PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

ARUP LABORATORIES, INC. MEDICAL BENEFIT PLAN

EFFECTIVE JANUARY 1, 2017

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ESPAÑOL: Para obtener asistencia en Español, llame al 1-800-426-7453.

INTRODUCTION

This document is a description of ARUP Laboratories, Inc. Medical Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

To the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Network Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Health Care Plan Privacy Notice. Explains how medical information may be used, disclosed and accessed.

Open Enrollment. Explains some options for enrollment and benefit selection.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees who qualify under one of the classes below:

- Regular Full-Time Employees: Employees designated by the Employer as Regular Full-Time Employees who are scheduled to work at least 20 hours per week. Coverage for Regular Full-Time Employees becomes effective on the date the Employee is employed as a Regular Full-Time Employee, subject to completion of enrollment requirements

New Hires

- Qualifying Employee: A Qualifying Employee is an Employee who is not a Regular Full-Time Employee but who averages at least 20 Hours of Service per week over the Employee's Initial Measurement Period. Coverage will be effective on the first day of the Qualifying Employee's New Employee Stability Period, subject to completion of enrollment requirements. A Qualifying Employee will remain eligible throughout the New Employee Stability Period to the extent that the employee remains employed, subject to the Plan's Break in Service rules.

  Note: if there is a gap between the end of the Qualifying Employee's New Employee Stability Period and the start of the Qualifying Employee's first Ongoing Employee Stability Period (see below), the Qualifying Employee will remain eligible under the Plan until the day preceding the start of the Ongoing Employee Stability Period (to the extent the employee remains employed, and subject to the Plan's Break in Service rules.)

  If a Qualifying Employee transfers to a Regular Full-Time Employee position prior to the start of the Qualifying Employee's New Employee Stability Period, the Employee will become eligible for coverage. Coverage for the new Regular Full-Time Employee will become effective on the date the Employee is employed as a Regular Full-Time Employee, subject to completion of the enrollment requirements.

Ongoing Employees:
Once an Employee has completed the Plan's Initial Measurement Period, eligibility will be based solely on the Employee's Hours of Service during the Plan's Standard Measurement Period. Any Employee who averages 20 Hours of Service per week during the Plan's Standard Measurement Period ("Ongoing Employees") will be eligible for coverage under the Plan during the Plan's next Ongoing Employee Stability Period, provided that the Ongoing Employee remains employed, and subject to the Plan's Break in Service rules. Coverage will be effective on the first day of the Ongoing Employee Stability Period, subject to completion of the enrollment requirements.

Impact of Breaks in Service:
If you have a Break in Service and then return to work, you will be treated as a New Hire, and eligibility for coverage under the Plan upon return will be determined in accordance with the New Hire rules above. However, if you are not actively at work for a period and return to work or are otherwise credited with Hours of Service before you incur a Break in Service, you will be treated as a continuous employee and will be eligible for coverage under the Plan upon return if you were enrolled in coverage prior to the start of the period during which you had no Hours of Service. Your coverage will be effective on the date you resume Hours of Service, subject to completion of enrollment requirements.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person with whom covered Employee has established a valid marriage under applicable State law and shall include Common Law marriages. The Plan Administrator may require documentation proving a legal marital relationship.

The term "Spouse" shall also mean the person who is currently registered with the Employer as the Domestic Partner of the Employee and shall include opposite sex and same sex couples. An individual is a Domestic Partner of an Employee if that individual and the Employee meet each of the following requirements:

(a) The Employee and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract.

(b) The Employee and the individual are not married to anyone.

(c) The Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

(d) The Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole Domestic Partner. Each of the foregoing characteristics of the Domestic Partner relationship must have been in existence for a period of at least 12 consecutive months and be continuing during the period that the applicable benefit is provided. The Employee and the individual must have the intention that their relationship will be indefinite.

(e) The Employee and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership.

To obtain more detailed information or to apply for this benefit, the Employee must contact the Plan Administrator, ARUP Laboratories, Inc., 500 Chipeta Way, Salt Lake City, Utah, 84108, 801-583-2787, option 1, and extension 2182.

In the event the Domestic Partnership is terminated, either partner is required to inform ARUP Laboratories, Inc. within 60 days of the termination of the partnership by providing a notarized Statement of Termination of Domestic Partnership. The termination of the domestic partnership will terminate coverage under this plan for the Dependent.

The Plan Administrator may require documentation proving a legal marital and/or Domestic Partner relationship.

(2) A covered Employee's Child(ren).

An Employee's "Child" includes his or her natural child, stepchild, foster child, adopted child, or a child placed with the Employee for adoption. An Employee's child will also include children, adopted children and children placed for adoption with the Employee's Domestic Partner. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

(3) A covered Employee's Qualified Dependents.

The term "Qualified Dependents" shall include individuals who do not qualify as a Child as defined above, but who are children for whom the Employee is a Court Appointed Legal Guardian.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be under the limiting age of 26 years. Coverage will end on the last day of the month in which the Qualified Dependent ceases to meet the applicable eligibility requirements.

Any child of a Plan Participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(4) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; grandchildren; any person who is on active duty in any military service of any country; any former Domestic Partner of the Employee; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both parents are Employees, their eligible Dependent will be covered as the Dependent of one of the parents, but not both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Domestic Partner, Qualified Dependent or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. ARUP Laboratories, Inc. shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements for Employee and Dependents. An Employee must enroll for coverage and authorize applicable payroll deductions as specified by the Employer. If the Employee wishes to cover eligible dependents, the Employee also is required to include the eligible Dependents on the enrollment application.

Newly acquired Dependents, including newborn children and children adopted or placed for adoption, must be enrolled to continue coverage under the Plan after the first 60 days. Eligible newborn children and children adopted or placed for adoption of a Covered Employee are automatically covered under the Plan for the first 60 days. However, to continue coverage for the newborn or newly adopted child under the Plan beyond the first 60 days, they must be enrolled.

See Special Enrollment and Timely Enrollment sections for enrollment requirements and effective dates. Newly acquired Dependents who are not enrolled within 60 days of the event (birth, marriage, adoption or placement for adoption, etc.) are not eligible for coverage until open enrollment.

If the Timely Enrollment requirements are not met and the applicable forms are not received within 60 days from the date of birth, adoption or placement for adoption, the dependent will be terminated from the plan on the day following 60 days.

TIMELY ENROLLMENT

Timely Enrollment - The enrollment will be "timely" if received by the Plan Administrator no later than 60 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (who are legally married under applicable State law or are Domestic Partners) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee as long as coverage has been continuous.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 60 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days of the birth, adoption or placement for adoption.

In the case of a marriage or domestic partnership, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days of the marriage or domestic partnership registration.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, ARUP Laboratories, Inc., 500 Chipeta Way, Salt Lake City, Utah 84108, 801-583-2787, option 1, and extension 2182.

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period. The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 60 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment is received.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).

(b) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(c) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) Acquiring a newly eligible Dependent may create a Special Enrollment right. If:

(a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, registration of domestic partnership, birth, adoption or placement for adoption,

then the Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll. In the case of the birth or adoption of a child, the Spouse or Domestic Partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or Domestic Partner is otherwise eligible for coverage.

The Special Enrollment Period for newly eligible Dependents is a period of 60 days that begins after the date of the marriage or domestic partnership registration, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 60-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, on the date of marriage, or in the case of Domestic Partner relationship, on the date of registration of the domestic partner relationship; or

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State Child Health Insurance Program (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining

benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The last day of the calendar month in which the Employee's final payroll check is issued. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(4) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Continuation During Periods of Employer-Certified Leave of Absence (not meeting the definition of FMLA leave). A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. These leaves run concurrently with FMLA, USERRA or any State-mandated family or medical leave. This continuance ends as follows:

For leave of absence (non-FMLA leave) only: If an Employee is granted a non-FMLA temporary leave of absence by his/her employer, he/she can continue coverage for a period of time extending no more than six months cumulative between any leave type that occurred in a rolling calendar year. Premium payments must be made through the Plan Sponsor in order to maintain coverage during **any type of an employer-certified leave of absence**.

A leave of absence is a period of time off work granted by the Employer at the Employee's request during which the Employee is still considered to be employed and is carried on the employment records of the Plan Sponsor. A leave can be granted for any reason acceptable to the employer.

If the Employee and/or covered dependents elect not to remain enrolled during the leave of absence, the Employee (and/or covered dependents) may re-enroll under the Plan only during the next annual open enrollment period**.**

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of:

1) an Employee who is rehired within 30 days of their last date of employment. The Employee is considered a rehire and benefits are reinstated in full without a break in coverage.

2) an Employee who resumes employment with the Employer within 13 consecutive weeks following the date of termination is considered a continuing Employee and not a new hire. Coverage will be effective on the date of rehire.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's covered Dependents under such an election shall be the lesser of:

(a) The 24-month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator ARUP Laboratories, Inc., 500 Chipeta Way, Salt Lake City, Utah 84108, 801-583-2787, option 1, and extension 2182.

The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The last day of the month in which a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) Coverage will end on the last day of the month in which the Qualified Dependent ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) Coverage will end on the last day of the month in which the Child ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(6) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(7) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

ACQUISITION OF A NEW COMPANY - WHEN COVERAGE BEGINS

When enrollment requirements are met, coverage for eligible Employees, and their eligible Dependents, who are employed by the newly acquired company will be effective as of the date of the acquisition, or the date of termination of the prior company's coverage, whichever is later, if they were covered under a plan offered by the prior company on the day before the date of the acquisition.

The Employee and his or her eligible Dependents will be given credit for deductibles and coinsurance provided they submit evidence of amounts satisfied under the prior plan.

New hires will be subject to Plan provisions.

HEALTH CARE PLAN PRIVACY NOTICE

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

The ARUP Laboratories, Inc. Medical Benefits Plan (the Plan) is required by law to maintain the privacy of "protected health information."

"Protected health information" includes any identifiable information that the Plan obtains from you or others that relate to your physical or mental health, the health care you have received, or payment for your health care. As required by law, this notice provides you with information about your rights and the Plan's legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures the Plan will make of your protected health information. If there is a breach of your unsecured protected health information, you have the right to be notified of the breach.

