Employee Health Care Plan

Healthy Premier

PPO PLANS

HEALTH PLANS
UNIVERSITY OF UTAH

ARUP-PPOPREMIER
ARUP LABORATORIES, INC., EFFECTIVE JANUARY 1, 2018

ARUP LABORATORIES, INC.

MEDICAL BENEFIT PLAN

HEALTHY PREMIER PPO

SUMMARY PLAN DESCRIPTION

University of Utah Health Plans
PO Box 45180
Salt Lake City, UT 84145

www.uhealthplan.utah.edu/aruplabs/

Customer Service (801) 587-6480
(888) 271-5870
Care Management (801) 587-6480, Option 2
(888) 271-5870, Option 2

ARUP Laboratories, Inc.
500 Chipeta Way
Salt Lake City, UT 84108

(801) 583-2787, Option 1
Extension 2182

Introduction

This ARUP Laboratories, Inc. Employee Health Care Plan Summary Plan Description describes the terms and benefits of coverage effective January 1, 2018, or a later date on which Your coverage became effective. This Summary Plan Description replaces any plan description or Summary Plan Description previously issued by the Plan Sponsor and makes them void.

Benefits under this Plan will be paid only if the Plan Sponsor decides, in its sole discretion, that You are entitled to them. 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 and the Claims Administrator. The term "Plan" refers to the ARUP Laboratories, Inc. Employee Health Care Plan. "Plan Sponsor" and "Company" mean ARUP Laboratories, Inc., whose 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 the terms of the Plan as it existed at the time they were incurred.

ARUP Laboratories, Inc. also reserves the right to interpret the Plan's coverage and meaning in the exercise of its sole discretion.

Using Your Summary 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/.

WHAT IS A PPO PLAN?

A PPO Plan has a broad network of providers to choose from throughout the United States. When you see an In-Network Provider, You will not be billed for balances on Covered Services beyond any Copayment, Deductible, and/or Coinsurance. If you choose to see a provider that is outside of the network, You are responsible to pay Your Deductible and/or Coinsurance, and you may also be billed for balances above the Plan's Allowed Amount, unless the services are related to a medical emergency.

For each benefit in this Summary Plan Description, Your payment amount for In-Network and Out-of-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 was designed to provide information and answers quickly and easily.

- **Learn more and receive answers about Your coverage.** Call Customer Service at (801) 587-6480 or (888) 271-5870 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) 587-6480 or (888) 271-5870, Option 2.

Notices

NOTICE OF WOMEN'S HEALTH CANCER RIGHTS ACT

In accordance with The Women's Health and Cancer Rights Act of 1998 (WHCRA), the Policy covers mastectomy in the treatment of cancer and reconstructive surgery after a mastectomy. If you are receiving benefits in connection with a mastectomy, coverage will be provided according to the Policy's benefit and Utilization Review Management Program criteria and in a manner determined in consultation with the attending Physician and the patient, for:

1. All stages of reconstruction on 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 in all stages of mastectomy, including lymphedemas.

Coverage of mastectomies and breast reconstruction benefits are subject to applicable deductibles and copayment limitations consistent with those established for other benefits.

Medical services received more than 5 years after a surgery covered under this section will not be considered a complication of such surgery.

Following the initial reconstruction of the breast(s), any additional modification or revision to the breast(s), including results of the normal aging process, will not be covered. All benefits are payable according to the Policy's Schedule of Benefits and Summary of Benefits and Coverage (SBC).

NOTICE OF NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

In accordance with the Newborns' and Mothers' Health Protection Act of 1996, the Policy provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth. The act requires that maternity coverage provide at least a 48-hour hospital stay following childbirth (96-hour stay in the case of Cesarean section). However, the attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. In any case, the attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours for Cesarean section).

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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 and Pharmacy Expenses as specifically indicated in the Summary of Medical Benefits. Any amounts You pay towards Premiums, Out-of-Network Providers, 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 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 copays or coinsurance towards Covered Medical and Pharmacy 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 first $1,000 of expenses related to an accident are not subject to the Deductible.

DEDUCTIBLE FOR A COMMON ACCIDENT

This provision applies when two or more covered Family Members are injured in the same accident. These Family Members are not required to meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

COPAYMENTS

Copayments are the fixed dollar amount that You must pay directly to the Provider for Emergency Room visits each time You receive a specified service. Once You have satisfied Your Deductible and paid any applicable Copayment, the Plan pays 85% of the remaining Allowed Amount for Covered Services You receive, unless otherwise noted. The Copayment will be the lesser of the fixed dollar amount or the Allowed Amount for the service or medication. Refer to the Summary of Medical Benefits to understand what Copayments You are responsible for.

COINSURANCE - PERCENTAGE PAID UNDER THE PLAN

The Plan pays 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. 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 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. See the Definitions Section for descriptions of Providers.

Refer to the Summaries of Medical Benefits and Behavioral Health 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.

