs at the time of purchase. You will be responsible for filing claims directly with the Program and will be reimbursed **16% less than the average wholesale price for the Prescription Drug, plus a \$2.00 dispensing fee, less any Deductible and/or Copayment.**

NOTE: In the event the Plan is terminated with respect to any Claimant, such Claimant must immediately surrender his or her Prescription Drug Card to the Claims Administrator.

COVERED PRESCRIPTION DRUG BENEFITS

Benefits under this COVERED PRESCRIPTION DRUG BENEFIT Section are available for the following:

- Prescription Drugs, including drugs, biologicals, and compounded prescriptions used to treat an Illness or Injury.
- Insulin and prescribed oral agents for controlling blood glucose levels.
- Diabetic supplies, including but not limited to lancets, swabs, syringes (hypodermic needles), diabetic testing strips and insulin pump supplies including tubing, dressings, infusion reservoirs, and power kits (batteries).
- Certain over-the-counter medications approved by the Plan and expressly identified by the Plan in writing as covered over-the-counter medications. The fact that a particular over-the-counter drug or medication is covered does not require the Plan to cover or otherwise pay or reimburse you for any other over-the-counter drug or medication.

CARE MANAGEMENT PROGRAM

In order to verify coverage, the prenotification provision of the Care Management Program, as detailed in the CLAIMS ADMINISTRATION Section, should be followed prior to presenting a Prescription Order at the pharmacy for certain Prescription Drugs. The types of Prescription Drugs that may require

prenotification include: anti-migraine drugs, arthritis and/or pain medications, antiemetics, antibiotics, controlled substances, drugs recently approved by the United States Food and Drug Administration, all injectable drugs, except insulin, or any other Prescription Drug deemed necessary by the Plan due to safety or efficacy concerns. If you have a question as to whether a specific Prescription Drug requires prenotification, please contact the Claims Administrator at the numbers below or visit their website.

The Special Telephone Numbers To Use Are:

333-2850 - Salt Lake area

1-800-228-8263 - outside the Salt Lake area

Regular business hours are from 8:00 a.m. to 5:00 p.m., Mountain Time, Monday through Friday, except holidays. Voice messaging service is available during non-business hours, including weekends and holidays.

LIMITATIONS AND EXCLUSIONS

In addition to the limitations and exclusions in the GENERAL LIMITATIONS AND EXCLUSIONS Section of this Summary Plan Description, the following limitations and exclusions apply to this COVERED PRESCRIPTION DRUG BENEFITS Section:

Limitations

Maximum Benefit

The benefits of this COVERED PRESCRIPTION DRUG BENEFITS Section are limited to the Maximum Benefit amount specified in the SUMMARY OF BENEFITS Section.

Exclusions

A Non-Legend Patent Or Proprietary Medicine

Charges For The Administration Or Injection Of Any Drug

Contraceptives

Contraceptives, other than oral or transdermal, whether medication or device, regardless of intended use.

Growth Hormones

Immunization Agents, Biological Sera, Blood Or Blood Plasma

Infertility

Prescription Drugs for the treatment of infertility or the promotion of fertility.

Investigational Or Experimental Drugs

Drugs labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual.

Medication Not Requiring A Prescription Order, Other Than Insulin

Medication Dispensed By A Facility

Medication which is to be administered to an individual in whole or in part while he or she is a patient in a licensed Hospital, Skilled Nursing Facility, Rehabilitation Facility, rest home, sanatorium, convalescent Hospital, nursing home, or similar institution which operates on its premises, or allows to be operated on its premise, a facility for dispensing pharmaceuticals.

Non-Medicinal Substances And Over The Counter Medication

Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, and other non-medicinal substances, regardless of intended use (except as provided under DISCOUNT PRESCRIPTION DRUG PROGRAM above); and any over the counter medication or item(s) purchased at a pharmacy other than: 1) Prescription Drugs, whether or not there is a Prescription Order for the item(s); or 2) over-the-counter medications approved by the Plan and expressly identified by the Plan in writing as covered over-the-counter medications. The fact that a particular over-the-counter drug or medication is covered does not require the Plan to cover or otherwise pay or reimburse you for any over-the-counter drug or medication.

Prescription Drugs For A Non-FDA Approved Purpose Or Dosage

Any Prescription Drug prescribed for use other than its FDA-approved purpose or in other than the standard dosage for an FDA-approved purpose.

Prescription Drugs For Personal Enhancement

Prescription Drugs for:

- impotence;
- enhancement of sexual performance, satisfaction or gratification;
- enhancement of athletic or intellectual performance;
- hair growth;
- impedance of the aging process; and
- weight management or weight reduction.

Prescription Drugs In Excess Of A Prescription Drug Unit

Prescription Drugs Newly Approved By The FDA

A Prescription Drug during the first 6 months following its approval by the United States Food and Drug Administration, unless the Claims Administrator's Pharmacy and Therapeutics Committee (or its successor) approves coverage sooner.

Prescription Drugs To Assist In Smoking Cessation

Progesterone Suppositories

Refills

Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original Prescription Order.

Retin-A

Retin-A for a Claimant over 30 years of age, regardless of intended use.

DEFINITIONS

In addition to the definitions in the DEFINITIONS Section of this Summary Plan Description, the following definitions apply to this COVERED PRESCRIPTION DRUG BENEFITS Section.

Mail Order Pharmacy means the Participating Pharmacy that has agreed to process mail order claims submitted by you or your covered dependents under the Program. The Mail Order Pharmacy is administered by:

Postal Prescription Program (PPS)
PO Box 42200
Portland, OR 97242-0200

Nonparticipating Pharmacy means a pharmacy which has no agreement with the Program.

Participating Pharmacy means a duly licensed pharmacy with which the Program has an agreement whereby Prescription Drugs are furnished to you. A roster of Participating Pharmacies can be obtained from the Claims Administrator.

Prescription Drug means a drug or medicine which can only be obtained by a Prescription Order and bears the legend "Caution, Federal Law prohibits dispensing without a prescription" or which is restricted by State law, or insulin.

Prescription Drug Card means the identification card issued to you.

Prescription Drug Unit means the amount of a drug normally dispensed on a single Prescription Order not to exceed a 34 day supply or 100 unit does, whichever is greater.

Prescription Order means a written or oral order for a Prescription Drug issued by a Physician or Practitioner within the scope of his or her professional license.

Program is administered by:
Regence BlueCross BlueShield of Utah

2890 East Cottonwood Parkway
Salt Lake City, Utah 84121-7035

PO Box 30270
Salt Lake City, UT 84130-0270

COVERED DENTAL SERVICES

Dental Services are those required for services or supplies provided to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues or structures. For purposes of the Plan, Covered Services include only the following:

BASIC DENTAL SERVICES

- repair of dentures and bridges;
- palliative emergency treatment;
- fillings consisting of silver amalgam, silicate, and plastic restorations (for other types of fillings such as gold foil, payment is limited to the amount that would have been paid for amalgam restorations);
- apicoectomy;
- extractions, including surgical extraction of bone impacted teeth and general dental anesthesia administered in connection with Covered Dental Services;
- periodontic services which consist of surgical periodontic examinations, subgingival and gingival curettage, gingivectomy and gingivoplasty, osseous surgery including flap entry and closure, mucogingivoplastic surgery, management of acute infections and oral lesions; and
- endodontic services consisting of pulpotomy, pulp capping and root canal treatment.

ORTHODONTIC DENTAL SERVICES

- the initial and subsequent installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and its attendant sequelae through the correction of malposed teeth for Claimants under **26** years of age;
- benefits for orthodontic services will be computed on the basis as though such expenses, other than for the initial diagnosis, were incurred prorata during the term of active treatment in progress at the commencement or termination of your or your dependents coverage under the Plan, a service will have been deemed to have been rendered on the date performed; and
- in a case which was started prior to the Effective Date of your or your dependents coverage under the Plan for such service, the Lifetime maximum will be prorated in direct relation to the portion of the total treatment period remaining.

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

- oral examinations limited to 2 per Claimant per Contract Year;
- 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;
- topical fluoride application for Claimants under 23 years of age, limited to 2 treatments per Claimant per Contract Year;
- prophylaxis, including cleaning, scaling, and polishing, limited to 2 per Claimant per Contract Year;
- space maintainers for Claimants under 13 years of age; and
- sealants, limited to permanent molars of Claimants under 15 years of age.

PROSTHODONTIC DENTAL SERVICES

- inlays, onlays and crowns (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);
- bridges, fixed and removable;
- vestibuloplasty; and
- dentures, full and partial, except that:
 - benefits will not be provided for any denture replacement made less than 5 years after denture placement or replacement whether or not covered under this COVERED DENTAL SERVICES Section;
 - benefits will not be provided for any denture replacement made necessary by reason of loss or theft of a denture; and
 - benefits are limited to the amount that would have been paid for standard procedures for prosthodontic services when you or your covered dependents request or the Dentist provides personalized restoration or when the Dentist employs special techniques or procedures

LIMITATIONS AND EXCLUSIONS

In addition to the limitations and exclusions in the GENERAL LIMITATIONS AND EXCLUSIONS Section of the Summary Plan Description, the following limitations and exclusions apply to this COVERED DENTAL SERVICES Section:

Limitations

Optional Techniques

In all cases in which there are optional techniques carrying different fees, the Plan will only be liable for the treatment carrying the lesser fee.

Transfer Of Care

In the event the Claimant transfers from the care of one Dentist to that of another Dentist during the course of treatment, or if more than one Dentist renders services for one dental procedure, the Plan will be liable for not more than the amount the Plan would have been liable for had but one Dentist rendered the service.

Exclusions

Appliances And Restorations For Malalignment Of The Teeth

Appliances or restorations necessary to increase vertical dimensions or restore occlusion including equilibration; periodontal splinting; restoration of tooth structure lost through attrition; and restoration for malalignment of the teeth.

Dental Implants And Aesthetic Services

Dental services for congenital malformations; dental services primarily for aesthetic purposes; and dental implants.

Dentist Practicing Beyond Scope Of License

Services rendered by a Dentist practicing beyond the scope of his or her license.

Expenses Incurred After Coverage Ends

Services and supplies incurred after termination under the Plan except for prosthetic devices which were fitted and ordered prior to termination and were delivered to the Claimant within 30 days after the date of termination.

Expenses Incurred Before Coverage Begins

Services and supplies incurred before enrollment under the Plan. With respect to prosthodontic services in connection with a course of treatment begun prior to enrollment under the Plan, services are excluded even if some such services were rendered after enrollment under the Plan.

Gold Foil RestorationOrthodontic Appliances

Replacement or repair of orthodontic appliances, whether or not such orthodontic appliances were furnished under the Plan.

Orthodontic Services

Orthodontic services to the extent that:

- if the orthodontic treatment is terminated before completion of the case for any reason, no coverage will be provided for expenses incurred after the date of termination; or
- such services are rendered after the termination of the Plan.

Orthognathic Surgery

Services and supplies to change the position (augmentation or reduction procedures) of a bone of the upper or lower jaw (orthognathic surgery).

Replacement Of Lost Or Stolen Dentures (full or partial)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 a result of Accidental Injury.

DEFINITIONS

In addition to the definitions in the DEFINITIONS Section of the Summary Plan Description, the following definitions apply to this COVERED DENTAL SERVICES Section.

Dentist means an individual who is duly licensed to practice dentistry.

Eligible Dental Expenses means charges for Covered Dental Services, up to the Service Benefit Payment amount.

Nonparticipating Dentist means a Dentist who does not have an effective participating contract with the Claims Administrator to provide services and supplies to Claimants.

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.

Service Benefit Payment means the amount Participating Dentists have agreed to accept as full payment for Covered Dental Services as determined by the Plan. Charges in excess of the Service Benefit Payment are not reasonable charges and are not reimbursable under the Plan. Consequently, all percentage payments are percentages of the Service Benefit Payment.