Permitted Uses and Disclosures. The Plan can use or disclose your protected health information for purposes of treatment, payment and health care operations. Except as noted below, uses and disclosures not described in this notice will be made only with your authorization.

Treatment means the provision, coordination or management of your health care, including any referrals for health care from one health care provider to another. For example, a provider under the Plan may need to know health care information in Plan files that might assist in treatment.

Payment means activities to obtain and provide reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, the information on or accompanying health care bills sent to the Plan may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

As another example, prior to providing health care services, the Plan may need information from a provider about your Medical Condition to determine whether the proposed course of treatment will be covered. When the Plan receives a bill from the provider, the Plan can obtain information regarding your care if necessary to provide payment.

Health care operations means the support function related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, Physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, the Plan may use your medical information to evaluate the performance of providers used in the Plan. The Plan may also combine medical information about many patients to decide how to better provide needed benefits under the Plan.

Other Uses and Disclosures of Protected Health Information. The Plan may contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

The Plan may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care.

The Plan may not use your genetic information for any underwriting purpose.

The Plan will only disclose the protected health information directly relevant to their involvement in your care or payment. The Plan may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition, or death. If you are available, the Plan will give you an opportunity to object to these disclosures, and the Plan will not make these disclosures if you object. If you are not available, the Plan will determine whether a disclosure to your family or friends is in your best interest, and the Plan will disclose only the protected health information that is directly relevant to their involvement in your care. When permitted by law, the Plan may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

Most uses and disclosures of psychotherapy notes, and uses and disclosures of protected health information for marketing purposes or that are considered to be a "sale" of protected health information can only be made with your written authorization. Except for the situations listed below, the Plan will not use or disclose your protected health information for any other purpose unless you provide written authorization.

You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that the Plan already has taken action in reliance on your authorization.

Exceptional Situations. The Plan may use or disclose your protected health information in the following situations without your authorization:

- **Coroners, Medical Examiners and Funeral Directors.** The Plan may release medical information to the coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information about patients to funeral directors as necessary to carry out their duties.

- **Health Oversight Activities.** The Plan may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. The Plan may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

- **Inmates.** If you become an inmate of a correctional institution or fall under the custody of a law enforcement official, the Plan may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

- **Law Enforcement.** The Plan may release medical information in these situations: if asked to do so by law enforcement official in response to a court order, subpoena, warrant, summons, or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances and are unable to obtain the person's agreement; about a death believed may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or dispute, the Plan may disclose medical information about you in response to a court or administrative order. The Plan may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

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

- **National Security and Intelligence Activities.** The Plan may release medical information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law.

- **Organ and Tissue Donation.** If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Protective Services for the President and Others.** The Plan may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- **Public Health Risks.** The Plan may disclose medical information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of product recalls, repairs or replacements; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate

government authority if believed a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

- **Serious Threats.** As permitted by applicable law and standards of ethical conduct, the Plan may use and disclose protected health information if, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

- **Workers' Compensation.** The Plan may release medical information about you for programs that provide benefits for work-related injuries or illness.

Your Rights

- You have the right to request restrictions on the Plan's uses and disclosures of protected health information for treatment, payment and health care operations. However, the Plan is not required to agree to your request. If you pay a provider of health care out of pocket in full for the cost of your treatment, you can request that the provider not share information about your treatment with the Plan. The health care provider must comply with your request.

- You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.

- Subject to payment of a reasonable fee for labor and copying, and the exceptions noted below, you have the right to inspect and copy the protected health information contained in the Plan's records. If you cannot afford to pay for copies, you will not be denied access. You have the right to ask for a copy of your electronic medical record in a reasonable electronic format. In some instances, the Plan may not have to provide you with copies of psychotherapy notes, information compiled in relation to a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. If your request for access is denied you will be informed in writing, and you can ask the Plan to review the decision. Not all denials are subject to review.

- You have the right to request a correction to your protected health information, but the Plan may deny your request for correction. Any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

- You have the right to receive an accounting of disclosures of protected health information made by the Plan to individuals or entities other than to you, except for disclosures to carry out treatment, payment and health care operations as provided above; to persons involved in your care or for other notification purposes as provided by law; for national security or intelligence purposes as provided by law; to correctional institutions or law enforcement officials as provided by law; or that occurred prior to April 14, 2003.

- You have the right to request and receive a paper copy of this notice from us.

Effective Date and Changes. This notice is effective as of September 23, 2013. The Plan reserves the right to change the terms of this notice from time-to-time and to make the revised notice effective for all protected health information the Plan maintains. The Plan must follow the terms of the notice currently in effect for any planned use or disclosure of protected health information. You can always request a copy of our most current privacy notice from our office or you can access it on our web site. We will tell you about changes to this notice by posting the notice on our website and mailing you a copy of the revised notice with the next annual mailing after the notice takes effect.

Filing a Complaint. If you believe that your privacy rights have been violated, you should immediately contact our Privacy Officer at 801-583-2787, option 1, and extension 2182.

The Plan will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

Contact Person and Exercising Your Rights. To exercise any of the rights described in this notice you must make a written request. Mail your request to: ARUP Laboratories, Inc., 500 Chipeta Way, Salt Lake City, Utah 84108. If you have any questions or would like further information about this notice, please contact ARUP Laboratories, Inc. at 801-583-2787, option 1, and extension 2182.

OPEN ENROLLMENT

Every year, during the annual open enrollment period, covered Employees and their covered Dependents will be able to **change** some of their benefit decisions based on which benefits and coverages are right for them.

Every year, during the annual open enrollment period, Employees and their Dependents who are Late Enrollees will be able to **enroll** in the Plan.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect through December 31 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

SCHEDULE OF BENEFITS

Verification of Eligibility

For those residing in Utah or Wyoming, call 1-800-426-7453. Outside of Utah or Wyoming, call 1-844-464-1771.

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: The following services must be precertified or reimbursement from the Plan will be reduced.

- **All Inpatient Hospitalizations**
- **Outpatient Surgical Procedures not performed in a physician's office**
- **Durable Medical Equipment charges over $1,500**
- **Transplants**
- **Residential Treatment**
- **Chemotherapy including services in Physician's office**
- **MRI/CT and PET Scan charges over $1,500**

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Please see the Cost Management section in this booklet for details.

The Plan contains the following Network Provider Organizations:

Location	NAME	PHONE #	WEB SITE
Utah and Wyoming	WISE Provider Networks	1-800-426-7453	www.wiseprovider.net
Employees residing outside of Utah or Wyoming	Aetna ASA	1-844-464-1771	www.aetna.com/asa
Utah or Wyoming Employees receiving care outside of Utah or Wyoming	Aetna ASA	1-844-464-1771	www.aetna.com/asa

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

If the Plan generally requires or allows the designation of a primary care provider, a Covered Person has the right to designate any primary care provider who is a Network Provider and who is available to accept the Covered Person. For children, a Covered Person may designate a pediatrician as the primary care provider if the pediatrician is a Network Provider and is available to accept the child as a patient. A Covered Person does not need prior authorization from the Plan, a primary care provider, or any other person in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who is a Network Provider. However, the health care professional may be required to comply with certain Plan procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

> If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.
>
> If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.
>
> If a Covered Person receives Physician or anesthesia services by a Non-Network Provider at an In-Network facility.
>
> If a Covered Person is traveling and is within a 50 mile radius of the service area and has no choice of a network provider.
>
> If a Covered Person resides outside of the service area and has no choice of network provider (50 miles from a Network provider), benefits will be paid at the Network level of benefits. Documentation may be required from the employee that they reside outside the Network service area.

Additional information about this option, including any rules that apply to designation of a primary care provider, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

Deductibles/Copayments payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required. This amount will accrue toward the out-of-pocket maximum payment.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments will accrue toward the out-of-pocket maximum payment.

MEDICAL BENEFITS SCHEDULE
PPO MEDICAL 750 PLAN

PPO MEDICAL 750 PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR (Combined Network and Non-Network)		
Per Covered Person	$750	
Per Family Unit	$1,500	
The Calendar Year deductible is waived for the following Covered Charges for Network and Non-Network Providers: Preventive Care services Routine Prenatal office visits RSV injections/treatment in a Physician's office First $1,000 of Supplemental Accident Charge Benefit		
COPAYMENTS		
Emergency room	$150	$150
The Emergency room copayment is waived if the patient is admitted to the Hospital on an emergency basis. For members residing in Utah and Wyoming, the utilization review administrator, CNIC Health Solutions, Inc., must be notified at 1-800-426-7453 within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission. Outside of Utah and Wyoming, the utilization review administrator, Active Health, must be notified at 1-855-277-2442 within 48 hours of the admission even if the patient is discharged within 48 hours of the admission.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (Combined Network and Non-Network)		
Per Covered Person	$4,000	
Per Family Unit	$8,000	
The Out-of-Pocket maximum amount includes deductible, copays, coinsurance and eligible prescription drug charges. The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Amounts over Usual and Reasonable Charges Non-covered expenses and Charges in excess of Plan maximums		

PPO MEDICAL 750 PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
COVERED CHARGES ***Precertification is required**		
Supplementary Accident Charge Benefit		
Maximum benefit of $1,000 per person, per calendar year..... payable at 100% up to $1,000 then 85% after deductible.		
Hospital Services		
*Room and Board	85% after deductible Semiprivate room rate	70% after deductible Semiprivate room rate
Intensive Care Unit	85% after deductible	70% after deductible
*Outpatient Hospital/ Outpatient Surgery Center	85% after deductible	70% after deductible
Ambulance Service	85% after deductible	85% after deductible
Emergency Room Visit		
Medical Emergency (Includes physician's emergency room visit)	$150 copay then 85% after deductible	$150 copay then 85% after deductible
Physician Services		
Inpatient hospital visits	85% after deductible	70% after deductible
Office visits	85% after deductible	70% after deductible
Surgery performed in physician's office	85% after deductible	70% after deductible
*Inpatient and outpatient surgery	85% after deductible	70% after deductible
Allergy testing, serum and injections	85% after deductible	70% after deductible
Other injections received in physician's office - RSV treatment	85% after deductible 100% (deductible waived)	70% after deductible 70% (deductible waived)
Acupuncture	85% after deductible 12 visits per Calendar Year	70% after deductible 12 visits per Calendar Year
Diagnostic X-ray and Laboratory Expenses (including interpretation fees)		
In physician's office	85% after deductible	70% after deductible
Inpatient, outpatient facility or independent lab	85% after deductible	70% after deductible
MRI, CT/PET Scans	85% after deductible	70% after deductible
Chemo/Radiation Therapy In physician's office or outpatient facility	85% after deductible	70% after deductible
Skilled Nursing Facility	85% after deductible Semiprivate room rate 60 days per Calendar Year	70% after deductible Semiprivate room rate 60 days per Calendar Year
Hearing Exam	100% (deductible waived)	70% (deductible waived)
Limited to 1 exam per year.		
Home Health Care	85% after deductible 130 visits per Calendar Year	70% after deductible 130 visits per Calendar Year

