SUMMARY PLAN DESCRIPTION

ARUP Benefit Plans

Healthy Preferred EPO
Effective January 1, 2021

ARUP Laboratories
500 Chipeta Way
Salt Lake City, UT 84108
801-583-1787, option 1, x2182

University of Utah Health Plans*
PO Box 45180
Salt Lake City, UT 84145
801-213-4008
833-981-0213 Toll Free
www.uhealthplan.utah.edu/aruplabs

*University of Utah Health Insurance Plans, a Utah non-profit corporation, is the legal entity acting as Claims Administrator and is registered to conduct business under the name "University of Utah Health Plans".

COVER/SIGNATURE PAGE

Effective January 1, 2021, ARUP Laboratories, Inc. reinstates self-funded Health Care Plan for the benefit of eligible Employees and their eligible Dependents entitled ARUP Laboratories, Inc. Medical Benefit Plan (the "Plan"). The purpose of this Plan is to provide reimbursement for Expenses Incurred for covered services, treatment or supplies because of Medically Necessary treatment for Illness or Injury of the Company's eligible Employees and their eligible Dependents. The Company, in conjunction with any required contributions by its Employees, agrees to make payments to the Plan's Trust in order for payments to be made for covered services, treatments or supplies as provided by this Plan.

The Company has caused this instrument to be executed as of the day first mentioned above.
ARUP LABORATORIES, INC.

BY: _____

TITLE: Compensation & Benefits Manager
ARUP

INTRODUCTION

This ARUP Laboratories, Inc. Medical Benefit Plan Summary Plan Description describes the terms and benefits of coverage effective January 1, 2021, or a later date on which Your coverage became effective. This Summary Plan Description ("SPD") replaces any plan description or Summary Plan Description previously issued by the Plan Sponsor and makes them void with respect to Your coverage effective on or after January 1, 2021.

Benefits under this Plan will be paid only if the Plan Sponsor decides, in its sole discretion, that You are entitled to them in accordance with this Summary Plan Description. As You read this Summary Plan Description, please keep in mind that references to "You" and "Your" refer to both the Plan Participant and Enrolled Dependents. The term "Family" refers to the Plan Participant and all individuals enrolled as his/her Eligible Dependents. The term "Claims Administrator" refers to University of Utah Health Plans. The term "Agreement" refers to the administrative services contract between the Plan Sponsor and the Claims Administrator. The term "Plan" refers to the ARUP Laboratories, Inc. Health Care Plan. "Plan Sponsor," "Plan Administrator," "Employer" and "Company" mean ARUP Laboratories, Inc., whose eligible employees may participate under this Plan. Other terms are defined in the Definitions section at the back of this Summary Plan Description or where they are first used.

ARUP Laboratories, Inc. reserves the right to amend or terminate this Plan in whole or in part, at any time, regardless of the health or treatment status of You or Your Enrolled Dependents. Amendment or termination may result in modification or termination of Your coverage and/or the coverage of Your Enrolled Dependents. Covered Services and Allowed Amounts incurred prior to the Plan's amendment or termination will be paid as provided under this Summary Plan Description as it existed at the time they were incurred.

USING YOUR PLAN DESCRIPTION

ARUP Laboratories, Inc. Health Care Plan offers the medical plan described in this Summary Plan Description. It is important for You to understand how the Plan works before You need health care services. Please read this material carefully. If You have any questions about benefits or procedures, please contact University of Utah Health Plans Customer Service Department or visit their website at www.uhealthplan.utah.edu/aruplabs

YOU SELECT YOUR PROVIDER AND CONTROL YOUR OUT-OF-POCKET EXPENSES

Your Plan gives You broad access to Providers and allows You to control whether You use an In-Network or Out-of-Network Provider. This choice affects Your out-of-pocket expenses, such as Copayments, Deductible and Coinsurance, for each Covered Service.

- **In-Network Provider.** When You choose to see an In-Network Provider, You will receive the highest level of benefits and will not be billed for balances on Covered Services beyond any Copayment, Deductible, and/or Coinsurance. This will usually result in lower out-of-pocket amounts for You.

- **Out-of-Network Provider.** When You choose to see a Provider that does not have a participating contract with the Claims Administrator, You will be responsible for 100% of the cost for services You receive, unless the services are related to a medical emergency.

For each benefit in this Summary Plan Description, Your payment amount for In-Network Providers is indicated. You can go to **www.uhealthplan.utah.edu/aruplabs/** for additional Provider network information and to find In-Network Providers.

GUIDANCE AND SERVICE ALONG THE WAY

This Summary Plan Description is designed to provide information and answers quickly and easily.

- **Learn more and receive answers about Your coverage.** Call Customer Service at (801) 213-4008 or (833) 981-0213 to talk with one of the Claims Administrator's Customer Service Representatives. Phone lines are open Monday-Friday 8 a.m. - 6 p.m. MST. You may also visit the website at: **www.uhealthplan.utah.edu/aruplabs/.**

- **Care Management.** You can request that a care manager be assigned to You, or a care manager may be assigned to help You utilize Your benefits and navigate the health care system in the best way possible. Care managers assess Your needs, develop treatment plans, coordinate resources and negotiate with Providers on Your behalf. Call Care Management at (801) 213-4008 or (833) 981-0213, Option 2.

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WHO IS ELIGIBLE

This section contains the terms of eligibility under the Plan.

Please Note: In the following sections starting with Who Is Eligible through When Coverage Ends, the terms "You" and "Your" mean the Plan Participant only.

Eligible Employees

An Employee becomes eligible under this Plan for each classification of employees as follows:

1. Class I: Is employed by the Company on a continuing and regular basis for at least twenty (20) hours per week; or
2. Class II: Is employed by the Company as a variable hour Employee, and completes a Measurement Period of twelve (12) consecutive months, during which the variable hour Employee averages thirty (30) hours per week of actual work and/or paid leave, FMLA leave or jury duty whether paid or not, for twelve (12) consecutive months.

"Measurement Period" is the period of time adopted by the Plan for variable hour Employees during which such Employees' work hours and applicable leave are measured to determine whether such Employees are eligible for coverage.

An Employee is not eligible while on active military duty if that duty exceeds a period of thirty-one (31) consecutive days.

Eligible Dependents

An eligible Dependent includes any person who is a citizen, resident alien, or is otherwise legally present in the United States or in any other jurisdiction that the related Participant has been assigned by the Employer, and who is either:

1. The Participant's legal spouse, according to the marriage laws of the state where the marriage was first solemnized or established. Proof of legal marriage must be furnished to the Plan Administrator upon request, including a copy of the Participant's most recent Federal tax return and signed Affidavit. An eligible Dependent does not include a spouse who is legally separated or divorced from the Participant and has a court order or decree stating such from a court of competent jurisdiction.

2. The Participant's Dependent child who meets all of the following Required Eligibility Conditions:

   A. Is a natural child; step-child; legally adopted child; a child who has been Placed for Adoption with the Participant and for whom as part of such placement the Participant has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Participant has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; and

   B. Is less than twenty-six (26) years of age. This requirement is waived if the Participant's child is mentally handicapped/challenged or physically handicapped/challenged, provided that the child is unmarried, incapable of self-supporting employment and is chiefly dependent upon the Participant for support and maintenance. Proof of incapacity must be furnished to the Plan Administrator upon request, and additional proof may be required from time to time.

An eligible Dependent does not include a spouse of the Dependent child or a child of the Dependent child.

Dependent Coverage Continuing Beyond Limiting Age

- You may continue coverage for Your (or Your spouse's) unmarried child at age 26 if the child is currently enrolled in the Plan as Your Eligible Dependent and is a Disabled Dependent (defined below).

To do so, You must provide to the Plan Sponsor's Human Resources Department the required form to continue coverage along with proof that the dependent meets the Plan's definition of Disabled Dependent, as follows:

- within 60 days after the dependent reaches age 26; and
- at reasonable times thereafter as the Claims Administrator may consider necessary, but not more often than annually.
- Likewise, if you are a newly hired employee with an unmarried Disabled Dependent who is age 26 or older upon your date of hire, your child may qualify for coverage under the Plan as a Disabled Dependent, provided that you and your child satisfy the requirements set forth immediately above.

You must promptly furnish or cause to be furnished to the Plan Sponsor's Human Resources Department any information necessary or appropriate to determine the validity of a dependent's status. Receipt of such information by Plan Sponsor's Human Resources Department will be a condition precedent to continuing coverage for a person as a dependent under the Plan. In addition, You or the dependent must notify Plan Sponsor's Human Resources Department when the dependent is no longer eligible under these exceptions.

DEFINITIONS SPECIFIC TO WHO IS ELIGIBLE, HOW TO ENROLL AND WHEN COVERAGE BEGINS SECTION

Disabled Dependent means a child who is and continues to be: 1) unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable Physical or Mental Impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and 2) dependent on You for more than 50% of their support (food, shelter, clothing, medical and dental care, education and the like).

Mental Impairment means a mental or psychological disorder such as: 1) mental retardation; 2) organic brain syndrome; 3) emotional or mental illness or 4) specific learning disabilities as determined by the Claims Administrator.

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

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 the identification of each plan to which the order applies.

HOW TO ENROLL AND WHEN YOUR COVERAGE BEGINS

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

Completed applications for coverage should be filed with the Plan Sponsor's Human Resources Department, or as otherwise instructed by the Human Resources Department.

WHEN YOU AND YOUR DEPENDENTS ARE INITIALLY ELIGIBLE

You become eligible for coverage on the first day of the month following 30 calendar days from the date You are hired by ARUP Laboratories, Inc. in a benefit-eligible position, or on the first day You are transferred into a benefit-eligible position from an ineligible position.

NEWLY ELIGIBLE DEPENDENTS

Coverage will become effective on the date of the event if the Employee makes a special enrollment request, verbally or in writing, within 30 calendar days of any special enrollment event and application for such coverage is made on the Plan's enrollment form within sixty (60) days of the event.

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your Eligible Dependents if You failed to do so when first eligible and not be considered a Late Enrollee (referred to as "Special Enrollment"). The Special Enrollment period lasts for 60 days beginning with the day of the triggering event (or 60 days in the event of loss of Medicaid or CHIP coverage, as described below). In each situation, You must submit a Life Status Event change within thirty (30) calendar days of any special enrollment event. If You do not submit Your request within the Special Enrollment period, You may only enroll You and/or Your Eligible Dependents during the Plan's subsequent Open Enrollment Periods, if any. In these situations, the rules regarding how to apply and when coverage begins are the same as those described earlier. The following triggering events allow for Special Enrollment:

- If You and/or Your Eligible Dependents lose coverage under another group or individual health benefit plan due to the exhaustion of federal COBRA or any state continuation coverage;
- the loss of eligibility due to legal separation, divorce, cessation of dependent status, death, termination of employment or reduction in hours; termination of the employer contributions;
- a significant curtailment in group coverage that qualifies as a loss of coverage under IRS rules and no other similar coverage is available through that group;
- a significant increase in Your cost of group coverage and no other similar coverage is available through that group; or
- involuntary loss of coverage under Medicare, CHAMPUS/Tricare, a medical care program of an Indian Tribal government, the Indian Health Service, a tribal organization, a State health benefits risk pool, or a Foreign government group health plan;

Then You and/or Your Eligible Dependents become eligible for coverage under this Plan on the date the other coverage ends. To be eligible for this Special Enrollment, each individual must have had coverage under any group health plan or health insurance coverage when coverage under this Plan was previously offered. Note that loss of eligibility does not include a voluntary termination of coverage (unless the other Plan permits participants to make an election for a period of coverage that is different from the period of coverage under this Plan), a loss because premiums were not paid in a timely manner, or termination of coverage because of fraud.
If You declined coverage for Yourself and/or Your Eligible Dependents when You were first eligible and You and/or one of Your Eligible Dependents loses eligibility for coverage under Medicaid or CHIP, or becomes eligible for premium assistance from Medicaid or CHIP, You become eligible for coverage under this Plan on behalf of Yourself and Your Eligible Dependents on the date of change in eligibility.

If You declined coverage for Yourself and/or Your Eligible Dependents when You were first eligible and You subsequently marry, You become eligible for coverage under this Plan on behalf of Yourself, Your spouse, and any eligible children and/or Your Eligible Dependents on the date of marriage.

If You declined coverage for Yourself and/or Your Eligible Dependents when You were first eligible (or You declined coverage for Your spouse when he or she was first eligible) and You subsequently acquire a new child by birth, adoption, placement for legal adoption, or placement for legal guardianship or foster care (if the order requires health coverage for the child), You become eligible for coverage under this Plan along with Your eligible spouse and eligible children on behalf of Yourself and/or Your Eligible Dependents, including the newly acquired child on the date of the birth, adoption, or placement.

If requested, You must provide valid documentation supporting your request for an election based on a Life Status Event.

LATE ENROLLMENT/OPEN ENROLLMENT PERIOD

If You wish to enroll and/or add Your Eligible Dependents under the Plan but did not enroll when first eligible or during a previous Open Enrollment Period (making you a "Late Enrollee") and You do not qualify for any of the Special Enrollment exceptions, You may enroll in coverage and/or add Your Eligible Dependents only during a future Open Enrollment Period, if any. Coverage for a Late Enrollee will commence on the Effective Date, which for a Late Enrollee, is always the first day of the next Contract Year. In other words, if You fail to enroll within the specified timeframe when you initially become eligible to enroll in the Plan, You waive Your right to participate in the Plan until the next Open Enrollment Period, unless you qualify for a Special Enrollment exception. Likewise, for ongoing employees, if You fail to enroll during an Open Enrollment Period, You waive Your right to participate in the Plan until the next Open Enrollment Period, unless you qualify for a Special Enrollment exception.

TRANSFER DURING ANNUAL OPEN ENROLLMENT PERIOD

If You and Your Enrolled Dependents are transferring directly to this option from one of the Plan's other options during an Open Enrollment Period, You must complete Your election changes during Open Enrollment through the online benefits portal and indicate all Eligible Dependents You want to enroll. If You transfer from one of the Plan's other options to this option during an Open Enrollment Period, You will not be considered a Late Enrollee. Coverage in this option will commence on the first day of the next Contract Year.