GENERAL LIMITATIONS AND EXCLUSIONS

The following are the limitations and exclusions from coverage under the Plan. Other limitations and exclusions may apply and, if so, will be described elsewhere in the Summary Plan Description.

WAITING PERIOD FOR PREEXISTING CONDITIONS

This coverage has a waiting period for Preexisting Conditions which means the Plan does not pay for expenses you or your covered dependents incur for Preexisting Conditions during the time period described below after your or your covered dependents Enrollment Date of coverage under this Plan. The Plan's payment of a claim related to a Preexisting Condition does not mean that this limitation is waived for that claim or for any subsequent claim if the Plan later determines the condition was preexisting.

Preexisting Condition means a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period before the Enrollment Date. Enrollment Date means the first day coverage begins or, if earlier, the first day of any applicable waiting period for coverage. For Late Enrollees (a participant who enrolls under the Plan other than during their initial period of eligibility), the Enrollment Date is the Effective Date of coverage. Pregnancy is not considered a Preexisting Condition. In addition, waiting periods for Preexisting Conditions are not imposed on a child, if the child was covered at any time within 30 days of birth, adoption or placement with You for adoption, and such child has not had any break in coverage greater than 63 days since then (breaks in coverage prior to adoption or placement are not taken into account).

Waiting Period Time Limit

The waiting period will end 8 months following your Enrollment Date, unless you or your covered dependents enrolled as a Late Enrollee in which case the waiting period will end 18 months following your Effective Date of coverage under this Plan.

Creditable Coverage

The Plan will reduce the duration of the Preexisting Condition waiting period by the amount of your or your covered dependent's combined periods of Creditable Coverage if you or your covered dependents have been covered by Qualifying Coverage, provided there is no break in coverage greater than 63 days, immediately preceding your or your covered dependent's Enrollment Date of coverage under this Plan. Coverage may be concurrent.

Qualifying Coverage means any of the following: group coverage (including self-funded plans not qualified for regulatory exception); individual coverage (including student health plans); S-CHIP; Medicaid; Medicare; CHAMPUS/Tricare; Indian Health Service or tribal organization coverage; state high risk pool coverage; and public health plans (including foreign government and US government plans).

Qualifying Coverage is determined separately for each Claimant.

The following periods do not count in the calculation of the length of a break in coverage:

- Days in a waiting period for eligibility for coverage under this Plan; and
- For an individual who elects COBRA continuation coverage during the second election period offered under the Trade Act of 2002, days between the loss of coverage and the first day of that second election period.

You have the right to demonstrate the existence of Qualifying Coverage by providing the Plan with one or more certificates of Qualifying Coverage from a prior group or individual plan or with other documentation. You may obtain a certificate of Qualifying Coverage from a prior group health plan or insurer by request within 24 months of coverage termination. The College or the Claims Administrator can assist you in obtaining a certificate from a prior plan or insurer or suggest other documents that will serve as alternatives to a certificate of Qualifying Coverage as provided by federal law.

EXCLUSIONS

No benefits will be provided for any of the following conditions, treatments, services, supplies, or accommodations, or for any direct complications or consequences thereof:

Alternative Care

The following types of alternative care:

- acupuncture and acupressure;
- holistic and homeopathic treatment;
- massage or massage therapy;
- naturopathy;
- faith healing;
- milieu therapy;
- hypnosis;
- sensitivity training;
- behavior modification;
- biofeedback;
- electrohypnosis, electrosleep therapy, or electronarcosis;
- ecological or environmental medicine; and
- other therapies: scream therapy; psychic surgery, channeling, sensory deprivation; rolfing; thermography; music, art, dance, or recreation therapy; crystal therapy; and hypertherapy (therapeutically induced fever) for the treatment of cancer.

Appliances Or Restorations Necessary To Increase Vertical Dimension Or Restore Occlusion

Automobile Personal Injury Protection Coverage

Services and supplies for the treatment of an illness or injury that are the responsibility of any automobile personal injury protection ("PIP") coverage, including:

- Coverage up to the minimum amount required by state or federal law, regardless of whether or not such coverage is in force; and
- Any amount of coverage carried in excess of the minimum amount required by state or federal law, regardless of whether or not the Claimant files a claim for benefits under such coverage.

Benefits Not Stated

Services and supplies provided for which there is no stated benefit under the Plan. When a non-covered service or supply is performed or received at the same time as a Covered Service, then only the portion of charges relating to the Covered Service will be considered eligible for payment under this Plan.

Birth Control/Infertility

Services and supplies in connection with the following:

- non-prescription contraceptives;
- reversal of voluntary surgically performed sterilization or subsequent re-sterilization;
- artificial insemination or in vitro fertilization; and
- fertility drugs and medications for the treatment of Secondary Infertility.

Charges That Exceed Eligible Medical or Eligible Dental Expenses

Any charge for services and supplies that exceed Eligible Medical or Eligible Dental Expenses.

Cosmetic/Reconstructive Services And Supplies

Cosmetic and/or Reconstructive services and supplies, including blepharoplasty and otoplasty, except in the case of surgery that is:

- performed to restore a physical bodily function;
- related to an Accidental Injury; or
- related to breast Reconstruction following a Medically Necessary mastectomy to the extent required by law.

Cosmetic means services or supplies that are applied to normal structures of the body primarily for the purpose of improving or changing appearance.

Reconstructive means services, procedures, and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to restore function, but may also be done to approximate a normal appearance.

For the purposes of this Plan, psychological factors (for example, poor self-image, difficult social or peer relations) are not relevant and are not considered a physical bodily function.

Counseling

Charges for counseling a Claimant, including the following:

- marital counseling;
- family counseling;
- educational, social, occupational, or religious counseling;
- counseling in the absence of Illness or Injury; and
- counseling with a patient's family, friend(s), employer, school counselor, or school teacher.

This exclusion does not apply to services for counseling a Claimant when incidentally provided, without separate charge, in connection with Covered Services.

Court-Ordered Or Court-Related Services/Services In Connection With Legal Proceedings

Services, supplies, examinations, reports, or appearances in connection with legal proceedings or court ordered or court-related services.

Custodial, Domiciliary and Convalescent Care

Custodial Care, domiciliary care, convalescent care (other than extended care), rest cures, and services provided for or in connection with institutional care which is for the primary purpose of controlling or changing the Claimant's environment.

Custodial Care means care that mainly provides room and board (meals), or if it is for a physically or mentally disabled person who is not receiving care specifically to reduce the disability so that the person can live outside a medical care facility or nursing home. No matter where the person lives, care is considered Custodial Care if it is non-skilled nursing care, training in personal hygiene, other forms of self-care, supervisory care by a Provider, or care provided by a health care facility licensed by the State of Utah as an assisted living facility, hospice, residential health care facility, or small health care facility, or that is similarly licensed by the state in which it is located. Custodial Care does not mean outpatient palliative and supportive care provided by a hospice program to a Claimant who is terminally ill with a life expectancy of not more than 6 months and is in lieu of institutional or inpatient Hospital care.

Dental Services

Dental Services, unless the Plan specifically covers them.

Erectile Dysfunction

Services and supplies for or in connection with erectile dysfunction, regardless of its origin.

Expenses Incurred Before Coverage Begins Or After Coverage Ends

Services and supplies incurred whether before enrollment under the Plan or after termination under the Plan.

Experimental Or Investigational Services

Experimental or investigational treatments or procedures; and services, supplies, and accommodations provided in connection with experimental or investigational treatments or procedures. A treatment or procedure will be considered experimental or investigational if reasonable and substantial scientific evaluation has not been completed, effectiveness has not been established, or the procedure or treatment has not been accepted and generally used by the medical provider community for a period of 5 years. The Claims Administrator's Medical Director will determine whether a treatment or procedure is experimental or investigational. The absence of any alternative treatment or procedure or any effective non-experimental or non-investigational treatment or procedure for an Illness or Injury shall not make or be deemed to make an experimental or investigational treatment or procedure a Covered Service.

Fees, Taxes, Interest, Etc.

Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. The Plan also do 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.

Foot Care

Foot care, including but not limited to:

- treatment of corns and calluses;
- trimming of nails, except when Medically Necessary for diabetic patients (the Plan does cover surgery for ingrown toenails);
- foot impression casting including x-rays;
- nonsurgical treatment of bunions, flat feet, fallen arches, weak feet, chronic foot strain, or other symptomatic complaints of the foot;
- arch supports;
- special shoe accessories; and
- foot orthotics other than Medically Necessary.

Gastric Procedures

Services and supplies for or in connection with gastric or intestinal bypass, gastric stapling, or other similar surgical procedure or for or in connection with reversal or revision of such procedures.

Genetic Services

Services and supplies for or in connection with nucleic acid level genetic studies or for genetic alteration. This exclusion does not apply to chromosomal analysis.

Growth Hormone

Growth hormone therapy once bone growth is complete.

Hearing Treatment

Cochlear implants, programs, or treatment for hearing loss, including but not limited to hearing aids (internal or external); implantable hearing aids and the surgery and services necessary to implant them.

Military Service-Related Conditions

Services and supplies for treatment of an Illness or Injury caused by or incurred during service in the armed forces of any state or country.

Obesity Or Weight Reduction/Control

Medical or surgical treatment (including reversals), programs, or supplies that are intended to result in weight reduction, regardless of diagnosis or psychological conditions.

Other Party Liability

Services and supplies for treatment of Illness or Injury for which a third party is responsible, including:

- Any work related Injury or Illness, including any claims that are resolved pursuant to a disputed claim settlement; and
- Any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowners coverage, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to or makes benefits available to a Claimant, whether or not the Claimant, if eligible, files a claim for benefits under such coverage.

Any benefit provided contrary to this exclusion is not a waiver of the Plan's right to reimbursement or subrogation. Refer to the Other Party Liability provision in the CLAIMS ADMINISTRATION Section for additional information.

Personal Comfort Items

Items that are primarily used for personal comfort or convenience, contentment, personal hygiene, aesthetics, or other nontherapeutic purposes. For example, the Plan does not cover telephones, television, and guest meals while in a facility if they are charged separately from the cost of the room.

Personality Disorder, Learning Disability, etc.

Care or treatment of chronic organic brain syndrome, personality disorder, learning disability, or mental retardation, except to the extent Covered Services are required to diagnose such conditions.

Physical Exercise Programs And Equipment

Physical exercise programs or equipment, including hot tubs, or membership fees at spas, health clubs, or other such facilities whether or not the program, equipment, or membership is recommended by the Claimant's Provider.

Preparation Of Forms/Missed Appointments

Charges for preparing medical reports, itemized bills or claims forms; appointments scheduled and not kept ("missed appointments").

Prescription Drugs And Other Medications

Over-the-counter drugs and medications (except as provided in the Prescription Drug provisions of the COVERED SERVICES Section), vitamins, and minerals. Also excluded are special formulas, food supplements, or special diets, except as provided by a Hospital or Skilled Nursing Facility during a confinement for which benefits are available and as required for inborn metabolic errors.

Private Duty Nursing

Private duty nursing or hourly nursing services, including ongoing hourly shift care in the home.

Psychoanalysis/Psychotherapy

Psychoanalysis or psychotherapy credited toward earning a degree or furthering a Claimant's education or training.

Riot, Rebellion, War And Illegal Acts

Services and supplies for treatment of an Illness or Injury caused by a Claimant's **voluntary participation** in a riot, war, insurrection, rebellion, armed invasion or aggression, commitment of an illegal act, or felony.

Routine Physical Examinations, Tests, Screening Procedures, And Immunizations

Except as specifically described as a benefit under the Plan, routine physical examinations, including tests, screening procedures, and immunizations when the Claimant has no symptoms of Illness or Injury (for example, cancer screening tests and general health screening tests). The Plan will, however, cover tetanus or rabies vaccinations administered in connection with an Accidental Injury.