LIFETIME MAXIMUM BENEFIT

Per Claimant: Unlimited

CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Medical and Pharmacy copay, deductible and coinsurance)

PPO 750 PLAN

Per Claimant:	$4,000
Per Family:	$8,000

PPO 1500 PLAN

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

CALENDAR YEAR DEDUCTIBLE (Includes Medical and Pharmacy)

PPO 750 PLAN

Per Claimant:	$750
Per Family:	$1,500

PPO 1500 PLAN

Per Claimant:	$1,500
Per Family:	$3,000

COPAYMENTS, DEDUCTIBLE, AND COINSURANCE

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

ACCIDENTAL INJURY

In-Network Provider	Out-of-Network Provider
The Plan pays 100% of the Allowed Amount for the first $1,000 per person, then after Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

Accidental injury charges may be incurred for 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, covered prescription drugs, 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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Limited to 12 visits per calendar year	

ALLERGY TESTING, TREATMENT AND SERUM

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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.	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 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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.
Prior authorization required	

The Plan covers up to 600 hours per calendar year of Applied Behavior Analysis (ABA) Therapy for the treatment of autism.

CHEMOTHERAPY, RADIATION AND DIALYSIS

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

CHIROPRACTIC 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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Limited to 12 visits per calendar year	

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

The Plan will cover expenses incurred for the following services when provided by a Physician, other professional provider, and facilities necessary for treatment. (1) Oral and facial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons; (2) Habilitative speech therapy; (3) Otolaryngology treatment; (4) Audiological assessments and treatment; (5) Orthodontic treatment; (6) Prosthodontic treatment; (7) Prosthetic treatment such as obturators, speech applicances and feeding appliances.

DIABETIC COUNSELING, SUPPLIES AND 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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Prior authorization required for services over $1,500.	

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

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

In-Network Provider	Out-of-Network Provider

$150 Copayment, then after Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	$150 Copayment, then 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 emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be pre-authorized. 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.

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Prior authorization required.	

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Limited to 130 visits per calendar year.	

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Respite Care is limited to 14 days per lifetime.	

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. The Plan also covers Respite Care and Bereavement Counseling for family members.

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
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.

HOSPITAL CARE – OUTPATIENT AND AMBULATORY SERVICE FACILTY

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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.

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

The Plan covers care, supplies and services for the **diagnosis** of infertility only. Any services obtained after a diagnosis of infertility has been reached are not covered. Reproductive services are not covered.

INJECTIBLE 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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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. See the Newborn Care benefit in this Summary Plan Description to see how the care of Your newborn is covered.

MATERNITY CARE – OUTPATIENT HOSPITAL AND PHYSICIAN SERVICES

In-Network	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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

MATERNITY CARE – PRENATAL AND POSTNATAL VISITS

In-Network	Out-of-Network Provider
The Plan pays 100% of the Allowed Amount.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

MENTAL HEALTH AND CHEMICAL DEPENDENCY

	In-Network Provider	Out-of-Network Provider
Office Visit	After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Outpatient	After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Inpatient	After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Residential Treatment	After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Prior authorization required for Inpatient and Residential Treatment.		

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Limited to 40 visits per calendar year for dependent children up to age 6	

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

The Plan covers services and supplies, under the newborn's own coverage, in connection with nursery care for the natural newborn or newly adoptive child. The newborn child must be eligible and enrolled as

explained later in the Who Is Eligible, How to Enroll and When Coverage Begins Section. There is no limit for the newborn's length of inpatient stay. For the purpose of this provision, "newborn care" means the medical services provided to a newborn child following birth including well-baby Hospital nursery charges, the initial physical examination and a PKU test.

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Specialist Care	After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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.)

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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.

PREVENTIVE CARE

The following Preventive Care benefits are covered by the Plan in accordance with the Patient Protection and Affordable Care Act ("PPACA"), as amended by the Health Care and Education Reconciliation Act. As required by PPACA, Preventive Care benefits of the Plan are covered in accordance with recommendations by the United States Preventive Service Task Force ("USPSTF") with an A or B rating in the current recommendations, the Health Resources and Services Administration ("HRSA"), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC"). In the event of any conflict between PPACA and this Preventive Care benefit section, the minimum requirements of PPACA will govern. In the event any of these bodies adopts a new or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit. For a complete list of services covered under this benefit please contact Customer Service at (801) 587-6480 or (888) 271-5870.

NOTE: Certain covered Preventive services that do not meet the PPACA requirements may be covered under this Preventive Care benefit when received and billed as Preventive care. Covered Services that do not meet the PPACA requirements will be covered the same as any other Illness or Injury.

	In-Network Provider	Out-of-Network Provider
Primary Care	The Plan pays 100% of the Allowed Amount.	The Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Specialist Care	The Plan pays 100% of the Allowed Amount.	The Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

Adult and Pediatric Immunizations	The Plan pays 100% of the Allowed Amount.	The Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Elective Immunizations	The Plan pays 100% of the Allowed Amount.	The Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Preventive Screenings	The Plan pays 100% of the Allowed Amount.	The Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Breast Pumps	The Plan pays 100% of the Allowed Amount.	The Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Routine Vision and Hearing Exams	The Plan pays 100% of the Allowed Amount.	The Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Other Preventive Services	The Plan pays 100% of the Allowed Amount.	The Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

The Plan covers the preventive care services provided by a professional Provider or facility. Preventive care services include routine well-baby care, routine physical examinations, routine immunizations, routine health screenings, as well as preventive mammograms (includes 3-D mammography), preventive prostate exams, preventive colonoscopies, and skin cancer screenings. Preventive screenings and routine vision and hearing exams are limited to one per calendar year per Claimant. If a problem is found during a preventive screening, the screening and any treatment performed during the screening will still be considered preventive. Any follow-up screenings and treatment will be paid at the regular benefit. The Plan covers immunizations for adults and immunizations for children (up to 18 years of age), according to, and as recommended by, the USPSTF and the CDC.