TRANSFER OUTSIDE OF ANNUAL OPEN ENROLLMENT PERIOD

If You or Your Enrolled Dependents move outside of this Plan's coverage area, You may elect to transfer coverage to one of the Plan's other options. You must complete the transfer request within 30 calendar days of the event.

ENROLLMENT BY OTHERS

In the event Your child is the subject of a court or administrative order requiring You to provide health coverage for the child and You are eligible for health coverage for the child, but fail to apply to cover the child, application for enrollment of the child may be made by the child's other parent, any state Medicaid agency or by the state agency administering 42 U.S.C. 651 through 699 (the child enforcement program). If You are not enrolled in coverage, You will automatically be enrolled and the child will be enrolled as Your Eligible Dependent.

NOTICE OF STATUS CHANGE

In the event You acquire a dependent or a dependent loses eligibility under the Plan, You must complete a Life Status Event within 30 calendar days of any special enrollment event. In order for an individual who loses eligibility for coverage under the Plan to be eligible for continuation of coverage under COBRA, You must complete a Life Status Event within 60 calendar days after such date in order for the dependent to be eligible for continuation of coverage under COBRA.

COST OF COVERAGE

You and the Company share in the cost of the Plan. Your contribution amount depends on the type of coverage You select and the Family members You choose to enroll. Your contributions are deducted from Your paychecks on a before-tax basis. Before-tax dollars come out of Your pay before federal income and Social Security taxes are withheld and, in more states, before state and local taxes are withheld. This gives Your contributions a special tax advantage and lowers the actual cost to You. The Company reserves the right to change your contribution amount from time-to-time.

COORDINATION OF BENEFITS

If You are covered under any other individual or group medical contract or policy (referred to as "Other Plan" and defined below), the benefits under this Plan and those of the Other Plan will be coordinated in accordance with the provisions of this section. This provision does not apply to prescription drug coverage.

Benefits Subject to this Provision

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

Definitions

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

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

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

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

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

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

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

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

- Individual and group accident and health insurance and subscriber contracts.
- Uninsured arrangements of group or Group-Type Coverage.
- Group-Type Coverage.
- Coverage through closed panel plans (a plan that provides coverage primarily in the form of services through a panel of Providers that have contracted with or are employed by a plan and that excludes benefits for services provided by other Providers, except in the cases of emergency or referral by a panel member).

- Medical care components of long-term care contracts, such as skilled nursing care.
- Medicare and other governmental coverages, as permitted by law.

Other Plan does not include:

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

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

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

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

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

Order of Benefit Determination

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

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

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

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

- If there is no court decree allocating responsibility for Your health care expenses or health care coverage, the order of benefits is as follows:
    - The plan of Your custodial parent shall be primary to the plan of Your custodial parent's spouse;
    - The plan of Your custodial parent's spouse shall be primary to the plan of Your noncustodial parent; and
    - The plan of Your noncustodial parent shall be primary to the plan of Your noncustodial parent's spouse.

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

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

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

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

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

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

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

Primary Health Plan Benefits

When, in accordance with the order of benefit determination, this coverage is the Primary Plan, benefits of this Plan will be paid as if no other plan exists. Despite the provisions of timely filing of claims, where this Plan is the Primary Plan, benefits will not be denied under this Plan on the ground that a claim was not timely submitted if the claim was timely submitted to one or more Secondary Plans and was submitted to the Claims Administrator within 12 months of the date of service.

Secondary Health Plan Benefits

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

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

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

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

Right to Receive and Release Needed Information

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

Right of Recovery/Subrogation

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

- From You, if payment was made to You. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentations. This Plan will be entitled to recover the amount of such excess by the reversal of payment from You and You agree to reimburse this Plan on demand for any and all such amounts.
- If a third- party collection agency or attorney is used to collect the overpayment, You agree to pay collection fees incurred, including, but not limited to, any court costs and attorney fees. If You do not pay, future benefits under this Plan may be withheld to offset the amount owing to it. The Claims Administrator is responsible for making proper adjustments between insurers and Providers.
- From Providers, if payment was made to them. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentation(s). The Claims Administrator is responsible for making proper adjustments between insurers and Providers.
- From the Other Plan or an insurer.
- From other organizations.
- A Secondary Plan that provides benefits in the form of services may recover the reasonable cash value of the services from the Primary Plan to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by it.

WHEN COVERAGE ENDS

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

PLAN TERMINATION OR AMENDMENT

If the Plan is terminated by the Plan Sponsor, coverage will end on the date the Plan is terminated.

No person shall have or acquire a vested right to receive benefits after the date this Plan is terminated or the date they are no longer eligible to participate in the Plan. Termination of Your or Your Enrolled Dependents' coverage under this Plan for any reason shall completely end all of the Plan Sponsor's and the Claims Administrator's obligations to provide You or Your Enrolled Dependents benefits for Covered Services received after the date of termination whether or not You or Your Enrolled Dependents are then receiving treatment or are in need of treatment for any Illness or Injury incurred or treated before or while this Plan was in effect.

WHEN YOU MAY ELECT TO CANCEL COVERAGE

You may elect to cancel Your coverage and/or coverage for Your Enrolled Dependents during the Plan's future Open Enrollment Periods, if any. Coverage dropped during Open Enrollment will be terminated effective at the end of the then-current Contract Year.

If You and/or Your Enrolled Dependent(s) obtain other similar coverage during the Contract Year (including enrolling in Medicare), You may elect to cancel coverage for such covered individual(s). In order to drop coverage during the Contract Year, You must submit a Life Status Event change on the online benefit portal within 30 calendar days from the date You and/or Your Enrolled Dependent(s) gain other similar coverage. Coverage will be dropped at the end of the month.

In the event You experience a significant increase in Your cost of coverage and other similar coverage is available, You may choose to drop Your coverage in the Plan for You and all Your Enrolled Dependents. To drop coverage, You must submit a Life Status Event change on the online benefit portal within 30 calendar days from the date of the significant increase in Your cost of coverage. Coverage will be dropped at the end of the month of the change.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

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

Termination of Your Employment or Appointment or Change to an Ineligible Employment Status

If You are no longer eligible under the Plan due to termination of employment or appointment or change to an employment status that is ineligible for benefits, or You are no longer a member of an affiliated group, Your coverage will end for You and all Enrolled Dependents on the last day of the month on or following the date on which eligibility ends.

Nonpayment of Required Contribution

If You fail to make the required contribution in a timely manner, Your coverage will end for You and all Enrolled Dependents on the date You fail to make such a required contribution (or until the end of the grace period, if applicable) and You and Your Enrolled Dependents will not be eligible for continuation of coverage under COBRA in connection with such a termination.

Termination by ARUP Laboratories, Inc.

If ARUP Laboratories, Inc. terminates Your coverage for any cause not otherwise specified, Your coverage will end for You and all Your Enrolled Dependents at the end of the month following such a termination.

If You Die

If You die, Your Enrolled Dependents may enroll under COBRA.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your dependents are no longer eligible as explained in the following paragraphs, their eligibility for coverage will end at 12:01 a.m., in the time zone of which the participant resides, on the date of the event that makes them ineligible. However, it may be possible for Your ineligible dependents to continue coverage under the Plan according to the COBRA continuation of coverage provisions of this Summary Plan Description. You must complete a Life Status Event change on the online benefit portal of such dependent's loss of eligibility within 30 calendar days of the date of the event. Any change to Your coverage level (e.g., two-party to single coverage), will be effective on the date of the event. **You or Your dependent must notify Plan Sponsor's Human Resources Department of the ineligibility within 60 days of the event in order to be eligible for COBRA continuation of coverage** (see the COBRA section for additional information).

Divorce or Annulment

Eligibility ends for Your enrolled spouse and the spouse's children at the end of the month that the divorce or annulment is final. You must complete a Life Status Event change on the online benefit portal to report the former spouse's ineligibility under the Plan. In the event the Plan is notified within 60 calendar days of the date of divorce or annulment, Your former spouse has the opportunity to continue coverage under the Plan for a limited period of time according to the COBRA continuation of coverage provisions of this Summary Plan Description.

Loss of Dependent Status

For an enrolled child who is no longer an Eligible Dependent due to exceeding the dependent age limit, eligibility ends at the end of the month of the child's 26th birthday (or the date the child is no longer capable of self-support because of mental retardation or a physical handicap, if over age 26).

For an enrolled child who is no longer eligible due to disruption of placement prior to legal adoption and the child is removed from placement, eligibility ends at the end of the month the child is removed from placement.

For an enrolled child who is no longer an Eligible Dependent for any other cause (except by reason of Your death), eligibility ends at the end of the month the child is no longer an Eligible Dependent. You or Your dependent must complete a Life Status Event change form of an Enrolled Dependent's ineligibility under the Plan. In the event You complete the online notification to the plan within 30 calendar days of the date the dependent becomes ineligible under the Plan, the dependent may continue coverage under the Plan according to the COBRA continuation of coverage provisions of this Summary Plan Description.

FRAUDULENT USE OF BENEFITS

If You or Your Enrolled Dependents engage in an act or practice that constitutes fraud in connection with coverage under this Plan or makes an intentional misrepresentation of material fact in connection with coverage, coverage under the Plan may be terminated, to the extent permitted by law, and You and Your Enrolled Dependents will not be eligible for continuation of coverage under COBRA. In the case of such fraud or intentional misrepresentation, coverage may be terminated retroactively (called a "rescission" of coverage), in which case You will receive a notice and will be provided an opportunity to appeal the rescission, as required by law. This notice and appeal procedure is not required for retroactive termination of coverage due to Your failure to pay a required contribution.

CERTIFICATES OF CREDITABLE COVERAGE

Requests for and inquiries about required certificates relating to period(s) of creditable coverage are available through the Claims Administrator.

LEAVE OF ABSENCE

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 that is consistent with and stated in the Company's current Absence Management Policy. 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.

FAMILY MEDICAL LEAVE ACT

If You are on a leave required by the Family Medical Leave Act (FMLA), the Plan will administer Your coverage as follows:

You and Your enrolled Dependents may continue Your coverage to the extent required by the FMLA as long as you arrange with ARUP Laboratories, Inc. to pay the applicable employee contributions towards the cost of coverage while out on approved FMLA leave of up to 12 weeks (unless the Employer agrees to permit you to make contributions before or after leave).

UNDERSTANDING YOUR BENEFITS

Under this section, You will discover information to help You understand what is meant by Copayments, Deductible, Coinsurance and Out-of-Pocket Maximum. Other terms are defined in the Definitions section at the back of this Summary Plan Description or where they are first used, and are designated by the first letter being capitalized.

OUT-OF-POCKET MAXIMUM

Members can meet the Out-of-Pocket Maximum with payments of Coinsurance, Deductible and/or Copayments for In-Network Provider categories as specifically indicated in the Summary of Medical Benefits. Any amounts You pay towards Premiums, Non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum amounts of the Plan.

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

The Family Out-of-Pocket Maximum for a Contract Year is satisfied when Family members' Deductible, Coinsurance and/or Copayments for that Contract Year total and meet the Family's Out-of-Pocket Maximum amount. Each Claimant will not be required to pay more than the individual Out-of-Pocket Maximum amount.

DEDUCTIBLE

"Deductible" is the amount You are required to pay before the Plan will start paying coinsurance towards Covered Services. The Family Deductible is satisfied when Family members' Deductibles for that Contract Year total and meet the Family's Deductible amount. Each Claimant will not be required to pay more than the individual Deductible amount. The deductible is waived for certain services as outlined in this SPD.

COPAYMENTS

Copayments are stated in the Schedule of Medical Benefits. Copayments are first-dollar amounts that are payable for certain covered services under the Plan, which are usually paid at the time the service is performed (e.g., emergency room visits). These Copayments do not apply towards the Medical Benefits Deductible but do apply towards the Out-of-Pocket Maximum (combined Medical/Pharmacy) and after the Out-of-Pocket Maximum is satisfied, Copayments will no longer apply for the remainder of the Benefit Period.

COINSURANCE - PERCENTAGE PAID UNDER THE PLAN

"Coinsurance" is the Plan's payment of a percentage of the Allowed Amount for Covered Services You receive under the Plan. See the Definitions section for a detailed description of what is meant by Allowed Amount. When the payment is less than 100 percent, the remaining percentage is Your Coinsurance amount that may need to be paid by You. The percentage paid by the Plan varies, depending on the kind of service or supply. If the applicable benefit for a Covered Service requires You to pay a Deductible, the Coinsurance amount will be a percentage of the Allowed Amount after You have met Your Deductible. The Coinsurance is waived for certain services as outlined in this SPD.

The Plan does not pay Providers for charges above the Allowed Amount. In-Network Providers will not charge You for any charges for Covered Services beyond Your applicable Copayment, Deductible or Coinsurance amount.

Refer to the Summaries of Medical Benefits for a description of percentages paid, cost-sharing, and Out-of-Pocket Maximum amounts.

HOW CONTRACT YEAR BENEFITS RENEW

Many provisions of the Plan are calculated on a calendar year basis. Each January 1, the calendar year maximums begin again.

Some benefits of the Plan have a separate maximum benefit and do not renew every calendar year. Those exceptions are specifically noted in the benefits sections of this Summary Plan Description.

SUMMARY OF MEDICAL BENEFITS

In this section, You will learn about Your health plan's benefits and how Your coverage pays for Covered Services. There are no referrals required before You can use any of the medical benefits of this coverage, including women's health care services. For Your ease in finding the information regarding benefits most important to You, these benefits have been listed alphabetically.

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

A Health Intervention may be medically indicated yet not be a Covered Service under the Plan or otherwise be Medically Necessary. If benefits under the Plan change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began. This applies to facility claims only.

SCHEDULE OF MEDICAL BENEFITS
HEALTHY PREFERRED EPO 750
Per Calendar Year

COST SHARING	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual Family	 $750 $1,500	Not Covered
Benefit Percentage After Deductible After Out-of-Pocket	 85% 100%	Not Covered
Out-of-Pocket Maximum Individual Family	 $4,000 $8,000	Not Covered
Lifetime Maximum Benefit (per claimant)	Unlimited	
Copayments, Deductible and Coinsurance	Copayments, Deductible and Coinsurance are listed in the tables for Covered Services for each applicable benefit.	