Self-Help, Self-Care, Training, Or Instructional Programs

Self-help, non-medical self-care, training, educational, or instructional programs. Unless specifically described as a benefit, this includes diet and weight monitoring services, instruction programs including those to learn how to self-administer prescriptions or nutrition, and programs that explain how to use Durable Medical Equipment or how to care for a person in the family. This exclusion does not apply to services for training or educating a Claimant when incidentally provided, without separate charge, in connection with Covered Services.

Services And Supplies For Which No Charge Is Made Or No Charge Is Normally Made

Services and supplies for which a Claimant is not required to make payment or for charges that in the absence of this Plan there would be no obligation to pay. This would include but is not limited to:

- services or supplies for which a Claimant cannot be held liable because of an agreement between the Provider rendering the service and another third party payor which has already paid for such service or supply;
- services for which the Claimant incurs no charge or has no legal obligation to pay; and
- charges for services or supplies provided by the Employer or any of its employees or agents.

Services And Supplies Otherwise Available From A Governmental Agency Or Program

Services and supplies to the extent benefits are provided or covered by any governmental agency (for example, a federal hospital or the Veterans Administration), unless reimbursement under the Plan is otherwise required by law. Also excluded are services covered by programs (such as Medicare) created by the laws of the United States, any state, or any political subdivision of a state, or which would be so covered except for coverage under this Plan.

Services And Supplies Provided By A Member Of Your Family

Services and supplies provided to you or your covered dependents by a member of your Immediate Family. For purposes of this provision, "Immediate Family" means parents, spouse, children, siblings, half-siblings, or in-laws, or any relative by blood or marriage who shares a residence with you.

Services And Supplies Provided By A School Or Halfway House

Services and supplies provided by any public or private school or halfway house, or by their employees and services provided solely to satisfy institutional requirements.

Services And Supplies Provided Outside Of Utah

Services and supplies provided outside of Utah that would not have been licensed in Utah, or that may not be legally provided in Utah.

Services And Supplies That Are Not Medically Necessary

Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury except for preventive care benefits if specifically provided under the Plan.

Services, Supplies And Drugs Not Yet Approved By The FDA

Services, supplies or drugs which have not yet been approved by the United States Food and Drug Administration (FDA) or which are used for other than its FDA-approved purpose.

Sexual Counseling, Treatment, Or Surgery

Counseling, treatment (including drugs), or surgery for sexual dysfunction, including but not limited to transsexualism, psychosexual identity disorder, psychosexual disorder or gender dysphoria.

Tobacco Addiction Treatment

Treatment of tobacco addiction, including supplies for addiction to tobacco, tobacco products, or nicotine substitutes.

Travel And Transportation Expenses

Travel and transportation expenses other than covered Ambulance Services provided in the Plan.

Treatment, Procedures, Techniques Or Therapies Outside Accepted Health Care Practice

Treatment or prevention of an Illness or Injury by means of treatments, procedures, techniques or therapies outside generally accepted health care practice, as determined by the Plan.

Vision Care

Services and supplies related to vision care, unless specifically described as a benefit under the Plan, including but not limited to:

- the fitting, provision, or replacement of eyeglasses;
- contact lenses, including contact lens checks, except for the first intraocular lenses following cataract surgery;
- visual therapy, training, and eye exercises;
- vision orthoptics;
- vitamin therapy for vision;
- fundus photography ; and
- surgical procedures to correct refractive errors/astigmatism. Additionally, reversals or revisions of surgical procedures which alter the refractive character of the eye are excluded.

Visits Or Consultations That Are Not In Person

Any telephone, internet (or other electronic communication, including tele-medicine) visits or consultations, whether initiated by you or your covered dependents or the Provider.

DISCLAIMER

ANYTHING NOT SPECIFICALLY PROVIDED FOR IN THE PLAN IS NOT A COVERED BENEFIT.

CLAIMS ADMINISTRATION

This section explains various matters having to do with administering benefits and/or claims, including situations that may arise in which health care expenses are the responsibility of a source other than the Plan.

CARE MANAGEMENT PROGRAM

The Plan uses a program called Care Management to help ensure the services that you or your covered dependents receive are Medically Necessary, appropriate and consistent with current medical practice. (It is important to note that Medical Necessity does not make a service that is a specific exclusion of the Plan a Covered Service.) The Claims Administrator has four methods of reviewing the health care received. Care Management consists of the following:

Prenotification

The Claims Administrator reviews certain services before they are received. Because many types of treatment may be available for certain conditions, the prenotification process helps Physicians work together with you, other Providers, and the Plan to determine the treatment that best meets your or your covered dependent's medical needs. The Claims Administrator looks for these things: 1) the benefit to the individual patient; 2) whether the service meets accepted medical guidelines, using the latest scientific information and recommendations; 3) whether the requested service is consistent with benefits under the Plan; and 4) whether the level of care and length of stay meet our guidelines.

Concurrent Review

The Claims Administrator monitors and reviews certain services while they are being received. The Claims Administrator does this to see if they meet the Plan's medical guidelines. The Claims Administrator can also help you and your Provider plan for anticipated needs, such as physical therapy after leaving the Hospital, and help coordinate these services.

Post Service Review

The Claims Administrator reviews some services already received to ensure they meet the Plan's criteria and that they were appropriate for the condition. This also helps the Claims Administrator monitor how care is being delivered by Providers in the community.

Case Management

The Claims Administrator helps you coordinate medical needs for complex and catastrophic Illnesses or Injuries as well as certain chronic Illnesses. Case management is designed to provide early detection, intervention and assistance in cases of serious or long-term Illness or Injury that have the potential for major continuing expense so that the appropriate level of care and treatment settings can be coordinated and a plan of care developed. The Plan may assess treatment methods and propose possible alternative health care to help promote positive treatment outcomes and maximize use of your benefits under the Plan.

It is your responsibility to notify the Claims Administrator before receiving any of the following services:

- home health care and home infusion therapy;
- transplants, including the use of Myeloablative Therapy with Hematopoietic Stem Cell Support; and

- all inpatient admissions, including admissions to a Skilled Nursing Facility or Rehabilitation Facility, except as follows:
 - when the admission cannot be scheduled in advance (an emergency admission), the Claims Administrator must be notified of the admission on the next business day or no later than the next business day following stabilization of the patient;
 - notification is not required for any maternity (delivery) admission having a duration of 48 hours or less following vaginal delivery or of 96 hours or less following cesarean delivery. An admission having a longer duration requires notification of the continued stay; and
 - when the Plan is the Secondary Health Plan.

It should be noted that although you notify the Claims Administrator of the intent to receive a service, it does not guarantee that the Plan will cover the service. In the event the Plan determines that the service is not covered, the Plan will not provide any benefit for the service, regardless of whether notification was received.

The Plan also encourages you or your covered dependents to contact the Claims Administrator when receiving the following services:

- high risk maternity care;
- cosmetic and reconstructive procedures;
- high cost Durable Medical Equipment, including prosthetics and orthotics; and
- anti-migraine Prescription Drugs and all injectable Prescription Drugs, except insulin.

The special telephone numbers to use for Care Management are:

Within the Salt Lake area: (801) 333-2850

Outside of the Salt Lake area: (800) 228-8263

Regular business hours are from 8:00a.m. to 5:00p.m., Mountain Time, Monday through Friday, except holidays. Voice messaging service is available during non-business hours, including weekends and holidays.

IDENTIFICATION CARD

When you, the Plan Participant, enroll under the Plan administered by Regence BlueCross BlueShield of Utah, you will receive an identification card. It will include important information such as your identification number, your Group number, and your name and the names of your Enrolled Dependents.

It is important to keep your 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 (801) 333-2100 within the Salt Lake area or (800) 624-6519 outside the Salt Lake area. If coverage under the Plan terminates, your identification card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

The Plan has the sole right to decide whether to pay you, the Provider, or you and the Provider jointly.

Timely Filing Of Claims

To be filed timely, a claim must be received by the Claims Administrator within one year after the date the Covered Service to which the claim relates was provided to you or your covered dependents. A claim that is not filed timely will be denied. You may appeal the denial in accordance with the Appeal Process when you can demonstrate that the claim could not have been filed timely.

Participating Provider Claims

When obtaining Covered Services from a Participating Provider, your identification card must be presented and you must furnish any additional information requested. The Participating Provider will furnish to the Claims Administrator the necessary forms and information to process your claim.

Participating Provider Reimbursement

The Plan will pay the Participating Provider directly for Covered Services as follows:

- Participating Physicians, Participating Practitioners and other professionals who are Participating Providers have agreed to accept Eligible Medical Expenses as full compensation for Covered Services. Your share of Eligible Medical Expenses is any amount you must pay due to Deductible, Copayment and/or Coinsurance. A Participating Provider may require you to pay your share at the time you or your covered dependents receive care or treatment;
- Participating Hospitals, Participating Skilled Nursing Facilities and other facilities that are Participating Providers have agreed to accept Eligible Medical Expenses as full compensation for Covered Services. Eligible Medical Expenses can be greater than or less than the facility's actual charges for Covered Services. Your obligation for payment to a Participating Provider is the Deductible, Copayment and/or Coinsurance as provided in the Summary Plan Description. Your Coinsurance will be calculated as a percentage of the lower of: 1) the facility's actual charges; or 2) Eligible Medical Expenses. A Participating Provider may require you to pay your share at the time you or your covered dependents receive care or treatment.

NOTE: It is generally to your financial advantage to use Participating Providers. When a Participating Provider is used, you are responsible to pay only Deductible, Copayment and/or Coinsurance for Covered Services.

Nonparticipating Provider Claims

Before you will be entitled to payments under the Plan for Covered Services provided by a Nonparticipating Provider, you must furnish or cause to be furnished to the Claims Administrator with respect to each such claim all forms, information, statements, and certificates necessary or appropriate to process such claim, including without limitation the following:

- claim information including your or your covered dependent's name, age, sex, contract (identification) number, and the medical or other records necessary to establish the medical services provided, the reason for their provision, your condition prior to and at the time of treatment, the medical necessity of the treatment, the efficiency and non-investigational status of the treatment, and similar facts and circumstances; and
- statements from the Nonparticipating Provider itemizing the diagnosis, the accommodations, services and supplies provided to you, the date on which each such item was provided, and the charge for each such item. All statements furnished will be in such form and will contain such information as the Plan may require.

Nonparticipating Provider Reimbursement

All payments for Covered Services provided by a Nonparticipating Provider will be made directly to you, except that in the event payments are to be made for Covered Services provided by a Nonparticipating Provider to a child who is an Enrolled Dependent but for whom the Plan Participant is not the custodial parent, such payments will be made to the Enrolled Dependent's custodial parent or state Medicaid agency who or which submitted the claim(s):

- Nonparticipating Physicians, Nonparticipating Practitioners and other professionals who are Nonparticipating Providers have not agreed to accept Eligible Medical Expenses as full compensation for Covered Services. Thus, you are responsible for paying any difference between the amount billed by the Nonparticipating Provider and Eligible Medical Expenses in addition to any amount you must pay due to Deductible, Copayment and/or Coinsurance;
- Nonparticipating Hospitals, Nonparticipating Skilled Nursing Facilities and other facilities that are Nonparticipating Providers have not agreed to accept payment in accordance with contractual payment schedules. Thus, you are responsible for paying any difference between the amount billed by the Nonparticipating Provider and the amount the Plan determines to be reasonable charges in addition to any amount you must pay due to Deductible, Copayment and/or Coinsurance.

NOTE: When Nonparticipating Providers are used, you are responsible not only for Deductible, Copayment and/or Coinsurance for Covered Services, but also for the difference between the Nonparticipating Provider's billed charges and Eligible Medical Expenses.

Nothing contained in the Plan will be construed to restrict you in exercising full freedom of choice in the selection of a Hospital, Skilled Nursing Facility or other Provider for care or treatment of an Illness or Injury.