Limited to 1 colonoscopy or mammogram – preventive or diagnostic – per year at this benefit level.

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Inpatient	After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Outpatient Limit: 36 days per calendar year		
Inpatient Limit: None		

The Plan covers outpatient rehabilitation services (physical, occupational, aquatic and speech therapy services only) and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness. Must be physician-ordered and meet medical necessity requirements.

SKILLED NURSING FACILITY (SNF) 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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Limited to 60 days per calendar year. 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.

TMJ (TEMPOROMANDIBULAR JOINT) 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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Limited to $1,000 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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Travel, meals and lodging may be reimbursed up to $10,000 per transplant	

The Plan covers services and supplies for covered transplants. A transplant recipient who is covered under this Plan and fulfills Medically Necessary criteria will be eligible for the following transplants: heart, lung, kidney, pancreas, liver, cornea, multivisceral, small bowel, islet cell and hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood).

Donor Organ Benefits

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

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

VIRTUAL VISIT

In-Network Provider	Out-of-Network Provider
The Plan pays 100% of the Allowed Amount.	Not Covered

VISION EXAMINATION

In-Network Provider	Out-of-Network Provider
The Plan pays 100% of the Allowed Amount.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Limited to 1 routine vision examination per year. Additional visits will be covered at the regular benefit level.	

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.
Limited to initial contact lenses or glasses required following cataract surgery.	

WIG (FOLLOWING CHEMOTHERAPY)

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.	After Deductible, the Plan pays 85% and You pay 15% of the Allowed Amount. This applies toward the Out-of-Pocket Maximum.
Limited to 1 per lifetime	

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) 587-6480 or (888) 271-5870, Option 2.

General Exclusions

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

WAITING PERIOD FOR PREEXISTING CONDITIONS

The Plan does not have a waiting period for Preexisting Conditions.

Enrollment Date means:

- For individuals who apply during their initial period of eligibility, Your date of hire into a benefit-eligible position with ARUP Laboratories, Inc.
- For all others (e.g., including those who applied as Late Enrollees or during a special enrollment), the Enrollment Date is the Effective Date of coverage.

GENERAL EXCLUSION EXAMPLES

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

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
    - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
    - related to a congenital disease or anomaly of a covered child that has resulted in functional defect;
- complications relating to services, supplies or medications which have not yet been approved by the United States Food and Drug Administration (FDA) or which are used for purposes other than the FDA-approved purpose; or
- complications that result from an Injury or Illness resulting from active participation in illegal activities as determined by the plan administrator.

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. However, these exclusions will not apply with regard to an otherwise Covered Service for: 1) an Injury if the Injury results from an act of domestic violence or a medical condition, including physical and mental, and regardless of whether such condition was diagnosed before the Injury, as required by federal law; or 2) a preventive service as specified under the Preventive Care and Immunizations benefit in the Medical Benefits Section.

Adoption Services

Services and supplies related to adoption expenses are not covered.

Advanced Direct Midwife

Services from an Advanced Direct Midwife are not covered. Services provided by a Certified Nurse Midwife (CNM) will be covered if birth takes place in a medical facility or at home.

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

Cosmetic/Reconstructive Services and Supplies

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

- to treat a congenital anomaly for Claimants up to age 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.

Counseling

Charges for counseling a Claimant, including the following:

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

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

Custodial Care

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

Clinical Trials

Any charges associated with participation in a clinical trial.

Dental Services

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

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 aphakic 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.

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

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

Hair Loss
Care and treatment for hair loss, including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician. Hair loss treatment is not covered unless it is precertified and is due to a congenital condition. Wigs after chemotherapy are covered by the Plan.

Hearing Care
Hearing aids (externally worn or surgically implanted) and the surgery, services and exams necessary to fit or implant them. This exclusion does not apply to cochlear implants.

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

Immunizations
Immunizations for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever.

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

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

Mental Health Services

Care or treatment of the following mental and behavioral health conditions are not covered:

- ADD/ADHD, except for the purpose of assessment and medication management;
- Adjustment disorder;
- Conduct disorders;
- Enuresis and encopresis;
- Gambling addiction;
- Grief;
- Kleptomania;
- Learning disabilities;
- Mental or emotional conditions without manifest psychiatric disorder;
- Mental retardation;
- Non-specific conditions;
- Oppositional disorders;
- Paraphilia;
- Personality disorders;
- Psychosexual disorders;
- Pyromania; and
- Tourette's.