PPO MEDICAL 750 PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospice Care	85% after deductible	70% after deductible
Respite care	85% after deductible 14 days per lifetime	70% after deductible 14 days per lifetime
Bereavement Counseling	85% after deductible	70% after deductible
Rehabilitation Services/Occupational, Speech and Physical Therapies		
*Inpatient	85% after deductible	70% after deductible
Outpatient facility	85% after deductible 30 visits for each therapy per Calendar Year	70% after deductible 30 visits for each therapy per Calendar Year
***Durable Medical Equipment**	85% after deductible	70% after deductible
Prosthetics	85% after deductible	70% after deductible
Orthotics	85% after deductible	70% after deductible
Jaw Joint/TMJ	85% after deductible Limited to $1,000 per Lifetime	70% after deductible Limited to $1,000 per Lifetime
Spinal Manipulation Chiropractic	85% after deductible 12 visits per Calendar Year	70% after deductible 12 visits per Calendar Year
Mental Health and Substance Abuse Treatment		
*Inpatient or outpatient facility	85% after deductible	70% after deductible
Outpatient physician's office visit	85% after deductible	70% after deductible
Intermediate Outpatient Care	85% after deductible	70% after deductible
*Inpatient detoxification	85% after deductible	70% after deductible
Neurodevelopmental Therapy (Limited to dependent children up to age 6)		
*Inpatient	85% after deductible	70% after deductible
Outpatient	85% after deductible	70% after deductible
NOTE: Limited to dependent children up to age 6. Outpatient visits are limited to 40 visits per Calendar Year.		
Diabetic Counseling, Supplies and Equipment	85% after deductible	70% after deductible
Nutritional Counseling/ Dietitian Consultations	85% after deductible	70% after deductible

PPO MEDICAL 750 PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
PREVENTIVE CARE		
Routine Well Adult and Well Child Care	100% (deductible waived)	70% (deductible waived)
Coverage includes the following routine services: office visits, pap smears, mammograms, prostate screenings, PSA tests, gynecological examinations, well baby care and immunizations, routine physical examinations, X-rays, laboratory blood tests, thyroid function tests, hearing screenings, immunizations/flu shots, health fair testing, cholesterol testing, urinalysis, colorectal exams, diabetes screenings and preventive child care screenings. Includes 3-D mammograms. Preventive Colonoscopy screenings and mammograms are covered under Routine Well Adult Care and include all treatment received during the procedure. Limited to 1 colonoscopy or mammogram – preventive or diagnostic - per year at this benefit level. Any subsequent treatment/surgery is covered under the Medical portion of the Plan, subject to deductible and coinsurance as long as charges are within Usual and Reasonable. Coverage also includes all recommended preventive services that have a rating of "A" or "B" from the U.S. Preventive Task Force, recommendations made by the Advisory Committee on Immunization Practices, and guidelines supported by the Health Resources and Services Administration. For information on preventive services, visit https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1 **Note:** Preventive Prescription Drugs are covered as required by the Patient Protection and Affordable Care Act (PPACA). See the Prescription Drug Benefits Section.		
Routine Well Newborn Nursery Care	85% after deductible	70% after deductible
Maternity Care		
Routine prenatal office visits	100% (deductible waived)	70% (deductible waived)
Network routine prenatal visits, including certain lab services, tobacco cessation counseling and certain immunizations as required by applicable regulations, are covered without cost share if billed in an office visit setting. This Plan includes coverage of pregnancy for a dependent daughter.		
*Inpatient and delivery	85% after deductible	70% after deductible
Breast Pumps	100% (deductible waived)	100% (deductible waived)
Genetic Testing and Counseling	85% after deductible Limited to $5,000 per Lifetime	70% after deductible Limited to $5,000 per Lifetime
Note: Genetic testing and counseling required by PPACA under the Preventive Care benefit are covered at no cost share and have no limits.		
Infertility Benefits	85% after deductible	70% after deductible
Includes: care, supplies and services for the **diagnosis** of infertility only.		
Urgent Care Facility/Extended Hour/Walk-in Facility (not ER of Hospital)		
Urgent or Illness care	85% after deductible	70% after deductible
Vision Exam	100% (deductible waived)	100% (deductible waived)
Limited to 1 exam per year		
Organ Transplants	85% after deductible	70% after deductible
Donor expenses	85% after deductible	70% after deductible
Travel, meals and lodging	$10,000 maximum per transplant	

PPO MEDICAL 750 PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Institute of Excellence Organ Transplants (Aetna Network)		
For those Covered Persons outside of Wyoming and Utah and whose network provider is Aetna, this plan contains a separate Organ and Tissue Transplant Policy. The benefits listed above apply to Covered Expenses not reimbursable under the separate Organ and Transplant Policy and for Covered Expenses incurred after the Organ and Transplant Policy has been exhausted. Refer to the separate Organ and Tissue Transplant Policy and the Medical Benefits section of this Plan document for the full transplant benefit.		
Organ Transplants	85% after deductible	70% after deductible
Donor expenses	85% after deductible	70% after deductible
Travel, meals and lodging	$10,000 maximum per transplant	
Dialysis Treatment Outpatient	100% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance Please refer to Dialysis Treatment Outpatient description page 41.	
Wig after Chemotherapy	85% after deductible 1 per lifetime	
All Other Eligible Expenses	85% after deductible	70% after deductible

MEDICAL BENEFITS SCHEDULE
PPO MEDICAL 1500 PLAN

PPO MEDICAL 1500 PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR (Combined Network and Non-Network)		
Per Covered Person	$1,500	
Per Family Unit	$3,000	
The Calendar Year deductible is waived for the following Covered Charges for Network and Non-Network Providers: Preventive Care services Routine Prenatal office visits RSV injections/treatment in a Physician's office First $1,000 of Supplemental Accident Charge Benefit		
COPAYMENTS		
Emergency room	$150	$150
The Emergency room copayment is waived if the patient is admitted to the Hospital on an emergency basis. For members residing in Utah and Wyoming, the utilization review administrator, CNIC Health Solutions, Inc., must be notified at 1-800-426-7453 within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission. Outside of Utah and Wyoming, the utilization review administrator, Active Health, must be notified at 1-855-277-2442 within 48 hours of the admission even if the patient is discharged within 48 hours of the admission.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (Combined Network and Non-Network)		
Per Covered Person	$5,000	
Per Family Unit	$10,000	
The Out-of-Pocket maximum amount includes deductible, copays, coinsurance and eligible prescription drug charges. The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Amounts over Usual and Reasonable Charges Ineligible Charges and Charges in excess of Plan maximums		

PPO MEDICAL 1500 PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
COVERED CHARGES ***Precertification is required**		
Supplementary Accident Charge Benefit		
Maximum benefit of $1,000 per person, per calendar year..... payable at 100% up to $1,000 then 85% after deductible.		
Hospital Services		
*Room and Board	85% after deductible Semiprivate room rate	70% after deductible Semiprivate room rate
Intensive Care Unit	85% after deductible	70% after deductible
*Outpatient Hospital/ Outpatient Surgery Center	85% after deductible	70% after deductible
Ambulance Service	85% after deductible	85% after deductible
Emergency Room Visit		
Medical Emergency (Includes physician's emergency room visit)	$150 copay then 85% after deductible	$150 copay then 85% after deductible
Physician Services		
Inpatient hospital visits	85% after deductible	70% after deductible
Office visits	85% after deductible	70% after deductible
Surgery performed in physician's office	85% after deductible	70% after deductible
*Inpatient and outpatient surgery	85% after deductible	70% after deductible
Allergy testing, serum and injections	85% after deductible	70% after deductible
Other injections received in physician's office - RSV treatment	85% after deductible 100% (deductible waived)	70% after deductible 70% (deductible waived)
Acupuncture	85% after deductible 12 visits per Calendar Year	70% after deductible 12 visits per Calendar Year
Diagnostic X-ray and Laboratory Expenses (including interpretation fees)		
In physician's office	85% after deductible	70% after deductible
Inpatient, outpatient facility or independent lab	85% after deductible	70% after deductible
MRI, CT/PET Scans	85% after deductible	70% after deductible
Chemo/Radiation Therapy In physician's office or outpatient facility	85% after deductible	70% after deductible
Skilled Nursing Facility	85% after deductible Semiprivate room rate 60 days per Calendar Year	70% after deductible Semiprivate room rate 60 days per Calendar Year
Hearing Exam	100% (deductible waived)	70% (deductible waived)
Limited to 1 exam per year.		
Home Health Care	85% after deductible 130 visits per Calendar Year	70% after deductible 130 visits per Calendar Year