Claims Procedures

The following time frames will be followed as required by the Department of Labor:

For The Following Type of Claim*...	You Must File a Claim Within...	The Plan must respond within...	
		Initial Claim**	Extension Claim***
Pre-service	NA	15 days	30 days
Urgent care	NA	72 hours	NA
Concurrent care	NA	Within a timeframe that provides sufficient opportunity to Appeal in cases of Pre-service care or within 24 hours when related to urgent care	
Post-service	See above Timely Filing of Claims provision	30 days	45 days

* Definitions are provided in the Appeal Process Section of the Plan

** In the case of urgent and Pre-service care, the initial claim refers to the initial request for services when an actual claim may not be filed.

*** For Pre-service and Post-service claims, the Plan may request a one time extension and pend the claim until all the information is received. If the information is provided within 45 days, the Plan will provide determination within 15 days after the information is received.

BLUECARD PROGRAM

When you or your covered dependents obtain Covered Services outside the geographic area the Plan serves through the BlueCard Program, the amount you pay for Covered Services is usually calculated from the lower of: 1) the Provider's billed charges for the Covered Services; or 2) the negotiated price that the on-site Blue Cross and/or Blue Shield organization ("Host Blue") passes on to the Claims Administrator. Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. However, it is sometimes an estimated final price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with the Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with the Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may be prospectively adjusted to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

In addition, statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods differently from the usual BlueCard method noted in the paragraph above or require a surcharge, the Claims Administrator would then calculate your liability for any Covered Services using that state's statutory methods in effect at the time you received Covered Services.

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 deemed null and void and will not be binding on the Claims Administrator or 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 for any reason the Plan pays any amount to or on behalf of you or your covered dependents: 1) for services, supplies or accommodations not covered under the Plan; 2) with respect to a person who is not covered under the Plan; 3) which exceed amounts to be paid as benefits under the Plan; 4) as duplicate payments; 5) for payment received from the Plan for the treatment of an Injury or Illness where another person, entity, firm or corporation is legally responsible for payment of the treatment, then you agree to reimburse the Plan on demand for any and all such amounts. Such demand will be made within 3 years after the date of loss (except in the case of third party responsibility, the Plan will have 3 years from the discovery of the payment to you or on your behalf by the third party through contract, settlement, judgment or any other means, to make such demand). You also agree to pay the Claims Administrator, on behalf of the Plan, interest at 18% per annum until such debt is paid in full, which will begin accruing the date the demand for reimbursement is made. In the event the Plan uses a third party collection agency or attorney to collect the overpayment, you agree to pay collection fees incurred, including but not limited to any court costs and attorney fees. In the event you do not make payment, the Plan may withhold future benefits to offset the amount owing 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 the 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 RECORDS

It is important to understand that health information about you and your covered dependents may be requested or disclosed by the Claims Administrator. The information requested or disclosed 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 a:

- Physician, dentist, pharmacist or other physical or behavioral health care Practitioner;
- clinic, Hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or
- an insurance carrier or group health plan.

Health information requested or disclosed by the Claims Administrator may include, but is not limited to claim records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

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.

REPLACING EARLIER PLAN

This Health Care Benefits Plan replaces a health benefit plan previously issued by the Employer, and benefits furnished under the previous health benefit plan will apply against the benefit maximums of this Plan as though such benefits had been furnished under this Plan.

LIMITATIONS ON LIABILITY

In all cases, you have the exclusive right to choose a health care provider. Neither the Claims Administrator, nor the Employer, are responsible for the quality of medical care you or your covered dependents receive, since all those who provide care do so as independent contractors. Since neither the Claims Administrator, nor the Employer, provide any medical care services, we cannot be held liable for any claim or damages connected with Injuries you or your covered dependents suffer while receiving medical and/or dental services or supplies provided by professionals who are not our employees or agents.

In addition, neither the Claims Administrator, nor the Employer, will be liable to any person or entity for the inability or failure to procure or provide the benefits of this Plan by reason of epidemic, disaster, or other cause or condition beyond the control of the Plan.

OTHER PARTY LIABILITY

The Plan does not provide benefits for any medical, prescription drug or time loss expenses resulting from an Injury or Illness, if the costs associated with the Injury or Illness may be recoverable from: 1) a third party; 2) worker's compensation; or 3) any other source, including but not limited to first party payer payments for any automobile personal injury protection or medical payments and uninsured or underinsured motorist coverage. The Plan may choose, at its discretion, reimbursement or subrogation as a means to recovery.

Recovery Rights

If you or your covered dependents have a potential right of recovery for an Injury or Illness for which a third party may have legal responsibility, the Plan may advance benefits pending the resolution of the claim upon the following conditions:

- By accepting or claiming benefits, you agree that the Claims Administrator, on behalf of the Plan, is entitled to reimbursement of the full amount of benefits that the Plan has paid, out of any settlement or recovery from any source, including judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which the Plan has provided benefits.
- This right applies without regard to the characterization as payment for medical expenses or other designation of the recovery by you or your covered dependents and/or any third party or the recovery source. The Plan's right to reimbursement, however, will not exceed the amount of recovery.

Documents

The Claims Administrator, on behalf of the Plan, may require you to sign and deliver all legal papers and take any other actions the Claims Administrator may ask to secure the Plan's rights (including an assignment of rights for the Claims Administrator to pursue your claim if you fail to pursue the claim yourself). If the Claims Administrator asks you to sign a trust agreement or other document to reimburse the Plan from the proceeds of any recovery, you may be required to do so as a condition for the advancement of any benefits. If benefits were paid before the agreement is signed, you agree to reimburse the Plan for such paid benefits upon recovery in any form from or on behalf of a third party.

Agreement

You agree that you will do nothing to prejudice the Plan's rights and will cooperate fully with the Claims Administrator, on behalf of the Plan, including signing any documents and providing prompt notice of any settlement. You are obligated to notify the Claims Administrator as follows:

- When a lawsuit is filed which involves the event which gave rise to the claims you or your covered dependents make or will make; or
- When negotiations commence with any party which relate in any way to the claims you or your covered dependents make or will make, including notice of when, where and with whom such negotiations will take place; or
- No less than 21 days before any settlement is negotiated; or
- No less than 5 business days before payment of any kind will be issued to the benefit of or on behalf of, you or your covered dependents, from any third party, which is related to the event which gave rise to the claims you or your covered dependents make or will make.

You acknowledge that the Claims Administrator is authorized, but not obligated to recover directly from any third party, any benefits paid from any party liable to you or your covered dependents upon mailing of a written notice to the potential payer and you or your representative.

Expenses

The Plan is entitled to reimbursement from the first dollars received from any recovery. The Plan will not reduce its reimbursement or subrogation right due to Your not being made whole. The Plan is not liable for any expenses or fees incurred by You in connection with obtaining a recovery. You, however, may request that the Plan pays a proportional share of attorney's fees and costs at the time of any settlement or recovery or to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid by the Plan.

Advancement of payment for otherwise excluded benefits or review of a request for attorney fees are conditioned upon the retention by your attorney of funds sufficient to satisfy the Plan's asserted lien in a client trust account, until such lien is satisfied or released. In the event that you and/or your agent or attorney fail to comply with the terms of these provisions, the Claims Administrator may recover any benefits advanced for any Injury or Illness resulting from the action or omission of a third party through legal action or offsetting of any future benefits owing you or any other individual whose eligibility is established through the same Plan Participant.

Please contact the Claims Administrator to obtain third party reimbursement forms and to obtain additional information.

COORDINATION OF BENEFITS

In the event you are covered under one or more Health Plans (as defined below), the benefits of the Health Plans will be coordinated in accordance with the following provisions:

Definitions

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

Health Plan means this coverage and any other similar plan, contract, or policy which has at least one benefit in common with this coverage and which provides benefits for or by reason of care or treatment of an Illness or Injury by or through any of the following:

- group, blanket, individual or franchise insurance or prepayment coverage;
- labor-management trust plan, union welfare plan or employer or employee organization benefit plan coverage;
- trade, professional or cooperative association plan coverage, or any other similar plan that arranges or pays for health benefits;
- group, group type, and individual automobile "no-fault" medical payment coverage in excess of the minimum statutory personal injury protection limit in Utah Code 31A-22-306 through 309 (or any successor thereto or any applicable analogous limit);
- federal, state or other governmental employer or employee (statutory or nonstatutory) plan coverage, including Medicare, or services rendered in a federal hospital or by the Veterans Administration; and
- health maintenance organization coverage.

Health Plan does not include:

- hospital indemnity coverage;
- accident-only coverage, specified disease or specified accident coverage;
- disability income protection coverage;
- nursing home and long-term care coverage;
- any state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time);
- any plan when, by state or federal law, its benefits are excess to those of any private insurance program or other non-governmental program; and
- Medicare supplement policies as defined in Utah Code Title 31A, Chapter 22, Section 620 or any successor thereto.

Primary Health Plan means the Health Plan that must determine its benefits for a person's health care first. There may be more than one Primary Health Plan. A Health Plan is a Primary Health Plan in either of the following conditions:

- the Health Plan has no Order of Benefit Determination provision (see below); or
- all Health Plans which cover the person use the Order of Benefit Determination provision (see below) and under that provision the Health Plan determines its benefits first.

Secondary Health Plan means a Health Plan which is not a Primary Health Plan. There may be more than one Secondary Health Plan. In the event a person is covered under more than one Secondary Health Plan, the "Order of Benefit Determination" provision (see below) decides the order in which the Secondary Health Plans' benefits are determined in relation to each other.

Allowable Expenses means the amount on which a Health Plan would base its benefit payment for Covered Services in the absence of any other coverage. When a Health Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

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

Order Of Benefit Determination

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

- The Health Plan which covers the person as the policyholder or certificate holder (that is, a person other than a dependent) will be determined before the benefits of the Health Plan which covers the person as a dependent;
- When this and another Health Plan cover the same child as a dependent of parents who are not separated or divorced (including parents who are living together):
 - The benefits of the Health Plan of the parent whose birthday falls earlier in the Calendar Year are determined before those of the parent whose birthday falls later in that year; and
 - If both parents have the same birthday, the benefits of the Health Plan which covered the parent longer are determined before those of the Health Plan which covered the other parent for a shorter period of time.
 - If, however, the other Health Plan does not fall within the jurisdiction of the Utah Insurance Department and has a rule based on another order, and if, as a result, the Health Plans do not

agree on the order of benefit determination, the rule in the other Health Plan will determine the order of benefits.

- When this and another Health Plan cover the same child as a dependent of parents who are separated, divorced, or not living together:
 - The benefits of the Health Plan which covers the child as a dependent of the parent with custody of the child will be determined first, then the benefits of a Health Plan which covers that child as a dependent of the current spouse of the parent with custody of the child, then the benefits of the Health Plan which covers the child as a dependent of the parent without custody, then the benefits of the Health Plan which covers the child as a dependent of the spouse of the parent without custody;
 - Notwithstanding the preceding paragraph, if there is a court decree which would otherwise establish financial responsibility for the child's medical, dental, or other health care or health insurance expenses and the Health Plan of that parent has actual knowledge of those terms, the benefits of that Health Plan will be determined before the benefits of any other Health Plan which covers the child as a dependent child. If the parent with financial responsibility has no coverage for the child's medical, dental, or other health care expenses, but that parent's spouse does, the benefits of the spouse's Health Plan will be determined before the benefits of any other Health Plan which covers the child as a dependent child. This paragraph does not apply with respect to benefits which are paid or provided before the entity has actual knowledge;
 - If the specific terms of a court decree state that the parents have joint custody, without stating that one of the parents is responsible for the health care expenses or health insurance coverage of the child and the child's residency is split between the parents, the order of benefit determination outlined in the paragraph above for a child as a dependent of parents who are not separated or divorced will apply. This paragraph does not apply with respect to benefits which are paid or provided before the entity has actual knowledge.
- The benefits of a Health Plan which covers a person as an active employee, member or subscriber are determined before those of a Health Plan which covers that person as an inactive employee, member or subscriber. If the other Health Plan does not have this rule, and if, as a result, the Health Plans do not agree on the order of benefits, this provision is ignored. The period of time a person has been covered by a Health Plan shall be calculated in accordance with the Utah Administrative Code R590-131-4.B.5. or any successor thereto.
- When none of the paragraphs above establish an order of benefit determination, the benefits of the Health Plan which has covered the person for the longer period of time will be determined before the benefits of the Health Plan which has covered the person for a shorter period of time.