The following costs and services are not covered:

- Behavioral modification;
- Biofeedback;
- Court committed treatment or court ordered services;
- Custodial care;
- Diagnostic work-ups to rule out organic disorders;
- Discontinuing treatment against medical advice;
- Encounter groups;
- Family therapy;
- Fitness for duty;
- Hypnosis;
- Long-term acute hospitalization;
- Massage;
- Methadone maintenance treatment;
- Office calls in conjunction with repetitive therapeutic injections;
- Psychiatric consults while admitted to a medical unit;
- Psychological evaluations for legal purposes;
- Psychotherapy while in a Skilled Nursing Facility;
- Treatment therapies for developmental delay or child developmental programs;
- Vagus nerve stimulation;
- Vocational counseling; and
- Weight control training.

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 Summary Plan Description.

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

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

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

Organ Donor Fees
Organ donor fees greater than $60,000 per transplant (requires prior authorization).

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.

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.

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

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.

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

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

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.

Reproductive Services and 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.

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.

Riot, Rebellion and Illegal Acts
Treatment for injury or illness of the Covered Person incurred in connection with actions by the Covered Person which could constitute a felony crime under applicable law and for which the Covered Person could be charged with a felony crime, whether or not the Covered Person is charged and/or convicted. This includes, but is not limited to, the following:

- Voluntarily participating in the commission of a felony; or
- Voluntarily participating in disorderly conduct, riot, or other breach of the peace; or
- Engaging in any conduct involving the illegal use or misuse of a firearm or other deadly weapon.

Self-Help, Self-Care, Training or Instructional Programs
Except as may be specifically provided in the Summary Plan Description 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; and
- 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.

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

Self-Inflicted Injuries
Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical or mental health condition.

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

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

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

Sleep Disorders
Care and treatment for sleep disorders unless deemed Medically Necessary.

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 a 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.

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 active participation in a war or insurrection.

Weight Reduction/Control
Medical or surgical treatment (including reversals), programs, or supplies that are intended to result in weight reduction, regardless of diagnosis or psychological conditions, except certain counseling required under PPACA. Bariatric surgery is not covered by the Plan.

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

Claims Administration

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

PLAN IDENTIFICATION CARD
When Participants enroll in the Plan, they will receive 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) 587-6480 or (888) 271-5870, 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 in the Coordination of Benefits provision for an exception to this timely filing rule.)

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

In-Network 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.

Out-of-Network Claims

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

- an itemized description of the services given and the charges for them;
- the date treatment was given;
- the diagnosis; and
- the patient's name, the group number, and identification numbers.

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

Out-of-Network Reimbursement

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

Reimbursement Examples: In-Network vs. Out-of-Network

Here is an example of how Your selection of In-Network and Out-of-Network Providers affects payment to Providers and Your cost sharing amount. The benefit table from the Summary of Medical Benefits (or other benefits section) would appear as follows:

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.	After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount, plus any balance from billed charges. The 30% You pay applies toward the Out-of-Pocket Maximum.

Now, let's assume that the Provider's charge for a service is $5,000 and the Allowed Amount for that charge is $3,800 for In-Network. The Plan will pay claims to an Out-of-Network Provider based on the Allowed Amount for an In-Network Provider. Finally, let's assume that You have not met the Out-of-Pocket Maximum. Here's how that Covered Service would be paid:

- In-Network Provider: the Plan would pay 85% of the Allowed Amount after You meet Deductible and then You would pay 15% of the Allowed Amount after You meet Deductible, as follows:

  - Amount Preferred Provider must reduce their contracted rate (that is, cannot charge You for): $1,200
  - **Amount to meet Your Deductible**: **$750**
  - Amount the Plan pays (85% of the $3,800 Allowed Amount less Deductible): $2,592.50
  - **Coinsurance You pay** (15% of $3,800, Allowed Amount less Deductible): **$457.50**
  - Total claim amount billed: $5,000

  - **Total amount You pay** (Deductible and coinsurance): **$1,207.50**

- Out-of-Network Provider: the Plan would pay 70% of the Allowed Amount after You meet Deductible and then You would pay 30% of the Allowed Amount after You meet Deductible, plus any balance from billed charges, as follows:

  - **Amount to meet Your Deductible**: **$750**
  - Amount the Plan pays (70% of the $3,800 Allowed Amount less Deductible): $2,135

- **Coinsurance You pay** (30% of $3,800, Allowed Amount less Deductible): **$915**
- **Balance between the Allowed Amount and Billed Charges** ($5,000-$3,800) **$1,200**
- Total claim amount billed: $5,000

- **Total amount You pay out of pocket** **$2,865**

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

Ambulance Claims

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

Claims Determinations

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

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

If the Claims Administrator seeks additional information from You, You will be allowed at least 30 days to provide the additional information. If the Claims Administrator does not receive the requested information to process the claim within the time allowed, the claim will be denied.

OUT-OF-AREA SERVICES

Services deemed as Urgent and Emergent will be covered as In-Network.

Nonparticipating Providers Outside the Claims Administrator's Service Area

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

WORLDWIDE

Worldwide coverage is also accessible to You. When You travel outside of the United States, services deemed Urgent and Emergent are covered as In-Network. All other services will be denied.

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 University of Utah Health Plans for reimbursement of Covered Services.

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

NONASSIGNMENT

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

CLAIMS RECOVERY

If a benefit to which You were not entitled is paid under the Plan, or if a person who is not eligible for benefits at all is paid under the Plan, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including a Provider of services. The Plan's right to recovery for an erroneous payment made on the Participant's or any of his or her 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 provision in this Claims Administration Section.