ACCIDENTAL INJURY (Calendar Year)

In-Network Provider	Out-of-Network Provider
The Plan pays 100% of the Allowed Amount for the first $1,000 per person, Deductible waived.	The Plan pays 100% of the Allowed Amount for the first $1,000 per person, Deductible waived.
$1,000 per year for accidents. Expenses exceeding the Benefit Limit are subject to the cost sharing that applies to those specific services. Accidental injury charges may be incurred for chiropractic services, dental services, physician services, hospital care and treatment, x-rays and lab tests, ambulance services, surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations, nursing services, anesthesia and use of physician's office or clinic operating room.	

ACUPUNCTURE SERVICES

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Limited to 12 visits per calendar year	

ALLERGY TESTING, TREATMENT AND SERUM (Includes office visit, diagnostic testing and injections)

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

AMBULANCE SERVICES

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	
The plan covers ambulance services to the nearest Hospital equipped to provide treatment, when any other form of transportation would endanger Your health and the purpose of the transportation is not for personal or convenience purposes. Covered ambulance services include licensed **ground and air ambulance** providers.	

AUTISM SERVICE/APPLIED BEHAVIORAL ANALYSIS

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

BARIATRIC SERVICES

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

Prior Authorization Required

One Bariatric Surgery Maximum Lifetime Benefit, including related services. Bariatric Surgery must be performed at a center accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).

Coverage includes charges for Bariatric Surgery for the following:

1. Roux-en-Y gastric bypass.
2. Bilio-pancreatic diversion with duodenal switch (BPD/DS) gastric bypass.
3. Sleeve gastrectomy.

Gastric banding is not included due to lower efficacy and higher complication rates relative to other available options.

All of the following must be met:

1. Covered Person is eighteen (18) years of age or older.
2. A documented history of a BMI greater than 40kg/m2 for the preceding three (3) years; OR a BMI>35kg/m2 with at least two (2) of the following co-existing conditions:
    a. Medically refractory Hypertension: persistent blood pressure reading of >140/90 mmHg (or >130/80 mmHg in diabetic patients) for a minimum of six (6) months despite use of at least two (2) anti-hypertensive medications.
    b. Uncontrolled diabetes (defined as HgbA1c > 7% of two (2) separate occasions at least six (6) months apart despite taking at least two (2) diabetic medications with separate mechanisms of action during this time.
    c. Dyslipidemia requiring medical therapy as defined by the American College of Cardiology and American Heart Association guidelines.
    d. Proven coronary artery disease or cerebral artery disease.
    e. Obstructive sleep apnea as diagnosed by a formal sleep study in an American Academy of Sleep Medicine (AASM) certified sleep lab and interpreted by a certified specialist in sleep disorders.
    f. Obesity hypoventilation syndrome with a diagnosis supported by a polysomnography with continuous nocturnal carbon monoxide monitoring (performed in an AASM certified sleep lab and interpreted by a certified specialist in sleep disorders), pulmonary function testing, a chest x-ray and relevant laboratory testing.
    g. Debilitating arthritis with disqualification from surgery as a result of obesity.
3. Active participation for at least twelve (12) months in a structured, medically supervised non-surgical weight reduction program. Documentation from the clinical records must indicate that all the following criteria have been met:
    a. Supervision is provided by a MD, DO, NP, PA; or by a registered dietician or certified health coach under the supervision of a MD, DO, MP or PA; and
    b. Participation has occurred during at least twelve (12) months within the twenty-four (24) months prior to the request for surgery; and
    c. Include at least six (6) visits occurring at intervals of no longer than sixty (60) days apart; and
    d. Include a comprehensive medical and surgical history, review of current and past medications/supplements, assessment of health-related behaviors (not limited to substance use, sleep adequacy, nutrition, engagement in physical activity, stress management and coping skills), physical exam and assessment of overall health as related to weight; and

e. Document consideration and medically-appropriate utilization of weight loss medications; and
f. Include assessment and counseling concerning behavior modifications, with specific focus on:
   i. Identification of eating and dietary styles (stress-related eating, nighttime eating, grazing, binging, etc.);
   ii. Recognition of personal lifestyle strengths and challenges as informed by patterns of prior weight losses or gains;
   iii. Incorporation of physical movement/activity into daily lifestyle habits; and
   iv. Identification of weight loss motivations and expectations, and management of stressors and coping skills.

4. Completion of psychological evaluation, performed by a practitioner specializing in surgical weight loss, confirming patient suitability for the procedure as evidenced by the lack of significant psychopathology which would impair ability to comply with pre-operative and post-operative recommendations. The following items need to be addressed specifically:
   a. Behavioral: untreated mental health or personality disorder, health related risk-taking behaviors;
   b. Cognitive and Emotional: Cognitive functioning, knowledge of obesity and surgical interventions, emotional modulation;
   c. Developmental history;
   d. Current Life Situation: stressors and utilization of social support; and
   e. Motivations and Expectations.
5. The bariatric surgery must be performed at a center accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).

BIRTHING CENTERS

In-Network Provider	Out-of-Network Provider
Facility Services: After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Provider Services: After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

BONE DENSITY SCAN - DIAGNOSTIC

In-Network Provider	Out-of-Network Provider
The plan pay 100% of the allowed amount. Deductible waived.	Not Covered
For women over fifty (50) years of age, limited to once every two (2) Benefit Periods; For women under fifty (50) years of age, limited to once every two (2) Benefit Periods if billed with osteoporosis related diagnosis.	

BREAST PUMPS

In-Network Provider	Out-of-Network Provider
Preventive benefit. Plan pays 100% up to the benefit limit of $450.	
Benefit Limit: 1 breast pump up to $450 per pregnancy**.** Any amount over that will be member's responsibility. Benefit limits are for services received from In-Network and Out-of-Network Providers. Member will need to submit a receipt for reimbursement if purchased at an out-of-network provider or retail.	

CARDIAC REHABILITATION THERAPY - OUTPATIENT

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

CHEMOTHERAPY AND RADIATION

Facility Services: After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Provider Services: After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

CHIROPRACTIC CARE

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Benefit Limit: 12 Maximum Number of Treatments per Benefit Period. Treatment includes all services provided during a calendar day, including X-rays.	

COCHLEAR IMPLANTS

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

COLONOSCOPY SERVICES

In-Network Provider	Out-of-Network Provider
All Routine Colonoscopy including diagnostic x-rays, labs or other tests or procedures provided on the same date of service. Pays 100% of Allowable Amount. Deductible waived.	Not Covered
Diagnostic Colonoscopy After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
First Colonoscopy per Benefit Period, whether Routine or Diagnostic, including diagnostic x-rays, labs or other tests or procedures provided on the same date of service, is payable at 100%, Deductible Waived. Subsequent Diagnostic Colonoscopies in any Benefit Period, including any diagnostic x-rays, labs or other tests or procedures provided in connection with the subsequent Colonoscopy, will be subject to the applicable Deductible and Benefit Percentage.	

CONTRACEPTIVES (INCLUDING CONTRACEPTIVE MANAGEMENT)

In-Network Provider	Out-of-Network Provider
Administered during Office Visit. The plan pays 100%, deductible waived.	Not Covered
See Pharmacy Benefit for details if obtained from a Pharmacy.	

DENTAL SERVICES (Accidental Injury Only)

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

DIAGNOSTIC TESTS - OUTPATIENT

In-Network Provider	Out-of-Network Provider
Facility After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Professional Services After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

DIALYSIS TREATMENTS OUTPATIENT

In-Network Provider	Out-of-Network Provider
Facility After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Professional Services After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

DURABLE MEDICAL EQUIPMENT

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Prior Authorization Required for services over $5,000. Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Claimant's home. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item. *Option to purchase CPAP machine following three (3) months rental. Durable Medical Equipment otherwise limited to rental, up to the purchase price. **Orthotics limited to initial purchase, fitting and repair of orthotic appliances. Retail shoe inserts and orthopedic shoes are specifically excluded.	

EMERGENCY ROOM (FACILITY AND PROFESSIONAL CHARGES)

In-Network Provider	Out-of-Network Provider
After Deductible and a $250 copay, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	
The Copayment is waived when admitted to a Hospital from an Emergency Room, and the applicable Deductible and Coinsurance amount applies. See the Hospital Care benefit in this Summary of Medical Benefits for coverage of inpatient Hospital admissions. For treatment of a qualifying Emergency Medical Condition received by Out-of-Network Providers, the Allowed Amount will be the same as the billed charges. Your responsibility will be calculated from the billed charges. If, due to an Emergency Medical Condition, a Claimant is admitted to an Out-of-Network Hospital through the emergency department and cannot be transported safely to an In-Network Hospital, the Plan will cover the services as if the services were received at an In-Network Hospital, until such time as the Claimant can be safely transported to an In-Network Hospital.	

EYE EXAM (not otherwise covered under preventive care)

In-Network Provider	Out-of-Network Provider
This plans pays 100% of the Allowable Amount. Deductible is waived.	Not Covered.

Benefit Limits: One (1) eye examination for refractory conditions and retinal screening. Maximum Benefit per Benefit Period for Covered Persons regardless of diagnosis. This benefit can be waived but waiver will not change the required contribution. Non-routine exam is subject to the applicable Deductible and Benefit Percentage.

GENDER DYSPHORIA

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

Prior authorization required. Please see exclusions for further detail and criteria.
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 18.
Psychotherapy and mental health services for Gender Dysphoria and associated co-morbid psychiatric conditions.
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.
See **Specific Exclusions** for services and/or related services that are considered cosmetic, unproven, or not medically necessary.

GENETIC TESTING AND COUNSELING

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

Limited to $5,000 per Lifetime. Must meet medical necessity requirements.
Genetic testing and counseling required by PPACA under the Preventive Care benefit are covered at no cost to the Claimant and have no limits.

HOME HEALTH CARE

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

Prior Authorization Required
The Plan covers home health care when provided by a licensed agency or facility for home health care. Home health care includes all services for homebound patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility.

HOSPICE CARE

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

Prior Authorization Required. Respite Care is limited to 14 days per hospice incident.
The Plan covers hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who are experiencing a life threatening disease with a limited prognosis. These services include acute and home care to meet the physical, psychosocial and special needs of a patient and his or her family during the final stages of Illness. In order to qualify for hospice care, the patient's physician must certify that the patient is terminally ill and is eligible for hospice services. Bereavement counseling not covered under medical plan.

HOSPITAL CARE - INPATIENT

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

Prior Authorization Required
The Plan covers inpatient services, diagnostic services, laboratory and pathology services, supplies of a Hospital for Injury and Illness (including services of staff providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. See the Emergency Room benefit in this Summary of Medical Benefits for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.
If benefits under the Plan change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began. If You are admitted to the hospital through the Emergency Room, all Hospital services will be covered at the In-Network benefit level until you are stabilized and can be transported, at the earliest medically appropriate time to a Network Hospital, clinic or other facility, or discharged.

HOSPITAL CARE – OUTPATIENT AND AMBULATORY SERVICE FACILITY

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

The Plan covers outpatient services and supplies of a Hospital or the outpatient services and supplies of an Ambulatory Service Facility for Injury and Illness (including services of staff providers billed by the Hospital). See the Emergency Room benefit in this Summary of Medical Benefits for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

IMMUNIZATIONS

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Charges for immunizations, medications and other preventive treatments that are recommended because of increased risk due to type of employer or travel including, but not limited to, immunizations, medications and/or other preventive treatments for malaria, yellow fever, anthrax, BCG, cholera, plague, and typhoid.	

INFERTILITY (DIAGNOSIS ONLY)

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Infertility treatment beyond diagnosis is not covered.	

INJECTABLE DRUGS AND SPECIALTY MEDICATIONS

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

MAJOR DIAGNOSTIC TESTS

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

MAJOR OFFICE PROCEDURES

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

MAMMOGRAMS

In-Network Provider	Out-of-Network Provider
All Routine Mammograms, including diagnostic x-rays, labs or other tests or procedures provided on the same date of service. Pays 100% of Allowable Amount. Deductible waived.	Not Covered
Diagnostic mammograms After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
*First Mammogram per Benefit Period, whether Routine or Diagnostic, including diagnostic x-rays, labs or other tests or procedures provided on the same date of service, is payable at 100%, Deductible Waived. 100% coverage is only for in-network services. Subsequent Diagnostic Mammograms in any Benefit Period, including any diagnostic x-rays, labs or other tests or procedures provided in connection with the subsequent Mammogram, will be subject to the applicable Deductible and Benefit Percentage.	

MATERNITY CARE – INPATIENT HOSPITAL SERVICES

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
There is no limit for the mother's length of inpatient stay. Where the mother is attended by a provider, the attending provider will determine an appropriate discharge time, in consultation with the mother.	

MATERNITY CARE – OUTPATIENT HOSPITAL AND PHYSICIAN SERVICES

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

MATERNITY CARE- PRENATAL AND POSTNATAL VISITS

In-Network Provider	Out-of-Network Provider
The Plan pays 100% of the Allowed Amount.	Not Covered
The Plan covers prenatal and postnatal maternity (pregnancy) care, routine lab services, breastfeeding support/supplies/counseling, screening for gestational diabetes, and certain immunizations, as required under PPACA, at no cost share if billed in an office setting. Maternity Care is available to all female Claimants. For ultrasound coverage, please see the Outpatient Services section of this SPD.	

MEDICAL SUPPLIES

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

MENTAL HEALTH, ALCOHOL AND CHEMICAL DEPENDENCY

	In-Network Provider	Out-of-Network Provider
Outpatient	After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Inpatient (includes Residential Treatment)	After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

Prior Authorization Required for Inpatient and Residential Treatment

Coverage under this benefit includes the following services:

- Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary Psychiatric Care and treatment including, but not limited to, group therapy.
- Charges for well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.
- Charges for Inpatient or Partial Hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.
- Charges for Medically Necessary treatment at a Psychiatric Facility.

MINOR DIAGNOSTIC TESTS

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum	Not Covered

NEURODEVELOPMENTAL THERAPY

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

NEWBORN CARE

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

Routine Newborn Inpatient Nursery/Physician Care including the following services:

Applies until the earlier of the Newborn's discharge from hospital or 48 hours for vaginal delivery or 96 hours for cesarean section.