Primary Health Plan Benefits

When, in accordance with the Order of Benefit Determination, this coverage is the Primary Health Plan, the Plan will pay the benefits of this Health Plan as if no other Health Plan exists.

Secondary Health Plan Benefits

This provision applies when, in accordance with the Order of Benefit Determination (see above), this coverage is a Secondary Health Plan. In that event, the benefits of this Health Plan may be reduced.

- When either this Health Plan or the Primary Health Plan has contracted for discounted provider fees, the Plan will limit payment to any Copayment and Deductible owed by you after payment by the Primary Health Plan.

- If none of the Health Plans has contracted for discounted provider fees, the Plan will reduce benefits so that the total benefits paid or provided by all Health Plans for a Covered Service are not more than the highest Allowable Expense of any of the Health Plans for that service.

If this Health Plan is the Secondary Health Plan according to the Order of Benefit Determination (see above), the Plan will calculate the benefits that the Plan would pay if this was the Primary Health Plan and apply that payable amount to unpaid covered charges owed by you after the Primary Health Plan's payment, including any Deductibles, Coinsurance, and Copayments you owe after the Primary Health Plan's payment. Deductibles, Coinsurance, and Copayments under this Health Plan will be used in the calculation of the benefits that the Plan would pay if this was the Primary Health Plan, but shall not be applied to the unpaid covered charges owed by you after the Primary Health Plan's payment. **Nothing contained in this Coordination of Benefits provision requires the Plan to make payment for all or part of any service that is not covered under the Plan.**

If this Health Plan is the Secondary Health Plan according to the Order of Benefit Determination (see above) and another Health Plan claims to be "always secondary" or uses order of benefit determination rules inconsistent with those above, this Health Plan shall pay its benefits first, but the amount paid shall be calculated as if this Health Plan is a Secondary Health Plan. If the other Health Plan does not provide the Claims Administrator with the information necessary for them to determine Secondary Health Benefits within a reasonable time after the Plan's request, the Claims Administrator shall assume its benefits are identical to the Plan's and pay Secondary Health Plan Benefits accordingly, subject to adjustment upon receipt of the information requested from the other Health Plan.

No Expansion Of Benefits

In no event will this Coordination of Benefits provision operate to increase the total benefits that would be provided under the Plan in the absence of this provision.

Recovery Of Overpayment

In the event the Plan provides benefits to or on behalf of you in excess of the amount which would have been payable hereunder by reason of your coverage under another Health Plan, the Plan will be entitled to recover 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 18 months of the overpayment, unless reversal is necessitated by fraudulent acts, fraudulent statements, or material misrepresentations by you. The Plan will be entitled to recover the amount of such excess made by the reversal of payment from you and you agree to reimburse the Claims Administrator, on behalf of the Plan, on demand for any and all such amounts. You also agree to pay the Plan interest at 18% per annum until such debt is paid in full, which will begin accruing the date the demand for reimbursement is made. In the event the Claims Administrator uses a third party collection agency or attorney to collect the overpayment, you agree to pay collection fees incurred, including but not limited to any court costs and attorney fees. In the event you do not make payment to the Claims Administrator, the Claims Administrator may withhold future benefits to offset the amount owing. The Claims Administrator is responsible to see that proper adjustments between insurers and providers are made;
- from Providers, if payment was made to them. Recovery would be by reversal of payments and be limited to a period within 36 months of the overpayment, unless reversal is necessitated by fraudulent acts, fraudulent statements, or material misrepresentations by you. The Claims Administrator is responsible to see that proper adjustments between insurers and Providers are made;
- from the other Health Plan or an insurer; or

- from other organizations.

Information

You will promptly furnish or cause to be furnished to the Claims Administrator any information necessary or appropriate for administration of the provisions of this Coordination of Benefits provision. Receipt of such information by the Claims Administrator will be a condition precedent to the Claims Administrator's obligation to provide benefits under the Plan.

Payments

- In administering and accomplishing the provisions of this Coordination of Benefits provision, the Plan will have the absolute right to: 1) make and recover any payments to or from you, a Provider of Covered Services, and/or any Health Plan; and 2) to release any information which the Plan deems appropriate in connection therewith.
- A payment made under another Health Plan may include an amount which should have been paid under this Health Plan. If it does, the Plan may pay that amount to the Health Plan which made that payment. That amount will then be treated as though it were a benefit paid under the Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

APPEAL PROCESS

This section describes the Appeal Process in the event you or your Representative (any representative authorized by you) have a complaint or grievance regarding a claim denial or other action by the Claims Administrator under this Plan and wish to have it reviewed. A request for Appeal must be submitted to the Claims Administrator within 180 days of the claim denial or other action giving rise to the complaint or grievance. Failure to Appeal within this time period will preclude all further rights to Appeal.

NOTE: In the event you or your Representative reasonably believes that a utilization management decision denying preauthorization of a Pre-service 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, you or your Representative may request an Expedited Appeal. Expedited review will also be granted to requests concerning admissions, continued stay, or other health care services for a Claimant who has received emergency care and has not been discharged from a facility. For procedures, see "Expedited Appeals" below.

APPEALS

First Level - Complaint/Grievance/Reconsideration

You may initiate an Appeal through either a written or oral request. Written Appeal requests should be mailed to: Benefits Administration, Regence BlueCross BlueShield of Utah, PO Box 30270, Salt Lake City, Utah 84130-0270. Oral requests can be made by calling the Claims Administrator at (801) 333-2100 within the Salt Lake area or (800) 624-6519 outside the Salt Lake area. Within 5 working days or 7 calendar days, whichever is sooner, of the receipt of request for an Appeal, Benefits Administration will send an acknowledgement of the request for Appeal and information describing the entire Appeal Process and your rights. "First Level - Complaint/Grievance/Reconsideration" is a review by a Benefits Administration Representative who was not involved in the initial decision. In the case of an Appeal involving a decision requiring medical judgment, the Benefits Administration Representative will consult with one of the Claims Administrator's Medical Directors prior to rendering a decision. For Appeals involving a Post-service investigational or experimental issue, a written notice of the decision will be sent within 20 working days (or 30 calendar days, if sooner) of the receipt of the "First Level - Complaint/Grievance/Reconsideration" and within 5 working days of the decision being made. For all other Post-service Appeals, a written notice of the decision will be sent within 30 days of receipt of the "First Level - Complaint/Grievance/Reconsideration" and within 5 working days of the decision being made. If your Provider requests reconsideration of a denial of preauthorization, a peer-to-peer discussion with one of the Claims Administrator's Medical Directors will be arranged within 1 working day of the request. For Appeals involving a Pre-service preauthorization of a procedure including a Pre-service investigational procedure, a written notice of the decision will be sent within 14 days of receipt of the "First Level - Complaint/Grievance/Reconsideration" and within 5 working days of the decision being made.

Second Level - Internal Appeal

If you disagree with the decision made in the "First Level - Complaint/Grievance/Reconsideration," you may request further Appeal to the "Second Level - Internal Appeal." The Appeal request must be made in writing or orally within 180 days after you receive notice of the decision at the "First Level - Complaint/Grievance/Reconsideration". Failure to request a "Second Level - Internal Appeal" within this time period will preclude your right to further internal Appeal of the decision. The written Appeal request,

including any additional information or comments, must be made to the Appeal Coordinator, Regence BlueCross BlueShield of Utah, PO Box 30270, Salt Lake City, Utah 84130-0270. Oral requests can be made by calling the Claims Administrator at (801) 333-2100 within the Salt Lake area or (800) 624-6519 outside the Salt Lake area. Within 5 working days or 7 calendar days, whichever is sooner, of the receipt of the request for "Second Level - Internal Appeal," the Appeal Coordinator will send information describing the entire Appeal Process and your rights. "Second Level - Internal Appeal" is a review by a Panel comprised of the Appeal Coordinator, one of the Claims Administrator's Medical Directors and another of the Claims Administrator's officers none of whom were involved in, or subordinate to anyone involved in, the First Level decision. You or your Representative, on your behalf, will be given a reasonable opportunity to personally appear or participate via telephone, video conference, or other technology, and/or to provide written materials. For Appeals involving a Post-service investigational or experimental issue, a written notice of the decision will be sent within 20 working days (or 30 calendar days if sooner) of receipt of the "Second Level - Internal Appeal" and within 5 working days of the decision being made. For all other Post-service Appeals a written notice of the decision will be sent within 30 days of receipt of the "Second Level - Internal Appeal" and within 5 working days of the decision being made. For Appeals involving a Pre-service preauthorization of a procedure including a Pre-service investigational procedure, a written notice of the decision will be sent within 14 days of receipt of the "Second Level - Internal Appeal" and within 5 working days of the decision being made.

OPTIONAL APPEALS

The following levels of Appeal are optional and you should know that other forums may be utilized as the final level of Appeal to resolve a dispute you have with the Plan, including but not limited to civil action. The optional levels of Appeal below are available to you after you have exhausted all of the applicable non-optional levels of Appeal. If your Appeal is based on the Medical Necessity of services or services that are investigational or experimental in nature, you may submit your Appeal to either the "Optional External Appeal," OR to "Optional Arbitration." If your Appeal is not based on the Medical Necessity of services or services that are not investigational or experimental in nature, you may submit your Appeal to "Optional Arbitration."

Optional External Appeal (Medical Necessity Issues Only)

If you disagree with the decision made in the "Second Level - Internal Appeal" (or if you disagree with the decision made in a "First Level - Expedited Appeal" (described below), but preauthorization could no longer be reasonably believed to be clinically urgent (e.g., the service has been provided)), and the issue on Appeal is the Medical Necessity of services or services that are investigational or experimental in nature, you may request further Appeal to the "Optional External Appeal." The Appeal request must be made in writing or orally within 180 days after you receive notice of the decision at the "Second Level - Internal Appeal." Failure to request an "Optional External Appeal" within this time period will preclude the Claimant's right to further appeal of the decision through this optional level. The written Appeal request, including any additional information or comments must be made to the Appeal Coordinator, Regence BlueCross BlueShield of Utah, PO Box 30270, Salt Lake City, Utah 84130-0270. Oral requests can be made by calling the Claims Administrator at (801) 333-2100 within the Salt Lake area or (800) 624-6519 outside the Salt Lake area. "Optional External Appeal" will be coordinated by the Appeal Coordinator while the decision is made by an Independent Review Organization (IRO) at no cost to you. The IRO is an independent physician review organization that is unbiased, independent and not controlled by the Claims Administrator nor the Plan. Within the IRO, there will be clinical expertise, use of evidence-based decision making, maintenance of confidentiality, and adequate administration and training capacity. Within 5 days of receipt of the request for a "Optional External Appeal," the Appeal Coordinator will determine if the Appeal concerns Medical Necessity and send information describing the entire Appeal

process and your rights. If the Appeal Coordinator determines the Appeal concerns Medical Necessity, he or she will provide the IRO with the Appeal documentation within 3 working days and a written notice of the IRO's decision will be sent to you within 30 days of receipt of the request for "Optional External Appeal." Choosing the "Optional External Appeal" for the settlement of an Appeal as the final level will be binding in accordance with the IRO's decision and this section.

-OR-

Optional Arbitration

Voluntary arbitration is available as a level of Appeal for a dispute you have with the Plan. All other (non-optional) levels of this Appeal Process must be exhausted before arbitration is available. Choosing arbitration as the final level for the settlement of such disputes will be binding in accordance with the Arbitration provision of this section. The Appeal Coordinator can assist you with procedures for initiating and participating in an arbitration.