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

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

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

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

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

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

The Claims Administrator is required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by calling the Claims Administrator's Customer Service department at: (801) 587-6480 or (888) 271-5870 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 and 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.

Workers' Compensation

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

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

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

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

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

Future 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.

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:

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

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

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

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

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

Order of Benefit Determination

The order of benefit determination is identified by using the first of the following rules that 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 36 months of the date of service.

Secondary Health Plan Benefits

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

The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges. The Claims Administrator will:

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

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

Right to Receive and Release Needed Information

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

Right of Recovery

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

- From You, if payment was made to You. Recovery would be by reversal of payments and be limited to a period within 24 months of the overpayment, unless reversal is necessitated by Your fraudulent

act(s), fraudulent statement(s), or material misrepresentations. This Plan will be entitled to recover the amount of such excess by the reversal of payment from You and You agree to reimburse this Plan on demand for any and all such amounts. You also agree to pay this Plan interest at 18 percent per annum until such debt is paid in full, which will begin accruing the date the demand for reimbursement is made. If a third-party collection agency or attorney is used to collect the overpayment, You agree to pay collection fees incurred, including, but not limited to, any court costs and attorney fees. If You do not pay, future benefits under this Plan may be withheld to offset the amount owing to it. The Claims Administrator is responsible for making proper adjustments between insurers and Providers.

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

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

Appeal Process – Medical and Mental Health Benefits

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 is an initial Appeal, as well as additional voluntary Appeal levels You may pursue. Certain matters requiring quicker consideration qualify for a level of expedited Appeal and are described separately later in this section.

APPEALS
Appeals can be initiated through written or verbal request or online at www.uhealthplan.utah.edu. A written request can be made by sending it to the Appeals Committee Chairperson at: University of Utah Health Plans, P.O. Box 45180, SLC, UT 84145. Verbal requests can be made by calling Customer Service at (801) 587-6480 or (888) 271-5870.

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 may jeopardize Your ability to pursue the matter in any forum. When an Appeal request is received, We will send a written acknowledgement and information describing the entire Appeal process and Your rights.

If Your treating Provider determines that Your health could be jeopardized by waiting for a decision under the regular Appeal process, he or she may specifically request an expedited Appeal. Please see Expedited Appeals later in this section for more information.

Initial Appeals
Initial Appeals are reviewed by an employee or employees who were not involved in the initial decision that You are appealing. In Appeals that involve issues requiring medical judgment, the decision is made by Our staff of health care professionals. A written notice of the decision will be sent within 45 days of receipt of the Appeal.

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 180 days of Your receipt of the notice of the prior adverse decision.

University of Utah Health Plans coordinates voluntary external Appeals, but the decision is made by an IRO at no cost to You. We 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. To request an IRO, a written request can be made by sending it to the Appeals Committee Chairperson at: University of Utah Health Plans, P.O. Box 45180, SLC, UT 84145. Verbal requests can be made by calling Customer Service at (801) 587-6480 or (888) 271-5870.

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.

EXPEDITED APPEALS
An expedited Appeal is available if one of the following applies:

- the application of regular Appeal timeframes on a Pre-Service or concurrent care claim could jeopardize Your life, health or ability to regain maximum function; or

- according to a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

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

Voluntary Expedited Appeal - IRO
If You disagree with the decision made in the panel-level Appeal and You or Your Representative reasonably believes that preauthorization remains clinically urgent (Pre-Service), 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.

University of Utah Health Plans 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 Our Customer Service department at: (801) 587-6480 or (888) 271-5870 or You can write to Our Customer Service department at the following address: University of Utah Health Plans, P.O. Box 45180, SLC, 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 University of Utah Health Plans and/or through assignment to Us via state regulatory requirements. The IRO is unbiased and is not controlled by the Plan.

Medical Director means for purposes of the Appeal process only, a Physician employed by, or consulted by, the Plan. The Medical Director will reserve the right, if not appropriately qualified to review a particular procedure, to consult with an outside Practitioner with specialty in the medical condition/procedure involved in the review.

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

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

Representative means someone who represents You for the purpose of the Appeal. The Representative may be Your personal Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the 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.

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 Other Continuation Options, the terms "You" and "Your" mean the Plan Participant only.

Employees
You are eligible to enroll in this Plan if You are an ARUP Laboratories, Inc. employee in a benefit-eligible position:

Dependents
Your Eligible Dependents (defined below) are eligible for coverage on the date You become eligible for coverage or any applicable date if You add them as dependents. Eligible Dependents are limited to the following:

- The person to whom You are legally married (spouse);
- Your domestic partner, provided that:
  - both You and Your domestic partner are age 18 or older;
  - You and Your domestic partner reside together in a permanent residence and have done so for at least 12 months and will remain members of the same household for the period of coverage;
  - You and Your domestic partner share a committed relationship and intend to continue that relationship indefinitely;
  - You and Your domestic partner are emotionally committed to one another and jointly responsible for the common welfare and financial obligations of the household or one is chiefly dependent upon the other for financial assistance;
  - neither You nor Your domestic partner are legally married to anyone else or the domestic partner of anyone else;
  - You and Your domestic partner are not related in any way that would prohibit legal marriage in Your state of residence; and
- Your (or Your spouse's or Your domestic partner's) children by birth, placement for legal adoption or foster care, or legal (court-appointed) guardianship granting full guardianship rights, who are under age 26;
- a child who is under 18 years of age for whom the noncustodial parent is required by a court order or administrative order to provide health coverage, whether or not the custodial parent is a Plan Participant and whether or not the noncustodial parent, who is eligible for this coverage, has enrolled hereunder. If You are not already enrolled in coverage, upon receipt of a court order, You will automatically be enrolled in the same coverage as the child; and
- a child, as described in the third bullet above, who is any age and incapacitated from earning a living and without sufficient means for whom the noncustodial parent is required by a court order or administrative order to provide health coverage, whether or not the custodial parent is a Plan Participant and whether or not the noncustodial parent, who is eligible for this coverage, has enrolled hereunder. If You are not already enrolled in coverage, upon receipt of a court order, You will automatically be enrolled in the same coverage as the child.

Dependent Coverage Continuing Beyond Limiting Age
- You may continue coverage for Your (or Your spouse's or Your domestic partner'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 ARUP Laboratories' 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.

You must promptly furnish or cause to be furnished to ARUP Laboratories' Human Resources Department any information necessary or appropriate to determine the validity of a dependent's status. Receipt of such information by ARUP Laboratories' 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 ARUP Laboratories' Human Resources Department when the dependent is no longer eligible under these exceptions.

DEFINITIONS SPECIFIC TO THE 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.

How to Enroll and When Coverage Begins

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

WHEN YOU AND YOUR DEPENDENTS ARE INITIALLY ELIGIBLE

You become eligible for coverage on the first day of the month after 30 days from when 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. Upon first becoming eligible for coverage at ARUP Laboratories, Inc., You may enroll Yourself and Your Eligible Dependents within 60 days of Your benefit eligibility date.

NEWLY ELIGIBLE DEPENDENTS

If You acquire a new dependent by marriage, birth or placement for adoption, or newly qualifying as a domestic partnership, You may enroll Yourself, the newly eligible dependent, and any other Eligible Dependents not already enrolled by completing a Life Status Event within 60 days of the date the dependent becomes eligible. Upon acceptance of Your life event, coverage for Your dependent will be effective retroactive to the date the dependent gained eligibility or, at Your request, coverage may be effective on the date ARUP Laboratories accepts Your life event. If the Life Status Event is not submitted within 60 days of the date the dependent gains eligibility, You may add the dependent to Your coverage only during the Plan's future Open Enrollment Periods, if any.

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. The Special Enrollment period lasts for 60 days beginning with the day of the triggering event. In each situation, You must submit a Life Status Event within the Special Enrollment period. 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 situations 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; or exhaustion of any Lifetime Maximum on total benefits;
- 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.

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 (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.

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 60 calendar days of moving outside of this Plan's coverage area.

ENROLLMENT BY OTHERS

In the event Your child is the subject of a court or administrative order requiring You to provide health coverage for the child and You are eligible for health coverage including the child, but fail to make application to cover the child, application for enrollment of the child may be made by the child's other parent, any state Medicaid agency or by the state agency administering 42 U.S.C. 651 through 699 (the child enforcement program). 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 60 days after such date. 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.

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 ARUP Laboratories, Inc., coverage for You and Your Enrolled Dependents will end on the date the Plan is terminated. If the terms of eligibility are amended and You are in a class no longer eligible to participate in the Plan, coverage for You and Your Enrolled Dependents will end on the date the terms of eligibility are amended.

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 You or Your Enrolled Dependents' coverage under this Plan for any reason shall completely end all ARUP Laboratories' 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 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 within 60 days from the date You and/or Your Enrolled Dependent(s) gain other similar coverage. Coverage will be dropped on the effective date that other coverage was obtained.

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 within 60 days from the date of the significant increase in Your cost of coverage.

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 of Your termination or change in employment status that makes You ineligible for benefits.

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 and You and Your Enrolled Dependents will not be eligible for continuation of coverage under COBRA or for conversion of coverage 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 remain enrolled in the Plan for 36 months if they enroll under COBRA within 60 days of Your death. (see the COBRA section for additional information).

Cancellation/Discontinuance is not Rescission
Termination of Your coverage is not a rescission if it is initiated by You or one of Your personal representatives.

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., Mountain Time, 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 of such dependent's loss of eligibility within 60 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 ARUP Laboratories' 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 (unless such children remain eligible by virtue of their continuing relationship to You) at the end of the month after the date the divorce or annulment is final. You must complete a Life Status Event 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 may continue coverage under the Plan for a limited period of time according to the COBRA continuation of coverage provisions of this Summary Plan Description.

Termination of Domestic Partnership
In the event Your domestic partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet the requirements outlined in the definition of an Eligible Dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing dependent relationship with You) at the end of the month after the date of termination of the domestic partnership. You are required to submit a notarized statement within 60 days of the termination of the domestic partnership. In the event the Plan is notified within 60 calendar days of the date of dissolution, Your domestic partner (and domestic partner's children) may 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 after the child's 26th birthday (or the date the child is no longer a full-time student or incapable 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 after the date the child is removed from placement.
- For an enrolled child who is no longer an Eligible Dependent for any other cause (except by reason of Your death), eligibility ends at the end of the month after the date the child is no longer an Eligible Dependent.