PPO MEDICAL 1500 PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospice Care	85% after deductible	70% after deductible
Respite care	85% after deductible 14 days per Lifetime maximum	70% after deductible 14 days per Lifetime maximum
Bereavement Counseling	85% after deductible	70% after deductible
Rehabilitation Services/Occupational, Speech and Physical Therapies		
*Inpatient	85% after deductible	70% after deductible
Outpatient facility	85% after deductible 30 visits for each therapy per Calendar Year	70% after deductible 30 visits for each therapy per Calendar Year
***Durable Medical Equipment**	85% after deductible	70% after deductible
Prosthetics	85% after deductible	70% after deductible
Orthotics	85% after deductible	70% after deductible
Jaw Joint/TMJ	85% after deductible Limited to $1,000 per Lifetime	70% after deductible Limited to $1,000 per Lifetime
Spinal Manipulation Chiropractic	85% after deductible 12 visits per Calendar Year	70% after deductible 12 visits per Calendar Year
Mental Health and Substance Abuse Treatment		
*Inpatient/Outpatient facility	85% after deductible	70% after deductible
Outpatient physician's office visit	85% after deductible	70% after deductible
Intermediate Care facility	85% after deductible	70% after deductible
*Inpatient detoxification	85% after deductible	70% after deductible
Neurodevelopmental Therapy (Limited to dependent children up to age 6)		
*Inpatient	85% after deductible	70% after deductible
Outpatient	85% after deductible	70% after deductible
NOTE: Limited to dependent children up to age 6. Outpatient visits are limited to 40 visits per calendar year.		
Diabetic Counseling, Supplies and Equipment	85% after deductible	70% after deductible
Nutritional Counseling/ Dietitian Consultations	85% after deductible	70% after deductible

PPO MEDICAL 1500 PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
PREVENTIVE CARE		
Routine Well Adult and Child Care	100% (deductible waived)	70% (deductible waived)
Coverage includes the following routine services: office visits, pap smears, mammograms, prostate screenings, PSA tests, gynecological examinations, well baby care and immunizations, routine physical examinations, X-rays, laboratory blood tests, thyroid function tests, hearing screenings, immunizations/flu shots, health fair testing, cholesterol testing, urinalysis, colorectal exams, diabetes screenings and preventive child care screenings. Includes 3-D mammograms. Preventive Colonoscopy screenings and mammograms are covered under Routine Well Adult Care and include all treatment received during the procedure. Limited to 1 colonoscopy or mammogram – preventive or diagnostic - per year at this benefit level. Any subsequent treatment/surgery is covered under the Medical portion of the Plan, subject to deductible and coinsurance as long as charges are within Usual and Reasonable. Coverage also includes all recommended preventive services that have a rating of "A" or "B" from the U.S. Preventive Task Force, recommendations made by the Advisory Committee on Immunization Practices, and guidelines supported by the Health Resources and Services Administration. For information on preventive services, visit https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1 **Note:** Preventive Prescription Drugs are covered as required by the Patient Protection and Affordable Care Act (PPACA). See the Prescription Drug Benefits Section.		
Routine Well Newborn Nursery Care	85% after deductible	70% after deductible
Maternity Care		
Routine prenatal office visits	100% (deductible waived)	70% (deductible waived)
Network routine prenatal visits, including certain lab services, tobacco cessation counseling and certain immunizations as required by applicable regulations, are covered without cost share if billed in an office visit setting. This Plan includes coverage of pregnancy for a dependent daughter.		
*Inpatient and delivery	85% after deductible	70% after deductible
Breast Pumps	100% (deductible waived)	100% (deductible waived)
Genetic Testing and Counseling	85% after deductible Limited to $5,000 per lifetime	70% after deductible Limited to $5,000 per lifetime
Note: Genetic testing and counseling required by PPACA under the Preventive Care benefit are covered at no cost share and have no limits.		
Infertility Benefits	85% after deductible	70% after deductible
Includes: care, supplies and services for the **diagnosis** of infertility only.		
Urgent Care Facility/Extended Hour/Walk-in Facility (not ER of Hospital)		
Urgent or Illness care	85% after deductible	70% after deductible
Vision Exam	100% (deductible waived)	100% (deductible waived)
Limited to 1 exam per year.		
Organ Transplants	85% after deductible	70% after deductible

PPO MEDICAL 1500 PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Donor expenses	85% after deductible	70% after deductible
Travel, meals and lodging	$10,000 maximum per transplant	
Institute of Excellence Organ Transplants (Aetna Network)		
For those Covered Persons outside of Wyoming and Utah whose network provider is Aetna, this plan contains a separate Organ and Tissue Transplant Policy. The benefits listed above apply to Covered Expenses not reimbursable under the separate Organ and Transplant Policy and for Covered Expenses incurred after the Organ and Transplant Policy has been exhausted. Refer to the separate Organ and Tissue Transplant Policy and the Medical Benefits section of this Plan document for the full transplant benefit.		
Organ Transplants	85% after deductible	70% after deductible
Donor expenses	85% after deductible	70% after deductible
Travel, meals and lodging	$10,000 maximum per transplant	
Dialysis Treatment Outpatient	100% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance Please refer to Dialysis Treatment Outpatient description page 41.	
Wig after Chemotherapy	85% after deductible 1 per lifetime	
All Other Eligible Expenses	85% after deductible	70% after deductible

PRESCRIPTION DRUG BENEFIT SCHEDULE

PRESCRIPTION DRUG BENEFIT		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR **Eligible Covered Charges under the Plan's Prescription Drug benefits are included in the Out-of-Pocket maximum for Network Providers**.		
	NETWORK	**NON-NETWORK**
Retail Pharmacy Option - ARUP Preferred Pharmacy (up to a 90 Day Supply) **(**3 copays required for a 90-day supply**)**		
Generic Drugs	$5 copayment	Not Applicable
Formulary Brand Name Drugs*****	$30 copayment	Not Applicable
Non-Formulary Brand Name Drugs	35% up to $145	Not Applicable
*****Certain Formulary Brand Name drugs are excluded from this plan. Contact the PBM (Prescription Benefit Manager) for a list of excluded Formulary drugs.		
Retail Pharmacy Option – ProCare Rx (up to a 30-Day Supply)		
Generic Drugs	$15 copayment	Not Applicable
Formulary Brand Name Drugs*****	$50 copayment	Not Applicable
Non-Formulary Brand Name Drugs	35% up to $150	Not Applicable
*****Certain Formulary Brand Name drugs are excluded from this plan. Contact the PBM (Prescription Benefit Manager) for a list of excluded Formulary drugs.		
Specialty Drugs	35%	Not Applicable
Specialty Drugs are only available through the ProCareRx Specialty pharmacy. **Not all Specialty Drugs are available with a 90-day supply, and special pricing may apply**.		
Mail Order Option –ProCare Rx (up to a 90-Day Supply)		
Generic Drugs	$45 copayment	Not Applicable
Formulary Brand Name Drugs	$150 copayment	Not Applicable
Non-Formulary Brand Name Drugs	35% up to $450	Not Applicable
Non-Formulary Specialty Drugs/Injectables	35% up to $450	Not Applicable

Certain prescriptions may require step therapy, where a different prescription may be required to be tried first before being eligible.

Step therapy is a process that requires you to use one or more first line agents before a medication which is part of a step therapy protocol can be utilized. As a patient, this means that, in some instances, you will need to try one or more medications which are considered first line before you are able to receive a "second step" medication through your pharmacy benefit plan. When you bring a prescription for a "second step" medication to the pharmacy, the pharmacist will submit the claim to your pharmacy benefits provider. At this time, your medication history will be reviewed to evaluate whether or not you have fulfilled the requirements of the first line medication. If you have met the requirements, your insurance will automatically cover the prescription and current copayments will apply. If you have not met the requirements of the first line medication, you have three options. The first option is to fulfill the requirements of the first step. The second option is to ask your physician to contact the pharmacy benefits provider to request coverage as a medical exception. The final option is to pay the cash price for the prescription.

If the Covered Person chooses a Formulary Brand or Non-Formulary Brand drug instead of a Generic drug, he/she will be responsible for the Formulary Brand or Non-Formulary Brand copayment plus the difference in cost between the Formulary Brand or Non-Formulary Brand drug and Generic drug. This difference in cost amount will **not** apply toward satisfaction of the Plan's Maximum Out-of-Pocket amount.

If a Provider recommends a particular contraceptive service or FDA-approved contraceptive item based on medical necessity for an individual, the Plan will cover the service or item at 100%.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

SUPPLEMENTARY ACCIDENT CHARGE BENEFITS

This benefit applies when an accident charge is incurred for care and treatment of a Covered Person's Injury and:

(1) the charge is for a service delivered after the date of the accident; and

(2) to the extent that the charge is not payable under any other benefits under the Plan (other than Medical Benefits).

BENEFIT PAYMENT

Benefits will be paid as described in the Schedule of Benefits.

ACCIDENT CHARGE

An accident charge is a Usual and Reasonable Charge incurred for the following:

(1) Physician services.

(2) Hospital care and treatment.

(3) Diagnostic X-rays and lab tests.

(4) Local professional ambulance service.

(5) Surgical dressings, splints and casts and other devices used in the reduction of fractures and dislocations.

(6) Nursing service.

(7) Anesthesia.

(8) Covered Prescription Drugs.

(9) Use of a Physician's office or clinic operating room.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE/COPAYMENT

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

This amount **will** accrue toward the maximum out-of-pocket payment.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

One person may not contribute more than the individual Deductible amount. Any amounts that are paid for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not count toward the Deductible.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

Copayments. A copayment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

Copayments **will** accrue toward the maximum out-of-pocket payment.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Schedule of Benefits) for the rest of the Calendar Year.

COVERED CHARGES

Covered Charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be Medically Necessary.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

(2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee, covered Spouse or covered Dependent daughter.

Group health plans 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).

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

Expenses for **amniocentesis testing and/or genetic counseling**, when recommended by a Physician for a Covered Person who is 35 years of age or older at the time of delivery, or for a documented high-risk pregnancy, or family history of genetic disorder. Any procedure intended solely for sex determination is not covered.

Fetal surgery will be considered as part of the mother’s care.

Birthing centers.

Elective home births are not covered; however, charges for prenatal diagnostic lab testing and birthing supplies when **ordered by a licensed or registered Midwife** for home births are covered.

Charges for services of a **Midwife** will only be covered if the birth takes place in a medical facility.

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% or a Physician’s Assistant will not exceed 15% of the surgeon's Usual and Reasonable allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Outpatient private duty nursing care is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or other covered Dependents). Bereavement services must be furnished within six months after the patient's death.