EXPEDITED APPEALS

First Level - Expedited Appeal

If you or your Representative reasonably believes that a utilization management decision denying preauthorization of a Pre-service 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, you or your Representative may request an Expedited Appeal. Expedited review also will be granted to requests concerning admissions, continued stay, or other health care services for a Claimant who has received emergency care and has not been discharged from a facility. The Appeal request must be made orally or in writing within 180 days after you receive notice of the initial written preauthorization denial, state the need for a decision on an expedited basis, and include documentation necessary for the Appeal decision. Oral requests can be made by calling the Claims Administrator at (801) 333-2100 within the Salt Lake area or (800) 624-6519 outside the Salt Lake area. The Appeal request, including any additional information or comments, must be made to the Appeal Coordinator, Regence BlueCross BlueShield of Utah, PO Box 30270, Salt Lake City, Utah 84130-0270. The "First Level - Expedited Appeal" is a review by a Panel comprised of the Appeal Coordinator, one of the Claims Administrator's Medical Directors and another of the Claims Administrator's officers none of whom were involved in, or subordinate to anyone involved in, the initial denial. You or your Representative, on your behalf, will be given the opportunity, within the constraints of the Expedited Appeals timeframe, to participate via telephone and/or provide written materials. A verbal notice of the decision will be provided to you and your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the request for "First Level - Expedited Appeal," and a written notice of the decision will be provided within 1 working day of providing the verbal notification.

OPTIONAL EXPEDITED APPEALS

The following levels of Expedited Appeal are optional and you should know that other forums may be utilized as the final level of Expedited Appeal to resolve a dispute you have with the Plan. The optional levels of Appeal below are available to you after you have exhausted all of the applicable non-optional levels of Appeal. If your Appeal is based on the Medical Necessity of services or services that are investigational or experimental in nature, you may submit your Appeal to either the "Optional Expedited Appeal," OR "Optional Expedited Arbitration." If your Appeal is not based on the Medical Necessity of

services or services are not investigational or experimental in nature, you may submit your Appeal to "Optional Arbitration."

Optional Expedited Appeal (Medical Necessity Issues Only)

If you disagree with the decision made in the "First Level - Expedited Appeal" and you or your Representative reasonably believe that preauthorization remains clinically urgent (Pre-service), and the issue on Appeal is the Medical Necessity of services or services that are investigational or experimental in nature you may request further Appeal to the "Optional Expedited Appeal." The Appeal request must be made verbally or in writing within 180 days after you receive either the verbal or written notice of the decision at the "First Level - Expedited Appeal." Failure to request an "Optional Expedited Appeal" within this time period will preclude the Claimant's right to further appeal of the decision through this optional level. If the request is received by the Claims Administrator orally, the Claims Administrator will send written confirmation to you that we received the oral notice within 24 hours after we receive the oral notice. Oral requests can be made by calling the Claims Administrator at (801) 333-2100 within the Salt Lake area or (800) 624-6519 outside the Salt Lake area. The Appeal request, including any additional information or comments must be made to the Appeal Coordinator, Regence BlueCross BlueShield of Utah, PO Box 30270, Salt Lake City, Utah 84130-0270. An "Optional Second Level - Expedited Appeal" will be coordinated by the Appeal Coordinator while the decision is made by an Independent Review Organization (IRO) at no cost to you. Within the IRO, there will be clinical expertise, use of evidence-based decision making, maintenance of confidentiality, and adequate administration and training capacity. Immediately upon receipt of the request for a "Optional Expedited Appeal," the Appeal Coordinator will determine if the Appeal concerns Medical Necessity and, if he or she determines that it does, provide the IRO with the Appeal documentation. A verbal notice of the decision will be provided by the IRO to you and your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the request for "Optional Expedited Appeal," whichever is sooner, and a written notice will be provided by the IRO within 2 working days of providing the verbal notification. Choosing the "Optional External Appeal" as the final level for the settlement of an Appeal based on Medical Necessity will be binding in accordance with the IRO's decision and this section.

-OR-

Optional Expedited Arbitration

Voluntary arbitration is available as a level of Appeal for a dispute you have with the Plan. All other (non-optional) levels of this Appeal Process must be exhausted before arbitration is available. Choosing arbitration as the final level for the settlement of such disputes will be binding in accordance with the Arbitration provision of this section. The Appeal Coordinator can assist you with procedures for initiating and participating in an arbitration.

ARBITRATION (IF OPTED)

In the event of any dispute or controversy concerning the construction, interpretation, performance or breach of the Plan arising between you, your heir-at-law or your Representative, and the Plan, whether involving a claim in tort, contract or otherwise, the same may be submitted, if opted by you as the final level of Appeal, to arbitration under the appropriate rules of the American Arbitration Association, a copy of which is available upon request from the Claims Administrator or the local office of the American Arbitration Association. All administrative remedies described in this Plan must be exhausted prior to the demand for arbitration. The costs of arbitration, including reasonable filing fees, administrative fees and arbitrator fees, will be borne by the Claims Administrator. Other expenses of arbitration (including but not

limited to attorney fees, expenses of discovery, witnesses, stenographers, translators, and similar expenses) will be borne by the party incurring those expenses. The parties agree that the arbitrator's award will be binding, may include attorney's fees if allowed by state law, and may be enforced in any court having jurisdiction thereof by filing a petition for enforcement of said award. Any arbitration will be conducted in Utah, as required by state law.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

Appeal means a written or oral request from you or, if authorized by you, your Representative, to change a previous decision made by the Plan concerning:

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

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision maker for Optional External Appeals and Optional Expedited External Appeals, through an independent contractor relationship with the Claims Administrator.

Medical Director means for purposes of the Appeal Process only, a physician employed by, or consulted by, the Claims Administrator. (The Medical Director shall reserve the right, if not appropriately qualified to review a particular procedure, to consult with an outside practitioner with specialty in the medical condition/procedure involved in the review.)

Post-service means any claim for benefits under this Plan that is not considered Pre-service.

Pre-service means any claim for benefits under this Plan which the Claims Administrator must approve in advance, in whole or in part, in order for payment of the benefits to be made.

Representative means any representative authorized by you, as designated in writing by you or your legal guardian on an executed Authorization Form. No Authorization Form 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, and no Authorization Form need be executed. Even if you have previously designated a person as your Representative for a previous matter, an Authorization Form designating that person as your Representative in a new matter will be required (but redesignation is not required for each Appeal level).

WHO IS ELIGIBLE

This section contains the terms of eligibility under the Plan for employees and their dependents.

PLEASE NOTE: In the following sections starting with WHO IS ELIGIBLE through COBRA CONTINUATION OF COVERAGE the terms "You" and "Your" mean the Plan Participant only.

EMPLOYEES

Full-time regular employees (75% FTE or more) hired in a designated benefits eligible position are eligible to participate in this Plan on either the 1st or the 16th of the month, whichever corresponds with or immediately follows Your date of hire.

DEPENDENTS

If You participate in the Plan, Your Enrolled Dependents are eligible for coverage when You have listed them on the application form or on subsequent change forms. Dependents are limited to the following:

- the person to whom You are legally married (spouse);
- Your (or Your spouse's) unmarried children by birth, legal adoption, placed for adoption, or legal (court-appointed) guardianship granting full guardianship rights who are under age 26 and who were dependent on You for more than 50% of their support, as "support" is defined in the United States Internal Revenue Regulations (see NOTE below), for the three months preceding the current premium due date (for a child born or placed for adoption within the three-month period preceding the current premium due date, the 50% support test will apply only to the period since the child's date of birth or placement for adoption);
- Your (or Your spouse's) unmarried children by birth, legal adoption, placed for adoption, or legal (court-appointed) guardianship granting full guardianship rights who are a Disabled Dependent due to a Physical Impairment or Mental Impairment that started before the child's 26th birthday, are covered as of that date or have been continuously covered since that date without any break in coverage greater than 63 days, and were dependent on You for more than 50% of their support, as "support" is defined in the United States Internal Revenue Regulations (see NOTE below), for the three months preceding the current date (for a child born or placed for adoption within the three-month period preceding the current date, the 50% support test will apply only to the period since the child's date of birth or placement for adoption);
- a child who is under 18 years of age for whom the noncustodial parent is required by a court order or administrative order to provide health insurance coverage, whether or not the custodial parent is a Plan Participant and whether or not the noncustodial parent, who is eligible for this coverage, has enrolled hereunder; and
- a child, as described in the third bullet above, who is any age and incapacitated from earning a living and without sufficient means for whom the noncustodial parent is required by a court order or administrative order to provide health insurance coverage, whether or not the custodial parent is a Plan Participant and whether or not the noncustodial parent, who is eligible for this coverage, has enrolled hereunder.

NOTE: "Support" as used above includes food, shelter, clothing, medical and dental care, education, and the like. Generally, the amount of an item of support will be the amount of expense incurred by the one furnishing such item. If the item of support furnished an individual is in the form of

property or lodging, it will be necessary to measure the amount of such item of support in terms of its fair market value. In computing the amount which is contributed for the support of an individual, there must be included any amount which is contributed by such individual for his own support, including income which is ordinarily excludable from gross income, such as benefits received under the Social Security Act. [Internal Revenue Regulation §1.152-1]

Dependent Coverage Beyond Limiting Age

- You may continue coverage for an enrolled child who is a Disabled Dependent due to a Physical Impairment or Mental Impairment that started before the child reached age 26. To do so, You must provide the Claims Administrator written notice of intent to continue coverage along with proof of the dependent's disability, as follows:
 - within 30 days after the dependent reaches age 26; and
 - at reasonable times thereafter as the Plan may consider necessary, but not more often than annually.
- You may enroll a child whose 26th birthday precedes Your Effective Date and who is a Disabled Dependent due to a Physical Impairment or Mental Impairment that started before the child reached age 26, if the child also, since reaching age 26, continuously has been covered by health insurance, with no break in coverage of more than 63 days, and chiefly dependent upon an insured person. To do so, You must provide the Claims Administrator written notice of the dependent's disability, as follows:
 - within 30 days after Your Effective Date; and
 - at reasonable times thereafter as the Plan may consider necessary, but not more often than annually.

You must promptly furnish or cause to be furnished to the Claims Administrator any information necessary or appropriate to determine the validity of a dependent's status. Receipt of such information by the Claims Administrator will be a condition precedent to enrolling a person as a dependent under the Plan.

DEFINITIONS SPECIFIC TO THE WHO IS ELIGIBLE SECTION

Disabled Dependent 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 (see NOTE above).

Physical Impairment 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.

Mental Impairment 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 Us.

HOW TO ENROLL AND WHEN COVERAGE BEGINS

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible, during a period of Special Enrollment, Open Enrollment or as a Late Enrollee. This section also describes when coverage under the Plan begins for You and/or Your eligible dependents.

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

WHEN YOU AND/OR YOUR DEPENDENTS ARE INITIALLY ELIGIBLE

Upon first becoming eligible for coverage under the eligibility requirements in effect with the Employer, You will be entitled to apply for coverage for Yourself and/or Your eligible dependents within 30 days of becoming eligible. Coverage for You and Your eligible dependents will commence on either the 1st or the 16th of the month, whichever corresponds with or immediately follows Your date of hire.

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage (including a new dependent child by birth, adoption, or placement for adoption) under the eligibility requirements in effect with the Plan by completing and submitting to the Claims Administrator a signed group change request within 30 days of the dependent's attaining eligibility. Coverage for such dependent will commence on the Effective Date as determined by the Plan Administrator.

NOTE: When the addition of a new dependent child by birth, adoption, or placement for adoption does not cause a change in the premium amount billed to the Employer (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 dependent, to submit to the Claims Administrator a signed group change request.