You or Your dependent must complete a Life Status Event of an Enrolled Dependent's ineligibility under the Plan. In the event You complete the online notification to the Plan within **60 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 and You and Your Enrolled Dependents will not be eligible for continuation of coverage under COBRA or for conversion of coverage. In addition, any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be subject to corrective action up to and including termination of employment with the University of Utah Hospitals and Clinics, and may be guilty of a criminal act punishable under law and subject to civil penalties.

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 extending no more than six months cumulative between any leave type that occurred in a rolling calendar year. Premium payments must be made through the Plan Sponsor in order to maintain coverage during **any type of an employer-certified leave of absence.**
>
> A leave of absence is a period of time off work granted by the Employer at the Employee's request during which the Employee is still considered to be employed and is carried on the employment records of the Plan Sponsor. A leave can be granted for any reason acceptable to the employer.
>
> If the Employee and/or covered dependents elect not to remain enrolled during the leave of absence, the Employee (and/or covered dependents) may re-enroll under the Plan only during the next annual open enrollment period.

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

FAMILY MEDICAL LEAVE ACT

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

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

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

COBRA Continuation of Coverage

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

In order to preserve Your rights under COBRA, You must meet certain notification, election, and payment deadline requirements. Those requirements are described below.

Qualifying Events

Qualifying Events are certain events defined by COBRA regulations that cause an individual to lose health care coverage. Qualifying Events that trigger Your right to COBRA coverage are:

- voluntary or involuntary termination of the Plan Participant's employment for reasons other than gross misconduct;
- voluntary or involuntary termination of appointment as a member of an affiliated group for reasons other than gross misconduct;
- reduced hours of work for the Plan Participant, resulting in ineligibility for coverage;
- divorce or legal separation of the Plan Participant;
- death of the Plan Participant;
- loss of status as an "Eligible child" under Plan rules;
- the Plan Participant becomes entitled to Medicare, resulting in ineligibility for coverage; or
- the employer files a Chapter 11 bankruptcy (only applicable to retired employees and their dependents covered under the Retiree Health Care Plan).

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

When and How You Must Give Notice

You, Your spouse, domestic partner, or child must notify ARUP Laboratories' 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, domestic partner, 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 ARUP Laboratories' 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 ARUP Laboratories' Human Resources Department within **60 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 ARUP Laboratories' 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

Each individual who was covered under the Plan on the day before the Qualifying Event is a "Qualified Dependent" and has independent rights to purchase COBRA coverage. An exception to this rule applies if coverage is reduced or eliminated in anticipation of a Qualifying Event. COBRA coverage may still be available to a spouse or child who has been dropped from coverage in anticipation of divorce or legal separation. In this case, COBRA coverage will be effective upon the date of divorce or separation, not the date that coverage was terminated, and will only be available provided that, but for the lost coverage, the spouse or child would otherwise have been eligible. Qualified Dependent includes the covered employee, employee's spouse, domestic partner, and child or children.

Individual Election Rights

Each Qualified Dependent can elect COBRA coverage independently, even if the covered employee chooses not to elect COBRA coverage. COBRA coverage is available to each person who had coverage on the day before the Qualifying Event.

Length of COBRA Coverage

The length of COBRA coverage offered depends on Your Qualifying Event. If the Qualifying Event is termination of employment or a reduction of work hours, Qualified Dependents are given the opportunity to continue COBRA coverage for 18 months. If the Qualifying Event is death of the covered employee, divorce or legal separation, or loss of dependent status, COBRA coverage is available for 36 months. If a Qualified Dependent is determined to have been disabled on the date of the Qualifying Event or during the first 60 days of COBRA coverage, additional coverage may be available (see Social Security Disability below).

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 ARUP Laboratories, within **60 days** after the date of the determination. The Social Security Administration determination must occur and You must notify ARUP Laboratories' Human Resources Department before the end of the original 18-month period. ***If You do not notify*** **ARUP Laboratories** ***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 NBS within **60 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 ARUP Laboratories' 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 ARUP Laboratories' Human Resources Department (Health Care Coverage Change Form or written notice) of the birth or placement. Notification must be received within **60 days** of the date of birth or placement (if notification is not received within 60 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 Are Retired and ARUP Laboratories, Inc. Files Chapter 11 Bankruptcy

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

If You Become Entitled To Medicare Before Electing COBRA

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

- up to 18 months from the 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, domestic partner, or child failed to notify ARUP Laboratories' 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, domestic partner, or child(ren) elect COBRA continuation coverage during the applicable election period, Your health care coverage will end according to the terms of the Plan. 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. 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 ARUP Laboratories 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.

Trade Adjustment Assistance (TAA)

If You are a TAA-eligible individual and do not elect continuation coverage during the 60-day COBRA election period that was a direct consequence of the TAA-related loss of coverage, You may elect continuation coverage during a **second** 60-day election period that begins on the first day of the month in which You are determined to be eligible. Provided such election is made not later than 6 months after the date of the TAA-related loss of coverage. Continuation coverage elected during the second election period will begin with the first day of the second election period, and not on the date on which coverage originally lapsed. In addition, TAA eligible persons could be eligible for a tax credit.