1. Routine Nursery Care includes Room and Board, and Hospital Miscellaneous Expenses for a Newborn Dependent child, including circumcision.
2. Routine Physician Care includes charges for services of a Physician for a Newborn Dependent child while Inpatient as a result of the child's birth, including circumcision.
3. Routine Newborn Care includes charges for circumcision performed on an Outpatient basis, within six (6) months of the child's birth.

NUTRITIONAL COUNSELING/DIETICIANS

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

OFFICE VISITS

	In-Network Provider	Out-of-Network Provider
Primary Care	After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Specialist Care	After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Primary Care Providers are those with a specialty of Family Medicine, General Medicine, Pediatrics, OB/GYN, and Internal Medicine. (This includes Nurse Practitioners/Skilled Nurses and Physician Assistants practicing in this area when claims are submitted under the rendering or supervising physician's name). Specialist Care Providers are those not listed above. (Examples: Dermatologist, Cardiologist, ENT, Asthma, etc.)		

ORTHOGNATHIC SURGERY

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Prior Authorization Required	

ORTHOTICS

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Orthotics limited to initial purchase, fitting and repair of orthotic appliances. Retail shoe inserts and orthopedic shoes are specifically excluded.	

OTHER PROFESSIONAL SERVICES

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

The Plan covers services and supplies provided by a professional provider. Coinsurance and any specified limits are explained in the following paragraphs:

Medical Services

The Plan covers professional services and supplies, including the services of a provider whose opinion or advice is requested by the attending provider that are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury.

Professional Inpatient

The Plan covers professional inpatient services for illness or injury.

OUTPATIENT SERVICES

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

The Plan covers services for diagnostic radiology, ultrasound, nuclear medicine, electronic diagnostic medical procedures, as well as, medical services, surgical services, including local anesthesia and supplies, and therapeutic injections.

Radiology and Diagnostic Procedures

The Plan covers services for diagnostic procedures including radiology, cardiovascular testing, pulmonary function studies and sleep studies. The Plan also covers routine diagnostic procedures such as colonoscopies.
Note: When the procedures are billed as Preventive care, benefits under the Plan will be paid according to the Preventive Care benefit. CT Scans will be covered in accordance with the guidelines being used by CMS at the time of the procedure.

Surgical Services

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

PHOTOTHERAPY SERVICES

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

PREVENTIVE CARE

In-Network Provider	Out-of-Network Provider
Plan pays 100%, deductible waived*	Not Covered

*First Colonoscopy or Mammogram per Benefit Period, whether Routine or Diagnostic, including diagnostic x-rays, labs or other tests or procedures provided on the same date of service, is payable at 100%, Deductible Waived. See Colonoscopy Benefit and Mammogram Benefit for further details.

Covered Services:

- Well-Child Care
- Physical examinations
- Pelvic examination and pap smear
- Laboratory and testing
- Hearing and vision screening
- Mammogram
- Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE)
- Cardiovascular screening blood tests
- Colorectal cancer screening tests
- Vaccinations and Immunizations recommended by Physician
- BRCA1 and BRCA2 when medically indicated
- Nutritional counseling
- Well Women Preventive Care subject to Plan limitations on sterilization procedures

Complete list of recommended preventive service can be viewed at:
https://www.healthcare.gov/coverage/preventive-care-benefits/

Except for the first Colonoscopy or first Mammogram per Benefit Period, whether Routine or Diagnostic, any diagnostic x-rays, labs or other tests or procedures ordered or provided in connection with any Preventive Care covered service will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services.

PREVENTIVE/PROPHYLACTIC MASTECTOMY/OOPHORECTOMY

In-Network Provider	Out-of-Network Provider
Inpatient Facility Services& Inpatient Professional Provider Services After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

PROSTHETICS

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum	Not Covered
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.	

REHABILITATION SERVICES

	In-Network Provider	Out-of-Network Provider
Outpatient	After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Inpatient	After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
The Plan covers rehabilitation services and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness.		

SKILLED NURSING FACILITY (SNF) OR REHABILITATION FACILITY

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Prior Authorization Required The Plan covers the inpatient services and supplies of a Skilled Nursing Facility for Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary.	

TEMPOROMANDIBULAR JOINT (TMJ) TREATMENT

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Prior Authorization Required. Surgical and non-surgical combined. Limited to $5,000 per lifetime.	

TRANSPLANTS

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

Prior Authorization Required
Travel: Travel, meals and lodging may be reimbursed up to $10,000 per transplant.

Coverage includes charges in connection with non-Experimental or non-Investigational organ or tissue transplant procedures, subject to the following conditions:

1. A second opinion is recommended prior to undergoing any transplant procedure. This second opinion should concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.
2. If the donor is covered under this Plan, Eligible Expenses Incurred by the donor will be considered for benefits to the extent that such expenses are not payable by the recipient's plan.
3. If the recipient is covered under this Plan, Eligible Expenses Incurred by the recipient will be considered for benefits. Eligible Expenses Incurred by the donor, who is not ordinarily covered under this Plan according to eligibility requirements, will be considered for payment to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the benefit maximums still available to the recipient.
4. If both the donor and the recipient are covered under this Plan, Expenses Incurred by each person will be treated separately for each person.
5. The cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ will be considered payment.

URGENT CARE

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered

VISION HARDWARE

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	Not Covered
Limited to initial contact lenses or glasses required following cataract surgery.	

WIG/HAIRPIECE

In-Network Provider	Out-of-Network Provider
After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	
Wig or hairpiece, up to $500, Maximum Lifetime Benefit due to loss of hair as a result of medical treatment or alopecia. Benefit limits are for services received from Network and Non-Network Providers. This benefit is subject to deductible and co-insurance with a $500 lifetime limit.	

PRESCRIPTION DRUG BENEFITS – ADMINISTERED BY NAVITUSRx

PHARMACY DRUG CHARGE

Prescription drug charges are payable only through the Plan's Pharmacy Benefit Manager (PBM) program, which program is sponsored in conjunction with and is an integral part of this Plan. **The PBM will provide separate information for details regarding Network pharmacies, Preferred Brand prescriptions and Specialty Drugs upon enrollment for coverage under this Plan. Additional information regarding the Prescription Drug Benefits is also available at: www.navitus.com or by calling (866) 333-2757.**

There is no coordination of benefits for Pharmacy Benefits.

COST SHARING PROVISIONS – 750 EPO

Pharmacy Deductible per Benefit Period

Per Covered Person. . . . . None
Per Family . . . . . None

Out-of-Pocket Maximum (Combined Medical/Pharmacy) per Benefit Period

Per Covered Person. $4,000
Per Family $8,000

Out-of-Pocket Maximum (combined Medical/Pharmacy) includes any applicable Pharmacy Copayments. Pharmacy Benefits are payable at 100% after satisfaction of the Out-of-Pocket Maximum for the remainder of the Benefit Period.

Copayment per Prescription			
Drug Type	**Retail PBM Network**	**Mail Order**	**Specialty Drug**
Tier 1	$5 1-30 day supply $10 31-60 day supply $15 61-90 day supply	$5 1-30 day supply $10 31-60 day supply $12.50 61-90 day supply	35% ($145 max) 1-30 day supply
Tier 2	$30 1-30 day supply $60 31-60 day supply $90 61-90 day supply	$30 1-30 day supply $60 31-60 day supply $75 61-90 day supply	35% ($145 max) 1-30 day supply
Tier 3	35% ($145 max) 1-30 day supply 35% ($290 max) 31-60 day supply 35% ($435 max) 61-90 day supply	35% ($145 max) 1-30 day supply 35% ($290 max) 31-60 day supply 35% ($375 max) 61-90 day supply	35% ($145 max) 1-30 day supply
Compound Medications	35% ($145 max)	No Benefit	No Benefit

Copayment per Prescription for Maintenance Therapy Drugs			
Drug Type	**1-30 Day Supply**	**31-60 Day Supply**	**61-90 Day Supply**
Tier 1	$5	$10	$12.50
Tier 2	$30	$60	$75
Tier 3	35% ($145 Max)	35% ($290 Max)	35% ($375 Max)

Maintenance Therapy Drugs: Prescriptions may be obtained for Maintenance Therapy Drugs, subject to the applicable Copayment as stated in this section. A complete list of Maintenance Therapy Drugs may be obtained from the Pharmacy Benefit Manager. The Maintenance Therapy Drug list may also be referred to as "Preventive Therapy Drug List" by the Pharmacy Benefit Manager. Generic diabetic products, preferred insulin products and drugs covered under the Affordable Care Act (ACA) are not covered under this benefit.

Generic (Tier 1) Preferred - Member Choice (DAW2): If the Physician does not prescribe "Dispense as Written" (DAW), and there is a Tier 1 alternative for the prescription drug, and the Covered Person chooses a Tier 2 medication instead, the Covered Person must pay the difference in cost between the Tier 1 and Tier 2 medication plus the applicable Tier 2 Copayment amount.

The following are payable at 100% and are not subject to any Deductible or Copayment:

1. Prescribed Tier 1 contraceptives or Tier 2 if Tier 1 is unavailable;
2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider;
3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/;
4. Navitus complete Vaccine list.

COVERAGE

Coverage for prescription drugs will include only those drugs requiring a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, and that are Medically Necessary for the treatment of an Illness or Injury.
Coverage also includes prescription drugs or supplies that require a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, as follows:

1. Self-administered contraceptives, injectables, transdermals, emergency contraceptives, IUDs, implants and over-the-counter FDA approved female contraceptives with a written prescription by a Physician or Licensed Health Care Provider. **Contraceptive Management, injectable contraceptives and contraceptive devices are covered under the Preventive Care Benefit of this Plan.**
2. Legend vitamins (oral only): Prenatal agents used in Pregnancy; therapeutic agents used for specific deficiencies and conditions; and hemopoetic agents used to treat anemia.
3. Legend fluoride products (oral only): Dental or pediatric.
4. Diabetic supplies (including insulin pumps, pump supplies, continuous glucometer meters and glucometers), subject to the Pharmacy Benefit Manager formulary and applicable Cost Sharing Provisions. Please contact Navitus at (801) 584-5144 for additional coverage details.
5. Smoking deterrents prescribed by a Physician or Licensed Health Care Provider covered under the Affordable Care Act, which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits. Post smoking cessation benefit limited to OTC and legend prescriptions, subject to the applicable Deductible and Copayment as stated in the section.
6. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the

Affordable Care Act, which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits

7. Sexual dysfunction. Quantity limits apply.
8. Weight loss medications. Prior Authorization required. Quantity limits apply.
9. Compound medications.

SPECIALTY ACCESS PROGRAM

The Plan offers the Navitus Specialty Access Program for specialty drugs. This program will provide you with personalized guidance and clinical expertise to help you find the most cost-effective solutions for your specialty medication(s).

This program will assist you in accessing eligible specialty medications at little or no cost to you. Enrollment is mandatory for any person taking a specialty medication covered by the program and will require prior authorization through Navitus.

Under the program, your specialty medications are subject to a coinsurance of 100% with no annual maximum. However, your copay will be capped at the applicable Specialty Drug copay/coinsurance amount.

Medications included in this program will be indicated on your formulary drug listing. The most up to date Formulary List can be found on https://members.navitus.com.

If you are currently taking or using a specialty medication, you will continue to contact Lumicera to fill your specialty medication, however, this new program will require that you provide additional information in order to determine if you qualify for this cost-savings program.

This is a financial program and requires detailed income and identification information to qualify you. You may be required to provide documentation including, but not limited to:

- W-2s
- Social Security Number
- Driver's License
- Household financial Information

If attempts to secure funding for your medication are unsuccessful, you can apply for the program's Specialty Drug Cost Share Waiver. Specialty Drug prescriptions covered by the program must be filled by a preferred network pharmacy. If a specialty drug does not qualify or is removed from the program, your copay will default to the formulary's current tiered Specialty Drug copay/coinsurance amount.

If you fail to enroll in the program or do not provide the required information, you will be responsible for the entire cost of the medication and your member responsibility amount will not apply toward your annual out of pocket maximum amount.

For additional questions, please contact a Lumicera member services specialist at 855-847-3556.

SERVICE OPTIONS

The Program includes the following Service Options for obtaining prescriptions under the Pharmacy Benefit:
PBM Network Prescriptions: Available only through a retail pharmacy that is part of the PBM Network. The pharmacy will bill the Plan directly for that part of the prescription cost that exceeds the Copayment (Copayment amount must be paid to pharmacy at time of purchase). **The prescription identification card is required for this option. Prescriptions obtained at non-participating pharmacies are not covered.**
Member Submit Prescriptions: Available only if the prescription identification card is used at a PBM Network pharmacy. **Prescriptions must be paid for at the point of purchase and the prescription drug**

receipt must be submitted to the PBM, along with a reimbursement form (Direct Reimbursement). The PBM will reimburse the contract cost of the prescription drug, less the applicable Copayment per prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription. Prescriptions obtained at non-participating pharmacies are not covered.

Mail Order Prescriptions: Available only through a licensed pharmacy that is part of the PBM Network which fills prescriptions and delivers them to Covered Persons through the United States Postal Service, United Parcel Service or other delivery service. The pharmacy will bill the Plan directly for prescription costs that exceed the Copayment.

Specialty Drugs: These medications are generic or non-generic drugs classified by the Plan and listed by the PBM as Specialty Drugs and require special handling (e.g., most injectable drugs other than insulin). Specialty drugs must be obtained from a preferred specialty pharmacy. A list of specialty drugs and preferred specialty pharmacies may be obtained from the PBM or Plan Supervisor.

DRUG OPTIONS

Tier1: All covered generics and some lower cost brand products
Tier 2: Preferred brand products
Tier 3: Non-preferred brand products
Tier 4: Specialty drugs

COPAYMENT

"Copayment" means a dollar amount fixed as either a percentage or a specific dollar amount per prescription payable to the pharmacy at the time of service. Pharmacy Copayments are not payable by the Plan and are specifically stated in this section.