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your eligible dependents if You failed to do so when first eligible and not be considered a Late Enrollee. In these situations, the rules regarding how to apply and when coverage begins are the same as those described earlier. For example:

- If You and/or Your eligible dependents lose 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, death, termination of employment, reduction in hours, exhaustion of lifetime maximum on total benefits; or the employer contributions were terminated; or
 - involuntary loss of coverage under Medicaid, Medicare, CHAMPUS/Tricare, Indian Health Service, or a publicly sponsored or subsidized health plan.

In all of the above situations, You and/or Your eligible dependents 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.

- If You declined coverage when You were first eligible and You subsequently marry You become eligible for coverage under this Plan on behalf of Yourself, Your spouse, and any eligible dependent children on the date of marriage.
- If You declined coverage when You were first eligible (or You declined coverage for Your spouse when he or she was first eligible) and You subsequently acquire a new dependent child by birth, adoption, or placement for adoption, You become eligible for coverage under this Plan along with Your eligible spouse and eligible dependent children including the newly acquired child on date of the birth, adoption, or placement.

Special Enrollment opportunities last for the 30 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.

OPEN ENROLLMENT PERIOD

If You are eligible for coverage under the Plan, but did not enroll You and/or Your Eligible Dependents for coverage under the Plan when first eligible to do so, You shall be entitled to apply for coverage for You and/or Your Eligible Dependents at the time of the Open Enrollment Period (if available in the Plan). Coverage under the Plan will commence on the Effective Date following acceptance of the application.

LATE ENROLLMENT

If You and/or Your eligible dependents wish to enroll under the Plan but did not enroll when first eligible or during an Annual Enrollment Period as a transfer from another health benefit plan offered by the Plan (Late Enrollee) and You do not qualify for any of the Special Enrollment exceptions, You may apply for coverage for Yourself and Your eligible dependents. Coverage for a Late Enrollee will commence on the Effective Date which, for a Late Enrollee, is always the Plan's annual Renewal Date.

TRANSFER DURING ANNUAL ENROLLMENT PERIOD

If You and/or Your eligible dependents are transferring directly to this Plan from one of the Plan's other health benefit plans during the Annual Enrollment Period, You will not be subject to the Late Enrollment requirements of the Plan. You must file an application on behalf of all dependents You want enrolled. Coverage for You and Your eligible dependents will commence on the Effective Date.

ENROLLMENT BY OTHERS

In the event Your child is the subject of a court or administrative order requiring You to provide health coverage for the child and You are eligible for health coverage including the child, but fail to make application to cover the child, application for enrollment of the child may be made by the child's other parent, any state Medicaid agency or by the state agency administering 42 U.S.C. 651 through 699 (the child enforcement program).

NOTICE OF STATUS CHANGE

In the event You acquire or lose a dependent after the Effective Date, You must give the Plan written notice within 30 days after such date. In the event of Your death, written notice must be given to the Plan within 30 days after the death.

WHEN COVERAGE ENDS

This section describes the situations when coverage will end for You and/or Your Enrolled Dependents.

PLAN TERMINATION

If the Plan is terminated by the Employer, coverage ends for You and Your Enrolled Dependents on the date the Plan is terminated.

No person shall have or acquire a vested right to receive benefits after the date this Plan is terminated. Termination of Your or Your Enrolled Dependent's coverage under this Plan for any reason shall completely end the Plan's obligations to provide You or Your Enrolled Dependent benefits for Covered Services received after the date of termination whether or not You or Your Enrolled Dependent 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.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, You and Your Enrolled Dependents' coverage will end as indicated. However, it may be possible for You and/or Your Enrolled Dependents to continue coverage under the Plan according to the continuation of coverage provisions of this Summary Plan Description.

Termination Of Your Employment Or You Are Otherwise No Longer Eligible

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Plan, Your coverage will end for You and all Enrolled Dependents on the last day of the pay period following the date on which eligibility ends.

Nonpayment Of Required Contribution

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

Plan Termination By Employer

Your coverage will end for You and all Your Enrolled Dependents on the date of such a termination.

Family And Medical Leave

If Your Employer grants You a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3) the following rules will apply. The Act is generally applicable to private employers of 50 or more employees and public employers of any size. 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 Enrolled Dependents 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;
 - the placement of a child with You for adoption or foster care;

- in order to care for Your spouse, child, or parent, if such spouse, child, or parent has a serious health condition; or
- You suffer a serious physical illness or Mental Health Condition.

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 purposes 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 through Your Employer. The provisions described here will not be available if this Plan terminates.
- If You and/or Your Enrolled Dependents elect not to remain enrolled during the leave, You (and/or Your Enrolled Dependents) 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 Enrolled Dependents) 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 Enrolled Dependents 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. This leave provision is available only to groups that are required by law to comply. The Plan must keep the Claims Administrator advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by the Act.

Leave Of Absence

If You are granted a non-FMLA temporary leave of absence by Your Employer, 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 through the Employer in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by Your employer 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 Employer, including disability and pregnancy.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your dependents are no longer eligible as explained in the following paragraphs, their coverage will end as indicated. However, it may be possible for Your ineligible dependents to continue coverage under the Plan according to the 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) on the last day of the pay period following the date a divorce or annulment is final.

If You Die

If You die, coverage for Your Enrolled Dependents ends on the last day of the monthly period in which Your death occurs.

Loss Of Dependent Status

- For an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the monthly period in which the child exceeds the dependent age limit.
- For an enrolled child who marries, eligibility ends on the last day of the pay period in which the marriage occurs.
- 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, eligibility ends on the date the child is removed from placement.
- For an enrolled child who is no longer an eligible dependent for any other cause (except by reason of divorce or Your death), eligibility ends on the last day of the pay period in which the child is no longer a dependent.

CERTIFICATES OF CREDITABLE COVERAGE

Requests for and inquiries about required certifications of coverage relating to period(s) of coverage under the Plan should be directed to the Plan or to the Claims Administrator at PO Box 30270, Salt Lake City, Utah 84130-0270.

COBRA CONTINUATION OF COVERAGE

This COBRA CONTINUATION OF COVERAGE Section applies only when the Employer is subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA. Under certain circumstances called qualifying events, Claimants may have the right to continue coverage beyond the time coverage would ordinarily have ended. The following rights and obligations regarding continuation of coverage are governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. In the event of any conflict between this continuation of coverage provision and COBRA, the minimum requirements of COBRA will govern. This provision will automatically cease to be effective when federal law requiring continuation of eligibility for coverage no longer applies to the Employer. This section does not provide a full description of COBRA and more complete information is available from the Employer.

WHO IS ELIGIBLE FOR COBRA CONTINUATION AND HOW LONG IT LASTS

If Your health coverage terminates due to either of the following qualifying events, You may elect COBRA continuation coverage for a maximum of 18 months following the date that Your coverage normally would have been lost:

- termination of Your employment for reasons other than gross misconduct; or
- reduction in Your hours of employment.

Your Enrolled Dependents whose health coverage terminates due to either of these qualifying events may also elect this COBRA Continuation Coverage for a maximum of 18 months.

If health coverage for any of Your Enrolled Dependents terminates due to any of the following qualifying events, that Enrolled Dependent 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 dissolve Your marriage (divorce) or legally separate;
- You become entitled to Medicare benefits; or
- the Enrolled Dependent is a child and loses eligibility as a dependent under the Plan.

By electing COBRA continuation coverage, unless You specify to the contrary, You will automatically be maintaining benefits on behalf of Yourself, as well as Your Enrolled Dependents. If COBRA continuation coverage is not desired for You or any of Your Enrolled Dependents, each Enrollee (including You) may independently elect such coverage on behalf of him or herself. Any election by Your spouse will automatically continue coverage of Your Enrolled Dependent children, unless specified to the contrary.

COBRA coverage following a termination of employment/reduction in hours qualifying event can be extended to a maximum of up to 29 total months if You or Your Enrolled Dependent is determined to have been disabled for purposes of Title II or Title XVI of the Social Security Act at the time of the initial qualifying event or within the first 60 days of COBRA continuation coverage. To be eligible for the extension, You or Your Enrolled Dependent must provide the Plan documentation of the Social Security disability determination within 60 days of the date it is made and while still within the 18-month continuation period. The disability extension extends to You and Your Enrolled dependents, even if only one of you is disabled.

An 18-month period of COBRA continuation coverage following a termination of employment/reduction in hours qualifying event (or a 29 month COBRA Continuation period involving such a termination/reduction followed by a disability extension) may be extended to a period of up to 36 months for Your Enrolled Dependent who would otherwise lose health coverage by virtue of any of the following "second" qualifying events occurring within the first 18-month (or, if there has been a disability extension, 29-month) period:

- Your death;
- You and Your spouse dissolve Your marriage (divorce) or legally separate;
- You become entitled to Medicare benefits; or
- the Enrolled Dependent is a child and loses eligibility as a dependent under the Plan.

However (except with regard to employer Chapter 11 bankruptcy as described below), in no event will COBRA continuation coverage extend beyond 36 months from the date coverage was first lost due to the termination of employment/reduction in hours qualifying event. You or Your Enrolled Dependent must provide the Plan notice of the occurrence of one of these qualifying events.

IF YOU ARE RETIRED AND THE EMPLOYER FILES CHAPTER 11 BANKRUPTCY

COBRA also allows continuation of coverage if You are retired, the Group files a Chapter 11 bankruptcy petition, and You or Your Enrolled Dependent experiences a loss of Plan coverage (or substantial reduction in coverage) within one year before or after the bankruptcy filing. Retired employees, and widows or widowers of retired employees who died before the bankruptcy, may continue coverage for the remainder of their lifetimes. If You are retired and die after the bankruptcy, Your Enrolled Dependents may continue coverage for up to 36 months after Your death.

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 Dependents will be allowed to continue their COBRA coverage until the later of:

- up to 18 months from the date coverage otherwise would be lost due to the termination of employment/reduction in hours, or
- up to 36 months from the date You became entitled to Medicare.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA continuation under this Plan will end for You and/or Your Enrolled Dependents as of the last day of the monthly premium payment period in which any of the following occurs:

- failure to make premium payments necessary to bring premiums current within 45 days of electing COBRA;
- failure to make the monthly premium payment within 40 days of the Premium Due Date;
- the date, after election of COBRA, that You and/or Your Enrolled Dependents become covered under another group health plan (which does not limit or exclude any Preexisting Condition the person might have, either because of no applicable Preexisting Condition or sufficient creditable coverage to eliminate any Preexisting Condition limitation) or become entitled to Medicare benefits;

- the date You reach the Lifetime Maximum Benefit under this Plan;
- the date this Plan terminates; or
- the applicable period of COBRA continuation ends.

COBRA Continuation under this Plan will end for You and/or Your Enrolled Dependents:

- when there is final determination that You and/or Your Enrolled Dependents are no longer disabled for the purposes of Title II or Title XVI of the Social Security Act, as of the later of:
 - the last day of 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.

This event will terminate the continuation of all Claimants who had qualified to extend by virtue of the Claimant's disability and it is Your or Your Enrolled Dependent's responsibility to notify the Plan of such a final determination within 30 days of the day it is made.

WHEN YOU ACQUIRE A NEW DEPENDENT CHILD WHILE YOU ARE ON COBRA

Children born to You or placed with You for adoption while You are on COBRA may be added to COBRA coverage and have all the rights extended to You and/or Your other Enrolled Dependents who have elected COBRA. Addition of such children must occur in accordance with the terms of the WHO IS ELIGIBLE Section of this Summary Plan Description.

NOTIFICATION RESPONSIBILITIES

In order to preserve rights under COBRA, Claimants and the Plan must meet certain notification, election and payment deadline requirements.

Under COBRA, You or one of Your Enrolled Dependents must inform the Plan in writing within 60 days of Your divorce or legal separation, or a loss of dependent status. The Plan is responsible for notifying You and/or Your Enrolled Dependents of the right to elect COBRA continuation due to any of the other qualifying events (for example, employee's death, termination of employment or reduction in hours, or Medicare entitlement).