(8) **Dialysis Treatment - Outpatient.** This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

The Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:

(a) the concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services;

(b) the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members;

(c) evidence of (i) significant inflation of the prices charged to Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers; and

(d) the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.

Dialysis Program Components. The components of the Dialysis Program are as follows:

(a) **Application.** The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

(b) **Claims Affected.** The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after January 1, 2016 regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.

(c) **Mandated Cost Review.** All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:

(i) Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

(ii) Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

(d) In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:

(i) Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

(ii) Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan Administrator's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

(iii) Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

(iv) Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

(v) Additional Information related to Value of Dialysis-Related Services and Supplies. The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

(vi) All charges must be billed by a provider in accordance with generally accepted industry standards.

(e) **Provider Agreements.** Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

(f) **Discretion.** The Plan Administrator shall have full authority and discretion to interpret, administer, and apply this Section, to the greatest extent permitted by law.

If a Covered Person has End-Stage Renal Disease (ESRD) and qualifies for Medicare coverage, the Plan encourages the Covered Person to obtain such coverage, which may pay for costs not covered by the Plan. For more information on Medicare and ESRD coverage, visit https://www.medicare.gov/people-like-me/esrd/getting-medicare-with-esrd.html.

For more information on enrolling in the Medicare program, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

(9) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) **Acupuncture**. Charges for acupuncture will be covered as described in the Schedule of Benefits.

(b) **Allergy testing**, treatment and injections. RAST (radioallergosorbent test) allergy testing will be allowed only when Medically Necessary as the only alternative to traditional allergy testing.

(c) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(d) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(e) **Assistant Surgeon's** fee when the procedure requires an assistant surgeon due to medical necessity.

(f) **Blood transfusions**, blood processing costs, blood transport charges, blood handling charges, administration charges, the cost of blood, plasma and blood derivatives and pre-surgical autologous storage of blood.

(g) **Breast pumps.** Charges for the rental or purchase of Breast pumps will be covered as described in the Schedule of Benefits.

(h) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(i) **Cleft Palate and Cleft Lip.** The Plan will provide benefits for cleft palate and cleft lip. Cleft palate is defined as a birth deformity in which the palate (the roof of the mouth) fails to close, and cleft lip is defined as a birth deformity in which the lip fails to close.

The Plan will cover expenses incurred for the following services when provided by a Physician, other professional provider, and facilities necessary for treatment.

(i) Oral and facial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons.

(ii) Habilitative speech therapy.

(iii) Otolaryngology treatment.

(iv) Audiological assessments and treatment.

(v) Orthodontic treatment.

(vi) Prosthodontic treatment.

(vii) Prosthetic treatment such as obturators, speech appliances and feeding appliances.

(j) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(k) Routine patient care charges for **Clinical Trials.** Coverage is provided only for routine patient care costs for a Qualified Individual in an approved clinical trial for treatment of cancer or other life-threatening disease or condition. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing to the satisfaction of the Plan Administrator that the individual's participation in such trial would be appropriate. Coverage is not provided for charges not otherwise covered under the Plan, and does not include charges for the drug or procedure under trial, or charges which the Qualified Individual would not be required to pay in the absence of this coverage.

(l) **Cochlear implants** and equipment and devices related to cochlear implants, including, but not limited to, internal receivers/stimulators, transmitters and speech processors.

(m) Initial **contact lenses** or glasses required following cataract surgery.

(n) **Contraceptives** as required by the Patient Protection and Affordable Care Act (PPACA). Injections and the insertion or removal of birth control devices and implants are covered under the Medical portion of this Plan. Birth control pills are only covered through the Prescription Drug Benefits.

(o) **Diabetes Education**. The Plan covers services and supplies for diabetic self-management training and education, including medical nutrition therapy if prescribed by a health care provider licensed to prescribe such items in accordance with applicable law. When prescribed, diabetes outpatient self-management and education must be provided by a certified, registered, or licensed health care professional with expertise in the care of diabetes.

(p) **Diagnostic Procedures.** The Plan covers services for diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies, sleep studies and neurology/neuromuscular procedures.

(q) **Domestic Violence.** Injuries resulting from an act of domestic violence.

(r) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

(s) **Gender Dysphoria.** Standard benefits for the treatment of Gender Dysphoria are limited to the following services when clinical criteria for eligibility are met and the member has reached the age of majority (18 years of age or older):

- Psychotherapy and mental health services for Gender Dysphoria and associated co-morbid psychiatric diagnoses.
- Certain drug therapies, including cross-sex hormone therapy, administered by a medical provider during an office visit or dispensed from a pharmacy.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Identified surgeries for the treatment of Gender Dysphoria, including female-to-male and male-to-female.

Specific documentation and written psychological assessments from one or more qualified behavioral health providers experienced in treating Gender Dysphoria are required prior to approval for a bilateral mastectomy, breast reduction surgery, or genital surgery.

Exclusions and limitations include surgeries and/or related services that are considered cosmetic, unproven, and not medically necessary.

(t) **Hearing Exam.** Routine hearing exams are subject to the limits described in the Schedule of Benefits.

(u) Expenses for treatment of kidney disorder by **hemodialysis or peritoneal dialysis** as an Inpatient in a Hospital or other facility, or for expenses in an Outpatient facility or in your home, including the training of one (1) attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or Outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in your home, except as provided by the Dialysis Treatment – Outpatient provision.

(v) Expenses incurred for the initial diagnosis and testing to determine **infertility** and **impotency**, whether a medical problem exists or not is covered; expenses incurred in connection with the treatment of infertility, impotency or promotion of conception, including drug therapy, are not covered.

(w) **Insulin,** related supplies, syringes.

(x) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**.

(y) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

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

(aa) Treatment of **Mental Disorders and Substance Abuse**. Regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate annual limit, financial requirement, out-of-network exclusion or non-quantitative treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(bb) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures. Benefits are not available for the charges of a dentist or for services received in a dentist's office.

(cc) **Neurodevelopmental Therapy.** The Plan covers inpatient and outpatient neurodevelopmental therapy services. To be covered, such services must be to restore and improve function for a Dependent Child age six and under with a neurodevelopmental delay. For the purposes of this provision, neurodevelopmental delay means a delay in normal development that is not related to any documented Illness or Injury.

Covered services include only physical therapy, occupational therapy and speech therapy and maintenance services, if significant deterioration of the child's condition would result without the service.

The Covered Person will not be eligible for both the Rehabilitative Services benefit and this benefit for the same services for the same condition.

(dd) **Nutritional Counseling.** Charges for nutritional counseling.

Charges for nutritional counseling are subject to the limits as described in the Schedule of Benefits.

(ee) **Occupational therapy** by a licensed therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

Charges for occupational therapy are subject to the limits as described in the Schedule of Benefits.

(ff) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

Benefit payments for transportation, meals and lodging are subject to the separate Maximum Benefit limit as shown in the Schedule of Benefits.

For Covered Persons who reside outside of Utah and Wyoming or who receive care outside of Utah and Wyoming, and whose network provider is Aetna, this Plan includes a separate Organ and Tissue Transplant Policy through the Institute of Excellence (IOE). All eligible Employees and their Dependents requiring human organ and tissue transplants will have transplant-related charges covered under this separate Organ and Tissue Transplant Policy, according to its terms and conditions, from the time of their evaluation through 365 days post transplant operation.

After this specified benefit period has elapsed and/or coverage has been exhausted, all transplant-related medical benefits will revert to the terms and conditions of health coverage under this Plan. A transplant case manager will be assigned to assist and coordinate the Employee or Dependent’s continuing transplant related needs. Benefits available for human organ and tissue transplants under the separate Organ and Tissue Transplant Policy are subject to the following:

a. The Employee and Dependent(s) are eligible for medical benefits under the group’s health plan document;

b. The Employee and Dependent(s) meet all the terms and conditions outlined in the Organ & Tissue Transplant Policy; and

c. The Employee and their Dependent(s) do not have a pre-existing condition as defined in the Organ & Tissue Transplant Policy.

Once it has been determined that the Covered Person or a Dependent may require an organ transplant, the Covered Person or a physician should call Aetna to discuss coordination of transplant care. Aetna will coordinate all transplant services. All precertification requirements must be followed. Organ means solid organ; stem cell; bone marrow; and tissue.

Benefits may vary if an Institute of Excellence (IOE) facility or non-IOE is used. In addition, some expenses are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the required procedure. A transplant will be covered as preferred care only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that is provided by a facility that is not specified as an IOE network facility, even if the facility is considered as a preferred facility for other types of services, will be covered at the non-preferred level. Please read each section carefully.

Covered transplant expenses include the following:

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative.
- Inpatient and outpatient expenses directly related to a transplant.
- Charges made by a physician or transplant team.
- Charges made by a hospital, outpatient facility, or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/Candidacy Screening: Includes HAL typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant Event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up Care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPY)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell transplant
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the Plan

The following will be considered to be more than one Transplant Occurrence:

- Autologous Blood/Bone Marrow transplant followed by Allogeneic Blood/Bone Marrow transplant (when not part of a tandem transplant)
- Allogeneic Blood/Bone Marrow transplant followed by an Autologous Blood/Bone Marrow transplant (when not part of a tandem transplant)

- Re-transplant after 180 days of the first transplant
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

Limitations
The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence.
- Services and supplies furnished to a donor when recipient is not a covered person.
- Home infusion therapy after the Transplant Occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

Transportation, lodging and meals benefits are outlined in the Schedule of Benefits. If the recipient is a minor, benefits are for one child and one parent or guardian. If the recipient is an adult, benefits are for the recipient and one companion.

Travel is reimbursed between the patient's home and the facility for round trip (air, train or bus) transportation costs (coach class only) when 100 miles from the patient's residence. If traveling by auto to the facility, mileage, parking and toll costs are reimbursed.

(gg) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. The Plan does not cover off-the-shelf shoe inserts and orthopedic shoes.

(hh) **Physical therapy** by a licensed therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

Charges for physical therapy are subject to the limits as described in the Schedule of Benefits.

(ii) **Physician's assistant fee** when the procedure requires a Physician's assistant due to medical necessity, in lieu of the service of an assistant surgeon.