Pharmacy Copayments do not apply towards the Medical Benefits Deductible. Copayments do apply towards the applicable Out-of-Pocket Maximum (combined Medical/Pharmacy) and after satisfaction of the Out-of-Pocket Maximum, Copayments will no longer apply for the remainder of the Benefit Period.

SUPPLY LIMITS

Supply is limited to 90 days for PBM Network, Member Submit, Mail Order and Maintenance Therapy prescriptions. Specialty prescriptions are limited to 30 day supply. Prescription drug refills are not allowed until 75% of the prescribed day supply is used for Retail prescriptions, or 70% for Mail Order prescriptions. For Opioid prescriptions, drug refills are not allowed until 85% of the prescribed day supply is used for Opioid Retail prescriptions, or 80% for Opioid Mail Order prescriptions.

The amount of certain medications are limited to promote safe, clinically appropriate drug usage. Any additional prescribed supply exceeding any clinically appropriate limits will be reviewed for Medical Necessity.

A current list of applicable quantity limits can be obtained by contacting the PBM at the number listed on the Participant's identification card.

STEP THERAPY PROGRAM

Certain medications may require Prior Authorization before obtaining a second fill. The PBM will send a letter to the Covered Person and to the Physician to explain the steps necessary to obtain step therapy refill medications. **Failure to use the step therapy program will result in the Covered Person being responsible for the entire cost of the drug.**

PRIOR AUTHORIZATION

Certain drugs require approval before the drug can be dispensed. A current list of drugs that require Prior Authorization can be obtained by contacting the PBM at the number listed on the Participant's identification card.

EXCLUSIONS

Prescription drugs or supplies in the following categories are specifically excluded:

- Cosmetic only indications including, but not limited to: photo-aged skin products (Renova), hair growth or hair removal agents (Propecia, Vaniqa) and injectable Cosmetics (Botox Cosmetic).
- Dermatology: Agents used in the treatment of acne and/or for Cosmetic purposes for Covered Persons thirty-five (35) years or older or depigmentation products used for skin conditions requiring a bleaching agent, unless Prior Authorization has been obtained
- Legend homeopathic drugs
- Fertility agents; oral, vaginal and injectable
- Allergens
- Serums, toxoids and vaccines, except as specifically covered
- Legend vitamins and legend fluoride products, except as specifically covered
- Over-the-counter equivalents and non-legend medications (OTC), except as specifically covered
- Experimental or Investigational drugs
- Abortifacient drugs
- Non-Preferred glucometer and supplies (blood monitors and kits)

OTHER BENEFITS

CARE MANAGEMENT PROGRAM

Because of University of Utah Health Plans' involvement as the Claims Administrator, You have access to the following Group-sponsored care management program. Your employer has chosen to provide this benefit to You. To the extent any part of this program (e.g., medications for smoking cessation) is also a benefit as a Medical Benefit or other benefit of the Plan, the Medical Benefits or other benefit applies first and until that benefit is exhausted.

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

To learn more or to enlist the services of a care manager, please call (801) 213-4008 or (833) 981-0213 Option 2.

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.

GENERAL LIMITATIONS AND EXCLUSIONS

The following are the general exclusions from coverage under the Plan. Other exclusions may apply and, if so, will be described elsewhere in this Policy.

WAITING PERIOD FOR PREEXISTING CONDITIONS

The Plan does not have a waiting period for Pre-existing Conditions.

SPECIFIC EXCLUSIONS

The Plan will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them.

Adoption Benefit

Expenses incurred for transportation, travel expenses or accommodations, passport fees, translation fees, photos, postage, etc.; and living expenses, food and/or counseling for the birth mother.

Allergy Services

Sublingual or colorimetric allergy testing and sublingual antigens.

Alternative Care

The Plan does not cover alternative care, including, but not limited to, the following:

- Acupressure
- Holistic and homeopathic treatment;
- Massage or massage therapy; naturopathy;
- Faith healing; milieu therapy; hypnotherapy; sensitivity training;
- Behavior modification; biofeedback
- Electro hypnosis, electro sleep therapy, or electro narcosis; ecological or environmental medicine
- Other therapies: scream therapy; psychic surgery, channeling, sensory deprivation; rolfing
- Thermography; music, art, dance, or recreation therapy; crystal therapy; and hyper therapy (therapeutically induced fever) for the treatment of cancer.

Ambulance Services

Any ambulance services, which are not medically necessary, including, but not limited to:

- Charges for common or private aviation services;
- Services for the convenience of the patient or family; after-hours charges; and
- Charges for ambulance waiting time.

Billing of Services

Claims submitted past the timely filing limit; unbundling fragmentation of surgical codes and unbundling of lab charges or panels are considered improper billing practices.

Cardiac Rehabilitation Therapy

Coverage includes charges for cardiac rehabilitation services rendered by a recognized cardiac rehabilitation program, subject to the following requirements:

1. The Covered Person must be recovering from a myocardial infarction or cardiac surgery or be suffering from angina pectoris.
2. The Covered Person must be accepted by, and have written referral from their attending Physician to a cardiac rehabilitation program.

Certain Illegal Activities

Services for an illness, condition, accident or injury arising from You or Your Dependent:

- Voluntarily participating in the commission of a felony;
- Voluntarily participating in disorderly conduct, riot, or other breach of the peace;
- Engaging in any conduct involving the illegal use or misuse of a firearm or other deadly weapon;
- Driving or otherwise being in physical control of a car, truck, motorcycle, scooter, off-road vehicle, boat or other motor-driven vehicle where either:
    - A subsequent test shows that the Covered Person or Dependent has either a blood or breath alcohol concentration above the legal limit; or
    - The Covered Person or Dependent had any illegal drug or other illegal substance in the Covered Person's or Dependent's body to a degree that it affected the Covered Person's or Dependent's ability to drive or operate the vehicle safely.
- Driving or otherwise being in physical control of a car, truck, motorcycle, scooter, off-road vehicle, boat or other motor-driven vehicle either without a valid driver's permit or license, if required under the circumstances or without the permission of the owner of the vehicle; or
- A complication of, or as the result of, or as follow-up care for, any Illness, condition, accident, or injury that is not covered as the result of this exclusion.
- The presence of drugs or alcohol may be determined by tests performed by or for law enforcement, tests performed during diagnosis or treatment, or by other reliable means.

Clinical Trials

Investigational items, devices or services being used in a Clinical Trial, except for Approved Clinical Trials, including items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient, or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Cosmetic/Reconstructive Services and Supplies

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

- Treat a congenital anomaly for Claimants up to age 18; to restore a physical bodily function lost as a result of Injury or Illness;
- Required as a result of an Accidental Injury, Illness, or therapeutic intervention and services are rendered or planned (as specifically documented in the Claimant's medical record) within 12 months of the cause or onset of the Injury, Illness or therapeutic intervention (generally performed to restore function, but may also be done to restore a normal appearance); or
- Related to breast reconstruction following a Medically Necessary mastectomy.

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

Reconstructive means services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance. Services specifically excluded include, but are not limited to, the following:

- Services not medically necessary
- Complications from cosmetic surgery, except in cases of reconstructive surgery following a trauma, breast reduction
- Mastectomy for gynecomastia
- Blepharoplasty
- Capsulotomy, replacement, removal or repair of breast implant originally placed for cosmetic purposes
- Rhinoplasty, except when related to an accident; rhytidectomy; injection of collagen
- Lipectomy, abdominoplasty, panniculectomy
- Repair of diastasis recti
- Hair transplants

- Treatment for spider or reticular veins
- Liposuction
- Chin implant, genioplasty or horizontal symphyseal osteotomy
- Otoplasty
- Treatment of varicose veins
- Chemical peels

Counseling

Charges for counseling a Claimant, including the following:

- Marital counseling
- Family counseling
- Encounter groups
- Parental counseling
- Stress management or relations therapy
- Educational, social, occupational, or religious counseling
- Counseling in the absence of Illness or Injury; and
- Counseling with a patient's family, friend(s), employer, school counselor, or school teacher

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

Custodial Care

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

Dental Services

Dental Services provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, and treatment that restores the function of teeth, including dental hospitalization and limited pediatric dental anesthesia; and orthodontic treatment in conjunction with jaw surgery.

Exception:
Services including local, regional, general, and/or intravenous sedation anesthesia, are not covered except for at Participating Facilities when members meet the following criteria:

a. You or your Dependent is developmentally delayed, regardless of chronological age;
b. You or your Dependent, regardless of age, have a congenital cardiac or neurological condition and documentation is provided that the dental anesthesia is needed to closely monitor the condition; or
c. You or your Dependent are younger than five years of age and:
    i. The proposed dental work involves three or more teeth;
    ii. The diagnosis is nursing bottle-mouth syndrome or extreme enamel hypoplasia; and
    iii. The proposed procedures are restoration or extraction for rampant decay.

Treatment for Temporomandibular Joint Disorder (TMJ) is limited to $5,000 per lifetime.

Domiciliary Care

Care provided in a residential institution, treatment center, half-way house or school, consisting chiefly of room and board, is not covered, even if therapy is included.

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

Eye 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. Lenses for the eyes, including eyeglasses and contact lenses, and exams for their fitting.

This exclusion does not apply to aphakia patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the Preventive Care section of this Plan.

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

Foot Care (Routine)
Routine foot care, including, but not limited to: treatment of corns and calluses and trimming of nails, except as medically necessary, determined in accordance with Medicare guidelines, metatarsalgia or bunions (except open cutting operations).

Gene Therapy
Gene Therapy or gene-based therapies.

Genetic Testing
Genetic Testing is covered **only** in the following circumstances and according to University of Utah Health Plans criteria, state, or federal law:

- Prenatal testing when performed as part of an amniocentesis to assess specific chromosomal abnormalities in women at high risk for inheritable conditions that can lead to significant immediate and/or long term health consequences to the child after birth;
- Neonatal testing for specific inheritable metabolic conditions (e.g., PU);
- When the Member has a more than five percent probability of having an inheritable genetic condition and has signs or symptoms suggestive of a specific condition or a strong family history of the condition (defined as two or more first-degree relatives with the condition) and results of the testing will directly affect the patient's treatment; or

- Pre-implantation embryonic genetic testing performed to identify an inherited genetic condition known to already exist in either parent's family, which has the potential to cause serious and impactful medical conditions for the child.

Government Programs
Benefits that are covered, or would be covered in the absence of this Plan, by any federal, state or government program, except for facilities that contract with the Plan and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. Expenses from government facilities outside the service area are not covered under the Plan (except for facilities contracting with University of Utah Health Plans or as required by law for emergency services). Services, treatments or supplies furnished by a hospital owned and operated by the United States Government.

Growth Hormone Therapy
Growth hormone therapy, once bone growth is complete.

Hair Loss
Care and treatment for hair loss, 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 pre-certified and is due to a congenital condition.

Exception: Wigs/Hair Piece are covered by the Plan (see Schedule of Benefits).

Hearing Care
Except as specifically provided under the Hearing Examinations benefit of the Plan. Hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion also applies to bone anchored hearing aids (Baha implants). This exclusion does not apply to cochlear implants.

Home Health Care
Services including, but not limited to, the following:
- Nursing or aide services, which are requested by, or are for the convenience of family member, which do not require the training, skill or judgment of a nurse
- Private duty nursing
- Custodial care
- Travel or transportation expenses, escort services to provider's offices or elsewhere, or food services

Home Birth
Home Birth services and supplies are not covered unless provided by a Certified Nurse Midwife (CNM).

Impotence
Care, treatment, services, supplies or medication in connection with treatment for impotence.

Infertility
Unless specified in your schedule of benefits the Plan will only cover the cost of tests to reach an initial diagnosis of infertility. Treatment to achieve pregnancy (including but not limited to ovulation-stimulating medication, tubal reconstructive surgery, intrauterine insemination, intrafallopian transfer, and in vitro fertilization) is not covered. Once the patient has received a diagnosis of infertility or begins medication specific to promoting pregnancy (not including medication for co-occurring conditions such as hypothyroidism), tests to monitor effectiveness of treatment or select additional treatments are not covered. Additional exclusions are as follows:

- Diagnostic testing after initial diagnosis of infertility has been reached
- Sexual dysfunction, treatment and surgery
- Assisted reproductive technologies
- Reversal of sterilization
- Sperm banking system, storage, treatment or other such services

Investigational or Experimental Services
Investigational or experimental treatments or procedures (Health Interventions) and services, supplies, devices, drugs and accommodations provided in connection with Investigational or Experimental treatments or procedures (Health Interventions). Also excluded are any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions section of this Policy.
Complications as a result of any of these services and procedures is also excluded. This exclusion does not apply to treatment or procedures related to the diagnosis and/or treatment of high-risk osteogenic sarcoma.

Medical Tourism
Care, treatment or supplies provided outside of the United States, if travel was for the sole purpose of obtaining medical services.

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

NON-COVERED SERVICES IN CONJUNCTION WITH A COVERED SERVICE
Non-Direct Patient Care
Services that are not direct patient care, including:
- Appointments scheduled and not kept ("missed appointments")
- Charges for preparing or duplicating medical reports and chart notes
- Itemized bills or claim forms (even at the Plan’s request)
- Visits or consultations that are not in person (including telephone consultations and e-mail exchanges), except as specifically provided under the telemedicine benefit.

Non-Emergency Hospital Admissions
Care and treatment billed by a Hospital for non-emergency medical admissions. This does not apply if surgery is performed within 24 hours of admission.

Not Specified as Covered
Non-traditional services, treatments and supplies, which are not specified as covered by this Plan.

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.

Other Specific Services
- Computer-assisted navigation for orthopedic procedures
- Cryoablation therapy for plantar fasciitis and Morton’s neuroma
- Platelet Rich Plasma or other blood derived therapies for orthopedic procedures
- Extracorporeal shock wave therapy for musculoskeletal indications
- Infrared light coagulation for the treatment of hemorrhoids
- Intimal Media Thickness (IMT) testing to assess risk of coronary disease
- Magnetic Source Imaging (MSI)
- Manipulation under anesthesia for treatment of back and pelvic pain
- Mole mapping

- Radiofrequency ablation for lateral epicondylitis
- Virtual colonoscopy as a screening for colon cancer
- Whole body scanning

Over-the-Counter Contraceptives
Over-the-counter contraceptive supplies and oral contraceptive.