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

As mentioned above, to be eligible for disability extension, You or Your Enrolled Dependent must provide the Plan documentation of a Social Security disability determination within 60 days of the date it is made and while still within the 18 month COBRA Continuation period following a termination or reduction of hours qualifying event. The determination must reflect that You or Your Enrolled Dependent was disabled for Social Security purposes at the time of the initial qualifying event or within the first 60 days of COBRA continuation. If a final determination is subsequently made that You or Your Enrolled Dependent is no longer disabled for Social Security purposes, You or Your Enrolled Dependent must provide the Employer notice of that determination within 30 days of the date it is made.

To be eligible for an extension of the 18-month continuation following a termination of employment/ reduction in hours qualifying event (or a 29 month COBRA Continuation period involving such a

termination/reduction followed by a disability extension), You or Your Enrolled Dependent must notify the Employer within 30 days of the occurrence of any of the following “second” qualifying events causing a loss of coverage within that 18-month (or 29-month) period:

- Your death;
- You and Your spouse dissolve Your marriage (divorce) or legally separate;
- You become entitled to Medicare benefits; or
- the Enrolled Dependent is a child and loses eligibility as a dependent under the Plan.

However(except with regard to employer Chapter 11 bankruptcy as described above), in no event will COBRA continuation coverage extend beyond 36 months from the date coverage was first lost due to the termination of employment/reduction in hours qualifying event. You or Your Enrolled Dependent must provide the Plan notice of the occurrence of one of these “second” qualifying events.

PAYING CONTINUATION PREMIUM

If Claimants wish to continue coverage, they must pay for it. The premium will reflect the total cost of the group health care coverage and up to a 2% administration fee. For those Claimants who receive COBRA Continuation Coverage due to a Social Security disability determination, the premium and administration fees will be 150% of the total cost for coverage. Coverage will cease if timely premium payments are not made. Claimants have a maximum of 45 days from the date that the election form is mailed to the Plan to submit the first payment. This first payment must retroactively cover any period of time after the date coverage was terminated. All subsequent payments are due on the first day of the month for which coverage is to be provided or within a 30-day grace period thereafter.

IF CLAIMANTS DO NOT ELECT COBRA CONTINUATION

If Claimants do not elect COBRA continuation coverage, coverage under the Plan will end according to the terms of the Plan and the Plan will not pay claims for services provided on and after the date coverage ends.

IMPORTANCE OF KEEPING INFORMATION CURRENT

It is very important that You keep the Employer informed of the current address of all Claimants who are or may become qualified beneficiaries.

GENERAL PROVISIONS

This section explains various general provisions regarding your benefits under the Plan.

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered under the Plan, they must be incurred when coverage is in effect. Coverage is in effect when:

- the person is eligible to be covered according to the eligibility provisions of the Plan; and
- the person has applied for coverage and has been accepted by the Plan.

The expense of a service is incurred on the day the service is rendered and the expense of a supply is incurred on the day the supply is delivered to you.

NOTICES

Any notice to Claimants or to the Employer required in the Plan will be deemed to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Plan Participant or to the Plan will be addressed to the Plan Participant or to the Plan 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 Plan Participant, the Claims Administrator will update their records accordingly. Additionally, the Claims Administrator may forward any notice for a Plan Participant to the Plan Administrator if the Plan fails to provide the Claims Administrator a valid mailing address or the Plan fails to update the Plan Participant's address with a mailing address the Claims Administrator can use to send the Plan Participant his or her mail. Any notice to the Claims Administrator required in the Plan may be given by mail addressed to: Regence BlueCross BlueShield of Utah at PO Box 30270, Salt Lake City, Utah 84130-0270; provided, however that any notice to the Claims Administrator will not be deemed to have been given to and received by the Claims Administrator until physically received by them.

MODIFICATION REQUIRED BY CHANGE IN LAW

In the event of a change in applicable federal law, the Claims Administrator will administer the Plan according to the change in law at the time such law becomes effective. Unless a prior notice is otherwise required by such change in federal law, the Plan Administrator may choose to incorporate the change in law by amendment to the Plan Document or reissue the Plan Document to the employer as modified by such change, upon the renewal date.

CHOICE OF FORUM

Any legal action arising out of this Plan must be filed in either state or federal court in the state of Utah.

GOVERNING LAW

The Plan will be governed by and construed in accordance with the laws of the United States of America and by the laws of the State of Utah without regard to its conflict of law rules. Where the law or judicial interpretation of the law changes over time, the administration of benefits for otherwise identical claims may differ, unless such change is expressly made retroactive. Where not directly in conflict with the laws

of the United States of America or the State of Utah, the Plan will be interpreted in accordance with the Plan's rules and regulations in effect at the time of interpretation.

SUMMARY PLAN DESCRIPTION TITLES AND HEADINGS ARE FOR CONVENIENCE

Section titles and headings throughout the Summary Plan Description are only for convenience and are not intended to be part of the provision that they introduce.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Plan on behalf of itself and its Claimants hereby expressly acknowledges its understanding that this Summary Plan Description constitutes a contract solely between the Plan and Regence BlueCross BlueShield of Utah, 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 the Claims Administrator to use the Blue Cross and Blue Shield Service Marks in the state of Utah and that the Claims Administrator are not contracting as the agent of the Association. The Plan on behalf of itself and its Claimants further acknowledges and agrees that it has not entered into this Plan based upon representations by any person or entity other than Regence BlueCross BlueShield of Utah and that no person or entity other than Regence BlueCross BlueShield of Utah will be held accountable or liable to the Plan or the Claimants for any of the Claims Administrator's obligations to the Plan or the Claimants created under this Plan. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueCross BlueShield of Utah other than those obligations created under other provisions of this Plan.

NO WAIVER

The failure or refusal of either party to demand strict performance of this 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 deemed waived by the Plan Administrator unless such waiver is reduced to writing and signed by one of the Plan's authorized officers.

REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements you make in an application will be deemed 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 has been furnished to you.

LEGAL OR ARBITRATION PROCEEDINGS

In case of any dispute under the Plan which becomes the subject of any arbitration or legal proceeding, you, on behalf of yourself and your heirs and Representatives, do hereby expressly waive the privileges and benefits of all and any laws and rules which are now in force or hereafter enacted or promulgated in regard to disqualifying any doctor, nurse, hospital official or employee, or any other person or organization providing medical services, supplies, or accommodations from testifying concerning any information obtained by such person or organization in a professional capacity, or other capacity which makes such information or knowledge privileged; and you, on behalf of yourself and your heirs and Representatives, do hereby expressly authorize and request such doctor, nurse, hospital official or

employee, or other person or organization to make full disclosure in the arbitration or legal proceeding concerning the Plan's liability for such benefits.

DEFINITIONS

The following definitions of important terms used in this Summary Plan Description will be capitalized throughout the Summary Plan Description. Other terms are defined and capitalized where they are first used in the text of the Summary Plan Description. The same term used in the Summary Plan Description but which is not capitalized does not have the same meaning as defined here or when first used in the Summary Plan Description:

Accidental Injury means an Injury sustained by a Claimant which is the direct result of an accident, independent of Illness or any other cause. Accidental 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.

Ambulatory Service Facility means a facility, licensed by the State of Utah or the state in which it is located, which is equipped and operated mainly to do surgeries or obstetrical deliveries that allow patients to leave the facility the same day the surgery or delivery occurs.

Calendar Year means the period from January 1 through December 31 of the same year; however, the first Calendar Year commences on the Claimant's Effective Date.

Claimant is a Plan Participant or an Enrolled Dependent.

Coinsurance means an amount, expressed as a percentage, that you must pay for Covered Services.

Contract Year means the period of twelve consecutive months beginning on the Plan Effective Date and at each Renewal Date thereafter.

Copayment means the fixed amount that you must pay each time you receive a specified service.

Covered Service means a service, supply, treatment or accommodation that is listed in the COVERED SERVICES Section of the Plan.

Deductible means the amount of Eligible Medical Expenses that you must pay each Contract Year before the Plan will provide payments for Covered Services.

Dental Services means services or supplies provided to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues or structures, including but not limited to services or supplies rendered:

- to repair defects which have developed because of tooth loss;
- to restore the ability to chew; or
- to control bruxism.

Effective Date means the date specified by Plan Administrator or its designee, following the Plan's acceptance of the application for coverage, as the date coverage begins for the Plan Participant or Enrolled Dependent.

Eligible Medical Expenses means:

- with respect to Participating Hospitals, Participating Skilled Nursing Facilities, and other facilities that are Participating Providers, the amount as provided in the applicable contractual payment schedule;

- with respect to Physicians, Practitioners and other professional Providers, the amount Participating Physicians/Practitioners have agreed to accept as full payment for Covered Services as determined by the Claims Administrator; and
- with respect to all other Providers, reasonable charges for Covered Services as determined by the Claims Administrator.

Charges in excess of Eligible Medical Expenses are not deemed reasonable charges and are not reimbursable under the Plan. For questions regarding the basis for determination of Eligible Medical Expenses, please contact the Claims Administrator.

Emergency Medical Condition means a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency department would result in:

- placing the Claimant's health, or with respect to a pregnant Claimant, the health of the pregnant Claimant or 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 Dependent means a Plan Participant's eligible dependent who is listed on the Plan Participant's application for coverage or on subsequent change forms who have been accepted for coverage under this Plan.

Family Unit means a Plan Participant and his or her Enrolled Dependents.

Home Health Care Agency means an agency that is duly licensed by the state in which it is located to provide home health care.

Home Infusion Therapy Agency means an agency that is duly licensed by the state in which it is located to provide home infusion therapy services.

Hospital means a facility that is licensed by the State of Utah as a general acute or specialty hospital or is similarly licensed 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. Hospital does not include the following:

- residential treatment facilities;
- health resorts or spas;
- nursing homes;
- Christian Science sanatoria;
- institutions for exceptional children;
- institutions which are primarily places for care of convalescents;
- institutions which are primarily places for treatment of pulmonary tuberculosis;
- clinics;
- Provider offices;
- Skilled Nursing Facilities;

- Rehabilitation Facilities;
- private homes;
- halfway houses; and
- Ambulatory Service Facilities.

Illness means a congenital malformation which 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.

Injury means physical damage to the body inflicted by a foreign object, force, temperature, or corrosive chemical.

Life-Threatening Illness means the initial and sudden onset of an Illness which, unless immediate medical attention is received, would result in the death or permanent disability of the Claimant. Final determination as to whether an Illness is Life-Threatening will be made by the Plan.

Lifetime means the period of time a Claimant is covered under the Plan or an earlier Plan previously issued to the Plan Administrator.

Maximum Benefit means that when payments total the specified amount or when benefits have been provided for a specified number of days, visits, or services, no more payments will be made by the Plan. When the Maximum Benefit is for a specified time period such as a Contract Year, no more payments will be made during the remainder of the specified time period.

Medically Necessary shall mean 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, injury, disease 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 interventions not yet in widespread use, the effectiveness shall be based on Scientific Evidence. For established interventions, the effectiveness shall be based on first Scientific Evidence; then professional standards; and then expert opinion.

For the purpose of this definition, Scientific Evidence shall mean 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.

Nonparticipating Provider means a Provider who does not have an effective participating contract with the Claims Administrator to provide services and supplies to Claimants.

Participating Provider means a Provider who has an effective participating contract with the Claims Administrator (or a Provider outside Utah who or which has a contract with another Blue Cross and/or Blue Shield organization for the BlueCard program) to provide services and supplies to Claimants in accordance with the provisions of the Plan.

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 Participant means an employee of the Employer who is eligible under the terms of the Plan, whose application is accepted by the Plan, and who is enrolled under this Plan.

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 their respective licenses.

Provider means a Hospital, Skilled Nursing Facility, Ambulatory Service Facility, 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 which is licensed by the State of Utah as a rehabilitation facility, or is similarly licensed by the state in which it is located, and which provides an intensive, multidisciplinary approach to rehabilitation services under the direction and supervision of a Physician.

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

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