(jj) Expenses for **preadmission testing** for a covered surgery.

(kk) **Prescription** Drugs (as defined).

(ll) **Vision Exam.** Routine vision exams are subject to the limits as described in the Schedule of Benefits.

(mm) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Standard Preventive Care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. Standard Preventive Care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force.

Examples of Standard Preventive Care include:

- Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  -Breastfeeding support, supplies, and counseling.
  -Gestational diabetes screening.

Standard Preventive Care includes women's contraceptives, sterilization procedures, and counseling.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/acip/index.html

Charges for **Routine Well Adult Care.** Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for **Routine Well Child Care.** Routine well child care is routine care by a Physician that is not for an Injury or Sickness. Standard Preventive Care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. Standard Preventive Care for children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
  -Diphtheria,
  -Pertussis,
  -Tetanus,
  -Polio,
  -Measles,
  -Mumps,
  -Rubella,
  -Hemophilus influenza b (Hib),
  -Hepatitis B,
  -Varicella.
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/acip/index.html.

(nn) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts. Repair or replacement of a prosthetic device due to normal use or growth of a child will be covered under the Plan.

(oo) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(pp) **Speech therapy** by a licensed therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness.

Charges for speech therapy are subject to the limits as described in the Schedule of Benefits

(qq) **Spinal Manipulation services** by a health care provider acting within the scope of his or her license.

Charges for Spinal Manipulation/Chiropractic services are subject to the limits as described in the Schedule of Benefits.

(rr) **Sterilization** procedures.

(ss) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(tt) **Therapeutic Injections.** The Plan covers therapeutic injections and related supplies when given in a professional Provider's office. The Plan covers Immune Globulin injections when given in a professional Provider's office for the treatment of Respiratory Synctial Virus (RSV), as described in the Schedule of Benefits. No preauthorization required, subject to Academy of Pediatric Guidelines.

(uu) **Tobacco cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under Standard Preventive Care, including smoking deterrent products.

(vv) Expenses incurred while **traveling outside the United States** on business or pleasure. Expenses incurred outside the United States, if the covered person traveled to such location for the primary purpose of obtaining medical services, drugs, or supplies, are not covered.

(ww) **Urgent Care Facility**. Services and supplies offered by an Urgent Care Facility.

(xx) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for **Routine Nursery Care.** Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal well-baby care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Reasonable Charges for routine well-baby nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Group health plans 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).

Charges for **Routine Physician Care.** The benefit is limited to the Usual and Reasonable Charges for routine well-baby care made by a Physician for pediatric visits to the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

(yy) **Wig.** Charges associated with the initial purchase of a wig after chemotherapy.

Charges for a wig after chemotherapy are subject to the limits as described in the Schedule of Benefits.

(zz) Diagnostic **X-rays**.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

For members in Utah and Wyoming, call CNIC Health Solutions, Inc. at 1-800-426-7453.

Outside of Utah and Wyoming, call Active Health at 1-855-277-2442.

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least **2 business days** before services are scheduled to be rendered or **within 48 hours** of the first business day after a Medical Emergency.

Any costs incurred because of reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

- All Inpatient Hospitalizations
- Outpatient Surgical Procedures not performed in a physician's office
- Durable Medical Equipment charges over $1,500
- Transplants
- Residential Treatment
- Chemotherapy including services in Physician's office
- MRI/CT and PET Scan charges over $1,500

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency inpatient basis or receives the other medical services listed above, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. For members in Utah and Wyoming, contact the utilization review administrator CNIC Health Solutions, Inc. at 1-800-426-7453, and outside of Utah and Wyoming, contact the utilization review administrator Active Health at 1-855-277-2442 at least **2 business days before services are scheduled to be rendered** with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician in Utah or Wyoming must contact CNIC Health Solutions, Inc. **within 48 hours** of the first business day after the admission, or outside of Utah and Wyoming, must contact Active Health **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive pre-authorization as explained in this section, a penalty copayment of $500 will apply.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

For members in Utah and Wyoming, the patient may contact CNIC Health Solutions, Inc. for a referral or choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty. Outside of Utah and Wyoming, the patient may contact Active Health for a referral or choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty. CNIC Health Solutions, Inc. or Active Health may at any time require a second or third opinion.

CENTERS OF EXCELLENCE PROGRAM

Please note that as part of the Employee Benefit Plan, Covered Persons residing in Utah and Wyoming have access to a Centers of Excellence Program. This is a voluntary program which allows the Covered Person to use one of several facilities throughout the country that offer the highest quality care at a discounted rate for major procedures such as transplants, heart surgery, etc. For more information, contact the Precertification Department at CNIC Health Solutions, Inc. at 1-800-426-7453.

INSTITUTE OF EXCELLENCE (IOE)

Please note that as part of the Employee Benefit Plan, Covered Persons outside of Utah and Wyoming whose network provider is Aetna have access to the Institute of Excellence. This is a facility that is contracted with Aetna to furnish particular services and supplies in connection with one or more highly specialized medical procedures such as transplants. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE. For more information, contact the Precertification Department at Active Health at 1-855-277-2442.

HEALTHCARE PRICE TRANSPARENCY

In an effort to help employees shop for fair healthcare prices and providers who offer them, CNIC provides employees with access to Healthcare Blue Book as a standard part of their benefits plan. Healthcare Blue Book is an online service that provides the following capabilities:

(1) **Search for price information.** Healthcare Blue Book provides employees with information that allows them to understand price variances among providers in their area and determine what the fair price is for the procedure they are researching.

(2) **Evaluate healthcare facility prices.** Healthcare Blue Book will list facilities in order of their price rating – low price to high price.

(3) **Research physicians**. Employees can find physicians who practice at those facilities and can review biographies and quality information about those physicians.

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis **within seven days** before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

OUTPATIENT SURGERY

Certain surgical procedures can be performed safely and efficiently outside of a Hospital. Outpatient surgical facilities are equipped for many uncomplicated surgical operations, such as some biopsies, cataract surgeries, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

CASE MANAGEMENT/ALTERNATIVE CARE

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;
-- contacting the family to offer assistance and support;
-- monitoring Hospital or Skilled Nursing Facility;
-- determining alternative care options; and
-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

The Plan reserves the right to allow for care at home or other alternative methods of treatment or medical care not otherwise covered under the Plan. In cases where the patient's condition is expected to be or is of a serious nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified to perform such services. The Plan Administrator shall have the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of patient care, provided such care is approved by the Plan's case management organization, the patient (or patient's legal representative), the attending Physician and the Plan Administrator.

Benefits provided under this section are subject to all other Plan provisions. Alternative care will be determined on the merits of each individual case and any care or treatment provided will not be considered as setting any precedent or creating any future liability, with respect to that Covered Person or any other Covered Person.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Accidental Injury means an Injury sustained by a Covered Person 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.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

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

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Break in Service means a period of at least 26 consecutive weeks during which the Employee has no Hours of Service. A Break in Service may also include any period for which the Employee has no Hours of Service that is at least four (4) consecutive weeks in duration and longer than the prior period of employment (determined after application of the procedures applicable to Special Unpaid Leaves.

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

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Exhaustion of COBRA continuation coverage means that an individual’s COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

Common-Law Marriage means a marriage recognized by the state in which the Covered Person resides as common-law, provides evidence of cohabitation as husband and wife, and by general reputation the two individuals are living together as husband and wife and claiming to be such, and submits a notarized affidavit verifying Common-Law Marriage status. By general reputation is meant the understanding among the neighbors and acquaintances with whom the parties associate in their daily lives, that they are living together as husband and wife, and not that they are merely living together.

Cosmetic Procedure/Surgery means a procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function. Cosmetic procedures performed for psychiatric or psychological reasons or to change family characteristics or conditions due to aging are not covered under the Plan.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee or Dependent who is covered under this Plan.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is ARUP Laboratories, Inc.

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good

faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child means a child who meets the eligibility requirements shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county or private foster care agency.

A covered Foster Child is <u>not</u> a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Habilitation/Habilitative Services are those services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. These services may include physical and occupational therapy, speech-language pathology, and other services in a variety of inpatient and/or outpatient settings.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing inpatient diagnostic and therapeutic services at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission, the American Osteopathic Association, or other accreditation program approved by the Centers for Medicare and Medicaid Services; it maintains diagnostic and therapeutic facilities on the premises which are provided by or under the supervision of a staff of Physicians; and it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s). The Plan Administrator may accept accreditation of a Hospital by an organization other than those specifically listed, provided that the designation of an alternative accreditation body is consistently applied across institutions.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Hours of Service means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i):

- Vacation
- Holiday
- Illness or incapacity
- Layoff
- Jury duty
- Military duty or leave of absence

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

Initial Measurement Period means the 12-month period beginning on the Employee's Date of Hire. Notwithstanding the foregoing, the Employer may make adjustments to the Initial Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Intermediate Outpatient Care means intermediate levels of mental health and substance use disorder services when provided on an outpatient basis, including residential treatment, partial hospitalization, and intensive outpatient treatment.

Laboratory, Pathology Services, X-ray and Radiology Services: Laboratory and pathology services – testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material which has been removed from the body. Diagnostic medical procedures requiring the use of technical equipment for evaluation of body systems are also considered laboratory services. Examples: electrocardiograms (EKGs) and electroencephalograms (EEGs). X-ray and radiology services – services including the use of radiology, nuclear medicine, and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for

the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

New Employee Stability Period means the 12 Calendar Month period that begins on the first day of the Calendar Month following the Calendar Month that begins on or after the Employee's anniversary date.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Network Provider means a legally licensed health care provider which provides services and supplies within the scope of its authority, but which has not entered into a contract with the Preferred Provider Organization.

Ongoing Employee Stability Period means the 12 Calendar Month period that begins on the first day of the month following the end of each Standard Measurement Period.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

Outpatient Service Facility means a facility, licensed by the state in which it is located, that 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.

Outpatient Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means ARUP Laboratories, Inc. Medical Benefit Plan, which is a benefits plan for certain Employees of ARUP Laboratories, Inc. and is described in this document.