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

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

Prenatal Services
Prenatal services that are not medically necessary for the health and life of the mother and/or fetus, including, but not limited to:

- Childbirth education classes;
- Epidemiological and predictive genetic screening, except genetic evaluations for pregnancy at high risk of genetic disease
- Amniocentesis or chorionic villi sampling, except for high risk pregnancy;
- Medical services for surrogate mothers.

Prescription Drugs and Other Medications
Outpatient prescription drugs and over-the-counter drugs and medications, vitamins, and minerals. **Note:** Also excluded are special formulas, food supplements, or special diets, except as provided by a Hospital or Skilled Nursing Facility during a confinement for which benefits are available and as required for inborn metabolic errors.

Post-Mortem Testing
Autopsies and other post-mortem testing.

Private Duty Nursing
Charges in connection with care, treatment or services of a private duty nurse.

Prolotherapy
Prolotherapy, proliferation therapy or regenerative injection therapy for pain management.

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

Pulmonary Rehabilitation
Phase 3 associated with pulmonary rehabilitation, which includes an independent exercise program.

Replacement Orthotic Devices
Replacement orthotic and other corrective appliances for the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in physical condition to make the original device no longer functional.

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

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.

Robot-Assisted Surgery
Direct costs for the use of the robot are not covered.

Self-Help, Self-Care, Training or Instructional Programs
Except as may be specifically provided in the Policy or required under PPACA, the Plan does not cover self-help, non-medical self-care, training programs, including:

- Diet and weight monitoring services
- Childbirth-related classes including infant care and breast feeding classes
- Instruction programs including those to learn how to stop smoking and programs that teach a person how to use Durable Medical Equipment or how to care for a family member
- Scholastic education
- Vocational training
- Special training for learning disabilities

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

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

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

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "immediate family" means parents, spouse, children, siblings, half-siblings, in-laws or any relative by blood or marriage who shares a residence with You.

Services and Supplies Provided By a School or Halfway House
Services and supplies provided by any public or private school or halfway house, or by their employees and services provided solely to satisfy institutional requirements.

Services and Supplies That Are Not Medically Necessary
Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury, except for preventive care benefits specifically provided under the Plan. Services without adequate diagnosis are also excluded. Specific exclusions are as follows, but are not limited to these:

- Any service or supply not specifically identified as a benefit
- Any surgery solely for snoring
- Hospital visits the same day as surgery except for treatment of a diagnosis unrelated to the surgery
- Physical or occupational therapy primarily for maintenance care
- Evaluations not required for health reasons, such as employment or insurance examinations autopsy procedures
- Charges for independent medical evaluations and testing for the purpose of legal defense
- Routine drug screening, except when ordered by a treating physician
- Autologous blood storage for future use
- Sodium amobarbital interviews
- Probability and predictive analysis and testing

- Hair analysis, trace elements or dental filling toxicity

Sexual Dysfunction
Services and supplies for or in connection with sexual dysfunction except for counseling services provided by covered, licensed mental health practitioners when Mental Health Services are covered benefits under the Plan.

Sexual Reassignment Treatment and Surgery
Treatment, surgery or counseling services for sexual/gender reassignment, except for those covered under gender dysphoria.

Charges for voice modification; suction assisted lipoplasty of the waist; blepharoplasty; facial reconstruction or facial feminization surgery; hair removal or other non-Medically Necessary services, care or treatment of Gender Identity Disorder or Gender Dysphoria.

Charges for treatment of Gender Identity Disorder/Gender Dysphoria when the services are for reversal of a prior gender reassignment surgery or reversal of a prior surgery to revise secondary sex characteristics.

Synvisc Injections
Synvisc or other viscosupplementation injections in the knee or other joints, unless prior authorization is obtained from the plan administrator.

Termination of Pregnancy
Services and supplies in connection with the performance of any induced abortion services except in the following circumstances in accordance with the Utah prohibition against public funding for abortions (U.C.A. 76-7-331): (a) in the professional judgment of the pregnant woman's attending physician, the abortion is necessary to save the pregnant woman's life; (b) the pregnancy is the result of rape or incest reported to law enforcement agencies, unless the woman was unable to report the crime for physical reasons or fear of retaliation; or (c) in the professional judgment of the pregnant woman's attending physician, the abortion is necessary to prevent permanent, irreparable, and grave damage to a major bodily function of the pregnant woman provided that caesarian procedure or other medical procedure that could also save the life of the child is not a viable option; or (d) the fetus is not viable, or the fetus has a defect that is uniformly diagnosable and uniformly lethal, provided that public funds are not used by the plan to pay for the procedure.

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

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

Travel and Transportation Expenses
Travel and transportation expenses other than covered ambulance services provided under the Plan, including, but not limited to:
- Commercial or private aviation services, meals, accommodations and car rental
- Charges for mileage reimbursement, except for eligible ambulance service

Exception: Transplant Services (see Schedule of Benefits)

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

War or Insurrection

The treatment of any condition caused by or arising out of a Claimant's voluntary participation in a war or insurrection.

Work-Related Conditions

Expenses for services and supplies incurred as a result of any work-related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. The Claims Administrator may require the Claimant to file a claim for workers' compensation benefits before providing any benefits under the Plan. The only exception is if a Participant is exempt from state or federal workers' compensation law. Functional or work capacity evaluations, employment examinations and pre-employment drug screenings are also excluded.

COBRA CONTINUATION OF COVERAGE

This COBRA Continuation of Coverage section applies only when the Plan Sponsor is subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA. Under certain circumstances called Qualifying Events, certain Claimants may have the right to continue coverage beyond the time coverage would ordinarily have ended if they timely enroll in such coverage. The following rights and obligations regarding continuation of coverage are governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. In the event of any conflict between this continuation of coverage provision and COBRA, the minimum requirements of COBRA will govern. This provision will automatically cease to be effective when federal law requiring continuation of eligibility for coverage no longer applies to the Company. This section does not provide a full description of COBRA. For more complete information, contact the COBRA Administrator.

In order to preserve Your rights under COBRA, You must meet certain notification, election, and payment deadline requirements. Failure to do so will result in the loss of eligibility for COBRA coverage. Those requirements are described below.

Qualified Beneficiaries

In order to be eligible for COBRA coverage, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any individual (including You and Your Eligible Dependents) covered by the Plan immediately before the occurrence of a "Qualifying Event" described below. In other words, You and Your Eligible Dependents must be enrolled in coverage immediately before the occurrence of a Qualifying Event in order to be eligible to enroll in COBRA coverage.

Qualifying Events and Length of Maximum Periods of Coverage

The following table outlines the situations in which a Qualified Beneficiary may elect to continue coverage under COBRA, and the maximum length of time available for each situation. These situations are called "Qualifying Events." Note that the time periods below indicate the maximum length of time a Qualified Beneficiary may continue coverage under COBRA. See "When COBRA Continuation Coverage Ends" to understand when COBRA coverage may end before these maximum time periods.

If Coverage Ends Because of the Following Qualifying Events:	**Qualified Beneficiary Type**		
	Employee	**Spouse**	**Dependent Child(ren)**
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	36 months	36 months

If Coverage Ends Because of the Following Qualifying Events:	Qualified Beneficiary Type		
	Employee	Spouse	Dependent Child(ren)
Company files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months	36 months

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a) the determination of the disability, b) the date of the Qualifying Event, or c) the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required contribution for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a Qualifying Event for any retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

There is a special rule for COBRA coverage and spouses concerning divorces and legal separation. Despite the general rule that an individual must be covered by the Plan immediately prior to the occurrence of the Qualifying Event in order to be eligible for COBRA coverage, this special rule provides that if the Plan Administrator determines that the Participant dropped the spouse's coverage in anticipation of divorce or legal separation, then the spouse has the right to elect COBRA coverage, which will start on the date of the divorce or legal separation.

When and How You Must Give Notice

The Qualifying Event You experience determines Your notice requirements and the amount of time You may retain COBRA coverage.

You, Your spouse, or child must notify the Company's Human Resources Department of a **divorce** or **legal separation**, or a **child losing dependent status** within **60 days** of the event. (The Plan is required to provide notice to You and/or Your Enrolled Dependents of the right to elect COBRA coverage due to any of the other Qualifying Events.) Your spouse, or child may give written notice of the Qualifying Event to ARUP Laboratories, Inc., 500 S Chipeta Way, Salt Lake City, UT 84108. The written notice must provide the individual's name and current mailing address, the specific Qualifying Event and the date of the Qualifying Event. If written notice is not provided to the Human Resources Department within **60 days** after the date of the Qualifying Event, all rights of that individual to elect COBRA coverage will be lost.

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

If You or one of Your Enrolled Dependents qualifies for a Social Security Disability extension (described below), You must provide written notice to the Company's Human Resources Department within 60 days of the date the Social Security Administration determination is made and while still within the 18 month

COBRA Continuation period following a termination or reduction of hours Qualifying Event. You must also

provide a written notice to the Company's Human Resources Department within **30 days** if a final determination is made that You are no longer disabled.

If You experience a Second Qualifying Event (described below), You must provide a written notice to the Company's Human Resources Department within 60 days of the second Qualifying Event and during the original 18-month COBRA coverage period (or 29-month period if there has been a disability extension), in order to extend COBRA coverage to 36 months.

Qualified Dependents

As noted above, each individual who was covered under the Plan immediately before the occurrence of a Qualifying Event has the right to be offered COBRA coverage. This includes enrolled Dependents who lose coverage due to a Qualifying Event, referred in this SPD as "Qualified Dependents." A Qualified Dependent has an independent right to elect COBRA coverage. This means that a Qualified Dependent has the right to enroll in COBRA coverage even if the Participant chooses not to enroll in COBRA coverage. COBRA coverage is available to each person who had coverage on the day before the Qualifying Event.

Social Security Disability

If Your Qualifying Event is termination of employment or reduction in hours and You or one of Your Enrolled Dependents is determined by the Social Security Administration to have been disabled on the date of the Qualifying Event or during the first 60 days of COBRA coverage, You and/or Your enrolled dependents may obtain an extension of coverage from 18 months to 29 months. It is Your responsibility to obtain the disability determination from the Social Security Administration and to provide a copy of the determination to the Company, within **60 days** after the date of the determination. The Social Security Administration determination must occur and You must notify the Company's Human Resources Department before the end of the original 18-month period. ***If You do not notify* the Company *and provide the determination within these time frames, You will not be eligible for the 11-month extension of COBRA coverage.*** If coverage is extended for an additional 11 months due to Social Security disability, Your COBRA premiums will be adjusted to 150% of the full cost during the extended 11-month coverage period. It is also Your responsibility to provide a written notice to the Company's Human Resources Department within **30 days** if a final determination is made that You are no longer disabled.

Second Qualifying Event

Qualified Dependents, other than the employee, who enrolled in COBRA coverage as a result of the employee's termination of employment or reduction of work hours, who experience another Qualifying Event (divorce, legal separation, death of the covered employee, Medicare entitlement, or loss of dependent status), may extend COBRA coverage beyond 18 months (or 29 months if there has been a disability extension) to 36 months. You must provide a written notice to the Company's Human Resources Department within 60 days of the second Qualifying Event and during the original 18-month COBRA coverage period (or 29-month period if there has been a disability extension), in order to extend COBRA coverage to 36 months. The written notice must provide the individual's name and current mailing address, the specific Qualifying Event and the date the event occurred. **COBRA coverage will never extend beyond 36 months of the date of the original Qualifying Event.**

When You Acquire a New Child While On COBRA

A child who is born to or placed for adoption with You while You are enrolled in COBRA coverage can be added to Your COBRA coverage upon proper written notification to the Company's Human Resources Department (Health Care Coverage Change Form or written notice) of the birth or placement. Notification must be received within **30 days** of the date of birth or placement (if notification is not received within 30 days of the date of birth or placement, You will not be able to add the child to Your coverage until the next Open Enrollment Period). The child will be a Qualified Dependent with an individual right to continue

COBRA coverage through Your maximum COBRA period, unless You cancel his or her coverage or one of the events permitting extension or termination occurs.

If You Become Entitled To Medicare Before Electing COBRA

If You become entitled to (i.e., enrolled in) Medicare before electing COBRA in connection with a termination of employment or reduction in hours Qualifying Event, You may maintain both Medicare and up to 18 months of COBRA coverage and Your Enrolled Dependents will be allowed to continue their COBRA coverage until the later of: up to 18 months from the Qualifying Event date, or up to 36 months from the date You became entitled to Medicare.

Electing Coverage

Qualified Dependents have **60 days** from the date of the Qualifying Event or if later, from the date of the notice offering COBRA, to elect COBRA coverage. (You are not eligible to elect COBRA coverage and this paragraph does not apply to You if You, Your spouse, or child failed to notify the Company's Human Resources Department of a divorce or legal separation, or a child losing dependent status within **60 days** of the event, as required by COBRA.) If neither You nor Your spouse, or child(ren) elect COBRA continuation coverage during the applicable election period, Your health care coverage will end in accordance with this Summary Plan Description. The Plan will not pay claims for services provided on and after the date coverage ends and You and Your dependents will have no right to elect COBRA coverage at a later date. If Claimants are not eligible for COBRA continuation coverage, they may be eligible for an individual conversion-type plan.

COBRA Premium Payments

If You elect COBRA coverage, You will be responsible to pay the full cost of coverage plus a 2% administration fee (except for the increased cost for the 11-month extension of coverage due to Social Security disability). The COBRA premiums, including this fee, will be listed on the "Notice of Right to Elect Continuation Coverage (COBRA)" that will be sent to You by ARUP Laboratories, Inc.

Initial Payment

Payment must be received by the COBRA Administrator within **45 days** of the date You elect COBRA coverage. Your first premium payment will include premiums due retroactive to the date You lost coverage as a result of Your Qualifying Event. If Your first payment is not received timely, COBRA coverage will not be effective and You will lose all rights to COBRA coverage.

Subsequent Payments

Payment for each subsequent period is **due on the first day of each month**. You will have a 30-day grace period from the premium due date to make subsequent payments. If the COBRA premiums are not paid within the grace period, Your COBRA coverage will terminate as of the end of the last period for which payment was received and You will lose all further rights to continue COBRA coverage.