Changes in COBRA Coverage

You will have the same rights to enroll dependents and change elections with respect to ARUP Laboratories health plan as similarly situated active employees of ARUP Laboratories, Inc. Changes to coverage may be made during ARUP Laboratories 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;
- ARUP Laboratories, Inc. 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 health 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. See the Conversion Section for details.

Questions, Notices, and 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.

If You divorce or legally separate, no longer qualify as a domestic partnership, or lose eligibility as a child under ARUP Laboratories Health Care Plan, You must provide the required written notice to ARUP Laboratories Human Resources Department within 60 days.

Notices

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.

Requests marked with a star (*) must be made in writing. Contact the Health Information Department at (801) 587-3887 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) 587-6480
E-mail: 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) 587-6480 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
  650 Komas Drive, Suite 102
  Salt Lake City, UT 84108
  (801) 587-9241
  Fax: (801) 587-9443

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a Participant in the Plan (which is a type of employee welfare plan called a group health plan) you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all group health plan participants shall be entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan

Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim if frivolous.

Assistance with Your Questions. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

General Provisions

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

CHOICE OF FORUM

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

GOVERNING LAW AND DISCRETIONARY LANGUAGE

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

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. You, through Your enrollment as the Participant, 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 doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be given by mail addressed to: UNIVERSITY OF UTAH HEALTH PLANS, P.O. Box 45180, Salt Lake City, UT 84145; provided, however that any notice to the Claims Administrator will not be considered to have been given to and received by it until physically received.

REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements You make by enrolling in the Plan 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.

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.
- For Out-of-Network Providers the amount the Claims Administrator has determined to be reasonable charges for Covered Services or supplies. The Allowed Amount may be based upon the amount an In-Network Provider has agreed to accept as payment in full or billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

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.

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.

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 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.

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

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.

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

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 means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy. Illness does not include any state of mental health or mental disorder.

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; or
- 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 enrollment 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 under the terms of the Plan, 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. 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 Health 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 the Group Health Plan (GHP). A GHP with different benefit plan options may describe them in one SPD or in separate SPDs for each alternative benefit plan option.

Virtual Visit means personal online care from the expert providers at University of Utah Health Care from Your phone, tablet or computer. Virtual Visits can be used for most non-emergent conditions and are available 7 days a week, from 9:00 am to 9:00 pm, including most holidays. Call 801-213-UNOW to connect.

General Plan Information

EMPLOYER
ARUP Laboratories, Inc.

PLAN NAME
The name of the Plan is Healthy Premier PPO by University of Utah Health Plans.

PLAN YEAR
The Plan year is the one year 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
ARUP Laboratories, Inc.
500 Chipeta Way
Salt Lake City, UT 84108

LEGAL PROCESS
Address where a processor may serve legal process:

University of Utah Hospitals and Clinics 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 ARUP Laboratories 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
(888) 271-5870

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 the terms of the Plan as it existed at the time they were incurred.

PLAN SPONSOR'S RIGHT TO INTERPRET THE PLAN
ARUP Laboratories, Inc. reserves the right to interpret the Plan's coverage and meaning in the exercise of its sole discretion.

Prescription Drug Benefits – Administered by ProCare Rx

PHARMACY DRUG CHARGE

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

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

COPAYMENTS

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

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

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

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

PERCENTAGES PAYABLE

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

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

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

MAIL ORDER DRUG BENEFIT OPTION

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

COVERED PRESCRIPTION DRUGS

1. All Drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, unless otherwise specifically excluded, but excludes any drugs stated as “Not Covered Under This Plan”.
2. Certain compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity. Contact the Prescription Benefit Manager (PBM) for a list of covered compounded prescriptions.
3. Insulin and other diabetic supplies when prescribed by a Physician.
4. Injectable drugs or any prescription directing administration by injection.
5. Smoking cessation medications and smoking deterrent products when prescribed by a Physician or as required by law under the PPACA.
6. Weight loss medications when prescribed by a Physician (requires prior authorization).

LIMITS TO THIS BENEFIT

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

1. Refills only up to the number of times specified by a Physician.
2. Refills up to one year from the date of order by a Physician.

EXPENSES NOT COVERED

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

1. **Administration.** Any charge for the administration of a covered Prescription Drug.
2. **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
3. **Devices.** Devices of any type, even though such devices may require a prescription. These include, but are not limited to, therapeutic devices, artificial appliances, braces, support garments, or any similar device.
4. **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A, or medications for hair growth or removal.
5. **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
6. **FDA.** Any drug not approved by the Food and Drug Administration.
7. **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.
8. **Immunizations.** Immunization agents or biological sera, except what may be required under the Preventive Care provision in PPACA.
9. **Impotence.** A charge for impotence medication.
10. **Infertility.** A charge for infertility medication.
11. **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while confined in a Hospital. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

12. **Investigational.** A drug or medicine labeled: “Caution – limited by federal law to investigational use”.

13. **Medical exclusions.** A charge excluded under the Medical Plan Exclusions.

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

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

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