Plan Administrator is a person who is responsible for the management of the Plan. The Plan Administrator is specifically designated by the terms of the Plan. If the Plan does not make a designation, then the Plan Sponsor is the Plan Administrator.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Sponsor is generally the employer that establishes or maintains an employee benefit plan.

Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

Preferred Provider Organization means an independent entity which has developed a network of quality health care providers who contractually provide services and supplies, within the scope of their authority, on a reduced fee basis, to the Employees and Dependents of Employer sponsored health plans.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Qualified Medical Child Support Order (QMCSO) means a judgment, decree or order issued by a court; domestic relations magistrate or administrator that provides for child support related to health benefits or enforces a state medical child support order under the Social Security Act for Medicaid purposes). It requires that the child(ren) named in the order have the right to receive benefits from their parent through any group medical plan under which the parent is enrolled, whether or not the parent has family coverage. The required contribution for coverage will be that of family coverage. The QMCSO must contain:

(1) the name and last known mailing address of the participant;

(2) the name and mailing address of each child (alternate recipient) covered by the order;

(3) a reasonable description of the type of coverage to be provided by the group health plan to each alternate recipient or the manner in which coverage will be determined;

(4) the period of time to which the order applies; and

(5) the identification of each plan to which the order applies.

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

Respite Care is somewhat similar to adult daycare in that it serves as a break in routine for both those who give and those who receive care. Respite Care can be provided at home, either yours or theirs, or it can be provided at a church or community center, or in a nursing facility. Respite Care provides monitoring and companionship, it does not provide organized activities or services.

Restorative or Reconstructive Surgery means surgery to restore or improve bodily function to the level experienced before the event which necessitated the surgery or, in the case of a congenital defect, to a level considered normal. Such surgery may have a coincidental cosmetic effect.

Schedule of Benefits means the outline of benefits.

Second Surgical Opinion means expenses incurred for examinations, X-rays, and lab performed by a qualified physician in the approved specialty to substantiate medical necessity of the procedure to be performed. A third opinion will be paid in case of a conflict between the first two opinions.

Semiprivate refers to a class of accommodations in a hospital or convalescent nursing facility in which at least two patient beds are available per room.

Sickness is a Covered Person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, Custodial or educational care.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Sound Natural Teeth means teeth which are whole or properly restored, are without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury.

Special Unpaid Leave of Absence means any of the following types of unpaid leaves of absence that do not constitute a Break in Service: (i) Leave protected by the Family and Medical Leave Act, (ii) leave protected by the Uniformed Services Employment and Reemployment Rights Act or (iii) Jury Duty (as reasonably defined by the Employer).

Specialty Medications: Specialty medications are generally prescribed for people with complex or ongoing medical conditions to include but not limited to cancer, Crohn's disease, HIV, multiple sclerosis, hemophilia, hepatitis C and rheumatoid arthritis. These high cost medications also have one or more of the following characteristics: injected or infused, but some may be taken by mouth; unique storage or shipment requirements; additional education and support required from a health care professional; and usually not stocked at retail pharmacies. Please note that as new medications having similar indications enter the market, they may be added to the specialty drug program without notice.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Standard Measurement Period means the 12-month period that begins each year on the first day of October and every 12 months thereafter. Notwithstanding the foregoing, the Employer may make adjustments to the Standard Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means the physical state of a Covered Person resulting from an Illness or Injury which wholly prevents that individual from performing the duties pertaining to his/her customary employment. That individual must be under the continuous care of a Physician. All determinations of a final definition of a disability are the decision of the Plan Administrator. In the case of a Dependent, Total Disability (Totally Disabled) means unable to perform the normal activities of a person of same age and sex in good health. The Dependent must be under the continuous care of a Physician.

Urgent Care Facility means a freestanding facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A Physician and registered nurse (R.N.) must be in attendance at all times. The facility may or may not have an X-ray technician and X-ray and laboratory equipment. The facility must have a life support system available.

Urgent Care Services means care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. For Network Provider charges, the Usual and Reasonable Charge will be the contracted rate except as provided by the Dialysis Treatment – Outpatient provision.

The Plan will pay benefits on the basis of the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

Waiting Period means the period of time that must pass before an Employee or Dependent is eligible to enroll under the terms of a group health plan. If an Employee or Dependent enrolls as a Late Enrollee or on a special enrollment date, any period before such late or special enrollment is not a Waiting Period. There is no waiting period in this Plan.

Well Baby Care means medical treatment, services or supplies rendered to a child or newborn solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

You, Your means any Covered Person, unless the language specifically refers only to the Employee or only to the Dependents.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless, in accordance with Utah law, 1) the life of the mother is endangered by the continued Pregnancy; 2) the Pregnancy is the result of rape or incest; 3) an abortion is necessary to prevent irreparable damage to the mother's bodily function; or 4) the fetus is not viable or has a lethal defect.

(2) **Adoption Expenses**. Services and supplies for or related to adoption expenses.

(3) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(4) **Ambulance for convenience**. Any expense for commercial transport, private aviation, or air taxi services are not covered regardless of the circumstances or their FAA certification. Any expenses for transportation by private automobile, commercial or public transportation are not covered. The Plan will not pay for any of these services even if other means of transportation were not available.

(5) **Artificial insemination,** including but not limited to invitro fertilization, GIFT procedure, surrogate parents, or expenses related to other direct attempts to induce pregnancy including drug and hormone therapy.

(6) **Biofeedback**.

(7) **Birthing classes.** Expenses for birthing classes.

(8) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

(9) **Convenience**. Expenses required only for the convenience of the Covered Person or the Covered Person's Physician are not covered.

(10) **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but

which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by injury, disease, trauma, congenital/developmental Anomalies, or previous covered therapeutic processes.

(11) **Court order.** Any expenses incurred as a result of a court order, unless the expenses for the Illness or Injury would be covered under the Plan in the absence of a court order.

(12) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance, Custodial Care or domiciliary care consisting chiefly of room and board.

(13) **Deluxe or luxury items** are not covered. Examples are motorized equipment when manually operated equipment can be used, wheelchair sidecars. The Plan will cover deluxe equipment only when additional features are required for effective medical treatment, or to allow the covered person to operate the equipment without assistance. Air conditioners, purifiers, humidifiers, corrective shoes, heating pads, hot water bottles, exercise equipment, whirlpools, waterbeds or other floatation mattresses, self-help devices and other clothing and equipment which is not medical in nature are not covered, regardless of the relief they provide for a Medical Condition.

(14) **Dental Services.** Dental Services provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth except where specifically indicated as a covered expense.

(15) **Domiciliary care**. Care provided in a residential institution, treatment center, half-way house or school because the Covered Person’s own home arrangements are not appropriate and consisting chiefly of room and board is not covered, even if therapy is included.

(16) **Educational or vocational testing.** Services for educational or vocational testing or training.

(17) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(18) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(19) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall

not apply to the extent that the charge is for routine patient care costs for a Qualified Individual who is a participant in an approved clinical trial. Charges will be covered only to the extent specifically set forth in the "Covered Charges" section.

(20) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

(21) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails except when indicated for diabetic patients.

(22) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services. Immunizations required for foreign travel are not covered.

(23) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(24) **Growth Hormone Therapy**.

(25) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician. Hair loss treatment is not covered unless it is precertified and is due to a congenital condition. However, wigs after chemotherapy are covered as defined in the Schedule of Benefits.

(26) **Health club membership**.

(27) **Hearing aids.** Charges for services or supplies in connection with hearing aids.

(28) **Homeopathic or naturopathic** treatments are not covered regardless of the relief they may provide unless otherwise stated in this Plan.

(29) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(30) **Hypnosis** whether for medical or anesthesia purposes.

(31) **Illegal Acts.** Treatment for injury or illness of the Covered Person incurred in connection with actions by the Covered Person which would constitute a felony crime under applicable law and for which the Covered Person is charged with a felony crime, whether or not the Covered Person is convicted.

(32) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance,

drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(33) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence. Charges in connection with the diagnosis of infertility will be covered.

(34) **Infertility.** Care, supplies, services and treatment for infertility, except for diagnostic services rendered for infertility evaluation. Non-covered treatment includes, but is not limited to, all assisted reproductive technologies (for example, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception) and fertility drugs and medications.

(35) **Late claims filing.** Post-service claims not filed in accordance with the terms of the Plan as specified in the How to Submit a Claim section.

(36) **Lifestyle and personal growth counseling**.

(37) **Mailing or sales tax**.

(38) **Marital, pre-marital or family counseling.** Care and treatment for marital or pre-marital counseling. However, family counseling will be covered when the identified patient is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment when Mental Health Services are covered benefits under the Plan.

(39) **Massage therapy**.

(40) **Missed appointments**.

(41) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(42) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(43) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(44) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(45) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(46) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(47) **Obesity or Weight Reduction/Control.** The Plan does not cover medical treatment, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions unless otherwise required by applicable law.

(48) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(49) **Occupational, physical or speech therapy** services to maintain function at a level to which it has been restored, or when no further significant practical improvement can be expected.

(50) **Orthognathic (Jaw) Surgery.** Services and supplies for orthognathic surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones. This exclusion does not apply to orthognathic surgery due to Injury, sleep apnea or congenital anomaly.

(51) **Over-the-Counter Contraceptives**. This does not apply to over the counter drugs that are prescribed by a Physician as required for Standard Preventive Care or to an over the counter contraceptive recommended by a Provider based on medical necessity.

(52) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(53) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(54) **Post-mortem testing**.

(55) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse.

(56) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(57) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(58) **Rhinoplasty**, **blepharoplasty or brow lifts** except expenses for rhinoplasties and blepharoplasties to correct a functional condition, or expenses for rhinoplasty to correct a condition as a result of an accidental injury.

(59) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(60) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(61) **Sexual Dysfunction**. Services and supplies (including medications) for, or in connection with, sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners when Mental Health Services are covered benefits under the Plan.