Changes in COBRA Coverage

You will have the same rights to enroll dependents and change elections with respect to ARUP Laboratories, Inc. health plan as similarly situated active employees of the Company. Changes to coverage may be made during the Company's Open Enrollment Period each year.

Financial Aid

Some states offer financial aid to help certain individuals pay for COBRA coverage. Contact Your appropriate state agency regarding availability and eligibility requirements.

When COBRA Continuation Coverage Ends

COBRA continuation under the Plan will end for You and/or Your Enrolled Dependents if any of the following occurs:

- The required premium payments are not paid within the timeframe allowed; You notify the COBRA administrator that You wish to cancel Your coverage;
- The applicable period of COBRA coverage ends;
- You become entitled to Medicare benefits;

- Plan Sponsor terminates its group health plan(s);
- You have extended COBRA coverage due to Social Security disability and a final determination is made that You are no longer disabled, coverage for all Claimants who had qualified for the disability extension will end as of the later of:
    - the last day of 18 months of continuation coverage, or
    - the first day of the month that is more than 30 days following the date of the final determination of the non-disability;
- After the date of Your COBRA election, You become covered under another group health plan that does not contain any exclusion or limitation for any of Your pre-existing conditions. If the other plan's pre-existing condition rule does not apply to You by reason of HIPAA's restrictions on pre-existing conditions clauses, You are no longer eligible to continue COBRA coverage; or
- An event occurs that permits termination of coverage under ARUP Laboratories, Inc. Employee Health Care Plan for an individual covered other than pursuant to COBRA (e.g., submitting fraudulent claims).

Conversion or Transfer to an Individual Policy

At the end of Your applicable maximum COBRA period, You may be allowed to convert Your coverage to an individual insurance policy.

Questions, Notices, and Address Change

It is your responsibility to timely notify the Cobra Administrator of any address change. This section does not fully describe COBRA coverage. For additional information about Your rights and obligations under the Plan and under federal law, contact ARUP Laboratories' Human Resources Department or the COBRA Administrator. For more information about Your rights under COBRA 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) in your area or visit the EBSA website at www.dol.gov/ebsa. COBRA administrator contact information:

COBRA Administrator
GBS Compliance Services
465 South 400 East #300
Salt Lake City, Utah 84111
Phone: (801) 364-7233

If You divorce or legally separate, or lose eligibility as a child under ARUP Laboratories, Inc. Employee Health Care Plan, You must provide the required written notice to the Company's COBRA Administrator within 60 days.

CLAIMS ADMINISTRATION

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

PLAN IDENTIFICATION CARDS

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

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

If You lose Your card, or if it gets destroyed, You can get a new one by calling the Claims Administrator's Customer Service department at: (801) 213-4008 or (833) 981-0213, or by visiting the Claims Administrator's website at **www.uhealthplan.utah.edu**. If the Plan terminates, Your Plan identification card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

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

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

TIMELY FILING OF CLAIMS

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

IN-NETWORK CLAIMS

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

In-Network Reimbursement

An In-Network Provider will be paid directly for Covered Services. These Providers have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount is any amount You must pay due to Copayment and/or Coinsurance. These Providers may require You to pay Your share at the time You receive care or treatment.

Ambulance Claims

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

OUT-OF-NETWORK PROVIDER SERVICES

Emergency Health Services will be covered as In-Network.

WORLDWIDE

Worldwide coverage is also accessible to You for Emergency Health Services. These services will be covered at the In-Network benefit level. Non-emergent care is not covered outside of the United States.

When You need health care outside of the United States follow these simple steps:

- Always carry Your current Plan identification card.
- If You need emergency medical care, go to the nearest Hospital.

You may be responsible for paying the Hospital or Physician at the time of service and then must complete a claim form and send it to the Claims Administrator for reimbursement of Covered Services.

You can obtain the claim form at **www.uhealthplan.utah.edu/aruplabs.**

NON ASSIGNMENT

Only You are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else and You (or a custodial parent, legal guardian or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits or payments to any person, corporation or entity (including Your health care providers). Any attempted assignment, transfer or delegation of benefits will be considered null and void and will not be binding on the Plan.

You may not assign, transfer or delegate any right of representation or collection other than to legal counsel directly authorized by You on a case-by-case basis. The Plan reserves all rights to enforce this provision even if it chooses, in its sole discretion, to directly pay Out-of-Network Providers.

CLAIMS RECOVERY

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

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

For the recovery of overpayments related to the coordination of Primary and Secondary Health Plan Benefits, refer to the Coordination of Benefits section.

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

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

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

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

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

- billing statements
- claim records
- correspondence
- dental records
- diagnostic imaging reports
- Hospital records (including nursing records and progress notes)
- laboratory reports
- medical records

The Claims Administrator is required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by calling the Claims Administrator's Customer Service department at: (801) 213-4008 or (833) 981-0213 or visiting their Web site **www.uhealthplan.utah.edu**.

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

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

LIMITATIONS ON LIABILITY

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

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

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

Coverage under the Plan will not be provided for any medical (or dental and vision, if applicable) or prescription medication expenses You incur for treatment of an Injury or Illness if the costs associated with the Injury or Illness may be recoverable from any of the following:

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

ADVANCEMENT OF BENEFITS

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

- You automatically assign to the Plan any right You may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of reimbursable payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to You or paid to another for You. By accepting or claiming benefits, You agree that the Plan is entitled to reimbursement of the full amount of benefits paid out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which benefits under the Plan have been provided.

- In addition to the Plan's right of reimbursement, the Claims Administrator may choose instead to achieve the Plan's rights through subrogation. The Claims Administrator is authorized, but not obligated, to recover any benefits paid under the Plan directly from any party liable to You, upon mailing of a written notice to the potential payer, to You or to Your representative.

This assignment applies on a first dollar basis, applies whether the funds paid to (or for the benefit of) You constitute a full or a partial recovery, applies regardless of the type of damages claimed, and even to funds paid for non-medical or dental charges, attorney fees, or other costs and expenses. The Plan's rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment or other characterization of the recovery by the Claimant and/or any third party or the recovery source. The Plan is entitled to reimbursement from the first dollars received from any recovery. This applies regardless of whether:

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

Reimbursement or subrogation under the Plan will not be reduced due to You not being made whole. You may be required to sign and deliver all legal papers and take any other actions requested to secure the Plan's rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third party or other source). If You are asked to sign a trust agreement or other document to reimburse the Plan from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.

You must agree that nothing will be done to prejudice the Plan's rights and that You will cooperate fully with the Claims Administrator, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the Claims Administrator of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:

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

You and/or Your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to Your benefit or on Your behalf that in any manner relates to the Injury or Illness giving rise to the Plan's right of reimbursement or subrogation, until the Plan's right is satisfied or released.
In the event You and/or Your agent or attorney fails to comply with any of these conditions, any such benefits advanced for any Illness or Injury may be recovered through legal action.

Any benefits provided or advanced under the Plan are provided solely to assist You. By paying such benefits, neither the Plan nor the Claims Administrator is acting as a volunteer and is not waiving any right to reimbursement or subrogation.

MOTOR VEHICLE COVERAGE

If You are involved in a motor vehicle accident (including, but not limited to automobiles, boats, motorcycles, ATVs, etc.), You may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, this right of reimbursement and subrogation provision still applies.

WORKER'S COMPENSATION

Here are some rules, which apply in situations where a workers' compensation claim has been filed: You must notify the Claims Administrator in writing within five days of any of the following:

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

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

FEES AND EXPENSES

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

FUTURE MEDICAL EXPENSES

Benefits for otherwise Covered Services may be excluded, as follows:

- When You have received a recovery from another source relating to an Illness or Injury for which benefits under the Plan have been previously paid.
- Until the total amount excluded under this provision equals the third-party recovery.
- The amount of any exclusion under this provision, however, will not exceed the amount of benefits previously paid in connection with the Illness or Injury for which the recovery has been made.

CLAIMS AND APPEALS PROCEDURE–MEDICAL & MENTAL HEALTH BENEFITS

GENERAL

The Claims Administrator has the exclusive and sole discretionary authority to interpret the provisions of the Plan and make claim determinations. Determinations made by the Claims Administrator are conclusive and binding unless found by a court to be arbitrary and capricious. The Claims Administrator will issue written claim and appeal determinations to You satisfying the content requirements imposed PPACA.

TYPES OF CLAIMS

The time deadline for issuing claim determinations depends on the type of claim. The three categories of claims are:

- *Urgent Care Claim* is a claim where failing to make a determination quickly could seriously jeopardize a Claimant's life, health, or ability to regain maximum function, or could subject the Claimant to severe pain that could not be managed without the requested treatment. A licensed physician with knowledge of the Claimant's medical condition may determine if a claim is an Urgent Care Claim.

- *Pre-Service Claim* is a claim for which the Claimant is required to get advance approval or pre-certification before obtaining service or treatment for medical services.

- *Post-Service Claim* is a request for payment for covered services the Claimant has already received.

Time Limits and Content Requirements for Claim Determinations

A Claimant will be notified of any determination on a claim (whether favorable or unfavorable) as soon as reasonably possible but in no event beyond the maximum time limits described below.

Time Limit	**Urgent Care Claim**	**Pre-Service Claim**	**Post-Service Claim**
To make initial claim determination	72 hours	15 days	30 days
Extension (with proper notice and if delay is due to matters beyond Group Health Plan's control)	None	15 days	15 days
To request missing information from claimant	24 hours	5 days	30 days
For claimant to provide missing information	48 hours	45 days	45 days
For claimant to request extension of course of treatment	24 hours before expiration of previously approved course of treatment	15 days before expiration of previously approved course of treatment	Not applicable

Except for Urgent Care Claims (where notification may be oral if followed by written notice within three days), the Claimant will receive written notice if the claim is wholly or partially denied, containing the following information, if applicable:

- The specific reason or reasons for the adverse determination;

- Reference to the specific Plan provision(s) on which the determination was made;

- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;

- 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;

- If an adverse determination is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided free of charge upon request; and

- If the adverse determination is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, or a statement that such explanation will be provided free of charge upon request.

APPEALS

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action under the Plan and wishes to have it reviewed, You may Appeal. There are **two (2)** levels of Appeal, as well as additional voluntary Appeal levels You may pursue.

All Appeals, except voluntary external review, must be pursued within **180 days** of Your receipt of Our original adverse decision that You are appealing. If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and the Claims Administrator's decision will be final and binding. This means that you will waive all appeal rights concerning the claim, and waive your right to file a lawsuit concerning the claim. When an Appeal request is received, we will send a written acknowledgement and information describing the entire Appeal process and Your rights.

The Claims Administrator will decide all appeals as soon as reasonably possible but in no event beyond the maximum time limits described below.

- Urgent Care Claim – 72 hours; the claimant will be notified orally and written notice will be provided within three days
- Pre-Service Claim – 15 days
- Post-Service Claim – 30 days

1st LEVEL INTERNAL APPEAL

A covered person may initiate a 1st level internal appeal within 180 days of the original adverse decision date. 1st level appeals will be reviewed by an appeals committee chairperson. A request for review, including for Urgent appeals, must contain the Claimant's name and address, the date that the Claimant received notice that the claim was denied, and the reason(s) for disputing the denial. The Claimant may submit written comments, documents, records, and other information relating to the claim. The Claimant may submit a written request for copies, free of charge, all documents, records and other information relevant to the claim.

1st Level appeals can be submitted by:

- **Verbal** requests can be made by calling the Claims Administrator at (801) 213-4008 or (833) 981-0213
- **Online** requests can be made through our website at www.uhealthplan.utah.edu
- **Written** requests can be mailed to:

  University of Utah Health Plans
  Attn: Appeals Committee Chairperson
  P.O. Box 45180
  Salt Lake City, UT 84145

2nd LEVEL INTERNAL APPEAL

A covered person may initiate a 2nd level internal appeal within 60 days of the first level appeal decision date. 2nd level appeals will be reviewed by an appeals committee chairperson who was not involved in the original or 1st level appeal. A request for review must contain the Claimant's name and address, the date that the Claimant received notice that the claim was denied, and the reason(s) for disputing the denial. The Claimant may submit written comments, documents, records, and other information relating to the claim. The Claimant may submit a written request for copies, free of charge, all documents, records and other information relevant to the claim.

2nd Level appeals can be submitted by:

- **Verbal** requests can be made by calling the Claims Administrator at (801) 213-4008 or (833) 981-0213
- **Online** requests can be made through our website at www.uhealthplan.utah.edu
- **Written** requests can be mailed to:

  University of Utah Health Plans
  Attn: Appeals Committee Chairperson
  P.O. Box 45180
  Salt Lake City, UT 84145

VOLUNTARY EXTERNAL APPEAL - IRO

A voluntary external Appeal to an Independent Review Organization (IRO) is available for issues involving medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service); or the determination that a treatment is Investigational, but only after You have exhausted all of the applicable non-voluntary levels of Appeal, or if We have failed to adhere to all claims and internal Appeal requirements.

Voluntary external Appeals must be requested within 120 days and/or 4 months from the receipt of the notice of adverse decision. The Claims Administrator coordinates voluntary external Appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the Appeal documentation. The IRO will make its decision and provide You with its written determination within 45 days after receipt of the request.

Choosing the voluntary external Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section, except to the extent other remedies are available under State or Federal law.

VOLUNTARY EXPEDITED APPEAL - IRO

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

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

The voluntary external Appeal by an IRO is optional and You should know that other forums may be utilized as the final level of Appeal to resolve a dispute You have under the Plan.

INFORMATION

If You have any questions about the Appeal process outlined here, You may contact the Claims Administrator's Customer Service department at: (801) 213-4008 or (833) 981-0213 or You can write to the Claims Administrator's Customer Service department at the following address: University of Utah Health Plans, P.O. BOX 45180, Salt Lake City, UT 84145.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

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

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

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary expedited Appeals and voluntary external Appeals, through an independent contractor relationship with the Claims Administrator and/or through assignment to the Claims Administrator via state regulatory requirements. The IRO is unbiased and is not controlled by the Claims Administrator.

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

Exhaustion of Administrative Remedies

You may not file a lawsuit in a court of law concerning a claim until You exhaust all administrative remedies available to You under this Plan as described above (this does not include optional appeals). If You fail to exhaust the administrative remedies available to You (for example, You fail to timely file a claim or appeal concerning denied benefits), You cannot file a lawsuit in court and the Claims Administrator's determination will be final and binding.

A determination made by the Plan will only be overturned if a court of law determines the decision to be arbitrary and capricious.

Limitation on Time to File Lawsuits

If You exhaust all administrative remedies available to You as discussed above and You wish to file a lawsuit in a court of law, You must file the lawsuit no later than **one (1) year** following Your exhaustion of Your administrative remedies.

PLAN ADMINISTRATION

The Plan Administrator administers the Plan. The Plan Administrator has full discretionary authority to:

1. administer and interpret the Plan;
2. determine eligibility for and the amount of benefits;
3. determine the status and rights of participants, beneficiaries and other persons;
4. make rulings and factual determinations;
5. make regulations and prescribe procedures;
6. gather needed information;
7. prescribe forms;
8. exercise all power and authority contemplated the Internal Revenue Code and all other laws with respect to the Plan;
9. employ or appoint persons to help or advise in any administrative functions, such as a Claims Administrator and other service providers; and
10. generally perform necessary functions to operate, manage and administer the Plan

GENERAL PROVISIONS

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

CHOICE OF FORUM

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

PLAN IS AGENT

The Plan is Your agent for all purposes under the Plan and not the agent of UNIVERSITY OF UTAH HEALTH PLANS. You are entitled to health care benefits pursuant to the Plan. In the Agreement, the Plan agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in the Summary Plan Description. Through the online enrollment form, You and as Dependents of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Summary Plan Description.

NO WAIVER

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

NOTICES

Any notice to Claimants or to the Plan required in the Plan will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Participant or to the Plan will be addressed to the Participant or to the Plan at the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address form (COA) for a Participant, it will update its records accordingly.

Additionally, the Claims Administrator may forward notice for a Participant to the Plan Sponsor or Plan if it becomes aware that it does not have a valid mailing address for the Participant.

Any notice to the Claims Administrator required in the Agreement may be given by mail addressed to: UNIVERSITY OF UTAH HEALTH PLANS, P.O. Box 45180, Salt Lake City, UT 84145; however that any notice to the Claims Administrator will not be considered to have been given to and received by it until physically received.

REPRESENTATIONS ARE NOT WARRANTIES

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

WHEN BENEFITS ARE AVAILABLE

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

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

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

DEFINITIONS

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

Affiliate means a company with which the Claims Administrator has a relationship that allows access to Providers in the state in which the Affiliate serves and includes the following companies: University of Utah Health Plans.

Allowed Amount means:

- For In-Network Providers, the amount that they have contractually agreed to accept as payment in full for a service or supply.

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

Ambulatory 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.

Claimant means a Participant or an Enrolled Dependent.

Contract Year means the period from January 1 through December 31 of the following year; however, the first Contract Year begins on the Claimant's Effective Date.

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

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

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

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

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

Emergency Health Services means health care services and supplies for the treatment of an Emergency Medical Condition.

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

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

Family means a Participant and his or her Dependents.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following: disease, Illness, Injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. A Health Intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

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

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

Illness "Illness" means a bodily disorder, Pregnancy, disease, physical sickness, Mental Illness, or functional nervous disorder of a Covered Person.

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

In-Network means the benefit reimbursement level for services that are received from a Provider who has an effective participating contract with the Claims Administrator or one of the Claims Administrator's Affiliates which designates him, her or it as a University of Utah Health Plan Provider to provide services and supplies to Claimants in accordance with the provisions of this coverage. If the Claims Administrator, or one of their Affiliates, have more than one In-Network Provider network from which the employer Group may choose for benefits under this Plan, then the Providers contracted under the network selected by the employer Group will be considered the only In-Network Providers for purposes of payment of benefits under this Plan. In-Network reimbursement is generally at the highest payment level and You will not be charged for balances beyond any Copayment and/or Coinsurance for Covered Services.

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

- If a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration (FDA) as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the medication may be provided when so used. To be considered effective for other than its FDA-approved use, it must be determined that the medication is effective for the treatment of that condition; or is determined by the Claims Administrator to be in an Investigational status.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Injury or Illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

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

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

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

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

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

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

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

Morbid Obesity means a severe state of obesity, as defined in the Claims Administrator's published medical policies.

Out-of-Network means the benefit reimbursement level for services that are received from a Provider who does not have an effective participating contract with the Claims Administrator or one of the Claims Administrator's Affiliates to provide services and supplies to Claimants. Out-of-Network reimbursement is generally the lowest payment level of all categories, and You may be billed by the Provider for balances beyond any Copayment and/or Coinsurance for Covered Services.

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

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

Plan Participant means an employee, member of an affiliated group, or surviving spouse who is eligible in accordance with this Summary Plan Description, whose application is accepted by the Plan, and who is enrolled under this Plan.

PPACA means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, and its implementing regulations and other applicable guidance issued by the agencies responsible for its implementation. In accordance with PPACA, Preventive Care benefits of the Plan are covered in accordance with guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

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

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

Rehabilitation Facility means a facility or distinct part of a facility 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.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

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

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

GENERAL PLAN INFORMATION

EMPLOYER
ARUP Laboratories, Inc.

PLAN NAME
The name of the Plan is ARUP Laboratories, Inc. Medical Benefit Plan.

PLAN YEAR
The Plan year is the twelve-month period beginning January 1 and ending on December 31.

TYPE OF PLAN
The Plan is commonly known as an employee welfare benefit plan. The Plan has been adopted to provide You certain benefits as described in this document.

PLAN FUNDING
Funding is derived first from the contributions made by the covered employees and then from general assets of ARUP Laboratories, Inc. The level of Your contributions will be set by ARUP Laboratories, Inc.
Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received.

PLAN SPONSOR AND PLAN ADMINISTRATOR
ARUP Laboratories, Inc.
500 Chipeta Way
Salt Lake City, UT 84108

PLAN SPONSOR EMPLOYER IDENTIFICATION NUMBER
87-0403206

LEGAL PROCESS
Address where a processor may serve legal process:

University of Utah
Office of General Counsel
201 President's Circle, Room 309
Salt Lake City, UT 84112

CLAIMS ADMINISTRATOR
ARUP Laboratories, Inc. has contracted with a Claims Administrator to assist the Company with claims adjudication. The Claims Administrator's name, address and telephone number are:

University of Utah Health Plans
PO Box 45180
Salt Lake City, Utah 84145
(833) 981-0213

PLAN SPONSOR'S RIGHT TO TERMINATE
ARUP Laboratories, Inc. reserves the right to amend or terminate this Plan in whole or in part, at any time, regardless of Your or Your Enrolled Dependent's health or treatment status. Amendment or termination may result in modification or termination of Your coverage and/or the coverage of Your Enrolled Dependents. Covered Services and Allowed Amount incurred prior to the Plan's amendment or termination will be paid as provided under this Summary Plan Description as it existed at the time they were incurred.

PLAN'S SPONSOR'S RIGHT TO INTERPRET THE PLAN

The Named Fiduciary and the Plan Administrator have full discretionary authority to interpret and apply all Plan provisions including, but not limited to, resolving all issues concerning eligibility and determination of benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Plan data, and perform other Plan-connected services. Final authority to interpret and apply the provisions of the Plan rests exclusively with the Plan Administrator. Decisions of the Plan Administrator made in good faith will be final and binding.

NOTICES

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT ENROLLMENT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance
3. Prostheses and
4. Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurances applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call the Claim Administrator's Customer Service department at (801)213-4008 or (833) 981-0213.

NOTICE OF NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

NOTICE OF HIPAA SPECIAL ENROLLMENT

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility of the other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 calendar days after your or your dependents coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 calendar days after the marriage, birth, or placement for adoption.

Example: When you were hired by ARUP Laboratories, Inc., you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 calendar days from the date of your marriage.

Medicaid and CHIP Coverage

You and/or your dependents who become eligible to participate in a Medicaid or CHIP premium assistance program may enroll in our health plan if application is made within sixty (60) days of eligibility for the premium assistance. If you enroll within sixty (60) days, the effective date of coverage is the first day of eligibility for the subsidy.

If you and/or your dependents lose coverage under a Medicaid or CHIP plan due to a loss of eligibility, you may enroll in our health plan if application is made within sixty (60) days of the loss of coverage. If you enroll within sixty (60) days, the effective date of coverage is the first day after your Medicaid or CHIP coverage ended.

NOTICE OF HIPAA PRIVACY PRACTICES

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.

If you have any questions about this notice, please contact ARUP Laboratories, Inc.

Who Will Follow This Notice

This notice describes the medical information practices of group health plan (the "Plan") and that of any third party that assists in the administration of Plan claims.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Plan for Plan administration purposes. This notice applies to all of the medical records we maintain. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information. We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed.

For Treatment. We may use or disclose medical information about you to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

For Payment. We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. We may also share medical information with a utilization review or pre certification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stoploss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

As Required By Law. We will disclose medical information about you when required to do so by law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

Other Situations Where We May Use and Disclose Medical Information About You

Disclosure to Health Plan Sponsor. Information may be disclosed to another health plan maintained by Group health plan for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to Group health plan personnel solely for purposes of administering benefits under the Plan.

Organ and Tissue Donation. If you are an organ donor, we 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.

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

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

Public Health Risks. We 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 recalls of products they may be using;

- 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 we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We 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.

Law Enforcement. We may release medical information if asked to do so by a 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, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at the hospital; and
- in emergency circumstances to report a crime;
- the location of the crime or victims;
- the identity, description or location of the person who committed the crime

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

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

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. You must submit your request in writing to University of Utah Health Plans, Attention: Medical Information Request at 6053 Fashion Square Drive, Suite 110, Murray, UT 84107. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

Your request must be made in writing and submitted to Group health plan. You must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list or accounting of disclosures, you must submit your request in writing to Group health plan. Your request must state a time period which may not be longer than six years and may not include dates before December 1, 2015. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request.

To request restrictions, you must make your request in writing to Group health plan. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (e.g., disclosures to your spouse).

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request Confidential communications, you must make your request in writing to Group health plan. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at University of Utah Health Plans, Attention: Medical Information Request at 6053 Fashion Square Drive, Suite 110, Murray, UT 84107.

Notification of Security Breach

If there is a breach of your unsecured protected health information, we will notify you as soon as reasonably possible—and in no event later than 60 days after we discover the breach. For a breach to occur, an unauthorized acquisition, access, use, or disclosure of unsecured protected health information has occurred which compromises the security or privacy of such information. The information's security or privacy is compromised if its disclosure brings a significant risk of financial, reputational, or other harm to the affected individual.

Changes to This Notice
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on the Plan website.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact Group health plan. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

UNIVERSITY OF UTAH HEALTH PLANS PRIVACY POLICY REGARDING PROTECTED HEALTH INFORMATION (PHI)

This notice describes how medical information about you may be used or disclosed and what your rights are in managing your health information.

Please review it carefully. We reserve the right to make changes to this notice at any time. Current notices will be available on our website at http://privacy.utah.edu/pdf/notice-of-privacy-practices-english.pdf .

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

You Have A Right To:

Get a copy of this privacy notice

Get a copy of health and claims records
You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why, in writing, within 30 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

Receive notification if there is a breach of your health information
We will notify you in writing about a breach and provide detailed information and instructions.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures, except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free, but we will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.
You can complain if you feel we have violated your rights by contacting us using the information listed below.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue SW, Washington, D.C. 20201, calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints

We will not retaliate against you for filing a complaint.

Contact the Health Information Department at (801) 587-9241 or visit our web site at http://www.privacy.utah.edu to find the right form for your request.

If you have concerns or wish to file a complaint, contact:
University of Utah Health Plans
PO Box 45180
Salt Lake City, UT 84145
(801) 213-4008
Email: uuhp@hsc.utah.edu

We will investigate all complaints and will not retaliate against you for filing a complaint. You may also file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services.

Our Organization:

This Notice describes the privacy practices of The University of Utah Health Plans. University of Utah Health Plans is required by law to:

- Maintain the privacy and security of your health information;
- Notify you promptly if a breach occurs that may have compromised the privacy or security of your health information; and
- Follow the terms and provide you a copy of the Notice currently in effect.

Privacy Promise

Privacy and Customer Service are our greatest concerns. Claims are processed quickly and confidentially. We follow strict federal and state laws that require us to maintain the confidentiality of your health information.

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you. Examples may include: A health plan administrator communicates information about your diagnosis and treatment plan so a doctor can arrange additional services.

Help ensure patient satisfaction while controlling costs to you
We can use your health information to ensure that your primary care provider receives key information to help you make informed, cost-effective choices about all of your care.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage or the price of that coverage.
  Example: We use health information about enrolled members in the aggregate to develop better services for them.

Pay for your health services
We can use and disclose your health information as we pay for your health services. *Example: We share information about you with any other insurance plans you might have to coordinate payment for services you receive.*

How else can we use or share your health information?
We are allowed or required to share your information in other ways. Non-identifying information can be used to contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues
We can share health information about you for certain situation such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law
We will share information about you if state or federal laws require it.

Address other government requests
We can use or share health information about you:

- With health oversight agencies, like the FDA, for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your Choices
For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- Confidential communications with a mental health professional (psychotherapy notes) and substance abuse treatment records

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

All other uses and disclosures, not described in this notice, require your signed authorization.
You may authorize us to use or share your health information, OR revoke your authorization at any time by completing the required form available through University of Utah Health Plans, or online at http://www.privacy.utah.edu, and submitting it to:

University of Utah Health Plans
PO Box 45180
Salt Lake City, UT 84145
(801) 213-4008
E-mail: uuhp@hsc.utah.edu

For more information about the practices and rights described in this notice:

- Visit our website at http://www.privacy.utah.edu; **OR**
- Contact the Information Privacy Office at:

  University of Utah Information Security and Privacy Office
  515 E 100 South #650
  Salt Lake City, UT 84102
  Phone: (801) 587-9241
  Fax: (801) 585-3608

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).