(62) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

(63) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(64) **Therapy and training** and self-help programs treatment, testing, procedures, devices and drugs, including but not limited to:

- **(a)** Any type of goal-oriented or behavior modification therapy.
- **(b)** Holistic medicine and environmental medicine.
- **(c)** Megavitamin therapy.
- **(d)** Myotherapy.
- **(e)** Recreational, sex addiction, primal scream and Z therapies.
- **(f)** Religious counseling.
- **(g)** Rolfing.
- **(h)** Self-help or stress management.
- **(i)** Sensitivity or assertiveness training.
- **(j)** Transactional analysis, encounter groups and transcendental meditation (TM).

(65) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge or those approved by an Organ Transplant Case Manager.

(66) **War.** Any loss that is due to a declared or undeclared act of war.

(67) **Vitamins, minerals, nutritional supplements, appetite suppressants, dietary** supplements, and formulas whether or not prescribed by a Physician, except as specifically indicated as a covered expense.

(68) **Vision Care.** Visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. ProCare Rx is the administrator of the pharmacy drug plan.

Preventive Prescription Drugs are covered as required by the Patient Protection and Affordable Care Act (PPACA). For more detailed information, please contact ProCare Rx at 1-855-828-1484 or https://www.procarerx.com/.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply. Copayments will apply to the satisfaction of the Plan's Out-of-Pocket maximum.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

When a Member or Physician chooses a brand name prescription when a generic is available, the member will be responsible not only for the appropriate co-pay, but for the difference in cost between the brand and generic. This difference in cost amount will **not** apply toward satisfaction of the Plan's Maximum Out-of-Pocket amount.

If a Provider recommends a particular contraceptive service or FDA-approved contraceptive item based on medical necessity for an individual, the Plan will cover the service or item at 100%.

Percentages Payable

The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits.

Certain prescriptions may require step therapy, where a different prescription may be required to be tried first before being eligible.

Step therapy is a process that requires you to use one or more first line agents before a medication which is part of a step therapy protocol can be utilized. As a patient, this means that, in some instances, you will need to try one or more medications which are considered first line before you are able to receive a "second step" medication through your pharmacy benefit plan. When you bring a prescription for a "second step" medication to the pharmacy, the pharmacist will submit the claim to your pharmacy benefits provider. At this time, your medication history will be reviewed to evaluate whether or not you have fulfilled the requirements of the first line medication. If you have met the requirements, your insurance will automatically cover the prescription and

current copayments will apply. If you have not met the requirements of the first line medication, you have three options. The first option is to fulfill the requirements of the first step. The second option is to ask your physician to contact the pharmacy benefits provider to request coverage as a medical exception. The final option is to pay the cash price for the prescription.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.) and for some specialty drugs. Because of volume buying, ProCare Rx, the mail order pharmacy, is able to offer Covered Persons significant savings on their prescriptions.

Covered Prescription Drugs

(1) Drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives unless otherwise specifically excluded, but excludes any drugs stated as not covered under this Plan.

(2) Certain compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity. Contact the PBM (Prescription Benefit Manager) for a list of covered compounded prescriptions.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection.

(5) Smoking cessation medications and smoking deterrent products when prescribed by a Physician or as required by law under the Patient Protection Affordable Care Act (PPACA).

(6) Weight loss medications when prescribed by a Physician.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(3) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(4) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(5) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(6) **FDA.** Any drug not approved by the Food and Drug Administration.

(7) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

(8) **Immunization.** Immunization agents or biological sera except as may be required under the Preventive Care provision in the Patient Protection and Affordable Care Act (PPACA).

(9) **Impotence.** A charge for impotence medication.

(10) **Infertility.** A charge for infertility medication.

(11) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(12) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(13) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(14) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over the counter drugs that are prescribed by a Physician as required for Standard Preventive Care.

(15) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

HOW TO SUBMIT A CLAIM

When a Covered Person has a claim to submit for payment, either the Employee or Provider should submit bills for services rendered.

ALL BILLS MUST SHOW:

Name of Plan: **ARUP Laboratories, Inc. Medical Benefit Plan**
Employee's name
Name, address, telephone number and tax ID number of provider of care
Diagnosis
Type of services rendered, with diagnosis and/or procedure codes
Date of Services
Charge
Group #: **22204046**

Send the above to the Claims Administrator at this address:

CNIC Health Solutions, Inc.
P.O. Box 3559
Englewood, Colorado 80155-3559
303-770-5710 or 1-800-426-7453

The claims administrator reserves the right to routinely request employment and /or other insurance information from the covered Employee/Spouse. These requests will be submitted in writing to the Employee. Claims payment may be pended until details are disclosed and submitted in writing to the Claims Administrator.

WHEN CLAIMS MUST BE FILED

Claims must be filed with the Claims Administrator within 12 months of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date will be declined or reduced unless the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator

must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Claims involving Urgent Care	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	15 days per benefit appeal

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	30 days per benefit appeal

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

If the claimant disagrees with the Adverse Benefit Determination on Appeal, he or she may file a request for a second level of Appeal. This request must be made in writing within 180 days following receipt of the Adverse Benefit Determination on Appeal. The claimant may submit written comments, documents, records, and other information relating to the Claim. The second level of review will be conducted, and written notification of the decision, shall be made in accordance with all of the procedures that apply to the first level of review. If the Claim is denied in whole or in part after this second level of Appeal, the written notification describing the Adverse Benefit Determination is the Final Adverse Benefit Determination.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. For requests made on or after September 20, 2011, the External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine within five days after receipt whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number 1-866-444-3272.

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile Limitations. When medical payments are available under vehicle insurance, the Plan shall have no liability for expenses covered by any other available vehicle coverage, regardless of whether under a no-fault or tort-based system. The Plan shall **pay excess coverage only**, without reimbursement for vehicle plan deductibles. Please refer to the Schedule of Benefits for specific coverage information. This Plan shall always be considered the secondary when other coverage is available.

For expenses resulting from an automobile accident such coverage carried through auto insurance carriers, which will be considered primary, includes but is not limited to:

- No-Fault Personal Injury Protection (PIP);
- Optional Medical Payments Coverage (MPC);
- Bodily injury liability coverage;
- Un-insured or under-insured motorist coverage; or
- Personal liability umbrella policies, which include excess benefits for medical expenses related to automobile accidents.

Auto related claims that are the responsibility of a third party are also subject to the Third Party Recovery Provision section of the Plan.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person

was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a state Child Health Insurance Program to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

RIGHTS OF SUBROGATION AND REFUND

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

2. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

3. The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Participant(s) fails to file a claim or pursue damages against:

   a. The responsible party, its insurer, or any other source on behalf of that party;
   b. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c. Any policy of insurance from any insurance company or guarantor of a third party;
   d. Workers' compensation or other liability insurance company; or
   e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

   the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Excess Insurance
If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds
Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death
In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations
1. It is the Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;

c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.

2. If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant(s)' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan.

Minor Status

1. In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under ARUP Laboratories, Inc. Medical Benefit Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA continuation coverage under the Plan is administered by the COBRA Administrator. The COBRA Administrator is GBS Benefits, Inc., 465 South, 400 East, Suite 300, Salt Lke City, Utah 84111, 801-364-7233. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

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

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Federal law does not recognize a Domestic Partner or his or her children as Qualified Beneficiaries. However, the Plan will treat a Domestic Partner and his or her Children or Qualified Dependents as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. For purposes of interpreting this Section, the Domestic Partner will be treated as the Spouse of the Employee, and a divorce will be deemed to have occurred on the first date that one or more of the eligibility requirements for a Domestic Partner ceases to be met. This gives the Domestic Partner, Children and Qualified Dependents the contractual rights outlined in this Section but does not extend statutory remedies to them. This provision does not apply to same sex spouses who are legally married. Same sex spouses who are covered under the Plan are Qualified Beneficiaries if they are covered under the Plan on the day before the Qualifying Event.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by or on behalf of a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even in the event of a failure to pay the required premiums for coverage under the Plan during the FMLA leave by the Employee and family members or on behalf of the Employee and family members. For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the end of the month after the leave ends, if the Employee does not return to work in an Eligible Class.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication - and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Medicare Eligibility:** You should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment -related health coverage ends. Electing COBRA coverage does not extend this 8-month period. For more information, see medicare.gov/sign-up-change-plan.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the COBRA Administrator has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce, legal termination of domestic partnership or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the COBRA Administrator, GBS Benefits, Inc., 465 South, 400 East, Suite 300, Salt Lake City, Utah 84111 within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person listed at the address shown above.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the COBRA Administrator receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(5) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator, GBS Benefits, Inc., 465 South, 400 East, Suite 300, Salt Lake City, Utah 84111 in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator, GBS Benefits, Inc., 465 South, 400 East, Suite 300, Salt Lake City, Utah 84111 in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay (or coverage must be paid for on behalf of Qualified Beneficiaries) for COBRA continuation coverage. Coverage for Qualified Beneficiaries will cost up to 102% of the applicable premium and up to 150% of the

applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, payment is permitted for covered employees or Qualified Beneficiaries until that later date for the coverage period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator, GBS Benefits, Inc., 465 South, 400 East, Suite 300, Salt Lake City, Utah 84111. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. ARUP Laboratories, Inc. Medical Benefit Plan is the benefit plan of ARUP Laboratories, Inc., the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by ARUP Laboratories, Inc. to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, ARUP Laboratories, Inc. shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of ARUP Laboratories, Inc.'s workforce are designated as authorized to receive Protected Health Information from ARUP Laboratories, Inc. Medical Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan: Human Resources.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees.

PLAN NAME: ARUP Laboratories, Inc. Medical Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 87-0403206

PLAN EFFECTIVE DATE: January 1, 2014

PLAN RESTATEMENT EFFECTIVE DATE: January 1, 2017

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION

ARUP Laboratories, Inc.
500 Chipeta Way
Salt Lake City, Utah 84108
801-583-2787, option 1, extension 2182

PLAN ADMINISTRATOR

ARUP Laboratories, Inc.
500 Chipeta Way
Salt Lake City, Utah 84108
801-583-2787, option 1, extension 2182

CLAIMS ADMINISTRATOR

CNIC Health Solutions, Inc.
P. O. Box 3559
Englewood, Colorado 80155
1-800-426-7453